Written evidence submitted by Help for Heroes

Executive Summary

- Current Government statistics do not reflect accurately the extent of mental health problems among service personnel and Veterans with statistics showing a negligible difference between the civilian and military communities; the reports of low prevalence among Veterans reflects neither what we see daily nor the international data, with far more are seeking support than official statistics suggest.

- Those in the military are less inclined to come forward for mental health support, believing that it could affect their careers. A recent H4H/YouGov survey demonstrated similar reticence in families of Veterans and serving personnel.

- There is not enough collaboration between MoD, DH, DWP, DGLG – or their agencies – to assess the scale of mental health issues accurately. Nor is there enough understanding of the impact of Government policies on those injured while serving their country. We are aware that the Veterans Board aims to improve this, but we believe third sector involvement is needed to represent the specific needs of wounded, injured and sick Veterans.

- There is a lack of information on Reservists, who are relied upon increasingly.

About H4H

H4H was set up to support serving personnel and Veterans (and families) who have suffered injuries or illness resulting from their service, no matter when they served. We believe that those prepared to put their lives second, deserve a second chance at life.

To-date we have been able to help over 19,000 men and women.

Our Hidden Wounds service, set up in 2014 using LIBOR funds, helps those living with common mental health disorders (CMD). Hidden Wounds has supported almost 2,000 individuals to date.

H4H is a member of Contact, a collaboration of military charities working with Government to improve access to mental health and wellbeing support for the armed forces community.

Current Statistics

1. Government statistics are insufficient because:
   a) The MoD does not hold information on the number of Veterans diagnosed with a mental health disorder after leaving service;
   b) Statistics fail to capture the scale of the “need” by not including those seeking support who do not meet full criteria for a diagnosable disorder;
c) Serving personnel risk being medically discharged if they have mental health issues; d) The NHS is inconsistent in the collection of data about Veterans.

2. In 2016, a King’s College London (KCL) study, commissioned by H4H, found that of those who served between 1991 and 2014, at least 61,319 might suffer from poor mental health compared to at least 6,195 who might suffer physical health problems. This contrast is not reflected in the MoD’s statistics which show mental health issues accounting for only 20% of all medical discharges.1

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<tr>
<td>Number Medically Discharged for Mental or Behavioural Disorders (RN, Army, RAF combined)</td>
<td>212</td>
<td>225</td>
<td>263</td>
<td>344</td>
<td>359</td>
<td>473</td>
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<td>Total Medically Discharged</td>
<td>1269</td>
<td>1615</td>
<td>2314</td>
<td>2714</td>
<td>2644</td>
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3. The Annual Medical Discharges in the UK Regular Armed Forces report (July 2017) states “More than half (one in two) of personnel medically discharged leave as a result of multiple medical conditions.” However, statistics only record a single reason for discharge, undermining the reliability of the entire data set. This masks the true scale of need.

4. According to MoD statistics, 3.2% of UK Armed Forces personnel were assessed with a mental disorder in 2016/17 (compared to 1.8% in 2007/2008). The report also states that only 0.2% of personnel present with PTSD.3 This does not reflect the prevalence of mental disorders after discharge. Those still serving who have concerns about their mental health may not come forward out of fear of being downgraded or discharged. The statistics also don’t show the prevalence of CMD which often presents later.

5. Little has been done to track the ongoing needs of those discharged. Canadian Armed Forces (CAF) studies have examined longer-term cumulative incidence of service-related mental health diagnosis. Those deployed 2001 – 2008 in Afghanistan showed increasing rates of mental health need.4 This suggests need increasing on return. There is a need for

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1 ‘Counting the Costs’, King’s College London, November 2015, link
2 Annual Medical Discharges in the UK Regular Armed Forces 1 April 2012 to 31 March 2017 Published 13 July 2017, link
3 UK Armed Forces Mental Health: Annual Summary & Trends Over Time, 2007/08 - 2016/17, link
4 From 13.5% initially to 20% in a 7 year follow up since return from operational duty. Operational Stress Injury and Outcomes study. Cited The 2013 Canadian Forces Mental Health Survey: Background and
longitudinal data collection on those who have left the Armed Forces to track accurately the impact of Service and plan for investment where services are most needed.

6. Discrepancy between KCL findings and Government statistics is reflected in the daily experience of our teams: almost 40% of requests H4H receives are for psychological support. Since 2014, Hidden Wounds has guided or supported 1,828 individuals, 35% for anxiety and depression, 31% for PTSD, and 7% for anger management. Anger is rarely captured in statistics as it is not a formal disorder, but it still has a profound impact.

International comparison

7. Data collected is relatively new in the UK with limited longitudinal studies on Falklands or WWII veterans. In the gathering of statistics, there is not enough granularity at point of discharge. A significant limiting factor is how we measure mental health “need”. A CAF study in 2002 noted a significant number of support-seekers did not have diagnosed conditions or meet criteria for a formal disorder. They concluded that basing “need” on a diagnosable condition alone is too simplistic. Access to support within CAF is based on presence of an “operational stress injury” which considers anyone with reduced social, occupational or psychological functioning because of their military service. Unlike the CAF, the UK data relies too heavily on the requirement for a diagnosed disorder. For example, ‘anger’ is not a diagnosis, but rather a symptom of struggle for which support is needed.

Mild Traumatic Brain Injury (mTBI)

8. The long-term effects of mTBI and the correlation with poorer mental health are a growing concern, with depression reported in over 50%. Those with an mTBI remain at elevated risk for years. Studies have noted major depression in 33%, comorbid anxiety in 76.7% and aggressive behaviour in 56.7%.

9. While mTBI appears to be low in British troops (4.4% compared to 15% in the US), there are serious concerns that differences in screening may lead to significant under-reporting. In the US, anyone within a specific blast radius or is suspected of having a head injury is screened. There is no such standard process in place for UK Armed Forces, which could explain the difference in prevalence. The impact of post-concussive symptoms is tracked even less accurately, and these are more frequently associated with later

Methods/L’Enquête de 2013 sur la santé mentale dans les Forces canadiennes: contexte et méthodes Zamorski, Mark A, MD, MHSA; Bennett, Rachel E, MSc; Boulos, David, MSc; Garber, Bryan G, MD, MSc, FRCCS; Jetly, Rakesh, MD, FRCP; et al. Canadian Journal of Psychiatry, suppl. Supplement 1 Vol. 61, Apr 2016


psychological issues.\textsuperscript{7} Post-deployment screening in the UK is far from adequate, with many cases missed, not contributing to the statistics and delaying help-seeking.

10. H4H recently secured £1.5m in LIBOR funding to develop a secure pathway of care for Veterans with very serious injuries and brain injuries (VSI-BI), because the Government has so far been unable to develop a successful model of care. More accurate statistics on prevalence and improved tracking would allow for more appropriate care. We believe this could be possible with the introduction of an exceptional tier of compensation. However, a recent Independent Medical Expert Group suggested this is not priority – H4H believes this must be reconsidered. Improved statistics would demonstrate this a priority and those with VSI-BI would not be left behind by the Government.

Reservists

11. In terms of prevalence of mental health issues between different groups within the armed forces community, we know Early Service Leavers are at increased risk. There are gaps in knowledge about the needs of Reservists, but some evidence suggests they are at increased initial risk of CMD. At 5-year follow up, operationally deployed Reservists have been found to have twice the risk of PTSD and are more likely to have significant relationship issues.\textsuperscript{8} This could be because they don’t always deploy as a unit and therefore lack the unit cohesion and social support network present in Regular forces. Upon returning, they also have no direct access to the appropriate mental health support.\textsuperscript{9}

12. MoD statistics on Reservists are poor and indicative of their overall collection of data. For our ‘Counting the Costs’ study, KCL had to submit FOI requests to source it. In the report they had to caveat findings because there was nothing available before 1995. It is unacceptable not to hold information on those who served as Reservists less than 25 years ago. However, the study estimated that out of 226,136 who served between 1991 and 2014, poor mental health affects 12,889 Veteran Reservists.\textsuperscript{10}

13. This statistical gap is acknowledged in the medical discharge statistics provided by MoD: “there may be a presence of a small unknown number of reservist personnel within the medical discharge dataset which may cause a small bias in the results.”\textsuperscript{11} Since the number of Reservist personnel in the medical discharge statistics is unknown, reliable estimates for medically discharged Reservists cannot be generated.

14. In the absence of Government investment in research, academics and charities have found it necessary to commission studies to assess the scale of the need. H4H is concerned this is

\textsuperscript{7} ibid
\textsuperscript{9} When deployed, reservists are cared for by the MoD, but when they are not deployed they are treated like every other civilian in the NHS.
\textsuperscript{10} Counting the Costs’, King’s College London, November 2015, link
\textsuperscript{11} MoD, Annual Medical Discharges in the UK Regular Armed Forces 2009/10 - 2013/14. link
not a Government priority. So far, H4H has spent over £1.7m on studies to ensure Veterans and their families are properly supported.

**Challenges to accurately assessing the “need”**

**Definition of “need”**

15. One of the biggest challenges is that existing statistics report on “diagnosed mental health conditions”. This does not accurately reflect those coming forward for mental health support who don’t meet full criteria for a recognised condition. Other nations have expanded their definition to take into consideration those who may not meet diagnostic criteria fully. When the CAF expanded their data capture to include those who were seeking support, they found almost one third of service personnel with some form of mental health “need”. The Government should consider expanding their definition of “need” to ensure those who need support are catered for.

**GP registration**

16. In 2010, the Chief Medical Officer requested all GPs record the status of Veterans. Today, not all surgeries record this information.

17. A lack of coherent thinking or data sharing among Government departments leads to huge difference in care and poorer statistics overall. This was raised by the Chief Clinical Information Officer of Birmingham and Solihull Mental Health NHS Foundation Trust in June 2017. He was talking about the impact on civilians, but the principle also applies to those transitioning from military to civilian care. The Government needs to do more to ensure consistency across departments and agencies.

**Stigma**

18. MoD statistics show a 135% increase in medical discharges due to mental and behavioural disorders since 2010/11. Witnessing peers being discharged after coming forward for help with their mental health may dissuade other serving personnel from seeking help. The MoD needs to reassess its discharge policy, the period allowed for treatment before discharge, and the scope of care offered.

19. Research suggests that approximately 60% of military personnel who experience mental health problems do not seek help. One of the most frequently reported barriers is concern about stigma. This causes difficulties assessing the extent of mental health issues in the community. Stigma is not only fear of judgement by others, and of discharge. It is often linked to a sense of being less worthy of help. Many report delaying seeking help as they

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12 The CF 2002 Supplement of the Statistics Canada Canadian Community Health Survey, link
13 ‘Sharing health data is vital to patient care, says mental health CCIO’, Evenstad, Computer Weekly, link
14 ‘Stigma as a Barrier to Seeking Health Care Among Military Personnel With Mental Health Problems’, Sharp, Fear, Rona, Wessely, Greenberg, Jones, Goodwin, 2015, Epidemiologic Reviews, link
perceive there are others “more in need”. More anti-stigma campaigns should recognise this. It is only when individuals feel they deserve support for mental health issues, as they would expect treatment for physical issues that the true scope of need will emerge.

Impact on MoD

20. H4H is concerned that there is little incentive for the MoD to improve collection of statistics on mental health issues because it might impact recruitment, expenditure, highlight issues with mental health treatment while serving, and could impact numbers of those seeking compensation.

Issues, Services, Outcomes

21. A recent study found that twice as many men in the military suffered from CMD compared to their civilian counterparts (18.7% and 9.1%). There is little awareness around CMD in the Armed Forces. We have observed almost as many coming forward for help with post traumatic symptoms (31%) as those with CMD such as depression or anxiety (35% combined). Possible reasons for this, which may contradict UK-based research stating that rates of PTSD are much lower than CMD, include:

a) Rates of PTSD are significantly under-reported. This is consistent with international findings which suggest higher prevalence of PTSD among military populations.
b) Those with PTSD feel more able to seek help than those with CMD, either because of the impact of awareness campaigns or because it is more socially acceptable.

22. For those discharged, seeking psychological support in the NHS can pose significant challenges. More consideration is needed about the seemingly mundane. Noisy waiting areas, complicated transport, crowded environments, poor punctuality, can be challenging for those with PTSD or who struggle with anger management. There needs to be more understanding of the barrier these environmental factors pose. Asking a Veteran to take public transport and wait in a noisy waiting room is the psychological equivalent to asking an amputee to visit an upstairs clinic with no lift access. Many countries offer specialist environments, tailored to the needs of those who are nervous about seeking care. They are key to research and scoping mental health need as they offer continuity of care and data collection to Veterans across their lifespan.

15 ‘Pathways into mental health care for UK veterans: a qualitative study’, Mellotte, Murphy, Rafferty & Greenberg, European Journal of Psychotraumatology, 2017, link
16 The effect on recruitment was raised by Dr Helen McCartney, a senior lecturer in defence studies at King’s College London in 2013. She said that if soldiers are routinely portrayed as “psychologically damaged and under supported victims” then the Army becomes “less attractive to young people looking for an exciting and fulfilling career”. link
17 ‘Are common mental disorders more prevalent in the UK serving military compared to the general working population?’, Goodwin, Wessely, Hotopf, Jones, Greenberg, Rona, Hull, Fear, 2015, link
23. In the UK, individuals can access Defence Community Mental Healthcare for 6 months post discharge, after which they fall under the jurisdiction of the NHS. **H4H has concerns over this when recommended models of care for complex mental health are often 18+ months. If this timeline cannot be extended, a smoother handover of responsibility from MoD to NHS must be sought to improve continuity of treatment.**

24. Challenges to accessing support have been encountered in other countries. To encourage those still serving, Canada revolutionised help-seeking pathways, differentiating between operationally and non-operationally derived mental health problems. Further, the Canadian Forces Member Assistance Programme (CFMAP), open access, confidential, short-term counselling provided by civilian clinicians, is distinct from the support available to serving members in the UK.

25. In Australia, Veterans can access private treatment for their service-attributed mental health conditions, paid for by the Government. This specialist therapy lowers waiting times and allows access to specialists in military mental health which would not be guaranteed otherwise.

26. These models would be hugely beneficial for UK Veterans, reducing waiting times and remedying Veteran’s reticence to access NHS treatment. **The Government should consider a similar model.**

27. We have observed a significant discrepancy in service and waiting times across the UK. Veterans seeking treatment for mental health issues have reported times exceeding 12 months for NHS and Combat Stress support. IAPT statistics (2014/15) show Veterans entering treatment within 6.7 days in some areas but, in others, over 100 days from referral to beginning treatment.\(^\text{18}\) Since the launch of Transition, Intervention and Liaison (TIL) services it has been difficult to access reports on wait times. **We believe TILs and Complex Treatment Services (CTS) should be required to publish wait times from the point of referral into assessment, and referral into treatment, ensuring transparency for service-users and policymakers.**

28. H4H has grant funded £1.25million to improve timely diagnosis and the treatment of Veterans experiencing mental health challenges. We have delivered £431,109 to the Pennine Care NHS Foundation Trust to recruit additional Band 7 therapists to improve support across the Greater Manchester and Lancashire area. Almost £700,000 was granted to NHS Wales and the Change Step project to enhance the support offered to Veterans and their families. Wait times have fallen from 25 to 13 weeks in the 6 months the funds have been available to NHS Pennine demonstrating that improvements can be made. **The Government needs to look again at resourcing in Trusts where wait times are exceedingly high.**

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\(^\text{18}\) Improving Access to Psychological Therapies, Waiting times for British Armed Forces veterans and their dependants: given by those entering treatment in the year 2014/15 and those completing treatment in the year 2014/15. Published September 2016, link
Other

29. The issue of attributability is complex and often requires specialist assessment of not only developmental, genetic and environmental factors. This must be done on a case by case basis.

30. In the UK, mental illness accounts for around 23% of the disease burden yet we invest less than 6% of the annual health research budget in it. H4H believe this imbalance needs to be addressed to ensure those who served their country receive the support they deserve.

6 March 2018

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19 Professor Sir Simon Wessely - Professor of Psychological Medicine, iNews, 2017, link