Written evidence submitted by Veterans Aid

On behalf of Veterans Aid by CEO Dr Hugh Milroy PhD, Honorary Psychiatrist Prof Ian Palmer and Head of Media & Communications Ms Glyn Strong MA. It reflects the experience of a charity that has been dealing with veterans in crisis for 85 years and individuals with combined experience of working with the Armed Forces & Veterans of 97: all have served on operations, in hostile environments.

Dr Milroy, whose PhD focused on street homeless veterans heads a charity well known internationally for the success of its Welfare to Wellbeing model. An Honorary Visiting Fellow at the UEA’s School of Social Work, he was a military advisor to the Howard League for Penal Reform

Professor Palmer who served as Regimental MO to infantry soldiers (four years with the SAS) then as a military psychiatrist, was medically discharged with a service-related mental disorder. He later became the first Tri-Service Professor of Defence Psychiatry and ran the Medical Assessment Programme on behalf of the MoD from 2006.

Ms Strong left the MOD post of A/Director Defence Publicity in 2007 after 15-years’ service, frequently in hostile environments.

EXECUTIVE SUMMARY

1. The ex-service community has been politicised - The solution is largely political and social as opposed to medical.

2. ‘Information’ (sic) about service personnel and veterans is largely media driven or based on unverified self-reporting – The exercise of power without responsibility has shaped a perception of linear damage, dysfunction and prevalence of PTSD.

3. Diagnoses and treatments are basically the same whatever the gender or occupational group - There are similarities in delay in presentation, diagnostic range, engagement with services and outcomes between civilians and ex-service personnel, especially men.

4. Diagnostic practice favours statistical, usually self-report questionnaires for reasons of cost. - Clinical observation of realities in the clinic is afforded a lesser importance in mental health publications.

5. Flawed methodologies - Routine use of questionnaires can medicalise distress and turn normal, short lived and understandable distress into putative mental disorders and to then conflate them with serious and enduring conditions such as schizophrenia. Reliance on self-reporting can lead to inappropriate diagnoses and wasted treatments by clinicians and NGOs. Clinical studies reflect exactly what is happening on the ground; questionnaires don’t.¹
6. Social isolation - Provision of services to specific occupational groups risks social isolation of those groups (i.e. veterans) are distinct from everyone else in society and require special treatment. Successful transition relies on integration, not differentiation.

7. Dissembling - This occurs in ex-service personnel and civilians. It is ‘the elephant in the room’ seldom acknowledged and, outside the criminal justice system, seldom addressed. It too can lead to inappropriate diagnoses, wasted treatments, misuse of resources and enforcement of harmful stereotypes.

8. Homogeneity – The military community is diverse and is often compared to an extended family. Some individuals cannot wait to leave and hated it throughout. Some have benefited from the structure/family environment, go on to great things and recollect it fondly.

9. Some individuals have trouble leaving home and are constantly in difficulties. As in most families they take up a disproportionate amount of time effort and money.

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

a) Statistics notwithstanding, military service does not explain the broad spectrum of issues presented to this charity by members of the veteran community on a regular basis. In 2017 Veterans Aid interacted with 479 ex-servicemen and women experiencing some kind of crisis; very few were suffering from clinically diagnosed PTSD and while a number described themselves as depressed, their low mood was entirely condign with their circumstances (e.g. poverty, homelessness, social isolation, addiction, unemployment). In our considerable collective experience, they respond positively to changes in these circumstances. Overwhelmingly, poverty is the single common factor as opposed to issues relating to service life.

b) It is important to note that the ex-service personnel seeking help from Veterans Aid are often those presenting with the most acute, complex and entrenched problems. They are individuals who have fallen through all the cracks in the system and can rightly be described as those most in need. In spite of this we are not swamped by PTSD sufferers. Given that more than 8 in 10 of those polled in Lord Ashcroft’s recent Perception of Service Leavers and Veterans’ paper believed that ‘mental health problems’ were among the three most common experienced by service leavers, the Veterans Aid client cohort might be expected to reflect this. It simply does not. We hear about PTSD more from agencies who have an interest in promoting the issue rather than from our clients. Many of those who comment have never served a day and have great difficulty in recognising genuine military stories. What is clear that those clients who talk about PTSD promote a script that promotes victimhood.

c) Statistical analysis of mental health in the AF was historically something of a blunt instrument and it is encouraging to see a more nuanced approach being taken – i.e. one that takes account of ranks, roles, gender and individual service experience. However, it would be even more meaningful if presented as a matter of course in tandem with a counterpart civilian demographic. To look at mental health issues in
the AF without context is inevitably going to deliver a result into which pre-enlistment and wider societal issues are not factored. (For example, one-in-four adults and one-in-ten children experience mental illness during their lifetime\(^\text{iv}\)). At Veterans Aid we routinely see ex-servicemen and women suffering from poverty which engenders stress, anxiety and low mood related to societal rather than legacy ‘military’ issues. Some of these ‘mental health issues’ are related to and/or exacerbated by alcohol or drug use – neither of which is tolerated in the AF.

c) The recent London Assembly Report on Supporting Mental Health for All\(^v\) concluded that “the prevalence of mental ill-health is significantly higher in LGBT+ communities, disabled people, deaf people and those with experience of the criminal justice system. And the issue is compounded by services that do not understand and meet their specific needs”. We also know that mental ill-health is higher in those with lack of education, literacy problems and behavioural difficulties. Veterans are represented in all of these groupings. Using snapshots of mental health taken in the serving and veteran communities and presenting them as direct outcomes of military service creates a false assumption of a causal link.

The London Assembly Report reference to ‘their specific needs’ in the groups identified relates to clinical and psychological needs, but it echoes the widespread belief that veterans too have ‘specific (mental health) needs’. Our experience supports a contrary view, which is that most clients recover best when reintegrated into civilian society. To this end we utilise NHS services and applaud the £9m investment in TIL which will act as a front door to a range of mental health services across the health and care system.\(^vi\)

2. 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?

a) The difference between a Focus Group and a Stakeholder Group might go some way towards answering this question. The former has no vested interest in the outcome – the latter has. Quite simply, people lie. They also exaggerate\(^vii\).

b) Just as there are clear advantages to claiming (real or fictive) military service, there are also advantages to attributing personal failure to an extraneous cause, such as PTSD. For example, it has been demonstrated (by the Howard League Inquiry into Former Armed Service Personnel in Prison – of which CEO VA was a member)\(^viii\) that many individuals who are serving (or have served) prison sentences, falsely represent themselves as veterans as a way of inspiring respect or acquiring ‘status’. We were asked to look at 42 inmates of a major prison. On checking 48% had never served a day but had gone through the CJ system without being detected as fraudsters. It has also been demonstrated that many veterans assign their personal failures to ‘mental health’ problems.

The media elevation of PTSD to a condition almost linearly linked to military service – to the point where it is almost regarded by some as a badge of honour - has made it a desirable ‘asset’ for veterans seeking to excuse, or refuse to take responsibility for, their actions.
c) The routine use of questionnaires can medicalise distress and turn normal, short lived and understandable distress into putative mental disorders and then conflate them with serious and enduring conditions such as schizophrenia.

d) Public – and official – reluctance to challenge the narrative of ‘heroes’ (sic) has made fabrication and exaggeration both widespread and easy. Veterans Aid is unique in its commitment to verifying service history before engaging in a support strategy. If courts, the NHS and other relevant organisations were able to exercise equal diligence we are confident that a different picture of the post-service mental health landscape would emerge.

e) Veterans Aid VA staff routinely deal with individuals - genuine veterans with genuine problems – who assign their difficulties to fictive PTSD rather than face up to other problems. This ranges from fabrication of narratives related to engagements/deployments that they were not involved in, to linking drug/alcohol-related psychosis to aspects of their service career. Time and again these have been examined by VA staff and exposed as fantasies; in one case a client was diagnosed with combat-related PTSD by a well-known charity only to plead guilty to fraud in court a few later having pretended to have served in the AF. The hero, villain and victim tags for veterans simply isn't helping anyone. Politicians', the media and the Third Sector continue to "milk" the tags. The numbers of genuine veterans on the streets of the UK are tiny but this doesn't seem to stop almost daily exaggeration and exploitation of the issue. Challenging the script is a constant battle. NB. Torquay photographer Ashley Simms, who recently spent time talking to homeless men in the town, told MailOnline "One guy told me he always wore combat kit because passers-by thought he was ex-services. He claimed it was 'better than having a dog'."

f) The challenges to accurately assessing the extent of mental health are further compounded by the fact that there may be genuine triggers to post service dysfunction that took place during military service - for example, bullying. However, the fact that this intimidation may have taken place while the individual was serving does not make it a 'military-specific' problem. Describing it as such takes not account of context i.e. pre-service experiences, personality or predisposition. The same can be said of depression and PTSD, both of which are conditions widely experienced by men and women with no military connection.

g) The lack of context referenced at 1(b) allows the media to exercise power without responsibility – driving pubic ‘opinion’ (not to be confused with ‘knowledge’) and ultimately political action. Not only has ‘mental health’ in the AF become politicised; it has led to inappropriate assignment of funding and replication of effort. At VA we regularly see examples of ‘high profile ‘news’ (sic) stories about individuals whose cases have been poorly researched and unverified. The authors/producers/broadcasters operate in a fast-moving ephemeral environment in which accountability rarely factors and statistics fabricated in earlier publications become ‘facts’. Chief among these are those relating to homeless and mental health among veterans.

h) Provision of services to specific occupational groups risks social isolation of those groups i.e. a belief that veterans are distinct from everyone else in society and require special treatment.
3. How does the level of mental health issues, services and outcomes in serving armed forces personnel and veterans compare etc:

N/A

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

Our experience at VA supports the conclusion that the proportion of mental health issues in veterans attributable to service is very low, difficult to measure and poorly understood. This is because:

It is driven by:

a) Self-reporting (= high number of claims/inadequate or no validation)
b) Stakeholder-funded and/or issue-specific research (= anticipated outcome/lack of context)
c) Journalists/academics/politicians/researchers who are not well-enough informed to distinguish fiction from truth with military narratives.
d) Groups who choose to conduct research by exclusion of wider-societal facts.

It is shaped by:

e) The impossible-to-ignore assertions of poorly informed media (even serving personnel are exposed to this which ranges from individual and usually unchallenged tabloid ‘news’ stories, putative ‘documentary’ output, films featuring ‘damaged war heroes’ such as American Sniper which netted US$337m and Jason Statham’s film Redemption which glamourised the activities of a damaged Afghan war veteran). In short, it is shaped by a script as opposed to reality.

It has been politicised by:

f) Organisations and individuals who stand to gain money, profile or approval from championing veterans ‘known to be uniquely vulnerable and at risk’.

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

a) Veterans Aid deals with many veterans who acknowledge problems pre- and post-military service. We see examples of where the comradeship, order and structure of service life have provided an environment of protective insulation, by dint of the psychological processes of enlistment and group. Where this leads to personal growth that survives transition, individuals are fine and the AF experience regarded as beneficial. However, for those who simply return to the place they started from (e.g. unemployment, social isolation, chaotic lifestyle, depression etc.) the loss of the
The structure of military life translates as a problem caused by service, rather than one simply postponed by it.

b) Health services are risk averse and likely to perceive ex-service personnel as dangerous because of their service. They may also believe that they have been damaged by the Crown and discarded, a perception shaped by narratives built on evolving societal tropes from literature, film and comedy. There are issues of perception, or more correctly misperceptions within society.

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1 The Psychiatrist Online Jul 2012, 36 (?): 263-270; DOI: 10.1192/pb.bp.110.033266
2 http://www.veteranstransition.co.uk/perceptions_of_veterans_research_2017.pdf
4 https://www.london.gov.uk/sites/default/files/mentalhealthfinal.pdf
5 https://www.england.nhs.uk/2017/04/next-steps-on-the-nhs-five-year-forward-view-veterans/