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Executive Summary

- Most of the UK research to date is based on epidemiological studies.
- There is no reliable information on who UK veterans are, making care provision a challenge.
- Very little research has been conducted on the social determinants of mental illness within the UK Armed Forces and in the veteran population.
- Recent developments in measuring wellbeing amongst US Serving personnel and veterans and the adoption of these validated tools in the UK, mean there are opportunities to better understand the wellbeing of UK Armed Forces personnel;
- Stigma and mental health discrimination within the UK Armed Forces need to be continually challenged.

To what extent do current statistics accurately reflect the level of mental health issues in serving armed forces personnel and veterans, including PTSD?

1. Despite the public perception and media portrayal of UK Armed Forces (UKAF) personnel as vulnerable to mental health issues (Ashcroft, 2012), this is not supported by research. Current statistics predominantly derive from a large epidemiological cohort study carried out by Kings Centre for Military Health Research (KCMHR). In general, the KCMHR findings suggest that common mental disorders such as anxiety and depression reported by both serving and ex-Service personnel reflect a similar prevalence to the general population (Fear et al., 2010, Iversen et al., 2009). Alcohol misuse is one of the most frequently reported mental health issues for UK Armed Forces military personnel deployed to Afghanistan and Iraq and is considerably higher than that of the general population (Fear et al., 2010). Levels of ‘probable’ PTSD in UK regular personnel following deployment to both of these conflicts are generally low (Fear et al., 2010; Hotopf et al., 2006), but those who deploy in a combat-related role are at an increased risk of developing PTSD; a risk which increases exponentially with the number of ‘combat intense’ experiences (MacManus et al., 2014). Compared with regular personnel, Reservists report twice the rate of ‘probable’ PTSD and common mental disorders post-deployment compared with those who did not deploy (e.g., Fear et al., 2010).

2. Due to limitations associated with the available statistics, there are gaps in our knowledge of the extent to which these statistics accurately reflect the level of mental health issues in UKAF serving personnel and veterans. Epidemiological cohort studies provide us with large numbers to broadly estimate the extent of mental health issues in the wider military population. However, because these prevalence rates are based on self-reported mental health symptoms, we cannot be sure of their accuracy. Furthermore, it is also important to consider possible self-selection bias, where
participants are not representative of the entire population. Previous KCMHR studies have also demonstrated that test-retest reliability of recall of deployment-related factors is poor (Wessely et al., 2003). Inconsistency of recall is also typically non-random due to the effects of change in the health status of participants (Iversen et al., 2009). Importantly, statistics also cannot capture those who do not present for treatment despite experiencing mental health issues (q.v.).

3. To what extent socio-political and cultural factors have implications in terms of impeding, or encouraging, military personnel to disclose mental health issues is also of key consideration. On the one hand, too much concern may increase fears of stigmatisation (Gribble et al., 2014). On the other hand, it may have a paradoxical effect, for example, by encouraging, some participants to report symptoms of PTSD in anticipation of perceived positive benefits associated with an enhanced status, recognition and potential financial recompense (Deahl et al., 2011). In addition, as highlighted in the Forces in Mind Trust review (Samele, 2013), media and popular stereotypes may contribute to inaccurate memories and beliefs that inflate traumatic memories to concur with these characterisations (Jones & Wessley, 2007).

4. Additionally, the most widely respected research based on the KCMHR cohort, only includes serving personnel and veterans from post-1991 conflicts, and as such cannot tell us about the mental health of those who were in service pre-1991. To gain an in-depth understanding of the true scope of mental health issues in the UKAF requires population level research using a mixed methods approach (i.e., comprising both quantitative and qualitative elements), which also permits the follow-up of UKAF personnel throughout their military career and their subsequent transition back to civilian life.

What are the challenges to accurately assessing the extent of mental health issues in serving armed forces personnel and veterans and how could government improve its understanding of those issues?

5. Recent moves have been initiated to address the issues of mental health stigma and discrimination in the UKAF (Coleman et al., 2017, Sharp et al., 2015), with the introduction of Trauma Risk Management (TRiM) (Jones et al., 2017), and significant funding. Yet, there are concerns re barriers to appropriate help-seeking in the military. Evidence of the impact of these new investments is extremely important, and this work needs to be commissioned as a matter of routine practice. Research that has focused on veterans suggests that hyper masculinity and weakness associated with mental illness is perceived to adversely impact on peer relationships and perceived career prospects (e.g., Fossey et al., 2017). As identified in the literature on stigma, this prevailing military-related ethos also deters help-seeking behaviour (see Clement et al. (2015) for a comprehensive review of the literature).

6. The limitations of epidemiological data have been discussed earlier (q.v.). An alternative way to determine the prevalence of mental illness could be to analyse anonymised medical records. However, it would be very difficult to obtain an

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accurate barometer of the levels of mental illness within the UKAF if a reliance is placed solely on estimates derived from Defence Medical Services (DMS) treatment figures. In part, this is because some personnel may wish to seek treatment outside of the military chain of command and receive interventions from the NHS or via private consultations. Moreover, challenges associated with poor help-seeking and reluctance to seek treatment mean that many conditions remain untreated and hidden. Currently there is no reliable system for identifying serving personnel or veterans when they seek treatment outside of the DMS and veteran-coding of NHS data is extremely poor.

7. Mental health and mental illness are complex phenomena, which should not be considered in isolation without due consideration of other potential contributory factors that may be out with military control. Physical health co-morbidities, historical (e.g., childhood abuse or deprivation), genetic and social determinants of mental illness are of equal importance (Marmot et al., 2008).

8. Although the Chilcot Inquiry\(^2\) concluded that the ‘...Ministry of Defence planned and prepared effectively to provide medical care in support of Operation Telic’, a subsequent BMJ Editorial\(^3\) highlighted that the long term outcomes for those Service personnel who survived injuries that once would have been fatal remains unknown (Greenberg et al., 2016) thereby endorsing the need for long term prospective studies. The 20 years rehabilitation outcome of the Armed Services Trauma Rehabilitation Outcome (ADVANCE) study led by Defence Rehabilitation will be critical in enhancing our understanding of the physical and psychosocial challenges faced by those military personnel who sustained the most severe injuries as a consequence of deployment to recent conflicts in Iraq and Afghanistan (Etherington et al., 2016; Greenberg et al., 2016).

9. Changes in mental wellbeing (or hygiene) are predictors of mental ill health but are not routinely measured in the UK population and are not measured in the military context. In the USA, work has been undertaken to consider the wellbeing of Service personnel, especially during the transition phase\(^4\) and an instrument has been developed and validated for use with this military population (Wellbeing Inventory) (Vogt et al, In Press). We are currently working to validate this tool for a UK military/veteran population\(^5\). Similar to the US Department of Defence work, a similar approach could be adopted in the UK with regular and consistent measurement of wellbeing, a proxy indicator for mental health.

10. The WBI is a multi-variant instrument, where individual responses across a range of domains (housing, finance, education/employment and personal relationships) are considered, and appropriate and timely interventions could be provided if required. These social determinants of mental health would benefit from an appropriate response. Some of our allies, such as the USA and Canada, have uniformed social workers to provide holistic care\(^6\). Welfare support at a unit level could be augmented

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\(^3\) Entitled ‘Chilcot: physical and mental legacy of Iraq war on UK service personnel’.
\(^4\) http://www.hjfcp3.org/tvmi/
\(^5\) Further details of the Covenant funded Outcomes Framework project will be made available should the Defence Committee be interested in this development.
\(^6\) An example of Military Social Work training can be found at the University of Southern California and if required Prof Carl Castro could comment on these innovations. https://msw.usc.edu/academic/electives-options/military-social-work/
by a similar professional service, and consideration should be given to reviewing the way wellbeing is addressed in the UK military. This would be much more effective if validated tools for measuring wellbeing were adopted and used systematically across whole careers. Inevitably, ethical and data protection issues would need to be considered, especially given the new GDP regulations.

What proportion of mental health issues in veterans is attributable to service in the Armed Forces and how well is this measured and understood

11. For the significant minority of UK veterans who do suffer from mental health issues, it is difficult to ascertain whether this is attributable to their military service. Most research has focused on in-service risk factors (e.g., deployment), but little work has been carried out looking at pre-service and post-service factors.

12. An association between operational deployment and PTSD has been reported, and Reservists and combat troops appear to be most at risk (Fear et al., 2010, Hotopf et al., 2006), as highlighted above Deployment to combat zones inevitably exposes military personnel to additional stressful and traumatic events not experienced by the majority of the general population in the UK (Forbes et al., 2011). It may be expected, therefore, that those who see combat will show higher levels of PTSD symptoms, due to the increased likelihood of having a traumatic experience. Similarly, it might be that these experiences whilst on deployment, rather than deployment itself, are most likely to contribute to post-traumatic psychopathology. Studies show that deployment-related factors (such as time spent outside the base in a hostile area) and being in a combat role increased the risk of mental health issues (e.g., Fear et al., 2010). A study investigating the impact of severe combat-related injury on Service personnel and their partners, however, found a high level of resilience for the majority (Klein et al., 2017). Why some individuals display positive changes after trauma, even in the face of the most extreme stressors (e.g., exposure to IEDs) requires further understanding.

13. Unit cohesion and good leadership during deployment are reported to be protective against the development of mental health issues (Jones et al., 2012). By nature of their role, Reservists may feel less connected to their unit, and report feeling a lack of connection to the military once they come home (Hunt et al., 2014). This is in contrast to Regular Service personnel, who return home and continue to work with those whom they deployed with. Reservists may be a group for whom military service represents a higher risk of mental health issues. However, it is clear from this research that because there are a number of situational and psychosocial variables at play, it is not possible to attribute mental health issues to deployment alone.

14. Whilst research has focused on the effect of deployment and combat exposure on mental health issues, little has focused on how other aspects of military culture may affect mental health. E.g. the transient nature of the military, specifically the Army, leads UKAF families to move a number of times. This not only disrupts family life but may repeatedly interrupt social support networks that protect against mental health issues. Indeed, research we have carried out for the MOD indicates that military spouses feel disadvantaged by the transient nature of the military, and indeed report slightly lower well-being scores than that of the general population (Caddick et al., in press). Research is needed to investigate how the military culture itself may act as a risk or protective factor for the development of mental health issues.
15. It is also possible that certain pre-service factors put Service personnel at risk of developing mental health issues, irrespective of their military service. The military often recruits from areas of socio-economic deprivation, from which individuals may already be considered a vulnerable population. For example, reports of increased risk of suicide and substance misuse in veterans could be attributed to the fact that a number of veterans fall into “at-risk” groups (i.e., being young and male). For former service men aged under 24 years, the risk of suicide is approximately 2-3 times higher than matched general and serving populations (Kapur et al., 2009). Being of a lower social class is in itself a risk factor for mental illness, and officers are found to fare better than other ranks (Fear et al., 2009). Risk factors such as childhood abuse and antisocial behaviour have also been linked to mental health issues in Service personnel (Iversen et al., 2007). However, based on the current evidence, it is not possible to determine if serving in the military mitigates, or exacerbates, these risk factors.

16. There are also a number of transition and post-service factors that could affect mental health in veterans. E.g., involuntary or medical discharge are unexpected, and personnel will have little time to prepare for discharge, both in practical and psychological terms. Research into the transition experience of Early Service Leavers indicates that they are a group vulnerable to poor post-discharge outcomes (Godier et al., 2018). Furthermore, factors such as having a deeply ingrained military identity and feeling unable to integrate back into society are associated with increased likelihood of developing mental health issues (Hatch et al., 2013). The VFI has published theoretical work that outlines how the strength with which Service personnel identify with the military at the point of discharge might have an impact on the ease with which they adjust to civilian life (Cooper et al., 2018, Cooper et al., 2017).

17. Research into the causal factors of mental health issues in UKAF personnel and veterans is sparse. Furthermore, there is no indication of whether individuals, particularly those from a disadvantaged background, would have fared better or worse if they had not joined the military. Single males, of lower rank, with lower educational status and who have served in the Army are most likely to have experienced adverse vulnerability factors in childhood (Iversen et al., 2007). To what extent, however, this association would be significantly different from a similar age-matched group in the general population has yet to be established. Moreover, it is not known to what extent these findings would generalise to women (Klein et al., 2013). Longitudinal studies following Service personnel through their service career and transition will be needed to delineate to what extent pre-service factors and experiences in the UKAF are linked to mental health issues.

To what extent does the military environment for serving armed forces personnel mitigate against the development of mental health issues?

18. Research has confirmed that the military exposes individuals to both risk and protective factors in relation to mental health. Potential risk factors include exposure to combat, socially prescribed norms of hyper-masculine behaviour, and ingrained excessive use of alcohol. The selection process is designed to mitigate against additional risk by selecting people who are not known to have pre-existing mental health issues, but pre-service problems may be masked or have manifested at the time
of entry. Policies are in place to promote and maintain mental and physical health; robust training and appropriate education on joining, in units and pre-deployment, and optimum deployment lengths and gaps between tours are designed to mitigate the stresses that may be encountered in service. Those considered to have mental health issues are supported in seeking assessment, diagnosis and/or treatment. The TRiM process is one example of how non-specialist monitoring and peer support takes place. Whilst TRiM is reported to have high face validity and be well-received by those who have experienced it, further evaluation is required to demonstrate its effectiveness in mitigating against the development of mental health issues (Whybrow et al., 2015).

19. In terms of protective factors, the military is renowned for endorsing masculine ideals of strength, bravery, endurance and stoicism – yet a well-run unit also embodies humour, comradeship and empathy. Together these may contribute to personal resilience, drawing from the abilities and temperament of those who join and serve (Caddick et al., 2015; King, 2013). Useful people, suitably led can make a unit far more than the sum of its parts and can sustain those individuals far beyond breaking point in the most testing of circumstances. The military is known for robust/inappropriate humour and use of alcohol; while these can be abused they are also understood to be factors in bonding and cohesion (Fox, 2010).

20. The nature of military operations/warfare requires combatants to endure extremes of danger, discomfort and uncertainty. The structures and ways of being that the military is known for have evolved over centuries to mobilise and direct the abilities of the people to achieve success and withstand failure. Whilst in civilian society, the military is often criticised for being unable or unwilling to reflect more closely the society from which it is drawn, historical awareness demonstrates the necessity of forming what can appear to be an overly masculine and ‘tribal’ society. On leaving the military it can be the loss of membership of the strong and supportive tribe – more so than trauma in many cases – that contributes to unhappiness and mental health issues (Cooper et al., 2018; Mobbs & Bonano, 2018).

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8 Alcohol consumption is an established part of UK military culture with some research indicating a role for moderate, responsible drinking in promoting group cohesion, social bonding and comradeship. However, data shows that drinking at levels that is harmful to health is common (KCMHR).

9 The association between bullying and psychological distress is well recognised. When surveyed, 10% of Regulars reported experiencing discrimination, harassment or bullying in a service environment in the last year; a level not significantly different to other workplaces (KCMHR).
References


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