House of Commons

Defence Committee

Mental Health and the Armed Forces, Part One: The Scale of mental health issues

Eleventh Report of Session 2017–19

HC 813

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The Defence Committee

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Summary

Focus on mental health has increased over recent years. Media coverage, particularly during the conflicts in Iraq and Afghanistan, and Armed Forces charities have made the public much more aware of mental health conditions in Servicemen and women, such as Post Traumatic Stress Disorder (PTSD).

The perception that most Service personnel leave the Armed Forces 'mad, bad or sad' is, however, not only a myth but 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. Indeed, this distorted public perception may be amplifying the stigma surrounding veterans' mental health, discouraging them from seeking help, and overly focussing attention on PTSD, when conditions such as depression are much more common.

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 we believe that the true figure will still be small. 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. Academic research suggests that the true rate of veterans with mental health conditions could be as high as 10%. Certain groups, such as those in combat roles and deployed Reservists in Iraq and Afghanistan, also show higher rates of probable PTSD than the rest of the Armed Forces.

Nevertheless, the small minority of serving personnel and veterans who do suffer from mental health conditions, especially those who are severely affected by conditions such as PTSD, clearly need timely and appropriate provision of care. The UK Government has sought to make improvements in its provision of mental health care to veterans, but problems remain. It is still taking too long for veterans to access treatment when they need it, and levels of care vary across the UK. There is also the risk that some can still fall through the gaps as they transition from the care of the Ministry of Defence into the National Health Service. We shall be examining in detail the provision of mental health care to serving personnel and veterans in Part Two of our inquiry.

We are particularly concerned that the Armed Forces Covenant principle of priority treatment when conditions are service-related is not being consistently applied across the UK. Confusion over how it should be implemented in both clinicians and veterans adds to the perception that the health service is failing veterans. The Ministry of Defence urgently needs to clarify this in its future veterans' strategy.

Accurate information about the extent of mental health problems in serving personnel and veterans is also critical to determining the resources required to care for those in need of it. Yet there is no clear and agreed approach across Government, academia and Armed Forces charities, which have different and incomplete datasets, compounded

by poor recording of the numbers of veterans treated in the NHS. Nor is it understood how numbers of veterans with mental health problems might vary across the UK, both regionally and locally.

Finally, we believe that the focus on mental health and the Armed Forces should also extend to the families of both serving personnel and veterans, with emerging evidence that their mental health also can be affected by the stresses of Service life and the traumatic events experienced by their military partners.

1 Introduction

1. There has been an increasing focus on mental health over recent years across the UK Armed Forces. In its latest strategy published in July 2017—the 'Defence People Mental Health and Wellbeing Strategy'—the Ministry of Defence highlighted that this reflected the changing perceptions around mental health nationally, as well as the context of sustained operations in Iraq and Afghanistan.[1]

Our inquiry

2. On 31 January 2018, we launched Part One of our inquiry into Mental Health and the Armed Forces. This was to examine the extent of mental health issues across both serving Armed Forces personnel and veterans. Our call for evidence asked for submissions which addressed the following questions:

- To what extent do current statistics accurately reflect the level of mental health issues in serving Armed Forces personnel and veterans, including PTSD?
- 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?
- How does the level of mental health issues, services and outcomes in serving Armed Forces personnel and veterans:
  - compare both to the actual level in the general population and to public perceptions of mental health issues in Armed Forces personnel and veterans?
  - vary between different groups of serving and former personnel, including Reservists, those who have been deployed on operations and early leavers?
  - vary regionally across the UK and across the devolved administrations?
- What proportion of mental health issues in veterans is attributable to service in the Armed Forces and how well is this measured and understood?
- To what extent does the military environment for serving Armed Forces personnel mitigate against the development of mental health issues?

3. We held three oral evidence sessions with contributions from academics; clinical leads of leading Armed Forces charities and statutory veterans' mental healthcare providers in Scotland and Wales; the Parliamentary-Under Secretary of State and Minister for Defence People and Veterans, Rt Hon Tobias Ellwood MP; the Surgeon-General, Lieutenant General Martin Bricknell; the Parliamentary-Under Secretary of State for Mental Health and Inequalities, Jackie Doyle-Price MP; and the Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning at NHS England, Kate Davies OBE.

4. We are grateful to all of our witnesses who gave oral and written evidence. We would also like to thank Professor Neil Greenberg, King's College London, who acted as a Special Adviser to the inquiry.

1 Ministry of Defence, Defence People Mental Health and Wellbeing Strategy 2017–2022, July 2017

Our report

5. Most UK Armed Forces Service personnel leave with a positive experience of military service and no ill-effects. However, some are clearly affected by mental health issues during or after service and, in Chapter 2, we examine the degree to which these can be attributed to or indeed militated by military service.

6. We then examine, in Chapter 3, the current data available from Government and how the limitations of such data may prevent a clear answer on what is the scale of mental health conditions in serving personnel and veterans' mental health. We consider the academic and Armed Forces charities data showing the effect of operations in Afghanistan and Iraq in Chapter 4 and the groups of serving personnel and veterans who may be more vulnerable to developing mental health conditions in Chapter 5.

7. Acknowledging the limitations on currently available data, we compare how the trends in military mental health compare to the general public, regionally and internationally in Chapter 6. We then compare the public's perception of the effect of military service on mental health and the consequences of any differences in Chapter 7. Finally, in Chapter 8, we examine how military service might impact on the mental health of the families of serving personnel and veterans.

8. This report on the extent of mental health issues forms Part One of our Inquiry into Mental Health and the Armed Forces. We have today (25 July) also launched Part Two into the provision of mental health care to serving personnel and veterans across the UK and we shall be accepting evidence submissions over the summer.[2]

2 Details of this inquiry can be found on the Defence Committee's webpage.

2 The effect of military service on mental health

Attribution of mental health conditions to military service

9. Witnesses consistently told us that it is very difficult to determine the extent to which military service may have caused an individual's mental health condition, given the range of factors that might have contributed. For example, Professor Sir Simon Wessely, Director at the King's Centre for Military Health Research, told us that mental health issues do not have a single cause and so it is "very difficult to be absolutely certain that what happened to them is solely and only the result of their military deployment. But you can say it contributed".[3] Professor Susan Klein, Professor of Health and Social Care at Anglia Ruskin University, also told us that no one yet knows why individuals may react differently when exposed to the same event.[4]

10. Nonetheless, witnesses also suggested that even if military service were not the direct cause of a mental health condition, it might have been the trigger to any underlying conditions.[5] Dr Lucy Abraham, Consultant Clinical Psychologist at Veterans First Point Scotland, told us that for those who are more vulnerable, perhaps due to other factors, military service may "have served more to exacerbate their difficulties making them less likely to cope with any secondary military related trauma".[6]

11. Potential non-military factors that could lead to the development of mental health issues both during and after military service included:

- **Pre-existing mental health conditions**—recruits may join with existing issues. The Ministry of Defence stated in its written evidence that those with "pre-existing social or childhood adversities" are at increased risk of developing mental health issues—a view supported by academics.[7] Dr Beverly Bergman, at the University of Glasgow, also told us that from her study of Scottish veterans this is most apparent in early Service leavers who had not even completed training. In such case it is clear that any mental health conditions would most probably have been pre-existing.[8]
- **Lower educational and social status**—younger, male recruits coming from such backgrounds are more likely to have pre-existing factors that could affect their mental health. For example, Professor Klein told us that there is evidence to show that "those who have a lower educational status, are male, in a younger age group, and of lower rank, which is probably associated with a lower educational status, are the ones who are likely to encounter more difficulties."[9] Walking with

3 Q59. Also for example, Q89 [Dr Bergman], Q94 [Professor Armour], Q138 [Rod Eldridge]
4 Q24 [Professor Klein]
5 For example, Walking with the Wounded (VMH0016), Dr Beverly Bergman (VMH0017) and Alison McDowell (VMH0004)
6 Veterans First Point Scotland (VMH0022)
7 Ministry of Defence (VMH0029). Also for example Q14 [Professor Fear], Q94 [Professor Armour]
8 Dr Beverly Bergman (VMH0017)
9 Q60

the Wounded also told us that recruits from regions with historic lower social economic status, such as the North-East and the North-West, often join with pre-service vulnerabilities.[10]

- **Non-military specific triggers**—there may be workplace triggers to mental health issues during military service that could also be found in civilian life. For example, Professor Wessely told us that half of the cases of PTSD identified as part of the King's Centre research are not related to deployment but events such as road traffic accidents and assaults.[11] Veterans Aid suggested bullying as another trigger, while Hilary Meredith, Visiting Professor of Law and Veterans' Affairs at the University of Chester, raised the poor support for Service personnel investigated for historic allegations as a key cause of mental health conditions in those affected.[12] We have also received correspondence which suggested that Ministry of Defence maladministration was a cause of individuals' mental health conditions.[13]

12. There is, however, a lack of understanding of the extent to which an individual's mental health might be affected by such factors. Anglia Ruskin University reported that, beyond deployment and combat exposure, research into the causal factors of mental health issues in UK serving personnel and veterans is "sparse".[14] Combat Stress and Veterans First Point Scotland reported that few of the veterans that they have supported report mental health difficulties before joining the Armed Forces.[15] Dr Bergman, however, suggested that from her study of Scottish veterans that the majority of mental health problems were likely to have originated from non-service factors.[16]

13. There is also currently a lack of research into the mental health effects of physical exposure to factors such as neurotoxicity or mild traumatic brain injury:

- **Neurotoxicity arising from prescription drugs—**An example is the anti-malarial drug Lariam, or Mefloquine, where our predecessor Committee found that a minority of those who used it suffered serious mental health issues. Such side effects were known to occur, yet the Ministry of Defence did not take the appropriate steps to minimise the risks to those whom it prescribed the drug.[17] A number of witnesses have suggested that other drugs being prescribed by the Armed Forces may be having similar effects but that the current lack of research and data over neurotoxicity and its potential mental health effects may be resulting in cases being missed or being misdiagnosed, for example as PTSD.[18]

- The Surgeon-General told us that the Ministry of Defence relies on expert advice to determine risk and balance and so would need the appropriate studies

10 Walking with the Wounded (VMH0016)
11 Q24 [Sir Simon Wessely]
12 Veterans Aid (VMH0038), Ms Hilary Meredith (VMH0003)
13 We have not published these to preserve anonymity, given the degree of personal information presented
14 Anglia Ruskin University (VMH0032)
15 Combat Stress (VMH0006) and Veterans First Point Scotland (VMH0024)
16 Dr Beverly Bergman (VMH0017)
17 Defence Committee, Fourth Report of Session 2015–16, An acceptable risk? The use of Lariam for military personnel, HC 567, pp30–33
18 Ms Hilary Meredith (VMH0003), Mrs Trixie Foster (VMH0009), Dr Ashley Croft (VMH0033), Brigadier General (Rtd) Donald Bolduc (VMH0034), The Quinism Foundation (VMH0013) and Lt Col (Rtd) Andrew Marriott (VMH0036)

conducted to prove causation. This was something that the department itself did not have the capacity to do.[19] Professor Wessely also told us that there remained an open verdict on the potential side-effects of prescription drugs. He believed that the Ministry of Defence's forthcoming new medical data system might help to link the data held by King's College London with the Armed Forces data on drug prescription to identify any correlation.[20]

- **Mild traumatic brain injury (mTBI)**—this is a term covering persistent symptoms, such as headache, dizziness or memory problems, to which UK Armed Forces personnel deployed to Iraq and Afghanistan were particularly exposed as a result of the volume of improvised explosive devices used by opposition forces in those countries.

- The rate of mTBI found in UK Armed Forces is much lower than in US military forces. A 2014 King's College London study found only small rates of mTBI cases (3.2%) in UK forces deployed in Afghanistan during 2011, concluding that the reporting of symptoms post-deployment may be inflated as a result of memory distortion. In comparison the rate in US forces was found to be around 23%.[21] Help for Heroes suggested that this was a result of everyone in the US Armed Forces being screened following a head injury or within a specific blast radius.[22] The Surgeon-General also told us that this might be a result of social and environmental differences between the US and the UK.[23]

- The long-term mental health effects on those who have suffered mTBI is also currently disputed. A summary by Professor Rona in 2012 of the research conducted at that time found little evidence to show that mTBI has anything but limited lasting mental health effects.[24] However, Help for Heroes and Mrs Mandy Bostwick, a trauma psychotherapist, both expressed concerns that the detection and follow-up of mTBI in serving personnel by UK Armed Forces was inadequate and might account for the low number of cases found.[25] The Surgeon-General again told us that this was an area where the Ministry of Defence would respond to any new evidence from the research currently being conducted.[26]

14. The Ministry of Defence is clear that it has responsibility for providing care to serving personnel from the day they join, regardless of whether any injury is directly as a result of military service. The Parliamentary Under-Secretary of State and Minister for Defence People and Veterans, Tobias Ellwood MP, told us that "as far as legal responsibility is concerned, our duties to look after them start on day one".[27]

15. The Ministry of Defence applies strict criteria for compensation claims. Serving personnel and veterans can claim for compensation if they consider that they have

19 Q207
20 Q50
21 King's Centre for Military Health Research, King's College London Mild traumatic brain injury (mTBI) among UK military personnel whilst deployed in Afghanistan in 2011, Brain Injury, 2014: 28(7): 896-899, May 2014
22 Help for Heroes (VMH0021)
23 Q209
24 Professor Roberto J. Rona, Long-term consequences of mild traumatic brain injury, The British Journal of Psychiatry (2012) 201, pp172–174
25 Help for Heroes (VMH0021) and Mrs Mandy Bostwick (VMH0047)
26 Q209
27 Q225

developed a mental health condition as a result of a service-related activity or that it made an existing condition worse. In assessing any claim, Veterans UK, as the defence body responsible, would consider whether the condition was as a result of service and this judgement would be based on the balance of probabilities.[28]

16. The Ministry of Defence reported that the number who receive compensation due to service-attributable mental conditions accounted for 5% (3,200) of total awards between April 2005 and March 2017. However, it also acknowledged that these figures should be treated as a minimum, given that there is a seven-year time limit for claims and some individuals may not yet have claimed or are still awaiting a decision.[29]

17. **It is very difficult to prove whether the mental health conditions that some serving personnel and veterans develop are caused by their military service. Non-military factors or underlying mental health conditions exacerbated by military service could all contribute to an individual's mental health. However, there is a lack of reliable research and data to indicate how significant these factors might be. Although the Ministry of Defence does not take attribution into account when providing care, a better understanding would at least help it to make decisions where judgement on attribution is required, such as awarding compensation.**

18. ***The Ministry of Defence should support further research into the factors that may affect mental health during military service. This should include following a cohort of recruits over time to understand how military service may have affected them.***

19. **The unknown mental health implications of what an individual might be exposed to during military service adds further uncertainty over whether the Ministry of Defence is capturing the full extent of mental health issues amongst its personnel and is providing appropriate care. The Ministry of Defence relies on external research to inform its clinical diagnoses and care practices. The current lack of understanding in areas such as neurotoxicity and mild traumatic brain injury, however, means that it cannot be certain about the balance of risk it accepts in its practices.**

20. ***We recommend that the Ministry of Defence should commission further research into neurotoxicity and mild traumatic brain injury to determine whether exposure to these is likely to be causing mental health effects. If there appears to be a link the Ministry of Defence should set out what mitigating actions it will take to reduce the risk of mental health conditions from such exposures.***

Military service militating against mental health problems

21. Witnesses told us that most Service personnel leave with no ill-effects and have good memories of their military career. In their evidence, Armed Forces charities and the Ministry of Defence sought to emphasise this point, with the Defence Minister, Tobias Ellwood MP, telling us that "the vast majority of personnel serve well, transition well and leave well".[30] Lord Ashcroft, in his series of reports since 2014 on veterans' transition in the UK, has consistently found that those who served had an "overwhelmingly positive"

28 Ministry of Defence, Guidance—Armed forces compensation: what you need to know, updated 9 April 2018

29 Ministry of Defence, Ad Hoc Statistical Bulletin: UK Armed Forces Mental Health Care delivered in the Primary Healthcare Setting 2013/14 – 2015/16 AFCS awards for Service attributable Mental Health 6 April 2005 – 31 March 2017, 8 March 2018

30 Q150, Combat Stress (VMH0006) and Walking with the Wounded (VMH0016)

view of the Armed Forces.[31] The Scottish Veterans Commissioner, Eric Fraser, also found that "the vast majority of veterans in Scotland are in relatively good health and lead happy and productive lives".[32]

22. We also heard that the military environment might have lasting positive effects on an individual's mental health or at least defer the presentation of existing mental health conditions until the end of an individual's military career. The Big White Wall, a provider of online mental health support to serving personnel and veterans, told us that the Armed Forces "community and support network is helpful for mitigating against the development of mental health issues to a point".[33] Anglia Ruskin University referred to unit cohesion and good leadership, while the Ministry of Defence also cited robust training as a reason why this might be the case.[34] Dr Abraham added that:

> Individuals from neglectful and abusive early backgrounds may benefit from the structure, routine and comradeship of the military. This environment is unlikely to mitigate against mental health difficulties developing, but may contain their difficulties during their service. What military service does achieve is to improve the individuals' financial, social and employment prospects—taking them away (at least during service) from a demographic group that is at higher risk of developing mental health difficulties."[35]

23. As a result, the loss of the benefits provided by the military environment may be a factor in veterans presenting mental health conditions after they leave. Veterans Aid told us that "for those who simply return to the place they started from (e.g. unemployment, social isolation, chaotic lifestyle. depression etc.) the loss of the structure of military life translates as a problem caused by service, rather than one simply postponed by it".[36] Queen's University Belfast also told us that in some cases soldiers involved with counter-insurgency warfare, such as that seen in Afghanistan, may find it more difficult to transition back into civilian life. This is because they may have become reliant on the camaraderie within their unit to cope with the intensity and stresses of such warfare and that loss of community may cause them to become withdrawn and isolated.[37]

24. The Ministry of Defence has support in place to help Service leavers through transition. The Defence Minister, Tobias Ellwood MP, told us that "there is a transition process, which is a wide package of support, and that actually increases the longer the service you have."[38] The Parliamentary Under-Secretary of State for Mental Health and Inequalities, Jackie Doyle-Price MP, also told us that the NHS "have put more transitional services in place to make sure that we are able to support veterans as they navigate going into civvy street and accessing all kinds of health treatment."[39] This includes the Veterans Mental Health Transition, Intervention and Liaison Service that NHS England launched in April 2017.[40]

31 Lord Ashcroft KCMG PC, The Veterans' Transition Review, Third follow-up report, October 2017, p5
32 Scottish Veterans Commissioner, Veterans' health and wellbeing: are we getting it right?, August 2017, p16
33 The Big White Wall (VMH0027), also for example Walking with the Wounded (VMH0016)
34 Anglia Ruskin University (VMH0032) and the Ministry of Defence (VMH0029)
35 Veterans First Point Scotland (VMH0024)
36 Veterans Aid (VMH0038)
37 Queen's University Belfast (VMH0048)
38 Q229
39 Q150 [Jackie Doyle-Price]
40 NHS England (VMH0031)

25. However, Contact, a collaboration of military charities working with the NHS and the Ministry of Defence, believes that more could still be done during this phase "to help reduce the number of leavers with mental health concerns who fall through the cracks". This included the involvement of charities before serving personnel are discharged.[41] We also raised an example with the Government witnesses of a Service leaver who had very specific care requirements as a result of his service-related illnesses and had over the years developed a trusting relationship with his military clinicians. However, since leaving the Service, he has not been able to access the additional support he needs during transition under the current NHS protocols.[42]

26. **Rather than causing problems, military service can have a positive effect on an individual's mental health. At the very least, the vast majority of Service personnel leave with good experiences of their military career. The structure and social community found in the Armed Forces particularly help those who might have been more vulnerable to mental health issues before they joined, for example, those who were unemployed or socially isolated. All Government Departments, not just the Ministry of Defence, should be doing more to promote to the public the message that military service has a positive effect on mental health, for example, by drawing attention to the veterans they employ.**

27. **This positive effect can be lasting, but the potential loss of support and community when personnel leave the Armed Forces may mean that, for some, military service will have only delayed the onset of mental health issues. Successful transition is therefore essential to ensuring that any mental health benefits from military service are retained. Support during transition is available but more could be done to ensure continuity of care and stop some veterans from falling through the gaps. We shall be examining the provision of mental health care to serving personnel and veterans, including during transition, in Part Two of our inquiry into Mental Health and the Armed Forces.**

41 Contact (VMH0026)
42 Q219

3 The Government's mental health data and its limitations

Serving personnel

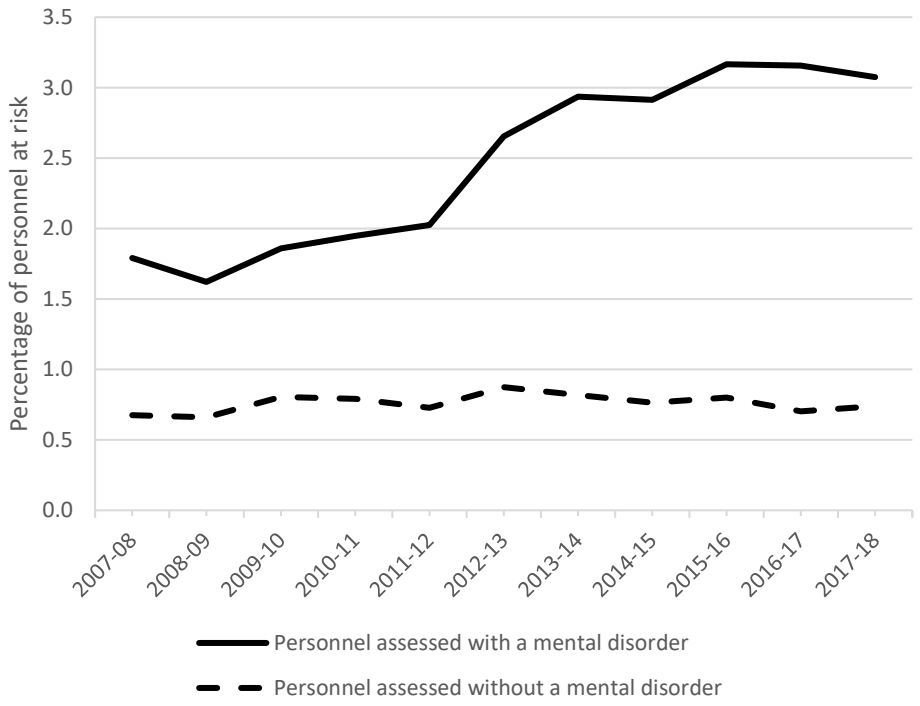
28. The Ministry of Defence is responsible for providing mental health care to all currently serving military personnel and mobilised Reservists, primarily through its Defence Medical Services.[43] As at the start of April 2018, there were 146,560 Regular UK Armed Forces personnel, plus a further 36,480 Reservists.[44] Defence Medical Services provide specialist mental health care at 20 locations across the UK, including 11 Departments of Community Mental Health (DCMHs), which have multi-disciplinary mental health teams. In-patient services are contracted out to a consortium of eight English and Scottish NHS Trusts.[45]

29. The percentage of Armed Forces personnel initially diagnosed with a mental health disorder at specialist mental health services has increased steadily over recent years from a rate of 1.6% (3,119) in 2008–09, plateauing at 3.2% (5,147) in 2015–16 (see Figure 1 overleaf). It has since fallen slightly to 3.1% (4,886) in 2017–8, which means that the proportion of personnel diagnosed with a mental health condition has nearly doubled over the last decade. The percentage of personnel who were assessed at specialist mental health services, but considered to have no mental health conditions, remained constant during this period at around 0.8% of all serving personnel (about a fifth of all those referred for an assessment).[46]

30. The Ministry of Defence also reports that these figures reflect what is seen at primary health care, given that over 90% of serving personnel diagnosed with a mental health disorder at primary health care were referred to secondary specialist care in 2015–16.[47]

43 Ministry of Defence (VMH0029)
44 Ministry of Defence, UK Armed Forces Quarterly Service Personnel Statistics 1 April 2018, May 2018, Table 1
45 Ministry of Defence, Defence Medical Services, website accessed 16 July 2018
46 Ministry of Defence, UK Armed Forces Mental Health: Annual Summary & Trends Over Time, 2007/08 - 2017/18, June 2018, Table 1
47 Ministry of Defence (VMH0029)

Figure 1: Rate of UK Armed Forces personnel referred for initial assessment at Ministry of Defence specialist mental health services



Note 1: From 2012–13, the Ministry of Defence revised its methodology to include electronic patient record data source

Source: Ministry of Defence, UK Armed Forces Mental Health: Annual Summary & Trends Over Time, 2007/08 - 2017/18, June 2018.

31. The main increase over the last decade has been in common mental health conditions. For example, among serving personnel, 3.5 of every 1,000 were diagnosed with mood disorders, such as depression, in 2008–09 but this more than doubled to 9.8 per 1,000 by 2017–18. Similarly, the rate of serving personnel with disorders such as phobias also more than doubled from 3.1 per thousand in 2008–09 to 8.5 per 1,000 in 2017–18.[48] The Ministry of Defence reported research that suggested that serving military personnel are more likely to experience symptoms of common mental disorders than the general population.[49] During the same period, the rate of serving personnel diagnosed with PTSD also nearly tripled, although rates remain much lower, from 0.7 per 1,000 in 2008–09 to 1.9 per 1,000 in 2017–18, although there was a slight drop down to 1.6 per 1,000 in 2013–14.[50]

32. Other Ministry of Defence statistics also indicate rising numbers of serving personnel reporting mental health issues. For example:

- We calculated that out of the total number of Service personnel medically discharged, the percentage discharged due to Mental and Behavioural Disorders

48 Ministry of Defence, UK armed forces mental health annual statistics: financial year 2017/18, June 2018, underlying data table for Figure 7
49 Ministry of Defence (VMH0029)
50 Ministry of Defence, UK armed forces mental health annual statistics: financial year 2017/18, June 2018, underlying data table for Figure 7

increased nearly each year from 14% (344) in 2013–2014 to 25% (588) in 2017–2018. Around three quarters of those discharged each year for this reason were army personnel.[51]

- The Ministry of Defence reported that the rate of serving personnel undertaking deliberate self-harm increased from 2.2 per 1,000 in 2010–11 to 2.8 per 1,000 in 2016–17, with increases seen each year between 2012–13 and 2015–16.[52]

Suicides

33. In contrast, the rate of suicide in serving personnel has remain broadly stable over the last decade, and is much lower than in the UK general population. The Ministry of Defence reported that in 2017 the suicide rate was 8 per 100,000 among male personnel across all three Services, which has broadly been the rate since 2007. The suicide rate among males aged 16–59 years for a comparative group in the UK general population was 18 per 100,000 in 2016. In total, the number of male personnel taking their own lives between 1998 and 2017 was 292. The Ministry of Defence has not conducted detailed analysis of suicides by female Service personnel, given the low number (17) during the same period.[53]

Veterans

34. The Government defines a veteran as anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations.[54] The 2014 Annual Population Survey estimated that there were around 2.6 million UK Armed Forces veterans living in the UK. Of these, over 50% are aged 75 or older.[55]

35. Statutory responsibility for mental health care to veterans falls to NHS England and its equivalents in the devolved administrations.[56] Armed Forces charities also provide mental health support to current and former serving Armed Forces personnel and their families. A 2017 report by the Directory of Social Change and the Forces in Mind Trust identified 76 such charities, with a third having such provision as their sole remit.[57] The Defence Minister, Tobias Ellwood MP, expressed how important these charities are, telling us that the Ministry of Defence is "reliant on the expertise and the knowledge and depth of experience that these charities provide … Some charities have existed for more than 100 years, doing an absolutely incredible job, which we rely on."[58]

51 Ministry of Defence, Annual Medical Discharges in the UK Regular Armed Forces, 1 April 2013 to 31 March 2018, July 2018
52 Ministry of Defence, Ad Hoc Statistical Bulletin, Deliberate Self Harm (DSH) in the UK Armed Forces 1 April 2010 – 31 March 2017, January 2018, Table 1
53 Ministry of Defence, Suicide and Open Verdict Deaths in the UK Regular Armed Forces: Annual Summary and Trends Over Time 1 January 1984 to 31 December 2017, March 2018
54 Ministry of Defence (VMH0029)
55 NHS England, Developing mental health services for veterans in England engagement report, September 2016, p5
56 Ministry of Defence, Defence People Mental Health and Wellbeing Strategy 2017–2022, July 2017, p31
57 Directory of Social Change and Forces in Mind Trust, Focus on: Armed Forces Charities' Mental Health Provision, June 2017, p4
58 Q234

36. The Government has limited data on the number of veterans with mental health conditions across the UK. For example, NHS England only began to record widely the number of veterans accessing its mental health services from April 2017, while in Northern Ireland mental health services do not record veteran status at all.[59] Dr Neil Kitchiner, Director & Consultant Clinical Lead at Veterans NHS Wales, told us that he was not aware of the Welsh Government holding detailed data on veterans that would help answer our questions.[60]

37. The Health Minister, Jackie Doyle-Price MP, accepted that collecting data on veterans has been particularly challenging for the NHS, but added that it was now beginning to collect the data needed to "build a much better picture". The Defence Minister, Tobias Ellwood MP, also noted that there were historic reasons for the inaccuracies of data on veterans, such as that the Ministry of Defence only started keeping proper records from 1975. He believed, however, that the introduction of the Veteran ID card and the inclusion of a question on veteran status in the 2021 census would also help to develop a picture of where veterans were and whether they were using health services.[61]

38. The data that is collected by Government showed more veterans accessing specific mental health services over recent years, although some of these may have previously sought care through mainstream NHS services:

- NHS England reported that the number of veterans in England referred to its Improving Access to Psychological Therapies (IAPT) programme has seen a 50% increase from 16,055 in 2013–14 to 24,390 in 2016–17.[62] Services provided under the IAPT programme are used to treat people with anxiety and depression and NHS England first began to identify referrals by veterans and their dependents from April 2013.[63]

- Veterans NHS Wales, the veteran-specific service provider in Wales, has seen the number of referrals made to it annually more than triple from 191 in 2010, when the service expanded to cover the whole of Wales, to 633 in 2017.[64]

- NHS Scotland funds veteran-specific statutory care through Veterans First Point Scotland, which also reports increasing numbers of veterans being referred to it as the service has expanded. One of its centres had received over 1,500 referrals since it began in 2009, with a current rate of 50 new referrals a quarter.[65]

Suicides

39. Witnesses raised the lack of national datasets on the rate of suicides in veterans as a significant data gap. For example, the Veterans Hub reported three suicides by veterans in Weymouth in one month, yet "because there is no central system to track these kinds of incidents, there is no discernible means for the local authority to differentiate between

59 NHS England (VMH0031), Ulster University Veterans Research Group (VMH0039)
60 Q69 [Dr Kitchiner]
61 Q179 [Mr Ellwood and Jackie Doyle-Price]
62 NHS England (VMH0031)
63 NHS England, Adult Improving Access to Psychological Therapies programme, webpage accessed 16 July 2018 and NHS England (VMH0031)
64 Veterans NHS Wales mental health support extended, BBC News, 5 January 2018 and Welsh Government, Written Statement: Review of Veterans NHS Wales, November 2014
65 Veterans First Point Scotland (VMH0024)

someone from the general population and a veteran who chooses to take this tragic, but avoidable, course of action".[66] The Health Minister, Jackie Doyle-Price MP, accepted that more could be done in tracking suicide rates among veterans.[67]

40. The data available suggests that, apart from young veterans, the rate of suicide amongst veterans is comparable to that of the general public. A 2009 study by Professor Kapur at Manchester University found that the only group of veterans to show higher rates of suicide than the general public were those aged under 24, who have a risk three times higher than their civilian counterparts.[68] The Health Minister told us that "the correlation of men as between a certain age group, who unfortunately and very sadly are prevalent to suicide as part of mortality suicides, is about the equivalent for ex-serving."[69] Dr Bergman also told us that from her research on Scottish veterans they were at no increased risk of suicide compared to the general public.[70]

What the trends represent

41. The increased reporting of mental health conditions in UK Armed Forces personnel and veterans may not, however, represent a real rise in mental health conditions. The Ministry of Defence suggested that the success of mental health awareness campaigns may have led to "greater detection rates and referrals to specialist care".[71] It also suggested that improved reporting could be a reason for the apparent increase in case of deliberate self-harm.[72] The King's Centre for Military Health Research (KCMHR) at King's College London, suggested in October 2014 that, as well as a true rise and greater awareness, other reasons could include a decrease in time taken to seek help and improvements by the Armed Forces in their mental health referral processes.[73]

42. The Ministry of Defence told us that it is difficult to determine the significance of these factors but it considered that the increase in serving personnel seeking help had been an important factor in the reported rise. The Defence Minister, Tobias Ellwood MP, certainly felt that the challenge over the stigma of mental health, not just in the military, but across the country had led to more people coming forward for help.[74] Professor Wessely similarly believed that more people were seeking help.[75]

43. **There have been significant increases in the number of serving Armed Forces personnel and veterans seeking mental health care over the last decade. The Ministry of Defence reports that since 2008–09 the proportion of serving Armed Forces personnel diagnosed with mental health conditions has nearly doubled, to 3.1%. Data on veterans is more limited, particularly in Northern Ireland, but statutory providers in England, Scotland and Wales also reported similar increases in the number of**

66 The Veterans Hub (VMH0020). Also Lt Col (Rtd) Andrew Marriott (VMH0036), Glen Art (VMH0028)
67 Q182
68 Q30
69 Q182
70 Q83
71 Ministry of Defence, UK Armed Forces Mental Health: Annual Summary & Trends Over Time, 2007/08 - 2017/18, June 2018, p5
72 Ministry of Defence, Ad Hoc Statistical Bulletin, Deliberate Self Harm (DSH) in the UK Armed Forces 1 April 2010 – 31 March 2017, January 2018, p2
73 King's Centre for Military Health Research, King's College London, The mental health of the UK Armed Forces, October 2014
74 Qq151–152
75 Q3

veterans they are seeing. A significant factor in the rise reported may be that, as in the civilian population, more serving personnel and veterans who have mental health issues are seeking help.

44. **We are particularly concerned, however, by the lack of national data on veteran suicides. The evidence that is available suggests that the rate in veterans is likely to be comparable to the general population. However, without robust data to know whether there may be specific groups or areas that need to be monitored more closely, Government health bodies and Armed Forces charities may be missing opportunities to help those most in need.**

45. ***We recommend that the Ministry of Defence works with the justice departments across the four nations to record and collate, as part of existing suicide records, whether someone had been a veteran to monitor the level and locations of veteran suicides. This will enable it to identify whether there are particular groups of veterans or particular locations where more effort is required to prevent such tragic events from occurring.***

Data limitations

Helpseeking

46. A significant limitation of most government and Armed Forces charity datasets on mental health is that they report only those serving personnel or veterans who have sought help.[76] Serving personnel and veterans might not seek help for their mental health conditions for reasons including stigma, their views on the provision of care, not being aware that they had mental health issues or not believing that they needed help.[77] The Ministry of Defence believed that many of these reasons also applied to the general population.[78]

Stigma

47. Negative beliefs and perceptions have created a stigma around mental health, which makes those with mental health issues afraid of discriminatory reactions from those around them.[79] Contact told us that high-profile campaigns, such as the Royal Foundation's Heads Together, had helped to destigmatise mental health issues within the Armed Forces.[80] The Ministry of Defence has also been campaigning against stigma, with the Defence Minister, Tobias Ellwood MP, telling us that they are "getting to a place where the stigma is being challenged and a cultural change is taking place".[81]

76 Ministry of Defence (VMH0029)
77 For example Alison McDowell (VMH0004) or King's Centre for Military Health Research, King's College London, and Forces in Mind Trust, Stigma and barriers to care in service leavers with mental health problems, November 2017, p5
78 Ministry of Defence (VMH0029)
79 For example, The RAF Association (VMH0045) or the King's Centre for Military Health Research, King's College London, and Forces in Mind Trust, Stigma and barriers to care in service leavers with mental health problems, November 2017, p10
80 Contact (VMH0026)
81 Q151, Ministry of Defence (VMH0029)

48. However, the stigma over mental health remains a reason as to why serving personnel and veterans may not initially seek help.[82] Contact also believed that the resilience and self-reliance promoted in the military meant that there is a "cultural reluctance to acknowledge a mental health concern [that] remains for many long after discharge".[83] A KCMHR and Forces in Mind Trust study in 2017 found that although stigma was not the main reason why veterans did not seek help, those seeking help the first time were most concerned by stigma.[84]

Provision of care

49. Veterans are similarly put off from continuing to seek help if they have been unable to access care when they need it or found it to be ineffective. The same 2017 KCMHR and Forces in Mind Trust study found that the most cited barrier by veterans was provision of care. Although they sought help, they found that they were unable to access the care they needed "due to eligibility issues and to waiting lists (affecting their ability to access services), and to services being withdrawn by providers when veterans were deemed 'fixed'".[85] Dr Walter Busuttil, Director of Medical Services at Combat Stress, told us that 80% of those who turn to Combat Stress for help had already tried their GP or NHS mental health services, or both.[86]

50. One specific concern over civilian care provision is a lack of understanding of the military among civilian clinicians. Dr Busuttil believed there was a weakness in the NHS around understanding "what a veteran is, how they tick and what they are actually describing in terms of their symptoms".[87] Walking with the Wounded also told us that for veterans encountering this lack of understanding, especially if it is was their first contact, the experience might lead to "disengagement and an unsatisfactory experience".[88] The Health Minister, Jackie-Doyle Price MP, and Kate Davies, the Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning at NHS England, told us that they wanted to improve GPs' and other NHS practitioners' understanding of veterans' mental health. This included working with the Royal College of General Practitioners to develop criteria on assessing a GP's competence in working with veterans and their families.[89]

51. We also found that the principle of veterans receiving priority treatment is not being consistently implemented across the UK. The Armed Forces Covenant sets out that "Veterans receive their healthcare from the NHS, and should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need".[90] We found, however, that:

- In England, the Health Minister, Jackie-Doyle Price MP, told us that "the fundamental principle of the NHS is that no one is given favour over anyone

82 For example, Veterans First Point Scotland (VMH0024), Anglia Ruskin University (VMH0032) and The British Association for Counselling and Psychotherapy (VMH0014)
83 Contact (VMH0026)
84 King's Centre for Military Health Research, King's College London, and Forces in Mind Trust, Stigma and barriers to care in service leavers with mental health problems, November 2017, p5
85 Ibid
86 Combat Stress (VMH0044)
87 Q112
88 Walking with the Wounded (VMH0016)
89 Q211
90 Ministry of Defence, The Armed Forces Covenant, May 2011, p6

else", which she accepted created a tension between that and the Armed Forces Covenant. NHS England has sought to resolve this tension by offering bespoke services for veterans instead.[91] The 2015 Community Innovations Enterprise and Forces in Mind Trust report on veterans' mental health needs in England found that there was a perceived lack of coherence between local bodies on implementing the Covenant's health commitments and that prioritisation "is often poorly understood in the correct context of attribution of health conditions to serving in the armed forces and assessment of clinical need".[92]

- The Scottish Veterans Commissioner, Eric Fraser, concluded in his 2018 report that priority treatment was a "largely meaningless concept" which should be re-considered. He argued that "the concept is flawed, often misunderstood and occasionally ignored by a number of health professionals and veterans… the current confusion about what priority treatment means and its impact serves nobody well, especially if it results in unrealistic expectations which cannot be matched."[93]

- In Wales, the 2016 Community Innovations Enterprise and Forces in Mind Trust report raised the need for clarity over how veterans are to be treated. It included one stakeholder's comments that "some executives in their Health Board saw [priority treatment] as 'queue jumping' and "veterans relying on being veterans rather than being normal citizens"; with the broad definition of a veteran (someone who has served for a day) "seen as not helping the situation".[94]

- There is a more fundamental difficulty in how the Armed Forces Covenant is implemented in Northern Ireland, given that the Northern Ireland Act 1998 aims to ensure equality across the population and so there is no priority treatment for veterans.[95]

Recording and Diagnosis

52. Veterans accessing mainstream NHS mental health care are also likely to be under-recorded. For example, Matt Fossey, Director of the Veterans and Families Institute at Anglia Ruskin University, told us that the data, particularly in primary care, is "pretty incomplete" as clinicians do not necessarily complete the relevant codes in the systems.[96] Witnesses told us that this could be because GPs do not ask or veterans choose not to disclose their status, particularly in Northern Ireland given their security fears, or indeed

91 Qq245–248

92 Community Innovations Enterprise and Forces in Mind Trust, Call to Mind: A framework for action - Findings from the review of veterans and family members mental and related health needs assessments, Final Report, October 2015, p48

93 Scottish Veterans Commissioner, Veterans' Health & Wellbeing - A Distinctive Scottish Approach, April 2018, p9

94 Community Innovations Enterprise and Forces in Mind Trust, Call to Mind: Wales - Findings from the review of veterans and family members mental and related health needs assessments, Final Report, May 2016, for example, p 29

95 Qq70–71

96 Q47 [Matt Fossey]

do not perceive themselves to be veterans, for example Reservists.[97] The Royal College of General Practitioners also highlighted the need for better coding of veterans within GP computer systems.[98]

53. Professor Klein pointed out that there is a "disability paradox", that someone might be clearly not be functioning well at all yet might not be diagnosed for a mental health condition as they had not met the full criteria.[99] Help for Heroes also believed that by not including all those who sought help, some datasets failed to capture the scale of need.[100]

Estimates of those not seeking help

54. The Ministry of Defence has acknowledged this limitation and the likelihood that the currently available data will not reflect the true extent of mental health in veterans. The Ministry of Defence told us that "statistics that might be frequently cited in debate is the extent to which veterans access health services, whether provided by the NHS or charities; however, this is not representative of the overall Veteran population since only a subset uses such services." It also recognised that it only collects data about those who seek treatment, "which is again not representative of overall prevalence."[101]

55. Current research suggests that about half to two-thirds of serving personnel and veterans with mental health issues may not be seeking help:

- a KCMHR study in 2015 found that approximately 60% of military personnel do not seek help. We calculate that this would suggest that the true rate of mental health conditions in serving personnel may be as high as 8%, based on the Ministry of Defence's reported 2017–18 rate of 3.1%;[102] and
- another report in 2015, a joint Help for Heroes and KCMHR study, suggested that at least 10% of veterans who served over the last 20 years may present mental health conditions that need treatment. It estimated that at least 61,300 out of 601,000 veterans who served as Regulars in the UK Armed Forces between 1991 and 2014 might suffer from mental health problems and require professional intervention.[103]

56. **UK Government statistics report only those who seek help and may therefore be significantly underestimating how many serving personnel and veterans have mental health conditions. The Ministry of Defence acknowledges that its statistics may not be representative of the overall veteran population. Current research suggests that the number of veterans with mental health conditions that require professional help could be up to three times higher than official statistics, at around 10%.**

97 Q47 [Sir Simon Wessely], Q86 [Dr Kitchiner], Q117 [Professor Armour], Q179 [Jackie Doyle-Price], King's Centre for Military Health Research, King's College London, ''Are You a Veteran?'' Understanding of the Term ''Veteran'' among UK Ex-Service Personnel A Research Note, Armed Forces & Society 00(0) 1–9, July 2012

98 Royal College of General Practitioners (VMH0040)

99 Q24 [Professor Klein]

100 Help for Heroes (VMH0021)

101 Ministry of Defence (VMH0029)

102 King's Centre for Military Health Research, King's College London, Stigma as a Barrier to Seeking Health Care Among Military Personnel With Mental Health Problem, Epidemiologic Reviews, Vol. 37, 2015, January 2015

103 Help for Heroes (VMH0021) and King's Centre for Military Health Research, King's College London, Counting the Costs, November 2015, pp iii and iv

57. **There are a number of barriers such as stigma and the failures in the provision of care, that continue to dissuade serving personnel and veterans from seeking help from statutory services. Although there have been improvements in the provision of care in recent years, more clearly needs to be done, especially in improving the timeliness of care. We will be examining the provision of mental health care to serving personnel and veterans in our follow up inquiry, where we will explore the issues around barriers to care. We also support the work being taken by the Ministry of Defence and Armed Forces charities in campaigning against the stigma surrounding mental health. However, stigma remains a barrier and this work needs to continue.**

58. **We are particularly concerned that the Armed Forces Covenant principle of priority treatment when a condition is service-related is not being consistently applied across the UK. The Department of Health and Social Care considers that the NHS founding principles on equality and clinical need constrain how it can provide priority treatment to veterans. This difference in interpretation is confusing not just to veterans but also to clinicians; this may add to veterans' perception that the health service is failing them. The situation is similar in Scotland and Wales, while there remains a more fundamental difficulty in implementing the Armed Forces Covenant in Northern Ireland.**

59. ***We recommend that in its forthcoming veterans strategy, the Government should set out clearly whether veterans may expect to receive priority treatment, subject to clinical need, and what that means in practice. The Government should ensure that this clarification is then cascaded down to both NHS staff and veterans and their families across the UK.***

60. **Poor recording of veterans at primary care level may also lead to an underestimation of the extent of mental health conditions in veterans and affect how they are being treated. GPs failing to ask, veterans themselves not telling and inadequate recording are all leading to an incomplete picture. If GPs are not aware that their patient is a veteran then they will not be able to refer them to the veteran-specific services that are available in England, Scotland and Wales. *We recommend that, as part of the ongoing work to improve their knowledge of military health, civilian medical practitioners, especially GPs, should be made aware of the importance of asking about veteran status and recording it correctly.***

4 Effect of operations in Afghanistan and Iraq

61. As one would expect, deployment to Iraq and Afghanistan was cited by witnesses as a significant factor in the onset of mental health conditions. For example, Combat Stress reported that 92% of veterans who approached it for support had been in at least two or more operational zones.[104] It had also seen significant increases in the number of veterans receiving its support over the last decade. Dr Busuttil told us that:

> one year recently, I had a 26% rise in people coming forward, and it's been really year-on-year. When I joined Combat Stress in 2007, there were around 996 new patients coming forward; last year, we had in excess of 2,600, which was an increase of 250 or so over the previous year.[105]

62. In its written evidence, the Veterans Hub also suggested that "many would speculate that this [increase in mental health problems] is a direct consequence of being involved in almost two decades of constant conflict and not having a workable system in place to support the mental health needs of those deploying".[106]

63. Walking with the Wounded, however, suggested that non-deployment could also affect an individual's mental health, with "some personnel feeling unfulfilled or not part of the unit's recent history and feel[ing] disconnected, resulting in difficulties."[107]

Academic research into the effects of the two operations

64. The King's Centre for Mental Health Research (KCHMR) has been conducting the largest study into the effects of operations in Afghanistan and Iraq on UK Armed Forces, based on three phases of data collection covering personnel who served in 2004–06, 2007–09 and 2014–16.[108]

65. Its research from its first two phases suggests that overall the mental health of UK Armed Forces personnel has remained stable during these operations. Findings showed that around 4% of those who deployed to Iraq and Afghanistan during 2004–06 and 2007–09 had probable PTSD, which was the same for the whole of the UK Armed Forces.[109]

66. Professor Nicola Fear, Director at the KCMHR, however, reported that the rate of PTSD in those deployed had increased to 6%, based on the latest data from the third phase of the research. No other mental health condition had shown an increase with, for

104 Combat Stress (VMH0006)
105 Q101
106 The Veterans Hub (VMH0020)
107 Walking with the Wounded (VMH0016)
108 King's Centre for Military Health Research, King's College London, The mental health of the UK Armed Forces, October 2014. The study began at the start of operations in Iraq, when the Ministry of Defence asked KCMHR to examine the health of those who had deployed on Op TELIC (phase 1 of the study - 2004–6). Since then, the study has been expanded to also look at the possible effects of deploying to Afghanistan on Op HERRICK (phase 2 2007–9 and phase 3 2014–16). The full results from phase 3 are expected to be published later in 2018. Serving and former Armed Forces personnel from all three Services, including Reservists, have taken part in the study since it began. Conditions are reported as probable as they are based on answers provided by serving personnel and veterans rather than clinical diagnosis.
109 Ibid

example common mental disorders remaining at around 20% across all three phases.[110] The KCMHR research also found increased rates of mental health conditions in certain groups: those deployed in combat roles, and Reservists who had been deployed.

Deployment in combat roles

67. KCMHR found double the rates of probable PTSD and alcohol misuse rates in those who had deployed in combat roles compared to those who did not deploy. It found that 6.9% of Regulars deployed in combat roles during 2007–09 reported probable PTSD compared to 3.6% in those not deployed. Alcohol misuse rates were higher with 22% of those deployed reporting such misuse compared to 11% in those not deployed.[111] Professor Wessely told us that the data from the latest phase suggests that PTSD in those deployed in combat roles could be as high as 9%.[112]

68. Combat Stress has reported significantly higher levels of PTSD in those veterans who seek the charity's help. It told us that among the veterans it works with, 82% that had deployed to an operational zone suffered from PTSD. Of those that deployed nearly two-thirds had a combat role.[113] Dr Busuttil acknowledged that the charity was seeing those most in need, those veterans "looking for help who are in really dire straits".[114]

Deployed Reservists

69. KCMHR found a similar story in deployed Reservists, where again probable PTSD and alcohol misuse rates were double compared to those not deployed. It found that in those deployed during 2004–06, probable PTSD was 6% for deployed Reservists compared to 3% in those not deployed. Both rates fell in 2007–09 where the rates were 5% and 2% respectively. KCMHR suggested that this may be due to different pre-deployment and homecoming experiences, rather than experiences in theatre. Some Reservists also reported that they felt alienated from the military once they have been demobilised, which may be linked to continuing poor mental health.[115]

70. Armed Forces charities also suggested that a lack of support for Reservists was a likely cause. Combat Stress told us that:

> they will often return to their civilian job in a matter of days with no ample support from civilian colleagues who cannot appreciate the pressures of deployment and combat. This lack of support and monitoring makes them more vulnerable to mental health issues.[116]

Walking with the Wounded agreed, further noting that even though services were available, Reservists might not understand what was out there for them.[117]

110 Q3 [Professor Fear]
111 King's Centre for Military Health Research, King's College London, The mental health of the UK Armed Forces, October 2014
112 Q14
113 Combat Stress (VMH0006)
114 Q101
115 King's Centre for Military Health Research, King's College London, The mental health of the UK Armed Forces, October 2014
116 Combat Stress (VMH0006)
117 Walking with the Wounded (VMH0016)

71. The Ministry of Defence recognised that deployed Reservists were at risk of developing mental health problems but considered that its support programme was effective in helping recovery. The Ministry of Defence set up the Veterans and Reservists' Mental Health Programme to support Reservists following KCMHR's initial findings. It also cited research conducted in 2011 by KCMHR which showed that "three-quarters of reserves assessed [by the Programme] return to full fitness and experience substantial improvements in mental health."[118]

72. **Deployment to Iraq and Afghanistan has clearly increased the likelihood of mental health conditions among those who saw combat or were deployed Reservists. The 2014 study by King's Centre for Mental Health Research found that the rate of PTSD in Regular personnel in deployed combat roles was 6.9% and for deployed Reservists 6%, compared to 4% for the Armed Forces as a whole. Armed Forces charities also report more cases of mental health conditions in veterans in these groups.**

118 Ministry of Defence (VMH0029) and King's Centre for Military Health Research, King's College London, The mental health of the UK Armed Forces, October 2014

5 Groups that might be more vulnerable to mental health issues

73. In addition to those deployed in combat roles or as Reservists, there are a number of other groups of personnel who are reporting higher levels of mental health conditions during or after their service:

- **Early Service leavers**—The Ministry of Defence defines these as those who leave before their minimum term of four years. They are widely recognised by witnesses, including the Ministry of Defence, as a group that presents higher levels of mental health conditions. For example, a 2012 KCMHR study found that nearly half (45.6%) presented common mental health difficulties compared to a quarter (26.5%) of other leavers.[119] Matt Fossey also told us that most leave before completing basic service.[120] It was this group which Dr Bergman found in her study on Scottish veterans to have had the highest presentation of mental health conditions, showing a 150% increase in risk of developing PTSD compared to people who had never served.[121]

  Possible reasons for this increased vulnerability include early Service leavers potentially already having pre-existing conditions, as reported in paragraph 11, or the short notice at which they leave, often less than two weeks with little time to plan the transition to civilian life.[122] Matt Fossey highlighted the fact that because most leave so early very little was known about them.[123] The Surgeon-General confirmed to us that the Ministry of Defence had specific support in place for early Service leavers, although the Defence Minister, Tobias Ellwood MP, also told us that the level of support during transition increased with length in service.[124]

- **Under 18s**—The minimum age for joining the UK Armed Forces is 16, although the Defence Minister emphasised that those under the age of 18 are not deployed on operations.[125] Witnesses such as Child Soldiers International, Medact and ForcesWatch emphasised that adolescents are in general more susceptible to mental health issues and that they may already be more vulnerable if they are joining with lower educational attainment and from lower socio-economic backgrounds. The stresses of the military environment may therefore have a greater effect on their mental health than older personnel. ForcesWatch also told us that younger recruits are more likely to be early Service leavers.[126]

  The Surgeon-General told us that those aged under 20 were less likely to seek help for mental health issues than older personnel, but accepted that academic data

119 Psychological Health of Military Personnel, POSTnote 518, Parliamentary Office of Science and Technology, February 2018
120 Q54 [Matt Fossey]
121 Q69, Dr Beverly Bergman (VMH0017)
122 Psychological Health of Military Personnel, POSTnote 518, Parliamentary Office of Science and Technology, February 2018
123 Q54 [Matt Fossey]
124 Q229 and Q234
125 Q178, Child Soldiers International, The British armed forces: Why raising the recruitment age would benefit everyone, May 2016
126 Child Soldiers International (VMH0007), Medact (VMH0030), ForcesWatch (VMH0023)

suggests that younger recruits may be more at risk.[127] Professor Wessely did not consider that there was currently strong evidence to show that those aged under 18 were more at risk of developing mental health conditions. However, KCMHR had taken only had a "partial look" at this group and could be doing more now that they had data on age of enlistment.[128] Child Soldiers International, Medact and ForcesWatch have all called for further research on how military service might affect the mental health of personnel in this group, including the effect of training.[129]

- **Female personnel**—The Ministry of Defence reports that serving female personnel are more likely to seek help for mental health conditions than male personnel, which reflects the trend in the general population. For example, in 2017–18, female personnel were twice as likely to seek help and be diagnosed with a mental health condition (6.1% of female personnel compared to 2.7% of male personnel).[130] Combat Stress also cited studies that show alcohol and drug misuse are significantly higher amongst female veterans.[131] Forward Assist believed that women are a "hidden population" and both it and Anglia Ruskin University highlighted the lack of research conducted into the specific support needs of female veterans.[132]

- **Those suffering physical injuries**—Professor Klein told us that in a study of severely injured personnel, 11.8% had reported PTSD, although she considered that was "surprisingly low", given the severity of injuries.[133] Hilary Meredith also highlighted the risk of those severely injured developing mental health conditions if they are medically discharged and lose the support and community they had during service.[134] The Surgeon-General told us that those who are very seriously injured and sick are fully cared for, including monitoring of their mental health. He did not confirm, however, whether this was also the case for those less severely injured.[135]

74. **Certain groups of Service personnel, regardless of deployment, may also be potentially more vulnerable to developing mental health conditions, both during and after service. These groups include female personnel, both currently serving and veterans, early Service leavers and recruits aged under 18. More reliable data is needed to show whether they are more at risk and hence whether the existing support they receive is good enough. *We recommend that the Ministry of Defence conducts or commissions further research into these groups to determine the extent to which they are at higher risk of developing mental health conditions. The Government should then consider what specific monitoring and mental health support might need to be provided or enhance existing provision to those groups that are at higher risk.***

127 Qq175–176
128 Q28
129 Child Soldiers International (VMH0007), Medact (VMH0030), ForcesWatch (VMH0023)
130 Ministry of Defence, UK Armed Forces Mental Health: Annual Summary & Trends Over Time, 2007/08 - 2017/18, June 2018, p10.
131 Combat Stress (VMH0006)
132 Forward Assist (VMH0022), Anglia Ruskin University (VMH0041)
133 Q4 [Professor Klein]
134 Ms Hilary Meredith (VMH0003)
135 Q178

6 Comparison of mental health datasets

Differences between UK Government, academics and charities datasets

75. As we have set out in Chapters 3 and 4, the Ministry of Defence reports lower levels of mental health conditions in current serving personnel compared to the KCMHR data and charities. Possible reasons for this included:

- The Ministry of Defence records only those who seek help from its medical services, whereas the KCMHR data is based on a wider cross-section of the Armed Forces. As a result, the KCMHR data may include some serving personnel who have mental health issues but have not sought help. However, as the KCMHR data is based on a questionnaire rather than clinical diagnosis, its findings are based on 'probable' diagnosis.[136] Clinicians and academics also use different diagnosis criteria.[137]

- Serving Armed Forces personnel may be concerned that reporting mental health problems could affect their career or how their comrades perceive them.[138] For example, Andrew Price, Project Manager of the Veterans Hub, told us that the fear of both was why he himself did not seek help after symptoms began to appear until much later in his life.[139]

- The onset of mental health conditions in veterans may be delayed, although the average time between veterans leaving service and seeking help is falling. For example, Dr Busuttil told us that "On average, for a Falkland veteran or a Gulf war veteran or a Northern Ireland veteran, it is still around 14 years after they leave the military. For Iraq and Afghanistan, it's much lower. It's two years for Afghanistan after they leave the military and it's about three or four years for Iraq veterans."[140]

- The Ministry of Defence reports that clinicians may tend to diagnose UK Armed Forces personnel with a less serious condition. This may potentially mean that they are reporting fewer cases of PTSD.[141]

- Those seeking help may also go to charities, rather than statutory care, and so are not recorded in Government statistics. In its written evidence NHS England suggested those seeking help from the NHS may represent only about half of help-seekers.[142] Anglia Ruskin University also told us that some serving personnel may look for treatment outside of the Armed Forces, for example through the NHS or private consultation.[143] The British Association for Counselling and

136 Q18, King's Centre for Military Health Research, King's College London, The mental health of the UK Armed Forces, October 2014, Ministry of Defence (VMH0029)
137 The Big White Wall (VMH0027), NHS News, Asperger's not in DSM-5 mental health manual, 4 December 2012
138 Q106 [Rod Eldridge], Combat Stress (VMH0006)
139 The Veterans Hub (VMH0020)
140 Q101
141 Ministry of Defence, UK Armed Forces Mental Health: Annual Summary & Trends Over Time, 2007/08 - 2017/18, June 2018, para 27
142 NHS England (VMH0031)
143 Anglia Ruskin University (VMH0032)

Psychotherapy told us that there is no information on how many veterans or serving personnel have access to counselling or psychotherapy, or whether they have accessed these services.[144]

- Royal British Legion Industries highlighted that they and many other charities could only gather data on health conditions as reported by a veteran.[145] In Scotland, Dr Lucy Abraham also stated that an individual may not understand the validity of their diagnosis by healthcare professionals, reporting that "during their initial registration approximately half the veterans at Veterans First Point, self-report a prior mental health diagnosis… These diagnoses are usually given by their General Practitioners (40%)."[146]

76. Along with other charities such as the Big White Wall and the Veterans Hub, Contact raised the broader difficulties of the differences in data collection by each research and mental health care provider. Contact concluded that "this lack of a coherent approach to gathering accurate data makes it incredibly difficult to develop policy and design and deliver effective services."[147]

77. Some steps have been taken across the military mental health sector to improve the quality of available data through the development of common principles. Contact published guiding principles in September 2015 for the provision of mental health care, including outcome measures and agreement to pool data, though it remains early days in its implementation.[148]

Comparisons to the UK general public

78. The Ministry of Defence reports lower levels of mental health conditions in current serving personnel compared to the general population, but again this comparison can only be indicative. The rate of mental disorder it reports among UK Armed Forces personnel assessed within specialised psychiatric services was 3.1% in 2017–18. In comparison in 2016–17 (the latest available figures) the rate in the general population accessing NHS secondary mental health services in England was 4.5%. However, the Ministry of Defence recognises that comparisons with the UK general population are difficult. For example, serving personnel may be referred to mental health services earlier than their civilian counterparts. In addition, the NHS England data includes services not directly relevant to the UK Armed Forces population, such as for learning disabilities.[149]

79. Professor Wessely also told us that any comparison between military and civilian rates of mental health conditions would need to be significantly caveated as they were not comparing like for like, citing differences in factors such as physical health. However, Professor Fear suggested that such comparators are useful to help assess whether the figures being reported were "good or bad".[150] She also said that it would be helpful to be

144 The British Association for Counselling and Psychotherapy (VMH0014)
145 Royal British Legion Industries (VMH0037)
146 Veterans First Point Scotland (VMH0024)
147 Contact (VMH0026), The Big White Wall (VMH0027), The Veterans Hub (VMH0020)
148 Contact, Guiding Principles for the delivery of Veterans' and Service Families' Mental Health Care, September 2015
149 Ministry of Defence (VMH0029), Ministry of Defence, UK Armed Forces Mental Health: Annual Summary & Trends Over Time, 2007/08 - 2017/18, June 2018, p6
150 Q21

able to compare military mental health data to civilian groups, such as emergency service workers, who may be exposed to traumatic events. However, it was very hard to get large datasets on the mental health of these groups to conduct comparison.[151]

International comparisons

80. Other countries are reporting higher rates of PTSD than UK. Professor Wessely told us that studies on US Armed Forces suggested that upon returning from deployment the rate of PTSD would be similar at around 7%, but that after two years the rate could be as high as 32%.[152] In terms of serving personnel only, Karen Mead, Head of Psychological Wellbeing at Help for Heroes, told us that the Ministry of Defence reports the rate of PTSD to be at 0.2% in serving personnel. In Australia it is 8.7%, in Canada 6% and in the US 12.6%, with rates even higher for veterans.[153] Unlike the Ministry of Defence figures, these other countries base their data on surveys of cross-sections of the military population, not just those seeking help, and the surveys are anonymous which may encourage more reporting.[154]

81. KCMHR suggested that differences both in how the US and UK military deployed and in their civilian health systems were reasons why the US reported much higher rates of PTSD. For example, US forces initially saw higher levels of combat at the start of the operations in Afghanistan and Iraq, had longer tour lengths and included greater numbers of reservists. The need for US veterans to show a service-related diagnosis to access enhanced healthcare post-service might also encourage a higher proportion of them to report mental health issues.[155] Professor Wessely also noted that the US would say the difference was due to delayed onset, but believed that if this were the case, it was not clear why UK personnel would not also be showing similar levels of delayed onset.[156]

82. **Knowing what the full scale of the mental health problem is across serving personnel and veterans is critical to determining the resources required to care for those that need it, yet there is no clear and agreed understanding across the sector. The Ministry of Defence, academic studies and Armed Forces charities all take different approaches to assessing and recording the number of serving personnel and veterans with mental health conditions. This has led to a wide range of estimates with at one end, the Ministry of Defence suggesting it is lower than the UK general population and at the other Armed Forces charities—which mainly see those veterans who need help the most—reporting much higher levels.**

83. ***We recommend that the Ministry of Defence and the health departments of the four nations work with Contact and the charity sector to agree and implement a shared set of methodologies for collecting and analysing data. This will enable a common understanding of what the demand for care services might be from serving personnel and veterans and for both Government and the Armed Forces charity sector to provision care accordingly.***

151 Q22
152 Q11
153 Q103
154 Q106
155 King's Centre for Military Health Research, King's College London, The mental health of the UK Armed Forces, October 2014
156 Q11

84. ***We recommend that such common methodologies consider how mental health statistics are collected more widely, so that like for like comparisons can be made with the UK population as a whole or indeed with other countries. This would ideally include the Government developing data on mental health conditions assessed in emergency services personnel, who by the nature of their roles, are more likely to encounter traumatic situations than the general public.***

Regional data

Serving personnel

85. As serving personnel can regularly be redeployed around the UK regardless of where they enlisted, the Ministry of Defence does not break down its data on mental health for serving personnel by devolved nation.[157] It does, however, collect and internally report data from its 11 specialist mental health centres, Departments of Community Mental Health (DCMHs) across the UK. We asked if this data could be made available, but the Surgeon-General noted that any variation would be a reflection of what work the serving personnel are employed on rather than any other factor.[158] Furthermore, we note that all, bar one DCMH in Scotland, are based in England, although there are smaller mental health teams in Wales, Northern Ireland and Scotland. This prevents even a rudimentary comparison between the four nations.[159]

Veterans

86. The provision of mental health care for veterans is devolved across the four nations and the services provided varies:

- NHS England offers veteran-specific out-patient services through its Veterans' Mental Health Transition, Intervention and Liaison Service, launched in April 2017, and its Complex Treatment Service, launched in April 2018. With the latter's introduction, NHS England moved away from residential care treatment, thereby ending its commission with Combat Stress, and intending instead to provide more community-based care.[160]

- The Welsh Government funds a veteran-specific out-patient service that provides therapy services and support through Veterans NHS Wales, though Help for Heroes has also provided funding to the service to recruit more staff. There is no residential provision, with Welsh veterans relying on Combat Stress to accept and fund their referrals to its in-patient centres in England and Wales.[161]

- In Scotland, the veteran-specific out-patient service is provided by Veterans First Point, which is co-funded by the Scottish Government and local NHS Boards. The Scottish Government also commissions Combat Stress to provide residential care.[162]

157 Ministry of Defence (VMH0029)
158 Q201 and Q202
159 Ministry of Defence, Defence People Mental Health and Wellbeing Strategy 2017–2022, July 2017, p33
160 NHS England (VMH0031), Combat Stress (VMH0044)
161 Q74 [Dr Kitchiner], Dr Neil Kitchiner (VMH0043), Help for Heroes (VMH0021)
162 Veterans First Point Scotland (VMH0024), Combat Stress (VMH0044)

- There are no statutory veteran-specific services in Northern Ireland and no special care in mainstream services. This is in part a result of the continued difficulties in balancing the requirements of legislation in Northern Ireland and the principles of the Armed Forces Covenant. Veterans are therefore reliant on charities if they wish to use veteran-specific services, such as that provided by Help for Heroes remotely or by Combat Stress if they travel to Scotland for residential care.[163] The 2017 Community Innovations Enterprise and Forces in Mind Trust review of mental health and social care in Northern Ireland also considered that the Armed Forces charity sector was less developed compared to the rest of the UK.[164]

87. As a result, each nation collects and publishes different datasets, which makes it very difficult to determine whether veterans have higher rates of mental health issues and whether they are getting better treatment based on where they live. For example, Dr Bergman told us that NHS Scotland holds more data on veterans' military service than other nations.[165] Data in Wales and England is more limited, with mainstream mental health services in England only starting to record veteran status since April 2017.[166] In Northern Ireland veteran status is not recorded at all and academic studies on Northern Irish veterans' mental health have only just started.[167]

88. Even where data exists, comparisons can be difficult. Professor Cherie Armour, Associate Dean (Research and Impact) at the Ulster University, told us that any large comparative study across the four nations should have the same questions and methodologies otherwise "sometimes it is the tiny differences, even in the way that you ask a question or the measure that you use that makes it difficult to compare".[168] The Ministry of Defence conducts an annual veterans survey, but even that excludes Northern Ireland, and mental health is just one of a series of questions.[169]

89. Witnesses have suggested possible differences between the four nations:

- It is most likely that veterans in Northern Ireland will have higher rates of mental health conditions compared to the other nations. Professor Armour told us that about 8.8% of the civilian population in Northern Ireland have experienced PTSD, compared to 4.4% in England. As veterans have broadly similar rates of PTSD to their civilian counterparts, she suggested that Northern Irish veterans will therefore also have higher rates than the rest of the UK.[170]

- Some Scottish and Welsh veterans may also be living in remote parts of the country, which may make it physically more difficult for them to be helped. For example, Dr Kitchiner told us that veterans from west Wales and Powys have to travel a significant distance to reach the out-patient clinics run by Veterans NHS

163 Q117, Ulster University Veterans Research Group (VMH0039)
164 Community Innovations Enterprise and Forces in Mind Trust, Call to Mind: United Kingdom - Common Themes and Findings from the Reviews of veterans' and family members mental and related health needs in England, Northern Ireland, Scotland and Wales, June 2017, p24
165 Dr Beverly Bergman (VMH0017)
166 See paragraph 36
167 Ulster University Veterans Research Group (VMH0039)
168 Q90
169 Ministry of Defence, Annual Population Survey: UK Armed Forces Veterans residing in Great Britain, 2016, October 2017
170 Q68, Ulster University Veterans Research Group (VMH0039)

Wales and there is no in-patient provision.[171] Dr Bergman and Dr Abraham also told us that some Scottish veterans with mental health issues will deliberately seek to live in very remote areas for "respite and tranquillity" and creative measures are needing to be taken in order to try and reach them, given they might be the ones most in need.[172]

- However, most Scottish and Welsh veterans that the statutory services see and support are from the more deprived areas in and around cities.[173] Combat Stress also found that "you are more likely to be socially deprived if you live in Scotland, next is Wales, then England and last Northern Ireland".[174]

90. The Government recognises that it needs to be better at collecting more detailed data, which includes regional and local variations. Kate Davies told us that, although she could not answer for the devolved nations, "the whole culture of the work that we are doing across the UK is to be more detailed about the needs of local variation, as well as breaking that data down."[175] The Armed Forces Covenant Fund is also funding a 'Map of Need' analysis to map veterans who receive mental health treatment. Conducted by Northumbria University, it has so far found four hotspots in England where there has been a high rate of veterans' referrals: the South West, the South East coast, the East Midlands and the northernmost area in the North West. Its analysis of the devolved nations is ongoing.[176]

91. The Surgeon-General and Kate Davies both told us that they worked closely with the devolved administrations through the structures of the Veterans Board and its sub-committees.[177] The Defence Minister, Tobias Ellwood MP, accepted that the political situation in Northern Ireland has meant those officials currently representing Northern Ireland on the Veterans Board had no involvement in the key aspects of service delivery, including mental health care.[178] We also raised in our report on the 2017 Annual Report of the Armed Forces Covenant our concerns over the "interaction of the Veterans Board and other levels of the governance structure with the devolved administrations, which have different bodies and mechanisms for implementation of the Covenant."[179]

92. **The provision of healthcare is devolved, but the Ministry of Defence is responsible for ensuring that veterans across the UK are receiving the level of care set out in the Armed Forces Covenant. Yet it has an inadequate understanding of the extent of veterans' mental health issues across the UK. The four nations take different approaches to both the provision of mental health care to veterans and the data they collect, which varies significantly. Without such information, it is difficult for the Ministry of Defence and the health departments in the four nations to ensure that there is sufficient coverage and adequacy of mental health services for veterans.**

93. ***We recommend that the Ministry of Defence works with the health departments in the four nations to develop and publish a single set of statistics on the number of veterans***

171 Q69 [Dr Kitchiner]
172 Q69 [Dr Bergman and Dr Abraham]
173 ibid
174 Q111
175 Q199
176 Northumbria University and Chester University (VMH0046)
177 Qq161–166
178 Qq196–198
179 Defence Committee, Ninth Report of Session 2017–19, Armed Forces Covenant Annual Report 2017, HC 707, paragraph 16

seeking help and being treated across all of the UK. This should include veterans treated under commissioned services, such as from Armed Forces charities. These should, at the minimum, be broken down to individual nations and should ideally be at the local commissioning level, where provision of care decisions are made.

94. ***We repeat the recommendation from our report on the Armed Forces Covenant Annual Report 2017 for the greater involvement of the devolved administrations at all levels of the structures charged with the implementation of the Covenant.***

95. **We are concerned that the Ministry of Defence does not monitor regional variations in the mental health of its serving personnel. We recognise that personnel move around the country but the Ministry of Defence will know where they were recruited from, regardless of unit, where they have been based and their medical history. Where recruits come from can be a factor in whether they develop mental health issues, so it is surprising to hear that this monitoring is not already being done.** ***We recommend that the Ministry of Defence assesses the extent to which there is variation in the mental health of its serving personnel, based on where they were recruited, not just at devolved administration level but at a local level.***

7 Public perceptions of mental health in UK Armed Forces

96. Most members of the public believe that mental health is a key issue for those leaving military service and that it is much more prevalent among them than in the rest of the population. For example, a 2017 report by Lord Ashcroft on the public's perception of veterans found that, of a representative sample surveyed:

- 82% believed that mental health problems were one of the three most common problems faced by people leaving the Armed Forces; and
- 78% believed that mental health problems were either somewhat or much more likely to happen to someone who has been in the Armed Forces compared to people in general.[180]

A 2018 Ulster University study also found that in Northern Ireland 63% of the public it surveyed believed that people who had been in the Armed Forces are more likely to have mental health problems than those in the general population.[181]

97. Professor Wessely told the Committee that all the large studies on this topic show that "most people believe that most people who served in Iraq and Afghanistan have come back physically, emotionally or psychologically damaged."[182] Dr Bergman also found that anecdotally in Scotland this perception was greater in younger generations, where veterans were less well represented.[183]

98. The public's perception of the extent of mental health problems, therefore, is much higher than the current data suggests, even if official figures are likely to be an underestimate. For example, Dr Busuttil told us that the public perception of the extent of mental health is much higher even than what charities, such as Combat Stress, would estimate.[184] Professor Wessely went further, telling us that public perception is "distorted from the facts".[185]

99. The public's perception of PTSD rates is particularly inaccurate. Karen Mead told us that when Help for Heroes conducted a survey of MPs, it found "the expectation of rates of PTSD was much higher than the reality. That is quite consistent [with the public expectation]".[186] The Veterans Hub told us that:

> A general misconception is that anyone seen to be struggling has a mental health problem (most commonly PTSD) and that must have been brought about by them being directly involved in combat or/and seeing casualties.

180 Lord Ashcroft KCMG PC, Perceptions of service leavers and veterans, October 2017, pp3–4
181 Ulster University, Northern Ireland Veterans Health and Wellbeing Study—Public Attitudes to the UK Armed Forces in Northern Ireland, June 2018, pp14–15
182 Q35 [Sir Simon Wessely]
183 Q82
184 Q136
185 Q35 [Sir Simon Wessely]
186 Q139

> The fact is that with the drop-in service the Veterans Hub provides, we would see an almost equal measure of veterans struggling with mental health problems as we do people struggling with adjustment issues.[187]

Reasons for the inaccurate public perception

100. The Ministry of Defence suggested the lack of public understanding of the military has enabled this perception to persist, arguing that "public understanding of the work of the Armed Forces and their recent missions is poor, which may have allowed myths, such as the idea that most Service personnel are damaged by their service, to be perpetuated in the face of contrary evidence."[188] Professor Klein also suggested that the public's negative perception of UK operations coloured perceptions on the health and wellbeing of the Armed Forces.[189] The Defence Minister, Tobias Ellwood MP, hoped that our inquiry would "help debunk the myth, often portrayed in the media, that veterans are mad, bad and sad", but he also accepted that the Ministry of Defence was not "doing enough to challenge it".[190]

101. The media has also had a significant influence on the public's perception of mental health in the Armed Forces. In Lord Ashcroft's 2017 report, many participants cited stories seen or read in the news, TV and films as to the reason why they had formed a negative impression.[191] Contact, whose written submission consolidated a number of charities' views, raised the need for more balanced media coverage to help address this. This view was supported by both academics and other charities.[192] Contact stated that the public perception of the Armed Forces has often been:

> created by unbalanced media coverage or tv/film dramatization of service personnel or veterans suffering mental health challenges, which overlooks the fact that the significant majority of individuals transition very successfully and have no mental ill-health issues.[193]

102. Armed Forces charities for veterans who are suffering from mental health conditions have also influenced the public's perception. Lord Ashcroft found in his report that charities' publicity "had a powerful role in shaping many people's perception of the challenges facing Service Leavers and veterans" but also that "people readily accepted that charities would inevitably want to pull on your heartstrings because they want you to open your wallet".[194] The Defence Minister also agreed that Armed Forces charities have a role to play in changing public's perceptions, stating that:

> You then have the charities that, by virtue of needing to raise money, have to underline some of the challenges that individuals face, and that can give a perception too. We all need to work hard on this because it is having a detrimental impact on the hard-earned reputation of the armed forces.[195]

187 The Veterans Hub (VMH0020)
188 Ministry of Defence (VMH0029)
189 Q35 [Professor Klein]
190 Q150 [Mr Ellwood], Q206
191 Lord Ashcroft KCMG PC, Perceptions of service leavers and veterans, October 2017, p8
192 Q35, Q123 [Rod Eldridge], Veterans Aid (VMH0038)
193 Contact (VMH0026)
194 Lord Ashcroft KCMG PC, Perceptions of service leavers and veterans, October 2017, p8
195 Q206

Effects of public perception

103. The mistaken public perception surrounding mental health and the Armed Forces may be leading not only to confusion but also to adverse effects in veterans. The Scottish Veterans Commissioner reported that differences between what the data was reporting and what the public were hearing anecdotally had "led to debate and understandably caused a degree of confusion amongst the general public".[196] Professor Wessely went further, telling us that "the distorted effect of seeing military service as a toxic occupation as opposed to a professional one that brings its own unique hazards is the single most worrying factor for the future."[197] Contact also believed such perceptions amplify the stigma surrounding mental health, while Veterans Aid believed that civilian medical practitioners are "likely to perceive ex-Service personnel as dangerous because of their service".[198]

104. In particular, the emphasis on serving personnel and veterans having PTSD may be resulting in under-reporting of other mental health conditions in veterans. Rod Eldridge, Clinical lead at Walking with the Wounded and Veterans Aid also suggested that PTSD has become a "badge of honour", with the former telling us that "it is more acceptable to talk about PTSD than it is to talk about depression, anxiety, hysteria and so on and so forth."[199] NHS England told us that its 2016 public consultation on NHS veterans' mental health services found that "too much emphasis is put on PTSD at the expense of other mental health problems".[200] Kate Davies added that:

> A lot of people are coming forward to our services now—mainstream NHS services and GPs, and also specialist services for veterans—who think they have PTSD. They often come forward saying, "I think I've got PTSD," but looking at the individual assessment it is often around anxiety, depression and alcohol, and maybe a mixture of issues that also includes their life circumstances.[201]

105. **The widespread public perception that all veterans are damaged by their military service is not only wrong but harmful. Even though current government statistics and Armed Forces charity providers may be underestimating the extent of mental health conditions, the vast majority of service personnel are likely to leave with no ill effect. The public impression to the contrary has in part been driven by media coverage and Armed Forces charity publicity on the subject which, although helping to improve mental health awareness and generate funding, has provided a distorted view of the extent of mental health conditions in both serving personnel and veterans.**

106. **Possible effects of this perception include an amplification of the stigma surrounding veterans' mental health and the mis-reporting of PTSD. Also, more common mental health disorders, such as depression, may not be sufficiently recognised as the focus has been on PTSD.** ***We recommend that, using accurate and complete data, the Ministry of Defence work with the health departments of the four nations, charity***

196 Scottish Veterans Commissioner, Veterans' Health & Wellbeing, A Distinctive Scottish Approach, April 2018, p26
197 Q35 [Sir Simon Wessely]
198 Contact (VMH0026) and Veterans Aid (VMH0038)
199 Q125 [Rod Eldridge] and Veterans Aid (VMH0038)
200 NHS England (VMH0031)
201 Q155

providers and academics to change the public's perception. Mental health providers should also ensure that the focus on PTSD does not mean that care provision for more common mental health disorders is neglected.

8 Impact of military service on Armed Forces families' mental health

107. Military service may not only affect serving personnel but also their families. Indeed, the impact of service life on their family remains the main reason cited by Service personnel for leaving the Armed Forces. In its most recent annual attitude survey of Regular Service personnel, the Ministry of Defence reported that over half of those who were leaving said that the impact on family and personal life was a reason for leaving.[202]

108. There is some evidence to suggest that the mental health of family members is also affected by military service and that they may also not be seeking help. Anglia Ruskin University told us its research found 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".[203] A 2016 systematic review of existing research by King's College London also found that spouses may be at risk of developing secondary traumatic stress if a veteran has suffered a traumatic event.[204] Dr Busuttil reported from a 2006 Combat Stress study that less than half of partners or spouses with mental health disorders sought help.[205]

109. We also heard that more data is needed to develop a robust understanding of the mental health impact of service life on families and how they should be supported. A number of academics and Armed Forces charity witnesses raised this as a key area that needed improvement, with Matt Fossey telling us that "because our lens tends to be on the veteran themselves we are not actually seeing the broader impact".[206] The Naval Families Federation also told us that:

> We consider that the issue of mental health for the Armed Forces needs to be considered in a more holistic way… The mental health of serving people and their families are interlinked, and have an impact on each other. It would be helpful to have data that shows the impact of military service on the mental health of immediate family members.[207]

110. The current provision of mental health care to the families of serving personnel and veterans varies across the UK. For example, Veterans First Point Scotland takes referrals from veterans' family members, though Dr Abraham told us that most are likely to seek help elsewhere. However, Dr Kitchiner told us that Veterans NHS Wales was not funded to look after families, which he considered a real missed opportunity.[208] Mental health

202 Ministry of Defence (VMH0029),Ministry of Defence UK Regular Armed Forces Continuous Attitude Survey Results 2018, May 2018, p13
203 Anglia Ruskin University (VMH0032)
204 King's College London, Veterans are not the only ones suffering from posttraumatic stress symptoms: what do we know about dependents' secondary traumatic stress?, Social Psychiatry and Psychiatric Epidemiology, October 2016
205 Q146
206 Q42 [Matt Fossey], Q64 [Professor Fear], Contact (VMH0026)
207 Naval Families Federation (VMH0018)
208 Q97

provision for families of serving personnel falls primarily to the respective national NHS bodies, although Kate Davies told us that families are part of the formal partnership NHS England has with the Ministry of Defence.[209]

111. **Work on mental health in the Armed Forces has so far focused on those who have served, but their families' mental health can be just as exposed to the stresses of service life. The impact of service life on families has been little understood, but there are now suggestions that spouses and other family members can also be affected by a traumatic event suffered by serving personnel or by constant redeployment. The Government accepts that it has a duty to support families as much as those who served but, as for veterans, the help they might get will depend on where in the country they live.**

112. ***We recommend that the Ministry of Defence, in conjunction with the health departments of the four nations, places a greater focus on service and veterans' families as part of its mental health care provision. This should include supporting further research into the mental health of current and former Service families to determine what provision is needed. The Ministry of Defence should also monitor how this provision is applied across the UK as part of its annual report on the Armed Forces Covenant.***

209 Ministry of Defence, Defence People Mental Health and Wellbeing Strategy 2017–2022, July 2018, p31 and Q236 [Kate Davies]

Conclusions and recommendations

The effect of military service on mental health

1. It is very difficult to prove whether the mental health conditions that some serving personnel and veterans develop are caused by their military service. Non-military factors or underlying mental health conditions exacerbated by military service could all contribute to an individual's mental health. However, there is a lack of reliable research and data to indicate how significant these factors might be. Although the Ministry of Defence does not take attribution into account when providing care, a better understanding would at least help it to make decisions where judgement on attribution is required, such as awarding compensation. (Paragraph 17)

2. *The Ministry of Defence should support further research into the factors that may affect mental health during military service. This should include following a cohort of recruits over time to understand how military service may have affected them.* (Paragraph 18)

3. The unknown mental health implications of what an individual might be exposed to during military service adds further uncertainty over whether the Ministry of Defence is capturing the full extent of mental health issues amongst its personnel and is providing appropriate care. The Ministry of Defence relies on external research to inform its clinical diagnoses and care practices. The current lack of understanding in areas such as neurotoxicity and mild traumatic brain injury, however, means that it cannot be certain about the balance of risk it accepts in its practices. (Paragraph 19)

4. *We recommend that the Ministry of Defence should commission further research into neurotoxicity and mild traumatic brain injury to determine whether exposure to these is likely to be causing mental health effects. If there appears to be a link the Ministry of Defence should set out what mitigating actions it will take to reduce the risk of mental health conditions from such exposures.* (Paragraph 20)

5. Rather than causing problems, military service can have a positive effect on an individual's mental health. At the very least, the vast majority of Service personnel leave with good experiences of their military career. The structure and social community found in the Armed Forces particularly help those who might have been more vulnerable to mental health issues before they joined, for example, those who were unemployed or socially isolated. All Government Departments, not just the Ministry of Defence, should be doing more to promote to the public the message that military service has a positive effect on mental health, for example, by drawing attention to the veterans they employ. (Paragraph 26)

6. This positive effect can be lasting, but the potential loss of support and community when personnel leave the Armed Forces may mean that, for some, military service will have only delayed the onset of mental health issues. Successful transition is therefore essential to ensuring that any mental health benefits from military service are retained. Support during transition is available but more could be done to ensure continuity of care and stop some veterans from falling through the gaps. We shall be

examining the provision of mental health care to serving personnel and veterans, including during transition, in Part Two of our inquiry into Mental Health and the Armed Forces. (Paragraph 27)

The Government's mental health data and its limitations

7. There have been significant increases in the number of serving Armed Forces personnel and veterans seeking mental health care over the last decade. The Ministry of Defence reports that since 2008–09 the proportion of serving Armed Forces personnel diagnosed with mental health conditions has nearly doubled, to 3.1%. Data on veterans is more limited, particularly in Northern Ireland, but statutory providers in England, Scotland and Wales also reported similar increases in the number of veterans they are seeing. A significant factor in the rise reported may be that, as in the civilian population, more serving personnel and veterans who have mental health issues are seeking help. (Paragraph 43)

8. We are particularly concerned, however, by the lack of national data on veteran suicides. The evidence that is available suggests that the rate in veterans is likely to be comparable to the general population. However, without robust data to know whether there may be specific groups or areas that need to be monitored more closely, Government health bodies and Armed Forces charities may be missing opportunities to help those most in need. (Paragraph 44)

9. *We recommend that the Ministry of Defence works with the justice departments across the four nations to record and collate, as part of existing suicide records, whether someone had been a veteran to monitor the level and locations of veteran suicides. This will enable it to identify whether there are particular groups of veterans or particular locations where more effort is required to prevent such tragic events from occurring.* (Paragraph 45)

10. UK Government statistics report only those who seek help and may therefore be significantly underestimating how many serving personnel and veterans have mental health conditions. The Ministry of Defence acknowledges that its statistics may not be representative of the overall veteran population. Current research suggests that the number of veterans with mental health conditions that require professional help could be up to three times higher than official statistics, at around 10%. (Paragraph 56)

11. There are a number of barriers such as stigma and the failures in the provision of care, that continue to dissuade serving personnel and veterans from seeking help from statutory services. Although there have been improvements in the provision of care in recent years, more clearly needs to be done, especially in improving the timeliness of care. We will be examining the provision of mental health care to serving personnel and veterans in our follow up inquiry, where we will explore the issues around barriers to care. We also support the work being taken by the Ministry of Defence and Armed Forces charities in campaigning against the stigma surrounding mental health. However, stigma remains a barrier and this work needs to continue. (Paragraph 57)

12. We are particularly concerned that the Armed Forces Covenant principle of priority treatment when a condition is service-related is not being consistently applied across the UK. The Department of Health and Social Care considers that the NHS founding principles on equality and clinical need constrain how it can provide priority treatment to veterans. This difference in interpretation is confusing not just to veterans but also to clinicians; this may add to veterans' perception that the health service is failing them. The situation is similar in Scotland and Wales, while there remains a more fundamental difficulty in implementing the Armed Forces Covenant in Northern Ireland. (Paragraph 58)

13. *We recommend that in its forthcoming veterans strategy, the Government should set out clearly whether veterans may expect to receive priority treatment, subject to clinical need, and what that means in practice. The Government should ensure that this clarification is then cascaded down to both NHS staff and veterans and their families across the UK.* (Paragraph 59)

14. Poor recording of veterans at primary care level may also lead to an underestimation of the extent of mental health conditions in veterans and affect how they are being treated. GPs failing to ask, veterans themselves not telling and inadequate recording are all leading to an incomplete picture. If GPs are not aware that their patient is a veteran then they will not be able to refer them to the veteran-specific services that are available in England, Scotland and Wales. *We recommend that, as part of the ongoing work to improve their knowledge of military health, civilian medical practitioners, especially GPs, should be made aware of the importance of asking about veteran status and recording it correctly.* (Paragraph 60)

Effects of operations in Afghanistan and Iraq

15. Deployment to Iraq and Afghanistan has clearly increased the likelihood of mental health conditions among those who saw combat or were deployed Reservists. The 2014 study by King's Centre for Mental Health Research found that the rate of PTSD in Regular personnel in deployed combat roles was 6.9% and for deployed Reservists 6%, compared to 4% for the Armed Forces as a whole. Armed Forces charities also report more cases of mental health conditions in veterans in these groups. (Paragraph 72)

Groups that might be more vulnerable to mental health issues

16. Certain groups of Service personnel, regardless of deployment, may also be potentially more vulnerable to developing mental health conditions, both during and after service. These groups include female personnel, both currently serving and veterans, early Service leavers and recruits aged under 18. More reliable data is needed to show whether they are more at risk and hence whether the existing support they receive is good enough. *We recommend that the Ministry of Defence conducts or commissions further research into these groups to determine the extent to which they are at higher risk of developing mental health conditions. The Government should then consider what specific monitoring and mental health support might need to be provided or enhance existing provision to those groups that are at higher risk.* (Paragraph 74)

Comparison of mental health data sets

17. Knowing what the full scale of the mental health problem is across serving personnel and veterans is critical to determining the resources required to care for those that need it, yet there is no clear and agreed understanding across the sector. The Ministry of Defence, academic studies and Armed Forces charities all take different approaches to assessing and recording the number of serving personnel and veterans with mental health conditions. This has led to a wide range of estimates with at one end, the Ministry of Defence suggesting it is lower than the UK general population and at the other Armed Forces charities—which mainly see those veterans who need help the most—reporting much higher levels. (Paragraph 82)

18. *We recommend that the Ministry of Defence and the health departments of the four nations work with Contact and the charity sector to agree and implement a shared set of methodologies for collecting and analysing data. This will enable a common understanding of what the demand for care services might be from serving personnel and veterans and for both Government and the Armed Forces charity sector to provision care accordingly.* (Paragraph 83)

19. *We recommend that such common methodologies consider how mental health statistics are collected more widely, so that like for like comparisons can be made with the UK population as a whole or indeed with other countries. This would ideally include the Government developing data on mental health conditions assessed in emergency services personnel, who by the nature of their roles, are more likely to encounter traumatic situations than the general public.* (Paragraph 84)

20. The provision of healthcare is devolved, but the Ministry of Defence is responsible for ensuring that veterans across the UK are receiving the level of care set out in the Armed Forces Covenant. Yet it has an inadequate understanding of the extent of veterans' mental health issues across the UK. The four nations take different approaches to both the provision of mental health care to veterans and the data they collect, which varies significantly. Without such information, it is difficult for the Ministry of Defence and the health departments in the four nations to ensure that there is sufficient coverage and adequacy of mental health services for veterans. (Paragraph 92)

21. *We recommend that the Ministry of Defence works with the health departments in the four nations to develop and publish a single set of statistics on the number of veterans seeking help and being treated across all of the UK. This should include veterans treated under commissioned services, such as from Armed Forces charities. These should, at the minimum, be broken down to individual nations and should ideally be at the local commissioning level, where provision of care decisions are made.* (Paragraph 93)

22. *We repeat the recommendation from our report on the Armed Forces Covenant Annual Report 2017 for the greater involvement of the devolved administrations at all levels of the structures charged with the implementation of the Covenant.* (Paragraph 94)

23. We are concerned that the Ministry of Defence does not monitor regional variations in the mental health of its serving personnel. We recognise that personnel move around the country but the Ministry of Defence will know where they were recruited from, regardless of unit, where they have been based and their medical history.

Where recruits come from can be a factor in whether they develop mental health issues, so it is surprising to hear that this monitoring is not already being done. *We recommend that the Ministry of Defence assesses the extent to which there is variation in the mental health of its serving personnel, based on where they were recruited, not just at devolved administration level but at a local level.* (Paragraph 95)

Public perceptions of mental health in UK Armed Forces

24. The widespread public perception that all veterans are damaged by their military service is not only wrong but harmful. Even though current government statistics and Armed Forces charity providers may be underestimating the extent of mental health conditions, the vast majority of service personnel are likely to leave with no ill effect. The public impression to the contrary has in part been driven by media coverage and Armed Forces charity publicity on the subject which, although helping to improve mental health awareness and generate funding, has provided a distorted view of the extent of mental health conditions in both serving personnel and veterans. (Paragraph 105)

25. Possible effects of this perception include an amplification of the stigma surrounding veterans' mental health and the mis-reporting of PTSD. Also, more common mental health disorders, such as depression, may not be sufficiently recognised as the focus has been on PTSD. *We recommend that, using accurate and complete data, the Ministry of Defence work with the health departments of the four nations, charity providers and academics to change the public's perception. Mental health providers should also ensure that the focus on PTSD does not mean that care provision for more common mental health disorders is neglected.* (Paragraph 106)

Impact of military service on Armed Forces families' mental health

26. Work on mental health in the Armed Forces has so far focused on those who have served, but their families' mental health can be just as exposed to the stresses of service life. The impact of service life on families has been little understood, but there are now suggestions that spouses and other family members can also be affected by a traumatic event suffered by serving personnel or by constant redeployment. The Government accepts that it has a duty to support families as much as those who served but, as for veterans, the help they might get will depend on where in the country they live. (Paragraph 111)

27. *We recommend that the Ministry of Defence, in conjunction with the health departments of the four nations, places a greater focus on service and veterans' families as part of its mental health care provision. This should include supporting further research into the mental health of current and former Service families to determine what provision is needed. The Ministry of Defence should also monitor how this provision is applied across the UK as part of its annual report on the Armed Forces Covenant.* (Paragraph 112)

Formal minutes

Thursday 19 July 2018

Members present:

Rt Hon Dr Julian Lewis, in the Chair

Rt Hon Mr Mark Francois	Rt Hon John Spellar
Mrs Madeleine Moon	Phil Wilson

Draft Report (*Mental Health and the Armed Forces, Part One: The Scale of mental health issues*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 112 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Eleventh Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 4 September at 2pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Tuesday 27 March 2018	*Question number*
Professor Nicola Fear, Director, the King's Centre for Military Health Research, King's College London; **Matt Fossey**, Director, Veterans and Families Institute, Anglia Ruskin University; **Professor Susan Klein**, Professor of Health and Social Care, Veterans and Families Institute, Anglia Ruskin University; and **Sir Simon Wessely**, Director, the King's Centre for Military Health Research, King's College London	Q1–66

Tuesday 24 April 2018	
Professor Cherie Armour, Associate Dean (Research and Impact), Institute of Mental Health Sciences, Ulster University; **Dr Beverly Bergman**, Institute of Health and Wellbeing, University of Glasgow; **Dr Lucy Abraham**, Clinical Psychologist, Veterans First Point Scotland; and **Dr Neil Kitchiner**, Director & Consultant Clinical Lead, Veterans NHS Wales	Q67–98
Karen Mead, Head of Psychological Wellbeing, Help for Heroes; **Rod Eldridge**, Clinical Lead, Walking with the Wounded; and **Dr Walter Busuttil**, Director of Medical Services, Combat Stress	Q99–146

Tuesday 26 June 2018	
Rt Hon. Tobias Ellwood MP, Parliamentary Under-Secretary of State and Minister for Defence People and Veterans, Ministry of Defence; **Lieutenant-General Martin Bricknell**, Surgeon General, Ministry of Defence; **Jackie Doyle-Price MP**, Parliamentary Under-Secretary of State for Mental Health and Inequalities, Department of Health and Social Care; and **Kate Davies**, OBE, Director of Health and Justice, Armed Forces and Sexual Assault Services Commissioning, NHS England	Q147–249

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

VMH numbers are generated by the evidence processing system and so may not be complete.

1 Alison McDowell (VMH0004)
2 Anglia Ruskin University (VMH0032)
3 Anglia Ruskin University (VMH0041)
4 Big White Wall (VMH0027)
5 Brigadier General (Rtd) Donald Bolduc (VMH0034)
6 Child Soldiers International (VMH0007)
7 Combat Stress (VMH0006)
8 Combat Stress (VMH0044)
9 Contact (VMH0026)
10 Dr Ashley Croft (VMH0033)
11 Dr Beverly Bergman (VMH0017)
12 Dr Neil Kitchiner (VMH0043)
13 ForcesWatch (VMH0023)
14 Forward Assist (VMH0022)
15 Glen Art (VMH0028)
16 Help for Heroes (VMH0021)
17 Help for Heroes (VMH0049)
18 Lt Col Andrew Marriott (VMH0036)
19 Medact (VMH0030)
20 Ministry of Defence (VMH0029)
21 Mrs Mandy Bostwick (VMH0047)
22 Mrs Trixie Foster (VMH0009)
23 Ms Hilary Meredith (VMH0003)
24 NHS England (VMH0031)
25 Northumbria University and Chester University (VMH0046)
26 Queen's University Belfast (VMH0048)
27 Royal British Legion Industries (VMH0037)
28 Royal College of General Practitioners (VMH0040)
29 The British Association for Counselling and Psychotherapy (VMH0014)
30 The Naval Families Federation (VMH0018)
31 The Quinism Foundation (VMH0013)
32 The RAF Association (VMH0045)
33 The Veterans Hub (VMH0020)

34 Ulster University Veterans Research Group (VMH0039)

35 Veterans aid (VMH0038)

36 Veterans First Point Scotland (VMH0024)

37 Walking With The Wounded (VMH0016)

38 Walking With the Wounded (VMH0050)

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

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Second Report	Unclear for take-off? F-35 Procurement	HC 326
Third Report	Sunset for the Royal Marines? The Royal Marines and UK amphibious capability	HC 622
Fourth Report	Rash or Rational? North Korea and the threat it poses	HC 327
Fifth Report	Lost in Translation? Afghan Interpreters and Other Locally Employed Civilians	HC 572
Sixth Report	The Government's proposals for a future security partnership with the European Union	HC 594
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Eighth Report	Indispensable allies: US, NATO and UK Defence relations	HC 387
Ninth Report	Armed Forces Covenant Annual Report 2017	HC 707
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First Special Report	SDSR 2015 and the Army	HC 311
Second Special Report	Armed Forces Covenant Annual Report 2016	HC 310
Third Special Report	Investigations into fatalities in Northern Ireland involving British military personnel: Government Response to the Committee's Seventh Report of Session 2016–17	HC 549
Fourth Special Report	Gambling on 'Efficiency': Defence Acquisition and Procurement: Government Response to the Committee's First Report	HC 846
Fifth Special Report	Unclear for take-off? F-35 Procurement: Responses to the Committee's Second Report	HC 845
Sixth Special Report	Sunset for the Royal Marines? The Royal Marines and UK amphibious capability: Government Response to the Committee's Third Report	HC 1044
Seventh Special Report	Rash or Rational? North Korea and the threat it poses: Government Response to the Committee's Fourth Report	HC 1155