THE MENTAL HEALTH OF THE UK ARMED FORCES (September 2018 version)

This briefing note provides an outline of the current evidence on UK military mental health, including prevalence rates of mental health problems in serving regulars, serving reserves and those who have left service[1]. Findings relating to suicide, help-seeking, risk-taking, violence, offending and deployment mental health support are also addressed.

Main Findings:

1. MENTAL HEALTH (REGULARS)

a. The PTSD rate, in a combined sample of veterans and still serving personnel, was 4% in 2004/6 and 2007/09, but had risen to 6% in 2014/16[2]. This compares to a rate of 4.4% within the civilian population.

b. Potentially harmful alcohol misuse remains a common behavioural problem, but has declined steadily from 16% in 2004/6 to 10% in 2014/16.

c. The rate of common mental disorders has remained stable at around 20% from 2004/6-2014/16.

d. The prevalence of PTSD is not uniform across groups. In still serving regular personnel the overall prevalence is 4.8% and is statistically higher in ex-regular veterans at 7.4%.

Combat Role

e. In 2014/16, PTSD in serving regular combat personnel was 6% whereas in serving combat service support personnel it was 4%. Among ex-service regulars who had not deployed was the rate of PTSD 5.0% and for those who had deployed the rate of PTSD was 9.4%. However, we found considerable differences in the rates of PTSD dependent on the role troops had in their last deployment before leaving service. For those veterans whose last deployment had been in a combat role the rate of PTSD was 17%[3] compared to 6% among veterans whose last deployment was in a service support role.

Deployment

[1] The main data source for this briefing is the KCMHR cohort study. KCMHR completed three waves of questionnaire-based data collection from serving UK Armed Forces personnel in 2004-6 (phase 1), 2007-9 (phase 2) and 2014-16 (phase 3), with phase 2 surveying recent Service leavers who constituted approximately 50% of the cohort in phase 3. These findings are supplemented with data from a range of other KCMHR research projects, research from Defence Statistics (Health) and US military health research, as well as open sources. The publications produced by KCMHR, ADMMH and associates can be found at www.kcl.ac.uk/kcmhr/publications

[2] All reported percentages are rounded up or down.

[3] This figure should not be misinterpreted; this does NOT mean that 17% of all personnel who last deployed in a combat role developed PTSD. Factors other than just combat may well explain the PTSD rate in this specific group; we also know that mental health problems are associated with discharge from Service.

f. In 2014/16, PTSD was lower among regulars with a history of deployment[4] (6% non-deployed, 4.4% deployed) which may possibly be because personnel diagnosed with a mental health problem were less likely to deploy.

g. PTSD was greater in those with a history of deployment who have left service. The rate was 4% in serving regulars who had deployed and 9% in ex-serving regulars who had deployed.

Number of deployments

h. Among serving regular Army personnel and Royal Marines there was no evidence that greater number of deployments was associated with any health outcomes. This is in contrast to US data.

Harmony Guidelines

a. In 2004/6 and 2007/09, deployment per se was not associated with CMD or PTSD in regulars, except for personnel who deployed for longer than recommended in the Land Harmony Guidelines[5].

2. MENTAL HEALTH (RESERVES)

a. In contrast to regulars, in 2004/6 and 2007/09 the prevalence of PTSD in deployed reserves was higher than in non-deployed reserves and continued to be so in 2014/16. The prevalence of PTSD in deployed regulars and reserves did not differ in 2014/16 (7% in each) but non-deployed reserves had lower PTSD rates (3%) than non-deployed regulars (5%).

b. Alcohol misuse was lower in reserves than in regulars across time but the prevalence in deployed reserves did not decline over time and, unlike we had found previously, in 2014/16 alcohol misuse was significantly higher among deployed reserves than non-deployed reserves.

c. The increase in health problems and associated difficulties in deployed reserves compared to non-deployed reserves persisted for five years between 2007/09 and 2014/16 although the nature of the difficulties experiences varied a little. In 2004/6 deployed reserves had only higher rates of CMD, in 2007/09 they had higher rates of PTSD and in 2014/16 all three (PTSD, AMD and alcohol misuse) were significantly higher in deployed, compared to non-deployed, reserves.

3. SUICIDE

a. Overall, rates of suicide are lower in the Armed Forces than they are in the general population. The exception is an increased suicide rate in young Army men (under the age of 20). Young veterans (aged 16-24) or those classified as early service leavers are also at an increased risk of suicide. This increase is influenced mainly by pre-Service vulnerabilities, such as childhood adversity [6] [7]. Self-harm in Service personnel is mainly impulsive, is not associated with deployment and is a poor predictor of subsequent increased suicide risk. The longer an individual stays in the military, the lower the suicide risk: long-serving personnel appear to be an increasingly select and resilient group.

[4] Deployment here refers to a history of any deployment to Iraq or Afghanistan since 2003.
[5] Up to one year on deployment in three years.
[6] Kapur, N., While, D., Blatchley, N., Bray, I., & Harrison, K. (2009). Suicide after leaving the UK Armed Forces—A cohort study. PLoS medicine, 6(3), e1000026.
[7] Pinder, R. J., Iversen, A. C., Kapur, N., Wessely, S., & Fear, N. T. (2012). Self-harm and attempted suicide among UK Armed Forces personnel: Results of a cross-sectional survey. International journal of social psychiatry, 58(4), 433-439.

b. It is not true that "*more Falklands Veterans died of suicide than in conflict*". But regardless of absolute numbers, what matters is whether the suicide rate is higher among Falkland veterans compared to members of the Armed Forces who did not deploy to the Falklands, or the general population. Defence Statistics (Health) has shown that neither is true.

4. SCREENING

a. KCMHR recently completed the first ever randomised controlled trial of post-deployment mental health screening. This showed that mental health screening and the provision of tailored advice carried out with a large number of personnel within 6 to 12 weeks since the end of deployment had no impact on either mental health or help seeking; at present post deployment screening cannot be recommended.

b. Pre-deployment mental health screening does not reduce the rate of post deployment mental health problems and fails to accurately detect those at risk of poorer post-deployment mental health.

5. HELP SEEKING

a. The most recent KCMHR interview study (2014/16) suggested that help-seeking increased among both serving personnel and those that have left service. 31% of those with recent mental health problems had accessed a mental health specialist and 47% had consulted a GP or Medical Officer.

b. Alcohol misusers were the least likely to seek help.

c. Only 7% had not sought any help at all

d. Rates of usage, awareness and willingness to use a range of medical and support services were similar in serving and ex-serving regulars and reservists.

e. Among help-seekers, Mental Health Specialists were rated as the most helpful source of support.

f. One paradox is that nearly everybody said that they would be willing to use health services for their mental health problems, while in practice only about a third actually did so. Recent studies suggest that some believe that their emotional problem is not sufficiently serious to warrant support, they wish to deal with the problem themselves or question the quality of mental health services.

g. Mental health-related stigmatisation is one barrier to care. There is evidence that levels of stigma in the UK military have been declining since 2008 and also that recent service leavers are seeking help more rapidly than ever before. Stigma appears to be particularly problematic for those who have not accessed mental healthcare before.

h. Unwillingness to use mental health services is a general problem across society and is not specific to the UK Armed Forces. The same pattern of help-seeking and reluctance to seek care has been found in the US and Canadian militaries and the Australian Defence Force.

6. VIOLENCE AND OFFENDING

a. Defence Statistics (Health) estimates that 3.5 % of the current prison population have served in the UK military. This is lower than expected or predicted by press narratives

b. Ex-service men still constitute a significant subset of the adult male prison population and are the largest occupational group. They are also more likely to be in prison for a sexual offence or violence

against the person than the general population. Rates of acquisitive offending are, however, lower than in the general population.

c. Self-reported violence increases after deployment and is associated with pre-Service adversity, alcohol misuse and PTSD. Combat personnel are twice as likely to report violence on return from deployment as those less exposed to combat. However, higher levels of pre-enlistment adversity and deployment related mental health problems account for much of this increased risk.

d. Those who have served have a lower lifetime rate of criminal convictions than those who have not. However, this is not true for violent convictions, which are increased. The main associations are age, gender and previous convictions. Violent offending is not associated with deployment *per se*, but is associated with experiencing combat and the link is mediated by alcohol, traumatic exposures and PTSD.

7. RELEVANT IN-SERVICE POLICY INITIATIVES

Reserves Support

a. The Veterans and Reservists' Mental Health Programme (now incorporating the medical assessment programme) was set up in response to KCMHR findings on Reservists' mental health. Uptake has been low, but the service appears to be clinically and occupationally effective.

Trauma Risk Management

b. The peer support programme TRiM (Trauma Risk Management) seeks to provide the right support for the right people at the right time. A randomised controlled trial found that the TRiM was a safe and acceptable approach; it is now being used across the UK military. TRiM may help people access social support and mental healthcare following deployment and in non-military studies its use is associated with a reduction in traumatic-event related sickness absence.

Leadership, Morale and Cohesion

c. Our deployment studies confirm that good leadership, morale and cohesion are the main determinants of better mental health when deployed. Events at home, including relationship problems and lack of family support are as important as combat exposure.

Deployment Clinical Care

d. Our evaluations of clinical support provided during operations suggest that the provision of mental healthcare in the operational setting is associated with good occupational outcomes both in the short and longer-term.

Third Location Decompression

e. Decompression is popular, although personnel are initially reluctant to engage with it; our evidence suggests that it has a modest positive impact upon mental health and alcohol misuse but not post-deployment readjustment and is less helpful following substantial combat exposure. It equally useful for individual augmentees and personnel in formed units.

UK Battlemind

f. In a large randomised controlled trial, a UK version of the US post-deployment Battlemind training system did not reduce rates of PTSD, but led to a modest decrease in problem drinking.

Physical Ill-health

g. Mental health problems are increased in severely physically injured service personnel, but there is an even greater impact on personnel who develop severe general medical conditions whilst deployed.

8. RISK-TAKING

a. Our previous studies have shown that risk-taking behaviour such as unsafe driving or alcohol misuse was more common among regulars and reserves who deployed to Iraq or Afghanistan. This had declined in 2007/09 and continued to do so up to 2014/16. A number of factors including increasing age of many cohort participants, the introduction of a hard-hitting road safety campaign and changes in driving practices on deployment may have contributed to the decline. For deployed reserves but not regulars, the rate of risky driving remained elevated following deployment.

9. RELATIONSHIPS

a. The majority of regulars and reserves participating in the cohort study reported satisfaction with their intimate relationships and deployment had no effect on this finding. However, divorce or relationship breakdown was higher in those deployed to Iraq or Afghanistan particularly for regulars.

10. CONCLUSIONS

In general terms there have been modest but important changes in the overall mental health of UK Armed Forces personnel throughout our period of study (2004-2016). Our data shows that there has been a moderate increase in PTSD in more recent years, largely accounted for by increases among ex-service cohort members. In still serving regulars with a combat role, PTSD increased modestly from 6% in 2004/6 to 7% in 2007/09 and remained stable at 7% in 2014/16; amongst regulars in a non-combat or support role, PTSD increased from 3% in 2004/6 to 4% in 2014/16. As such other than the increase in PTSD among combat arm personnel who have left service, there is no evidence of a “tidal wave” or “tsunami” of mental ill-health. However, rates of PTSD in those who have left service (overall 7.4%), especially those who have deployed in a combat role (17%), do appear to be elevated. This is a different picture to that reported from the USA. Harmful alcohol use has decreased over the years, but still remains high and is now significantly increased in deployed reserves. Higher rates of PTSD and CMD are also evident in deployed reserve personnel suggesting that further efforts to improve reserve forces mental health may be warranted.

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