Ministry of Defence

Defence People Mental Health and Wellbeing Strategy 2017-2022

Ministry of Defence

Foreword

by The Secretary of State for Defence

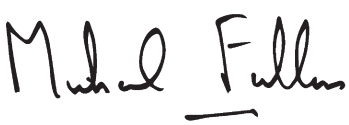
This government has put transforming the way that mental health and wellbeing is dealt with at the heart of our agenda. For too long mental illness has been ignored and misunderstood, shrouded in an unacceptable stigma and seen as secondary to physical health. Left unaddressed, it destroys lives, it breaks down relationships and it deepens divisions within our society. Changing this goes to the heart of the kind of country we are, the values we share, the attitudes we hold, and it drives our determination to support each other.

Across government we are introducing comprehensive reforms to how we deal with mental health, at every stage of people's lives. The emphasis is on early intervention, improving mental health within in our classrooms, at work and in our communities. Our aim is to reduce the need for mental healthcare in the longer term, manifested as a result of problems being left untreated. We want to change the way mental illness is viewed so that striving to improve mental wellbeing is seen as just as natural, as striving to improve our physical wellbeing.

Therefore I very much welcome this Strategy to improve the mental health and wellbeing of our Armed Forces, their families, veterans, and civilians. It builds on five years of health and wellbeing research and activity to establish the integration of mental and physical health. It is focused on promoting positive mental health and wellbeing; preventing and detecting mental health illness; and treating such illness when it is diagnosed.

The next five years promise many more improvements to those we have already delivered. Our approach recognises the importance of partnering with charities, the NHS, and other groups. We have identified resources to fund mental health-related innovative projects. Our ability to monitor the mental health of our people and build on our existing research base is ever-growing. Innovative healthcare delivery models are being designed. Finally, we will continue to increase awareness of the support that is available, particularly for veterans or their family members.

Mental health and wellbeing is everyone's responsibility. It is a matter of national concern, a Ministry of Defence priority and it is one to which I am committed to help delivering.



The Rt Hon Sir Michael Fallon MP
Secretary of State for Defence

Preface

by Chief of Defence People (CDP)

Since the publication of the Armed Forces Mental Health Strategy 2011, the mental health and wellbeing of our Defence People has been a subject of substantial investment and focus. At the time of writing it is extremely newsworthy and it seems everybody has something to say about it. This is a good thing; the more we talk about it the more it becomes normalised, and the more we can acknowledge and understand it.

Psychological symptoms are common and normal. It is only when they affect our function, at an individual level, in personal relationships, or at work, that a mental health disorder may be considered to be present. For Defence the stakes are high; mental health problems are now the second most common cause of medical downgrading and discharge in the Armed Forces, and a major cause of civilian sickness absence.

Much of this strategy emphasises promotion and prevention activity and how we can maintain our people in a positive state of mental wellbeing. Where symptoms do impact function, we aim for this to be detected early, providing leadership support and, where necessary, access to expert treatment. These approaches do not trivialise mental illness but aim to acknowledge its existence and ensure that, when needed, our Defence People are provided with reassurance that there is effective treatment available to help them.

The next five years will see a period of sustained focus on mental health and wellbeing. We need to engage everyone in Defence, at all levels, if we are to maintain a mentally healthy population. We cannot do this alone, and nor do we desire to. Working with our partners outside of Defence is critical to getting this right. That is why this document has been written, not just to set direction for Defence People but to communicate the direction of this work through close collaboration with others.

Lieutenant General Richard Nugee
Chief of Defence People

Preface

by Surgeon General (SG)

I am grateful for the opportunity to provide this preface alongside the Chief of the Defence People. Its publication is timely and important. The UK Armed Forces have faced significant challenges over the last decade, with two prolonged campaigns in Iraq and Afghanistan. The Defence Medical Services played a crucial part in this, grasping the necessity of providing timely and bespoke mental healthcare for our people.

There are many challenges facing mental health services nationwide. The Ministry of Defence, together with the National Health Service, continues to be committed to providing excellence in healthcare services to personnel in the UK Armed Forces and their families, the MOD Civil Service, and those veterans who have served in the past. For our Armed Forces personnel, healthcare provision not only recognises a formal commitment, but seeks to keep them fit to deploy, thereby maintaining our Defence operational capability.

The approach must begin with education and understanding, empowerment of our leaders and the promotion of positive mental wellbeing at all levels. It must be capable of rapidly detecting symptoms and treating mental ill-health, using high quality, safe and effective treatment for the small proportion of people who require it. There are already positive steps in place to address the stigma which may impede access to mental health services. We are pleased that the barriers to seeking mental healthcare appear to be reducing, but we know there is still some way to go.

Whilst the Defence Medical Services have our own dedicated treatment facilities, this should never replace the need for good leadership in maintaining a positive working environment, which this strategy clearly advocates. Fortunately, the rates of conditions like Post-Traumatic Stress Disorder in our people remain low, however, we are driven to increase the effectiveness of our interventions and maximise the effect of our resources where these important conditions do require our assistance. We strive to build on the achievements of the Mental Health Strategy of 2011, so that we can continue to deliver 'fit for purpose' services to our people. I am personally committed to delivering the Defence Medical Services' contribution to this strategy, and I know that my colleagues fully share this commitment.

Surgeon Vice-Admiral Alasdair Walker
Surgeon General

Contents

1. Executive Summary 8

Part One – The Context

2. Introduction 10
3. The Strategic Task 12

Part Two – Achievements Since Armed Forces Mental Health Strategy 2011

4. Mental Health and Wellbeing of the Defence People 14
5. What We Have Done 18
6. How We Measure Success 20

Part Three – The Future

7. What We Will Do Next 22
8. How We Will Do It - The Defence People Mental Health and Wellbeing Operating Model 26

Part Four – Conclusion and Appendices

9. Conclusion 36
10. Appendix 1: Activity Summary 37
11. Appendix 2: Facts and Figures 41
12. Appendix 3: Further Information 45

1. Executive Summary

Society is changing. Although two in every three of us are likely to remain free of mental illness in our lifetime,[1] many of us will, at some stage, experience symptoms of poor mental wellbeing. Defence People are a part of wider society and, as this society evolves, so do the needs of its people. As an employer the MOD must adapt to these changes; in order to maintain a mentally healthy working population and to ensure those who leave the Service are given the tools to lead long and healthy lives.

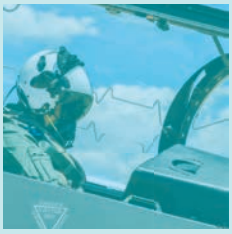
The *Defence People Mental Health and Wellbeing Strategy 2017-2022* is a sub-strategy of the *Defence People Health and Wellbeing Strategy 2016-2021*[2] and, although managed by the Mental Health Steering Group (see Part Three) it is acknowledged as a matter of national interest. The publication of this strategy follows a sustained period of activity on wider health and wellbeing matters. Five years after initial publication of the Armed Forces Mental Health Strategy, this update addresses our achievements and our challenges, looks ahead to the next five years and describes how we build on this success.

Since 2011 *our focus* has been on establishing a coordinated approach to physical and mental health and wellbeing. We have recognised the overlap between welfare, health and healthcare and the need to coordinate activity on all. We have launched anti-stigma campaigns, introduced resilience training and produced policy on workplace and operational stress. We have also commissioned research and refined our health statistics-monitoring, building our evidence-base and better-assessing our progress.

Our challenge has been to embed this approach into every level of the organisation, in order to meet the needs of its broad population; this strategy highlights collective responsibilities and describes the partnerships that are in place to enact them. Our focus will be on using health surveillance data, research and innovation to fully exploit the Mental Health and Wellbeing Operating Model (Figure 7.1). We will **promote** positive mental health and wellbeing, we will **prevent** and **detect** the onset of mental health illness and we will **treat** such illness when it is diagnosed. We will consider all Defence People, see Figure 2.2. Recognising we cannot do this on our own, we will forge partnerships with the health and third sectors to share best practice, ensuring a flexible, integrated, through-life approach to mental health and wellbeing is provided for all.

1 "One in three adults aged 16-74 with conditions such as anxiety or depression, surveyed in England, were accessing mental health treatment, in 2014. This figure has increased from one in four since the last survey in 2007". Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014, published 29 Sep 2016.

2 20160608-DPHWB-Strategy-16-20-3 star endorsed.





Vision of the Defence People Health and Wellbeing Strategy:

"All Defence People to enjoy a state of positive physical and mental health and wellbeing, feeling connected with, and supported by, the military and wider community, enabling them to contribute to the delivery of Defence outputs, including operational capability, as part of the Whole Force".

Strategic Aims:

- A leadership-based approach to through-life mental health and wellbeing for Defence People.
- Timely access to safe, effective and innovative mental healthcare services for those we serve.
- Working with partners to ensure mental health and wellbeing support for all Defence People.
- Promulgation of a robust Mental Health Plan and Communication Strategy.

This Strategy is based on:

- Understanding the health needs of the Defence People.
- Listening to the views of our external stakeholders, our MOD welfare, health and healthcare organisations, personnel, and subject matter experts.
- Evaluating the effectiveness of our current services and lessons learned.
- Collaborative partnerships with other Government departments and charity organisations.
- The best available evidence from international literature, the Academic Department of Military Mental Health, Defence Statistics (Health) and national guidelines.

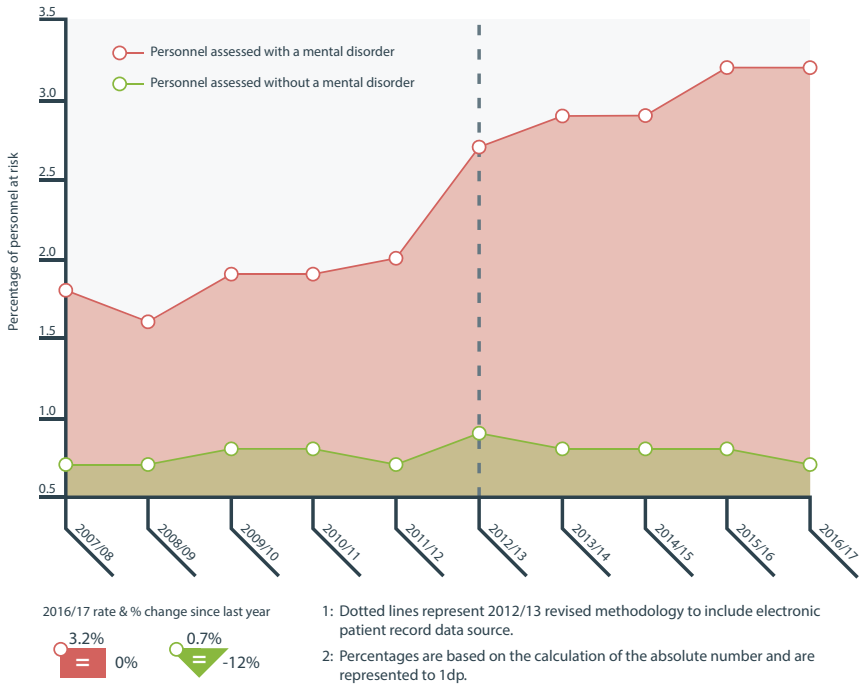
2. Introduction

Mental health issues are the highest cause of non-industrial MOD Civil Servant sickness absence, at 22%, and the highest cause of long-term sickness absence[3]

The revision of the Defence People Mental Wellbeing Strategy is consistent with a national recognition of the need for parity between mental and physical health. Our society, like any other, is characterised by a landscape of complex and dynamic social, health and care needs. The MOD must adapt, within the national context, to ensure the needs of its own people continue to be met.

The independent 'Mental Health Taskforce', formed in March 2015, brought together health and care leaders, service users and experts in the field[4] to create a *Five Year*

Figure 2.1 UK Armed Forces personnel presenting at MOD Specialist Mental Health Services by initial assessment



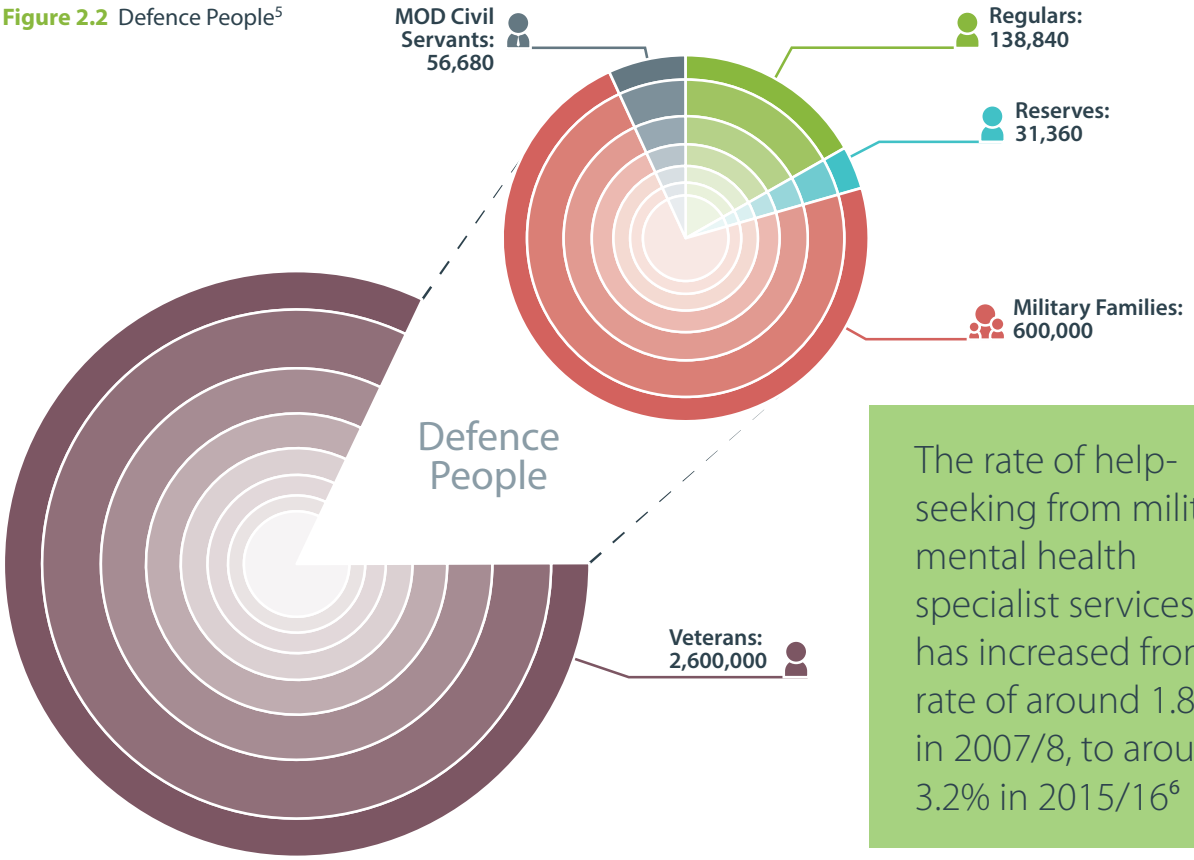
1: Dotted lines represent 2012/13 revised methodology to include electronic patient record data source.

2: Percentages are based on the calculation of the absolute number and are represented to 1dp.

3 MOD Civil Service Statistics 2017.

4 NHS England, NHS Improvement, Health Education England, the National Institute of Health and Care Excellence, Public Health England and the Care Quality Commission.

Figure 2.2 Defence People[5]



The rate of help-seeking from military mental health specialist services has increased from a rate of around 1.8% in 2007/8, to around 3.2% in 2015/16[6]

Forward View for Mental Health for the NHS in England. The national strategy, published in February 2016, set out a vision for the future of the NHS and signified the first time there had been a strategic and integrated approach to improving mental health outcomes across the health and care system.

The MOD, as a Government department, employer of over 200,000 people, and a provider of healthcare for a proportion of them, has a responsibility to align with the national mental wellbeing agenda; this can be done by combining its knowledge and resources intelligently to affect change. A national rise in the reporting of mental illness is also apparent within the Armed Forces; the percentage of military personnel diagnosed with a mental health disorder has increased steadily over recent years, see Figure 2.1.

The Defence People Mental Health and Wellbeing Strategy 2017-2022 has been expanded to incorporate all Defence People (see Figure 2.2) acknowledging the opportunity to make a positive impact on those groups not previously covered by the 2011 publication; Service people and their families, including Reserves, veterans and MOD Civil Servants. Much of this population relies on external services to access health and wellbeing support, in particular the provision of healthcare services. This Strategy is therefore closely mapped with the Government's national focus and, from a healthcare perspective, the NHS' plan for delivering it.

5 Estimates taken from MOD Official Statistics, May 2017: https://www.gov.uk/government/publications/mod-national-and-official-statistics-by-topic/mod-national-and-official-statistics-by-topic#personnel-statistics and Office of National Statistics, 2007: https://www.gov.uk/government/news/more-support-for-veterans-in-the-criminal-justice-system. UK Armed Forces Veterans residing in Great Britain, 2015: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/559369/20161013_APS_Official_Statistic_final.pdf

6 www.gov.uk/government/statistics/uk-armed-forces-mental-health-annual-statistics-financial-year-201516.

3. The Strategic Task

The MOD is required to maintain the health and wellbeing of its people primarily to 'deliver and support military effect'. This ensures its people can deploy on operations and remain fully employed in their day to day role. For Service Personnel, the MOD must also meet the commitment of the Armed Forces Covenant, ensuring that Armed Forces personnel and their families are not disadvantaged within wider society, either during their time in the Service or in their lives beyond the military.

The Defence Plan. The Defence Plan, *Defence Task 8*, 'Strategic Base Enabling Functions' (Figure 3.1) is delivered by the *Defence People Strategy*, which provides a framework for delivering the 'right mix of capable and motivated people'. The *Defence People Health and Wellbeing Board* sets the conditions for the *Defence People Health and Wellbeing Strategy* and runs a number of Steering Groups spanning physical and mental health. One of such groups is the *Mental Health Steering Group* which is allocated responsibility for delivering the *Defence People Mental Health and Wellbeing Strategy*. Joint responsibility for health and wellbeing is held by Chief of the Defence People and Headquarters Surgeon General, see Figure 3.2. The Mental Health Steering Group is 'People'-led, recognising the non-medical, chain of command responsibility of wellbeing in the workplace, and the need to minimise the requirement for medical care.

Application. This strategy applies to all Defence People and not just Service Personnel, for whom maintaining mental health and wellbeing is a *major contributor to the moral and physical components of fighting power*. Research shows that healthy behaviour and good physical health are associated with enhanced job performance and a reduction in sickness absence. As a responsible employer, the MOD has a duty to provide the physical and psychological environment necessary to maintain a healthy workforce, in order to meet the Defence outputs listed at Figure 3.1.

Armed Forces Covenant. The MOD has a unique remit as an employer to fulfil the principles of the Armed Forces Covenant. This is a pledge on behalf of the nation that our serving personnel, their families and our veterans are not disadvantaged in comparison to other citizens in the provision of public and commercial services. This includes healthcare; those injured in service, whether physically or mentally, should be cared for throughout their lives in a way which reflects the nation's moral obligation.

Figure 3.1 The Strategic Task: Defence Task 8.1 Strategic Base Enabling Functions

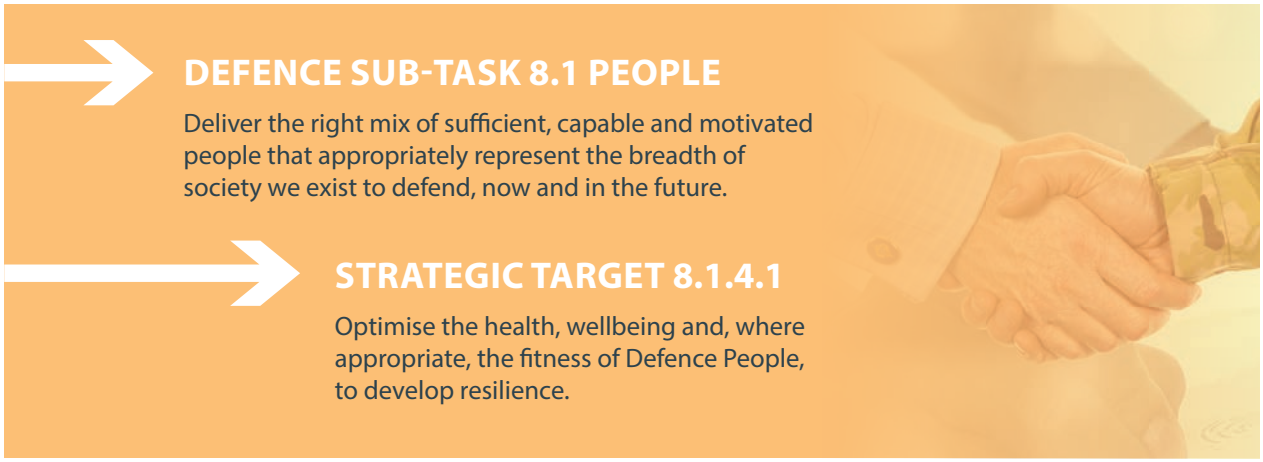
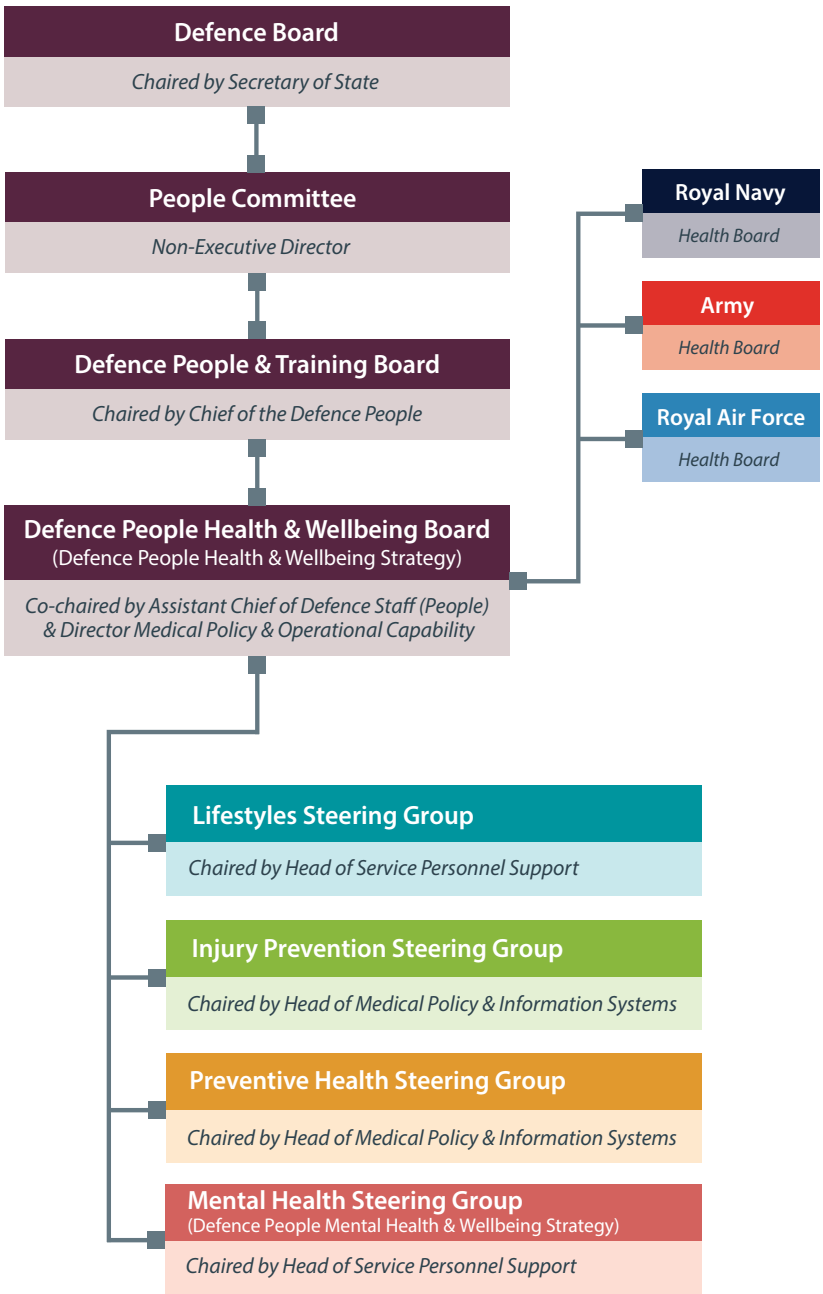


Figure 3.2 Governance route, outputs and ownership

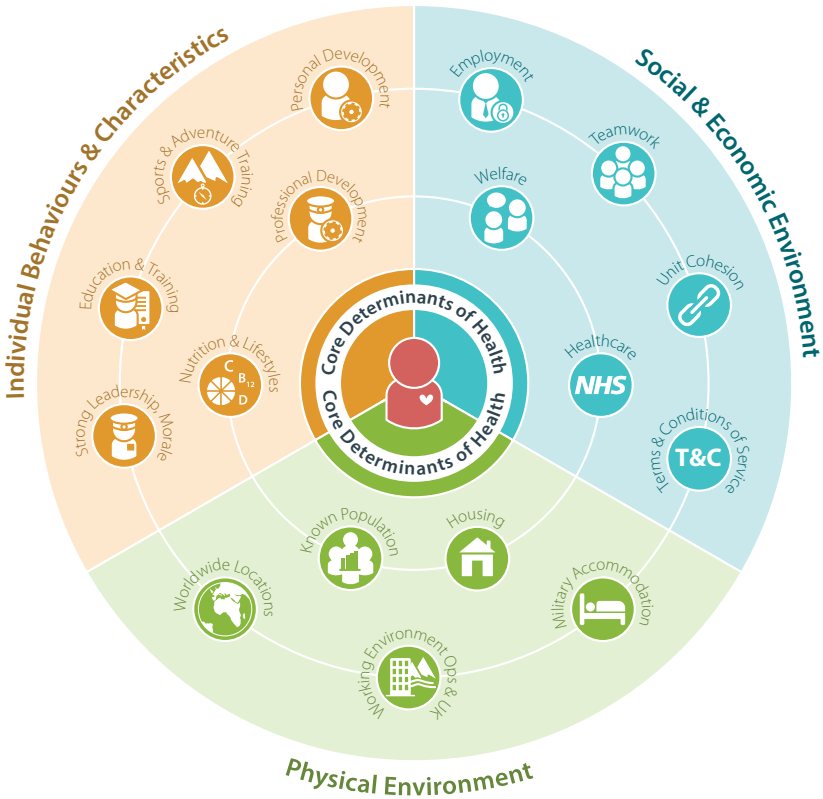


4. Mental Health and Wellbeing of the Defence People

The World Health Organization identifies three core determinants of health; the *social and economic environment, the physical environment and individual characteristics and behaviours*. In comparison to many employers, the MOD has an opportunity to influence these determinants of health across its population. Armed Forces personnel are provided with stable employment, housing, welfare services for its employees and their families, strong leadership and a sense of unit cohesion. Both Armed Forces and MOD Civil Service personnel are offered reasonable employment terms and career development/educational opportunities, see Figure 4.1. Equally, poor management of the above factors may also have a detrimental impact on mental health and wellbeing.

Whilst presented with an opportunity to make a positive impact on the core determinants of health, there are specific challenges, primarily related to military employment, which the MOD must take into account when setting a health and wellbeing agenda:

Figure 4.1 Opportunities to Impact on Core Determinants of Health



Operational Stress. Armed Forces personnel are called upon to undertake extremely hazardous duties, with potential exposure to severely traumatic and sometimes unique, life-threatening situations. Combat exposure, the stress associated with deployment and the return home are known risk factors for both Armed Forces personnel, although research on ground-based deployments suggests mental health during operational deployment is generally reported as good.[8] Robust training and good leadership are seen as key determinants of mental health for those on deployment.[9]

There are specific known risk groups for those deploying on operations, for example, personnel in combat or medical roles supporting combat units, or those experiencing family/relationship issues.[10] Deployed Reserve personnel appear to have higher rates of poorer mental health than deployed Regular personnel,[11] however, research suggests that three quarters of those Reserves assessed by the 'Reserves and Veterans Mental Health Programme' return to full fitness and experience substantial improvements in mental health.[12] The needs of specific risk groups associated with combat exposure and deployment continue to be monitored and addressed.

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[7]

Employment Terms and Conditions – 'The Offer'. Whilst not deployed, Service Personnel are required to work in varied locations across the UK and worldwide, being placed 'at readiness' to deploy. They may choose to move their primary place of residence on a regular basis, or live away from home in Service accommodation for prolonged periods. An attractive employment 'offer' must be made to optimise recruitment, and to encourage those serving to remain employed, whilst meeting this enhanced commitment. This might include pay and allowances, career and development opportunities, support to the Service family, provision of medical and dental care, support for funding for educational courses and wider Service experience such as Sport and Adventurous Training.

A Complex Organisation. Internally, the MOD incorporates a number of organisations. Policy and guidance must provide the appropriate level of standardisation and governance, whilst allowing the Royal Navy, Army, Royal Air Force, Joint Forces Command and MOD Civil Service the freedom to develop bespoke and innovative solutions.

Externally, the MOD interacts with a number of cross-Government and third sector organisations, in order to be able to reach, understand and share best practice on its population (see Figure 4.2). For example, the MOD/UK Departments of Health Strategic Partnership confirms the joint intent of the MOD and the UK Health Departments to renew and strengthen the partnership between military and civil healthcare services. It provides a cross-cutting partnership, via the MOD/UK Departments of Health Partnership Board, aimed at delivering the best healthcare needs for our Armed Forces, their families and veterans.

7 World Health Organization; http://www.who.int/mediacentre/factsheets/fs220/en/

8 Research Summary, Academic Department of Military Mental Health in collaboration with Kings Centre for Military Health Research pg 28, 20 Mar 2017.

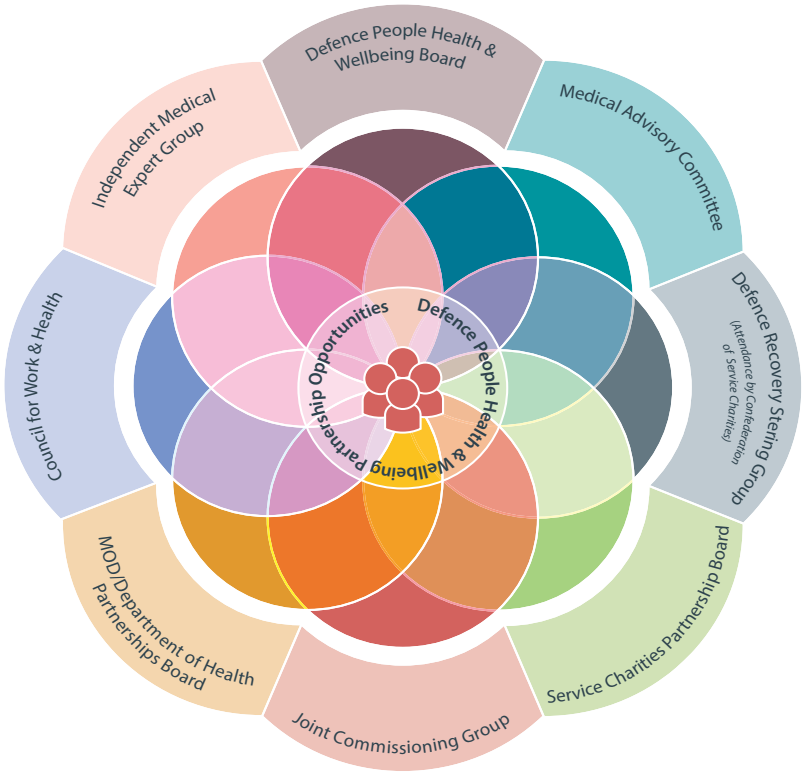
9 Ibid.

10 Ibid.

11 Browne T, Hull L., Horn O, et al. Explanations for the increase in mental health problems in UK reserve forces who have served in Iraq. The British Journal of Psychiatry, 190: 484-489.

12 Jones, N., Wink, P., Brown, R. A., Berrecloth, D., Abson, E., Doyle, J., & Greenberg, N. (2011). A clinical follow-up study of reserve forces personnel treated for mental health problems following demobilisation. Journal of Mental Health, 20(2), 136-145.

Figure 4.2 Existing Partnership Arrangements



Transition from Service Life: Keeping Tomorrow's Veterans Healthier Today. Childhood adversity and childhood antisocial behaviour are known risk factors for poorer mental health[13] and violent offending,[14] both of which are likely to occur at greater levels in areas of social deprivation. These factors may exist within the Armed Forces recruiting population, noting that the strong social support networks associated with Service life may, with time, mitigate against these risks. On leaving the Armed Forces, vulnerabilities may be re-exposed and it is therefore vital to ensure Service people and their families are well prepared to continue with their life beyond the Service.

Research has shown that those leaving the Service early are at greater risk of developing mental health problems.[15] Similarly, it was identified that those veterans at highest risk of mental health disorder were those who did not complete training or the minimum engagement, whilst those with longest service were at a reduced risk, suggesting that military service was not causative.[16] The high risk amongst the earliest leavers may reflect those pre-service vulnerabilities already present at recruitment.

Difficulties upon leaving the Service can be experienced by anyone, regardless of status, rank, or social background. Whilst the MOD does not provide social or health services to the majority of veterans and de-mobilised Reserves, it recognises a requirement for through-career training, a high level of support during the transition period, and communication with partner organisations to ensure that the longer term needs of ex-serving personnel are understood; "*The need to keep tomorrow's veterans healthy today*".

Further Considerations for All Defence People

Stigma. Although NHS and Defence Medical Services mental healthcare services are of a high standard and relatively easily accessed, many choose not to seek help. This may be due to the effects of stigma, either due to the personal meaning attached to help-seeking, or due to a wider concern about career progression and/or involvement of medical professionals.

13 Iversen, A. C., Fear, N. T., Simonoff, E., Hull, L., Horn, O., Greenberg, N., .Hotopf, M., Rona, R. & Wessely, S. (2007). Influence of childhood adversity on health among male UK military personnel. The British Journal of Psychiatry, 191(6), 506-511.

14 MacManus, D., Dean, K., Jones, M., Rona, R.J., Greenberg, N., Hull, L., Fahy, T., Wessely, S. and Fear, N.T., 2013. Violent offending by UK military personnel deployed to Iraq and Afghanistan: a data linkage cohort study. The Lancet, 381(9870), pp.907-917.

15 Buckman, J., Forbes, H., Clayton, T.,Jones, M., Jones, N., Greenberg, N., Sundin, J., Hull, L., Wessely, S., Fear, N., 2012. Early Service leavers: a study of the factors associated with premature separation from the UK Armed Forces and the mental health of those that leave early.

16 Bergman, B., Mackay, D., Smith, D., Pell, J. (2016). Long–Term mental Health Outcomes of Military Service: National Linkage Study of 57000 Veterans and 173,000 Matched Non-Veterans. Journal of Clinical Psychiatry, 77(6).

Fear of prejudice and judgement stops people from getting help and can destroy families and end lives[17]

'*Fighting Fit – A Mental Health Plan for Servicemen and Veterans*'[18] recognised the significance of stigma and of making interventions acceptable to a population accustomed to viewing itself as mentally and physically robust. Research has shown that in the military there is a "ubiquitous presence of stigmatising beliefs related to mental health and associated care processes"[19] which can be notably higher during deployment.[20]

The stigma associated with mental health issues is not a challenge unique to Defence, however, it is recognised as a cultural issue, and organisational culture is influenced by those in positions of responsibility. Wholehearted endorsement by the chain of command to open the dialogue on mental health and wellbeing, is seen as vital in the encouragement of 'taking the first step'. Research has shown that 'positive perceptions of leadership' and 'better unit cohesion' are significantly associated with lower stigma levels and a willingness to discuss mental health matters.[21] Tackling stigma is one of the highest priorities for MOD health promotion activity.

Occupational Stress. Work-related stress is the response people may have when presented with work demands and pressures that are not matched to their knowledge or abilities, and which can challenge their ability to cope. It can affect people in different ways at different times and is often the result of a combination of factors, such as prolonged high workload, working practices, working relationships or personal relationships. It can manifest in adverse mental and/or physical reactions such as anxiety, insomnia, tiredness, nausea, muscle tension or raised heart rate.

Stressors can include lack of support from leaders, poor team cohesion, social conflict with colleagues, harassment at work, role conflict and work overload. They present a significant occupational health hazard in the routine military work environment.[22] The MOD is committed to promoting a healthy and supportive environment in which to operate and recognises the importance of identifying, reducing and managing stress in the workplace; guidance is provided via the MOD *Stress in the Workplace policy*.[23] The importance of good leadership in the working environment is discussed more fully in Part Three.

'No One-Size Fits All'. Mental health disorders are usually multifactorial, with pre-disposing, triggering and maintaining factors where 'one person's stress may be another's stimulus'. The MOD recognises there is no single solution to prevent these issues, although the provision of choice and individual empowerment are considered vital. The MOD is therefore committed to ensuring that its approach to **promote**, **prevent**, **detect** and **treat** mental health and wellbeing is flexible, diverse, suited to individual needs, well-communicated and available to all. This approach includes not only clinical interventions but support from a wide range of non-medical sources. This may include training and education, online resources, welfare support or health promotion activity.

17 Heads Together Campaign, 2017: https://www.headstogether.org.uk/

18 "Dr Andrew Murrison, 'Fighting Fit - A Mental Health Plan for Servicemen and Veterans', August 2010.

19 Gould, M., Adler, A., Zamorski, M., Castro, C., Hanily, N., Steele, N., Kearney, S., & Greenberg, N. (2010). Do stigma and other perceived barriers to mental health care differ across Armed Forces? Journal of the Royal Society of Medicine, 103, 148-156. doi: DOI 10.1258/jrsm.2010.090426.

20 Osório, C., Jones, N., Fertout, M., & Greenberg, N. (2013). Perceptions of stigma and barriers to care among UK military personnel deployed to Afghanistan and Iraq. Anxiety, Stress & Coping, 26(5), 539-557.

21 Jones, N., Campion, B., Keeling, M., Greenberg, N. (2015). Cohesion, Leadership, Mental Health Stigmatisation and Perceived Barriers to Care in UK Military Personnel. Journal of Mental Health. (in press)

22 Brooks, S., Greenberg, N., Non-deployment factors affecting psychological wellbeing in military personnel: literature review. (2017). Journal of Mental Health, 1 February 17.

23 Joint Service Publication 385 Health and Safety at Work, Pt.2 Vol 1 (V1.0 Jan 16), Stress in the Workplace.

5. What We Have Done

The Mental Health Steering Group reports to the *Defence People Mental Health and Wellbeing Board*, see Figure 5.1, and was established following a recommendation by the *Armed Forces Mental Health Strategy* 2011. The Steering Groups address elements of physical and mental wellbeing, focusing on healthy lifestyles, the reduction of physical injury and the prevention of physical and mental illness. They also address the need to ensure those who are wounded, injured or sick are returned to work, or can transition out of employment with the appropriate support. The Mental Health Steering Group focuses on four themes: *Stigma Reduction, Occupational Stress, Suicide and Self-Harm and Culture and Behaviours* and has seen an unprecedented period of sustained mental health-related activity over the last six years. This activity is listed comprehensively (together with future activity) at Appendix 1. Key achievements are summarised below:

Figure 5.1 DPHWB and subordinate structures, including Mental Health Steering Group and Sub-Working Groups

General

- ✓ Establishment of the *Defence People Health and Wellbeing Board* and subsidiary Mental Health Steering Group with 4 themes; Stigma Reduction, Occupational Stress, Suicide and Self-Harm, Culture and Behaviours.
- ✓ Publication of the *Defence People Health and Wellbeing Strategy* and *Plan, 2016*, providing the first overarching direction for the single Services and MOD Civil Service.
- ✓ Publication/update of Resilience, Decompression, Deployed Welfare, Deployment Stress Briefing, Release from Capture and Stress in the Workplace policies.[24]
- ✓ Initiation of a pilot 'professional exchange programme' between Departments of Community Mental Health and local NHS teams.
- ✓ Pre and post-deployment mental health briefings for personnel and their families, aimed at the personal level and at recognising symptoms of poor mental health in loved ones.
- ✓ Launch of the MOD Wellbeing Online Service for Armed Forces personnel and MOD Civil Servants in May 2017.
- ✓ Support of launch of 'Big White Wall'; an anonymous digital site for those experiencing common mental health problems, such as depression and anxiety.

Stigma Reduction and Resilience

- ✓ Launch of anti-stigma campaign 'Don't Bottle It Up' and 'Time to Change'.
- ✓ Establishment of the Stress and Resilience Training Centre at the Defence Academy of the UK, providing resilience training to Regular, Reserve and MOD Civil Service personnel and authority for TRiM training.
- ✓ Launch of bespoke resilience initiatives: START Taking Control by the Stress and Resilience Training Centre, Royal Navy Op REGAIN, Army OP SMART[25] and Royal Air Force SPEAR.[26]

MOD Civil Service

- ✓ Publication of Civil Service Operational Deployment Policy, ensuring MOD Civil Servants benefit from equitable access to operational deployment support.
- ✓ On-going provision of MOD Civil Service Employee Wellbeing Service, incorporating a helpline and experienced wellbeing consultants based in regional hubs.
- ✓ On-going provision of an Occupational Health service to support managers and staff.
- ✓ Development of the e-learning package "Mental Health at Work".
- ✓ Launch of a Mental Wellbeing Toolkit to provide all civilian employees in the MOD, and their line managers, with relevant information, advice, support and training on mental health issues.
- ✓ Launch of the 'Line Manager's Deal', an online tool to help line managers understand how to lead their teams effectively.
- ✓ Launch of The Reasonable Adjustments Service Team who help line managers and employees to consider adjustments to assist with mental health challenges.
- ✓ Encouragement and support of Employee Networks; Defence Dyslexia Network, Fibromyalgia, Stammering, and Epilepsy Networks.

Veterans and Partnerships

- ✓ The MOD/UK Departments of Health and the MOD/NHS England Partnership Agreements, an important development in driving the needs and priorities of the Armed Forces community.
- ✓ Access for veterans to Defence Medical Services' Departments of Community Mental Health for up to 6 months post-discharge from the Service, in order to aid a smooth transition process. Linking to TIL Service (see below) following 6 months period.
- ✓ Provision of a Structured Mental Health Assessment prior to discharge from the Service.[27]
- ✓ Management of the 'Veterans' Transition Protocol', ensuring any Service Person discharged with a diagnosed mental health disorder is handed over specifically to the appropriate NHS clinicians.
- ✓ Establishment of 'Veterans and Reserves Mental Health Programme', providing assessment and treatment advice deployment related mental health issues.
- ✓ Linking to initiatives with NHS (England), devolved administrations and third sector agencies in recognising veterans' health needs. For example, an additional £1.68m NHS funding per annum (a total of £6.38 million annually) for veterans mental health initiatives. This has been focused on:
  - Understanding the barriers to veterans accessing mental health services.
  - Intensive treatment, including complex PTSD
  - Managing dual diagnosis
  - Transition, Intervention and Liaison Service (a total of £9 million over 3 years)
- ✓ Support of NHS (Wales) Supporting Transition of Military Personnel (SToMP) project. Aims to encourage the identification of former Armed Service Personnel across the Criminal Justice System to signpost them to specialist support services, to meet their individual needs.
- ✓ Access to full range of NHS mental health services[28] for all veterans, non-mobilised Reservists and families, in the local area in which they reside.
- ✓ Signature of the Crisis Care Concordat initiative, creating a cross-departmental approach to tackling mental health discrimination.
- ✓ Shared awareness of veterans' Gate to Gate report, exploring the effectiveness of health and criminal justice care pathways for veterans with complex mental health needs.
- ✓ On-going, historical provision of Veterans Welfare Service, working in collaboration with Services welfare staffs, ex-Service charities, statutory and non-statutory bodies, local community service providers and Veterans Advisory & Pensions Committees to deliver a welfare service that promotes independence, within a veterans' community, but provides continuous support through life.
- ✓ Development of GP and psychiatrist e-learning packages in military-related mental health issues.

24 Joint Service Publication 770 Trauma Risk Management Policy, Joint Service Publication 770 Post Operational Decompression Policy, Joint Service Publication 770 Deployment Welfare Support, Joint Service Publication 950 Mental Health and Wellbeing Briefing Before, During and After Deployment, Joint Service Publication 950 Release from Captured Personnel Policy and Joint Service Publication 375 Stress in the Workplace.

25 Optimising Performance through Stress Management and Resilience Training.

26 Social, Personal and Emotional Awareness for Resilience.

27 Joint Service Publication 950, Medical Policy, Lflt 2-7-5, Structured Mental Health Assessment.

28 Primary, community, secondary/specialist.

6. How We Measure Success

Chapter 5 described the headline activities on-going since the publication of Armed forces Mental Health Strategy 2011. How do we measure the impact of such activity? The *Defence People Mental Health and Wellbeing Plan, 2016*,[29] identified eight Key Performance Indicators (KPIs) against which to measure progress. The Mental Health Steering Group reports this progress biannually to the Defence People Health and Wellbeing Board, with the next full review due in 2022. Significant activity against these KPIs can be reported at the time of writing and is summarised at Fig 6.1.

Figure 6.1 Mental Health Steering Group Key Performance Indicators and associated activity

29 20160608-DPHW Plan 16_18-3star endorsed.

In the long term, success might be defined by a reduction in the prevalence of mental health illness, or a reduction in workplace stress; such change takes time and measures are complex. As a theoretical example, an absolute reduction in mental health illness might be offset by an increase in the number of people being willing to attend for appointment, as a result of successful anti-stigma campaigning. In the short to medium term, the Mental Health Steering Group monitors health surveillance data and available research. Routine analysis of this data against KPIs is carried out by Steering Group stakeholders, both clinical and non-clinical, from MOD Head Office, Joint Forces Command, MOD Civil Service, the Royal Navy, Army and Royal Air Force. Headline outcomes are listed below; Appendix 2 provides facts and figures on the current state of mental health of Defence People:

	Headline Outcomes by Mental Health Steering Group 'areas of focus'
✓	**Stigma Reduction**. A **sustained period of anti-stigma campaigning** since 2011 has been accompanied by **an increase in help-seeking from 1.8% to 3.2%** between 2007 and 2016. It is not possible to attribute this rise directly to successful anti-stigma campaigning, but presentation rates continue to be monitored within the context of promote and prevent activity.
✓	**Occupational Stress**. Formal statistics-based recognition that Common **Mental Health Disorders contribute to the vast majority of Service personnel and MOD Civil Service mental health issues**. **Stress in the Workplace policy** has been published to tackle this. This strategy strongly emphasises the need to focus on 'promote' and 'prevent' activity over the next five years in recognising and managing this issue. Educational courses are in place to support this requirement.
✓	**Suicide and Self Harm**. The UK regular Armed Forces have seen a **declining trend in male suicide rates since the 1990s**. Suicide remains a rare event, evidenced by the small number of deaths each year. From 1997-2016, the **male suicide rate for the UK regular Armed Forces was statistically significantly lower than the UK general population**. Historically, the only age group with a statistically significant increased risk of suicide compared to the UK general population were Army males aged under 20 years of age. However, the number of suicides in this age group has fallen and for the latest five-year period, there was no significant difference in suicides among young Army males compared to males of the same age in the UK general population. Suicide rates for females in the Armed Forces are too low for statistical analysis.
✓	**Culture and Behaviours**. Studies have already shown that a culture of **strong leadership in the Armed Forces is associated with reduced mental health issues following deployment**. This strategy aims to transfer this success to the wider workplace.

Significant gains have been made since the publication of Armed Forces Mental Health Strategy 2011. Joint leadership of health and wellbeing has been put in place. Anti-stigma campaigning has been aligned with national initiatives and recognised as a health priority. Strong partnerships have continued with the health and care sectors to share joint understanding and provide seamless care. Innovative partnership opportunities are being discussed with the charity sector, and resources have already been identified to make that happen. We are now much better placed to accurately monitor and evaluate the health and wellbeing of our people and, as Defence People Mental Health and Wellbeing Strategy 2017 looks ahead to the next five years, Chapter 7 will describe what we will do to build on this success.

7. What We Will Do Next

Defence People Mental Health and Wellbeing Strategic Aims

This Chapter outlines our new Strategic aims and how we promise to deliver them over the next five years. The overarching assumption is that current structure and resources will stay in place; in particular for training and education, policy setting and healthcare delivery. Where resources are yet to be identified, specific reference is provided and work is on-going. The production of a five year Action Plan and Communication Strategy will follow, allocating responsibilities for subsequent activities across Defence. Information is summarised with current activity at Appendix 1.

Aim:

A leadership-based approach to through-life mental health and wellbeing for Defence People.

Challenge:

- The need to recognise that health and wellbeing is primarily a non-medical, leadership responsibility. Acknowledging that culture change will take investment and time.
- Developing evidence-based policy and practice which recognises core principles, whilst meeting bespoke Service requirements.
- Reaching the extent of the Defence People, including Service families and veterans.

Deliver:

- A focus on Health Promotion and anti-stigma campaigns through charity partnerships; instilling a culture of positive mental wellbeing.
- Prevention of mental illness through innovative approaches and practices.
- Identification of areas of duplication between the Royal Navy, Army, Royal Air Force and MOD Civil Service health and wellbeing practices; joint initiatives, pooling of resources, the sharing of expertise.
- Introduction of standardised mandatory mental health and wellbeing education and training, providing refresher updates if required.
- Review and development of the role of the Stress and Resilience Training Centre.
- Standardisation and assurance of resilience initiatives.
- Incorporation of MOD Civil Service Health and Wellbeing policy into the mainstream framework.
- Research on resilience training and monitoring of risk groups via data analysis.
- Review and continued improvement of Lifestyles-related strategies/policies impacting mental wellbeing (Alcohol, Smoking, Families and Welfare).
- Enhanced consideration of the positive impact of families regarding anti-stigma and resilience.

Resourced:

- £30K Innovation Project funding identified for work in promoting mental health. Likely to be used in partnership arrangement.
- £30K health promotion funding allocated from Headquarters Surgeon General for 2017/18. The Mental Health Plan will further specify enduring requirements.

Aspirational/In progress:

- Discussions initiated with charity sector regarding partnership, advice and resources for development of core training material and communication strategy.
- Resources must be identified for development of the Stress and Resilience Training Centre.

Aim:

Timely access to safe, effective and innovative mental healthcare services for those we serve.

Challenge:

- Fixed number of uniformed Defence Medical Services staff (set against their deployment requirement) to meet an increasing mental healthcare demand.
- A national and international challenge in recruiting and retaining mental health clinicians.

Deliver:

- Development of a new mental healthcare operating model, improving initial access to clinical assessment and prioritisation for treatment.
- Commissioning of a dedicated out-patient psychological therapy service from an in-patient provider, with further plans for investment through in-house provision.
- Commissioning of High Intensity Capacity outpatient psychiatry service, providing direct access to 12 sessions of High Intensity Therapy as a means of providing DCMH 'surge' capacity.
- Consideration of enhancement option for an increase in mental healthcare staff numbers.
- Continuation of recently established HQ SG Manpower Support Cell to target and streamline civilian practitioner recruitment.
- Examination of employment terms to ensure the clinical recruitment offer remains competitive.
- Enhancement of data capture and exploitation; improved efficiency/visibility along the healthcare pathway, enhancing processes for transition to and from service. To be delivered via the CORTISONE programme, entering service 2019 in partnership with NHS, NHS Digital and PCS Capita.
- Investigation of the increasing demand for mental healthcare services.
- Explore possibility of greater mobility of mental health practitioners to reach the Defence People by trialling 'remote working' for Defence Medical Services clinicians*.
- Consideration of proposal to ensure that veterans with mental health conditions attributed to operational deployments can access a military consultant psychiatrist, linking with registered GP**.

Resourced:

- An emphasis on new and efficient ways of working within the Defence Medical Services will see many of the above deliverable within existing or previously identified resources. Specific exceptions are listed as **Aspirational**.

Aspirational/In progress:

- Case submitted for external review of civilian and military recruitment and transfer of Clinical Psychologists from broader banded to AfC pay bands. Resources subject to approval.

* Remote working and veterans' access to military psychiatrist is a future project subject to costing.

** Consideration of proposal to ensure that veterans with mental health conditions attributed to operational deployments can access a military consultant psychiatrist, linking with registered GP.

Aim:

Working with partners to ensure mental health and wellbeing support for all Defence People.

Challenge:

- Indirect influence of the majority of healthcare services for the majority of Reserves, veterans, families and MOD Civil Servants, and in-patient mental healthcare for our Service People.
- Complexity of interactions between cross-Government and third sector organisations.

Deliver:

- Support to delivery of NHS(E) Transition, Intervention and Liaison Service and NHS(Wales) in the Supporting Transition of Military Personnel project.
- Support of launch of the Veterans Gateway, providing a one-stop hub for veterans to seek advice on a full range of welfare matters and referral to partners such as Combat Stress, The Royal British Legion, SSAFA, NHS services and other delivery partners across the UK.
- Continued partnership with the Department of Health, NHS (England, Northern Ireland, Scotland, and Wales) and third sector through existing partnership, commissioning and governance boards, reviewing/expanding attendance where beneficial.
- Partnership with NHS and third sector organisations for mental health promotion programmes.
- Support NHS(E) with mental health services re-procurement programmes for intensive services commence Apr 2018.
- Assistance to NHS(E) in developing a clinical commissioning framework with the third sector in order to maximise patient outcomes.
- Monitor success of MOD Reserves and Veterans Mental Health Programme.
- Support to NHS(E) for Mental Health Taskforce objectives, ensuring that mental health of veterans and their families is embedded in supporting the pathway from discharge and for on-going healthcare requirements.
- Link to NHS(E) 'Improving Access to Psychological Therapies' initiative, aiming to direct investment for anxiety and depression.
- Communicating awareness of NHS out of hours services for those with mental health needs in the form of Crisis Care Teams and/or Liaison mental health services in A&E departments. We will link to Crisis Care teams via existing Partnership Boards.

Resourced:

- Annual funding for mental health services in NHS(E) has been increased to circa £6.38million. Existing partnership and commissioning arrangements that are in place have no impact on resources for the MOD.

Aspirational/In progress:

- Existing resources will be required to continue current Partnership arrangements.

Aim:

Promulgation of a robust Mental Health Action Plan and Communication Strategy.

Challenge:

- Communicating the extent of available support to all Defence People, particularly those who have left the service, de-mobilised or who are family members.
- Ensuring parity of awareness of/access to resources, policy and training at all levels.

Deliver:

- Promulgation of a Mental Health and Wellbeing Action Plan and Communication Strategy via the Defence People Health and Wellbeing Board, and Mental Health Steering Group.
- Annual identification of realistic milestones (KPIs) providing governance, health surveillance and ultimately policy direction.
- Health and Wellbeing initiatives underpinned by evidence, those identified as best practice being brought into mainstream health and wellbeing policy.
- Two-way communications with single Services/sharing of best practice to meet individual service needs.
- An optimised transition process for those leaving the Service, working with partners to better advise our 'future veterans' the services they may need.
- Better communicate to those leaving the service or demobilising, and their families, the full extent of resources and support available to them.

Resourced:

- Mental Health Steering Group ownership of MHP and Communication Strategy.
- Resource-neutral for web based communication.

Aspirational/In progress:

- Charity partnership and resources identified for support and alignment of communication strategy. Arrangement to be formalised.

8. How We Will Do It

The Defence People Mental Wellbeing Operating Model

The Defence People Mental Health and Wellbeing Operating Model emphasises the importance of achieving and maintaining a positive state of physical and mental wellbeing, in order to best prevent the onset of mental illness.

Where symptoms of poor mental health do occur, the Model aims for timely detection and access to appropriate treatment when needed. There are four overlapping areas of activity; **Promotion, Prevention, Detection and Treatment**, underpinned where applicable by research and evaluation. The approach is through-life, from joining the Service[30] through to retirement and beyond. There is recognition of those areas which the MOD cannot directly influence; for example healthcare provision for veterans, Reserves who are not mobilised and Service families. It is, however, applicable to all Defence People and therefore relies on close collaboration with partners.

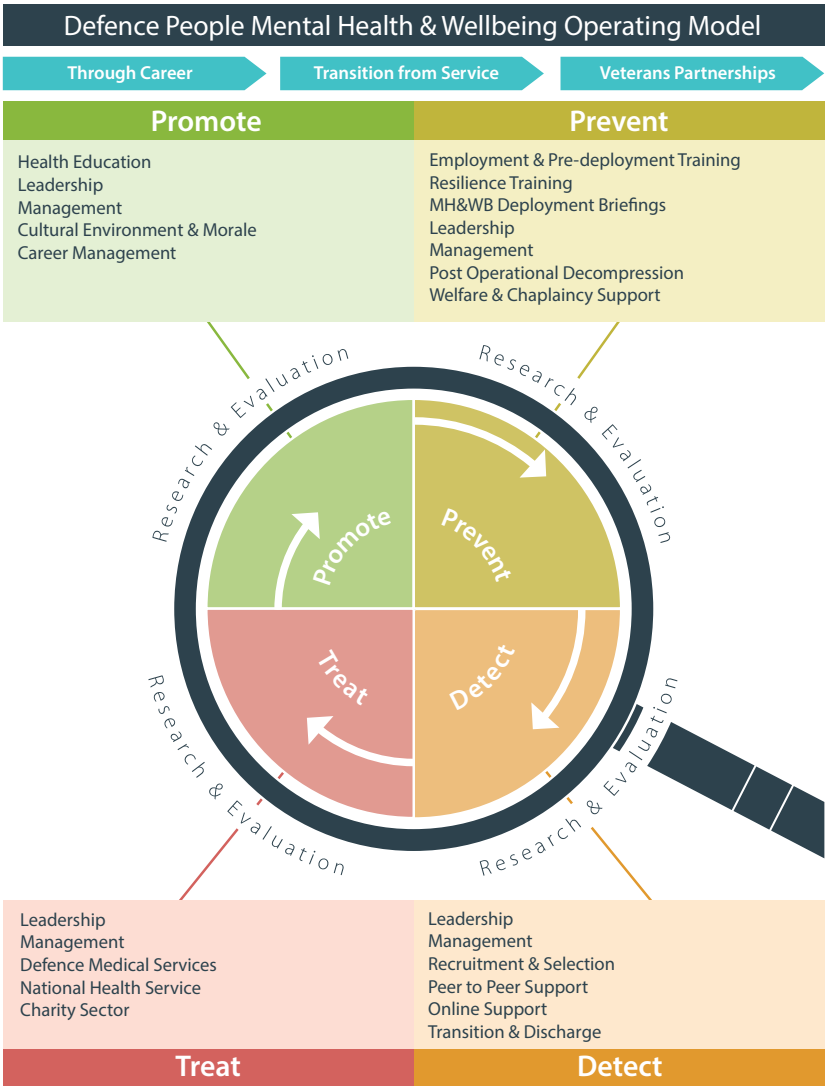


Figure 7.1 Defence People Mental Health & Wellbeing Operating Model

Promote

The promotion of positive mental wellbeing relates to organisational behaviour and the cultural environment which this creates; in practice it requires the adoption and maintenance of healthy lifestyles and the creation of good working conditions promoting better health. It relies on strong and compassionate leadership, a stable career structure, strong unit cohesion and a clear cultural message that our people are our single most important asset. The best results are achieved by an integrated approach involving individuals, peers, line managers and leaders, trainers and educators, healthcare professionals, wider Government and society.

Health Education. Health education relates to the promotion of all aspects of a healthy lifestyle. The Defence People Health and Wellbeing *Lifestyles Steering Group* monitors health trends, initiates research, facilitates access to resources including

30 Royal Navy, Army, Royal Air Force, MOD Civil Service.

Defence Statistics and develops health policies. The Group has good working relations with Public Health England and Health Education England. It focuses on four areas; Alcohol and Substance Misuse, Sexual Health and Fertility, Weight Management, Nutrition & Fitness and Smoking Cessation. One of its most visible outputs are health education campaigns; these may be in line with national initiatives or Defence-specific, targeting known risk groups.

Leadership, Management, Cultural Environment and Morale. The cultural environment created by good leaders is essential for a mentally healthy and productive workforce. In Defence there is a requirement for leaders at every level to influence and support its people. This must be underpinned by appropriately resourced, through-career health and wellbeing education for those in positions of responsibility. Leadership approaches must encourage a culture of open discussion and an awareness of organisational workload. The Defence MODified Health and Safety Executive (HSE) Management Standards Indicator Tool[31] is a management initiative developed by the Institute of Naval Medicine, utilised by anyone thinking of running a survey to investigate stress amongst personnel in their establishment. It consists of a questionnaire which indicates the risk of work-related stress by asking personnel to rate their working conditions according to eight factors.[32]

> If you're a leader you've got a responsibility to be a role model. If you say wellbeing is really important, that's a powerful message[36]

Good leadership and unit cohesion are said to have a positive impact on lowering stigma levels and encouraging open discussion.[33] By 'normalising' how we talk about mental health and wellbeing in the workplace, by non-medicalising it, and by being aware of the impact of our behaviour and management practices, we can increase our productivity accordingly.

Career Management. All Service Personnel and MOD Civil Servants are employed via *Terms and Conditions of Service* or equivalent employment contracts. These determine employment type, engagement and pay scale appropriate to trade or profession. Appropriate career management by managers and human resources staff is based on the need to retain *the right mix of sufficient, capable and motivated people*.[34]

Good career management will include employment, leadership development opportunities and geographical and family considerations. It will embrace new and modern ways of working, such as flexible working.[35]

31 Joint Service Publication 375 Health and Safety Pt 2 Volume 1 (V1.0 Jan 16).

32 Demands of the job, control of the job, managers' support, peer support, relationships, role, change, and work-life balance.

33 Jones, N., Campion, B., Keeling, M., Greenberg, N. (2015). Cohesion, Leadership, Mental Health Stigmatisation and Perceived Barriers to Care in UK Military Personnel. Journal of Mental Health. (in press).

34 Defence Sub-Task 8.1 'People'.

35 Joint Service Publication 750 Centrally Determined Terms of Service, Naval Service: BR3(1), Naval Personnel Management and BR3(2), Naval Personnel Management – Reserves; Army: QR (ORs), Promotions and Appointments Warrant 2009 (OFs), Army Reserve Regulations and Army Reserve Forces Act 1996; RAF: QR and AP 3376 Vol 1 (ORs), QR and AP 3393 Vol 1 (Officers), and AP3392 Vol 7 (Reserves).

36 https://www.ft.com/content/69d1f0a4-439f-11e6-9b66-0712b3873ae1

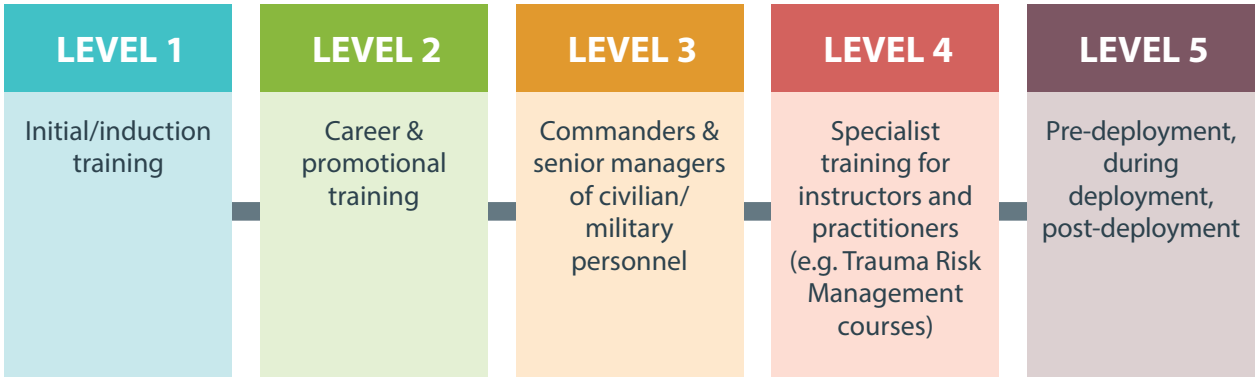


Figure 7.2 Levels of Resilience Training

Prevent

Prevention of mental health illness is concerned with non-medical initiatives aimed at mitigating the impact of stressors that will inevitably be encountered during a person's career. No system can guarantee total prevention, nevertheless, measures are in place at all levels and at various stages of a career. Prevention activity is the responsibility of chains of command, under guidance of the Defence People Health and Wellbeing Board.

Employment and Pre-Deployment Training. Service Personnel and occasionally MOD Civil Servants are required at times to place themselves in harm's way. They are required to work in hazardous environments, under stressful conditions whilst conducting activities that carry a high risk to personal safety. Consequently, according to job type, training systems must meet the very highest of standards. This is provided via initial recruit, employment, continuation and pre-deployment training. These provisions must be robust, realistic and challenging if they are to prepare its personnel for the full spectrum of situations they may face; "the purpose of Robust Training is to progressively develop a Service Person's resilience".[37] Employment and pre-deployment training form the foundation for mental health literacy and represent the start of the resilience-building process.

Resilience Training. Resilience is defined by the Stress and Resilience Training Centre (SRTC) as "the capacity to adapt successfully in the presence of risk and adversity".[38] It is recognised as an important part of through-career training, and aims to empower individuals and leaders in maintaining mental wellbeing rather than needing to seek help. Resilience is mandated via a five-stage, through-career process by the Royal Navy, Army and Royal Air Force, see Figure 7.2, with elective training available at the SRTC. It is available to Regulars, Reserves and MOD Civil Servants.

Specific initiatives are provided at the individual level and for those in command. The SRTC at the Defence Academy of the UK, for example, delivers the START Taking Control programme. This is aimed at stress management and resilience-building, educating both individuals and leaders about the physiological and psychological causes and effects of stress. It develops effective coping, management and prevention techniques and encourage their use when needed. The Army, Royal Navy and Royal Air Force provide developed bespoke initiatives; notably REGAIN (Royal Navy), OP SMART (Army) and SPEAR (RAF). To build on the success of such initiatives and identify best practice, the Academic Department of Military Mental Health has an on-going programme of resilience-based research.[39] In addition, the

37 Joint Service Publication 822, Defence Direction and Guidance for Training and Education Pt 1, 2.6 (V3.0 Mar 17).

38 Jenson J. & Fraser, M. (2005). Social policy for children & families: A risk and resiliency perspective. Thousand Oaks, CA: Sage.

39 https://www.kcl.ac.uk/kcmhr/research/admmh/index.aspx

Mental Health Steering Group discusses those areas of best practice for potential endorsement into mainstream policy, as directed by the Defence People Health and Wellbeing Board.

Military families are one of the most important contributors to the military effectiveness of serving personnel and are pivotal to successful transition from deployment

Mental Health and Wellbeing Deployment Briefings. Service Personnel and MOD Civil Servants on deployment may experience traumatic, potentially life changing events. Mental health and wellbeing briefings are routinely provided as part of the deployment process.[40] Such briefings provide information about potential deployment related mental ill-health to allow individuals, peers and family members to recognise when symptoms are prolonged or more deep-seated. These may be the early signs of developing disorders. Those affected can then be supported into help-seeking from the right source at the right time.

Among deployed UK Armed Forces personnel, receipt of pre-deployment educational briefings have had mental health benefits for those experiencing higher levels of combat whilst non-receipt of a post-deployment educational brief was associated with poorer mental health.[41]

Post-Operational Decompression. By their very nature, certain military operations are stressful. In order to allow Service Personnel and MOD Civil Servants returning from operational theatres to re-adjust to routine military and family life in a graduated and controlled manner, particularly where they have been exposed to high levels of intensity and risk, a period of 'decompression' is provided. The aim of post-operational decompression is to allow a period of rest, relaxation and reflection, within a safe and controlled environment, for personnel returning from an operation which has involved combat or a combination of other stressing factors which have the potential to cause high levels of post operational stress… to facilitate re-integration into life at home.[42]

Post-operational decompression research is limited to qualitative data collection, nevertheless studies have reported overwhelming support for decompression, with over 90% of those studies finding it moderately or very useful,[43] although it has been found that decompression may be less effective for units exposed to heavy combat.[44]

Welfare and Chaplaincy Support. The Royal Navy, Army and Royal Air Force provide their own specialist welfare services, inclusive of chaplaincy, welfare support and advice to Service personnel, their families and MOD Civil Servants. The value of welfare provision for Service families is of utmost importance, recognising the unique role and contribution of the family unit in a Service Person's career.

Welfare services are provided for those in the UK, posted abroad, or deployed on operations, including deployment-related briefings for families. It can include advice on relocation, schools, further education, housing, healthcare facilities, employment and training opportunities and transition from the Service. Although not trained counsellors, welfare staff can provide confidential advice for referral, or self-referral, to professional counselling agencies.

40 Joint Service Publication 950 Medical Policy Part 1 Lft 2-7-1 Mental Health and Wellbeing Briefings Pre, During and Post-Deployment.

41 Ibid.

42 Joint Service Publication 770 Welfare Chapter 3, Post-Operational Decompression Policy.

43 Jones, N., Burdett, H., Wessely, S. & Greenberg, N. (2011). The subjective utility of early psychosocial interventions following combat deployment Occupational Medicine, 61(2), 102-107.

44 Jones, N., Jones, M., Fear, N. T., Fertout, M., Wessely, S., & Greenberg, N. (2013). Can mental health and readjustment be improved in UK military personnel by a brief period of structured post deployment rest (third location decompression)?. Occupational and environmental medicine. 70(7), 439-445

Detect

Detection of the early signs and symptoms of mental health problems is the 'last line of defence' prior to medical intervention and is a non-medical approach to spotting the early signs of sub-optimal mental health and wellbeing. The responsibility exists at every level; the individual, family, peers and chain of command.

Routine mental health 'screening' is not a process employed by the UK Armed Forces to detect the onset of mental health illness. Studies carried out by the Academic Department of Military Mental Health have shown that it is wholly ineffective in predicting Post-Traumatic Stress Disorder, either carried out pre or post deployment,[45] or improving help-seeking.[46] Post-deployment screening was found not to reduce the prevalence of Post-Traumatic Stress Disorder, common mental health disorders or alcohol misuse.[47] Given that screening procedures are potentially resource-intensive and time-consuming, the MOD is committed to ensure that resources are channelled towards more effective forms of mental health and wellbeing support.

Recruitment and Selection. Selecting and recruiting mentally and physically healthy individuals are the starting points for a healthy force. All personnel are medically assessed prior to entry into the Armed Forces. This takes into account pre-existing mental health conditions which may present an unacceptable increased risk of adverse mental or physical health outcomes if placed under stress by their employer. Prior to joining the 'trained strength', personnel will be evaluated under stressful conditions, and where vulnerabilities cannot be overcome, they may be de-selected for service in the Armed Forces. Current psychiatric disease or dysfunctional behaviour may present a bar to recruitment; specific policy guidance exists for medical officers to assess each case individually.[48]

Peer to Peer Support. Noticing a change in the behaviour of colleagues or family members can be an early sign of a mental health issue. Trauma Risk Management (TRiM) is a peer to peer support initiative tried and tested following recent campaigns in Iraq and Afghanistan; it aims to provide support to Armed Forces personnel involved in a traumatic event, whether on operations or due to other circumstances. It has now been fully incorporated into tri-Service policy.[49] TRiM is a chain of command function that depends on good leadership and robust human resource management. The intention is to identify potentially-traumatised personnel and ensure availability of support and treatment to those individuals, as appropriate.

TRiM has been shown to be a useful tool with a potentially positive occupational effect, across all ranks,[50] when accompanied by support from the chain of command.[51, 52] It has also been shown to lead to a greater likelihood of help-seeking from mental healthcare services following deployment, in comparison to those exposed to the same trauma with no TRiM intervention.[53]

Online Support. There are many ways in which people may wish to take the first step in addressing their mental wellbeing. Online initiatives provide an alternative way to access support. Several resources are already in place. The *Big White Wall* is a safe online community of people who are

45 Rona, R. J., Hooper, R., Jones, M., Hull, L., Browne, T., Horn, O., Murphy, D., Hotopf, M.,. & Wessely, S. (2006). Mental health screening in armed forces before the Iraq war and prevention of subsequent psychological morbidity: follow-up study. BMJ, 333(7576), 991.

46 Ibid.

47 Rona, R. J., Burdett, H., Bull, S., Jones, M., Jones, N., Greenberg, N., .Wessely, S. & Fear, N. T. (2016). Prevalence of PTSD and other mental disorders in UK service personnel by time since end of deployment: a meta-analysis. BMC psychiatry, 16(1), 333.

48 Joint Service Publication 950 Medical Policy Part 1 Lft 6-7-7 (V1.1 2 Sep 16).

49 Joint Service Publication 770 Welfare, Chapter 2 Tri-Service Operational and Non-Operational Welfare Policy.

50 Greenberg, N., Langston, V., Iversen, A. C., & Wessely, S. (2011). The acceptability of 'Trauma Risk Management' within the UK Armed Forces. Occupational Medicine, 61(3), 184-189.

51 Greenberg N, Henderson A, Langston V, Iversen A, Wessely S. (2007). Peer responses to perceived stress in the Royal Navy. Occupational Medicine, 57(6):424-9. Epub 2007/06/15.

52 Langston, V., Greenberg, N., Fear, N., Iversen, A., French, C., & Wessely, S. (2010). Stigma and mental health in the Royal Navy: A mixed methods paper. Journal of Mental Health, 19(1), 8-16.

53 Research Summary, Academic Department of Military Mental Health in collaboration with Kings Centre for Military Health Research pg 15, 20 Mar 2017.

Defence People Mental Healthcare Commissioning Responsibilities

	Serving Armed Forces in UK *(including mobilised Reserves)*	Serving Armed Forces Overseas	Armed Forces Families in UK	Armed Forces Families Overseas	Veterans & Non-mobilised Reservists	MOD Civil Servants
Primary Care	Defence Medical Services	Defence Medical Services*	NHS**	Defence Medical Services*	NHS	NHS *(also Civil Service Occupational Health)*
Community Mental Health	Defence Medical Services	Defence Medical Services*	NHS	Defence Medical Services*	Clinical Commissioning Groups	Clinical Commissioning Groups
Secondary Acute Care	NHS	Defence Medical Services*	NHS	Clinical Commissioning Groups	Clinical Commissioning Groups	Clinical Commissioning Groups

Additional Mental Healthcare support offered to veterans	Structured Mental Health Assessment on discharge Veterans 'Transition Protocol' Veterans '& Reserves' Mental Health Programme Transition, Intervention & Liaison Service (NHS England) Supporting Transition of Military Personnel (NHS Wales) Access to military Department of Community Mental Health 6-months post-discharge Veterans Welfare Service

* Or locally commissioned service dependent on location. May include Royal Air Force Aeromedical Evacuation, for access to required service in UK.
** Unless located at a 'Defence Medical Services' designated family registered practice.

Figure 7.3 Summary of mental healthcare commissioning responsibilities

anxious, down or not coping who support and help each other by sharing what's troubling them, guided by trained professionals. Available 24/7, Big White Wall is completely anonymous to encourage free and open expression. Professionally trained 'Wall Guides' ensure the safety and anonymity of all members. It is available to all UK serving personnel, veterans, and their families. The *MOD Wellbeing Online Tool*, launched in May 2017 is confidential and designed to help colleagues manage their wellbeing in a fun and engaging way. Individuals can use the tool to assess their mental and physical health and stress levels, and take advantage of suggestions to address any issues identified. Finally, online Mental Health and Wellbeing training is available to all Armed Forces personnel and MOD Civil Servants on the *Defence Learning Environment*. A host of wider web-based support networks are listed at Appendix 3.

Transition and Discharge. The intent of the transition pathway is to ensure that the mental health and wellbeing of personnel is protected during their transition to civilian life, in order to ensure the optimum outcome for each individual. This will include communication of the full range of services, resources and benefits available to them. All Armed Forces personnel are entitled to a resettlement package which includes Graduated Resettlement Time, access to the Career Transition Partnership and provision of Individual Resettlement and Training Costs.[54]

There may also be a requirement to identify any existing mental health issues not previously addressed for those leaving the Service, which may or may not be attributed to Service life. Armed Forces personnel can be provided with a Structured Mental Health Assessment on leaving the Service[55] either via a final discharge medical or Medical Board.

54 Joint Service Publication 534 Tri-Service Re-Settlement Manual.

55 Joint Service Publication 950 Medical Policy, Lflt 275 Structured Mental Health Assessment.

Treat

'Treat' refers to the treatment provided for personnel who are suffering from a diagnosed mental health disorder, and is primarily the responsibility of the healthcare deliverer. In most cases, support other than healthcare will also be required; Headquarters Surgeon General is committed to collaborative, multi-disciplinary processes and evidence-based best practice interventions. The approach is one of recovery and rehabilitation, ensuring that, wherever possible, Service Personnel are supported in their return to duty. A collaborative approach is required, recognising that the majority of Defence People access healthcare services via the NHS. Figure 7.3 summarises the healthcare providers for different population groups.

Defence Medical Services. Led by the Surgeon General, the Defence Medical Services provide mental healthcare for Service Personnel (Regular and mobilised Reserves) via Primary Healthcare and regional Departments of Community Mental Health (DCMH). The emphasis is on local assessment and treatment supported by unit commanders and human resources staff. A key component of military healthcare is the provision of occupational health services to maintain and monitor the *employability and deployability* of military personnel. Assessment and care-management for patients suffering with mental health problems is available at 3 levels:

a. In Primary Care, by the patient's own Medical Officer.

b. In the community through specialists in military DCMH (Figure 7.4).

c. In hospitals, either the NHS or the contracted In/Out-patient Service Provider.

The level of care a patient may require is determined by a number of factors, based primarily on the severity of symptoms and degree of risk posed by the patient's current condition. Although primarily for regular Armed Forces personnel and mobilised Reserves, the Defence Medical Services also provide bespoke solutions for Reserves and veterans with healthcare needs where they meet specific criteria:[56]

- Access to Defence Medical Services care for up to six months beyond discharge date, providing the veteran is registered with a NHS GP.
- Case management via the *Veterans' Transition Protocol*, ensuring those with specific clinical needs are handed over to equivalent specialist services within the NHS.
- Veterans and Reserves Mental Health Programme, providing assessment and treatment advice for veterans who believe that their deployment may have affected their mental health.
- NHS (England) Transition, Intervention and Liaison Service.

> The DMS aim to deliver a safe and effective mental healthcare service for Defence in order to enhance and sustain the operational effectiveness of the three Services

In addition to the services above, the Royal Air Force provide a worldwide, 24/7 Aeromedical Evacuation Service to eligible mental health patients requiring return to the UK for further assessment or treatment.[57] Patients will generally be escorted by an appropriately qualified RAF Flight Nurse, depending on the severity of illness.

The National Health Service. The NHS provides mental healthcare for the majority of veterans, non-mobilised reservists, service families and Civil Servants, who will use the expanded mainstream mental health services that resulted from the Five Year Forward View alongside the general population. The MOD/UK Departments of Health Partnership Board and the NHS England–MOD Partnership Agreement[58] are in place to ensure that these are linked with any bespoke service

56 Joint Service Publication 950 Medical Policy Lflt 1-3-4.

57 Air Publication 3394 The Royal Air Force Aeromedical Evacuation Control Service.

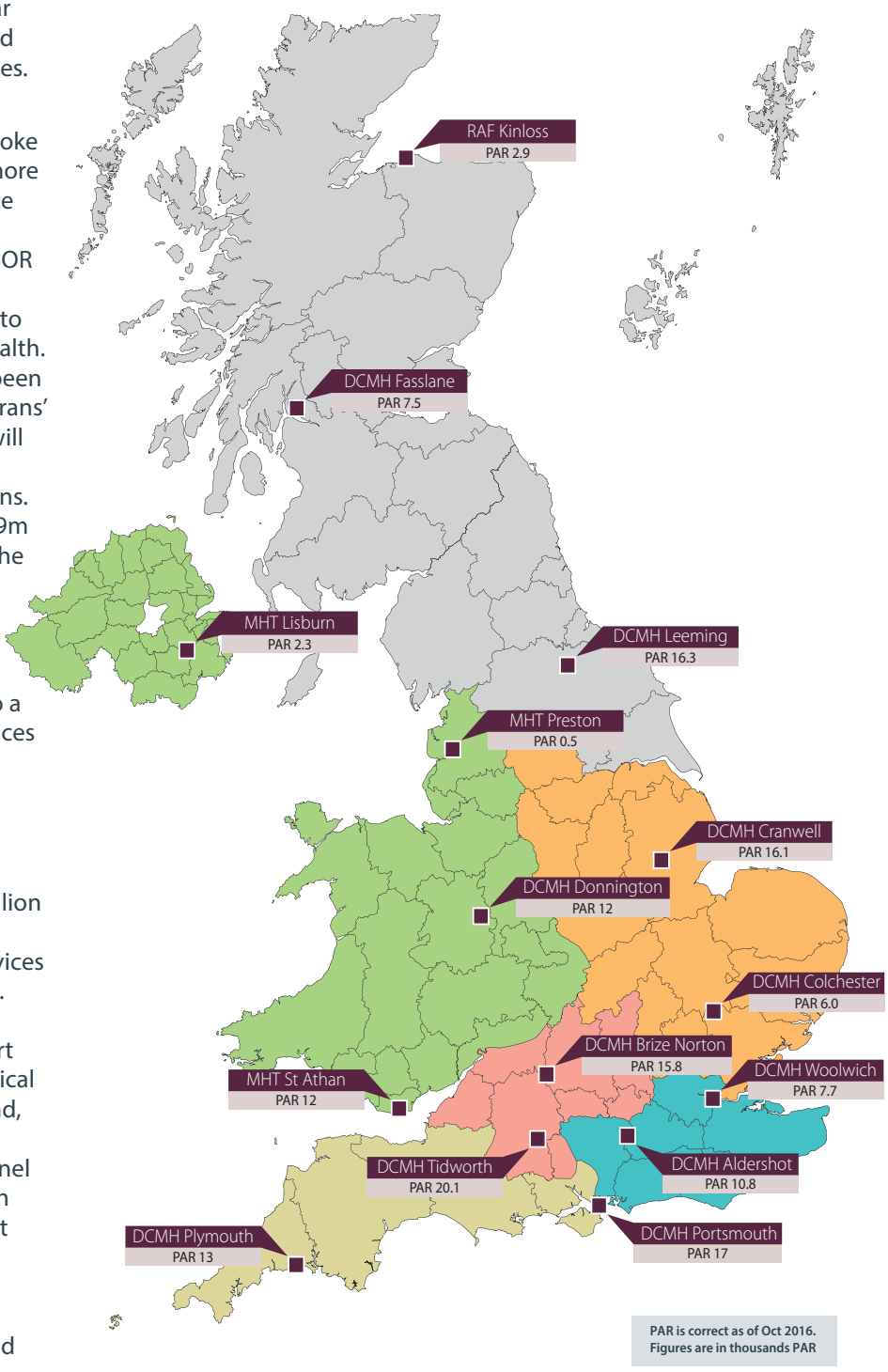
58 Noting that the vast majority of patients and commissioning are in England, hence an additional agreement arrangement.

provided in addition to the core services; for example, over 20,000 veterans per year are seen in the new improved psychological therapy services.

The NHS in England funds (circa £5m per annum) bespoke services to respond to the more specific needs of the Defence community. Furthermore, it has been allocated, from LIBOR fines, an additional £1.68m per annum from 2017-2021 to support veterans' mental health. Funding from 2017/18 has been combined with current veterans' mental health monies and will be used to fund a nationally consistent service for veterans. This newly commissioned £9m service, known officially as the NHS Transition, Intervention and Liaison (TIL) veterans' mental health service, will, over an initial three-year period, act as a front door to a range of mental health services across the health and care system for 17,500 people.

The Scottish Government, in partnership with NHS (Scotland), provided £1.2million to fund the provision of specialist mental health services for veterans across Scotland. The Welsh Government invested £650,000 to support improvements in psychological therapies. In Northern Ireland, the mental health needs of returning ex-Service personnel are dealt with either through the Ulster Defence Regiment and Royal Irish Aftercare Service, through Combat Stress, or directly within the mainstream primary care and mental health services.

Figure 7.4 DMS Mental Healthcare Services



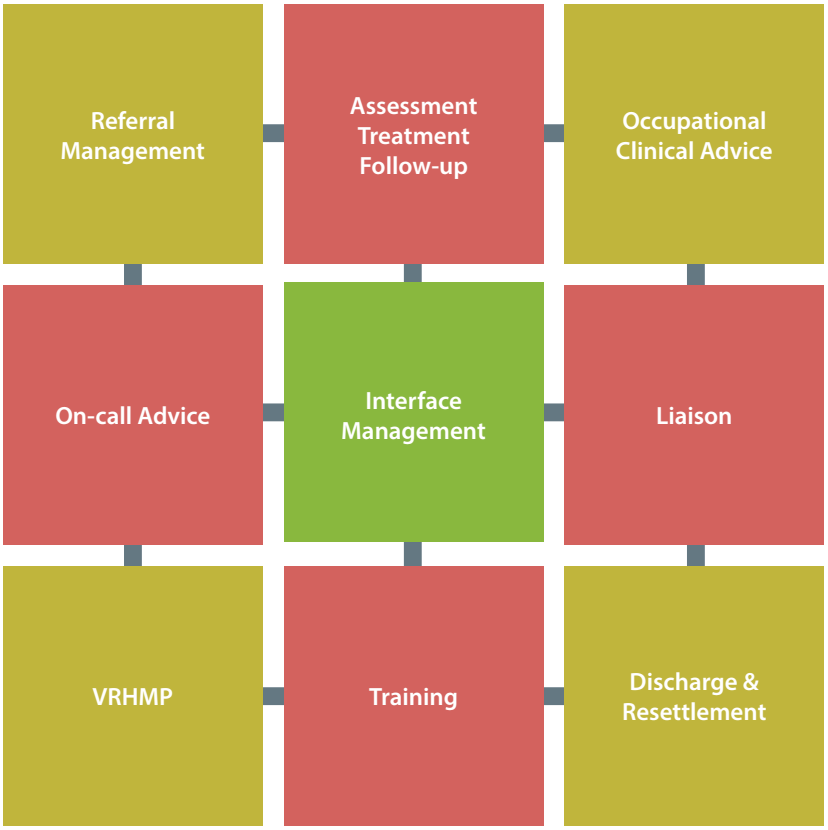


Figure 7.5 Key functions of DMS Mental Healthcare Services

Charity Sector. The majority of Service Personnel and MOD Civilians do not experience Service-related mental health illness, but are still prone to the same mental health problems as the general population. Experiences whilst serving and during transition to civilian life may mean that mental ill-health may be triggered by different factors. The MOD welcomes the opportunity to work closely with the charity sector in order to aid the positive promotion of veterans' mental health & wellbeing, and to recognise where different approaches may be more appropriate. Specific clinical services funded by the NHS may be open to tender and commissioned from the charity sector. In addition, charities can play an invaluable role in providing a 'safe place' by supporting people in taking the first step, engaging and, if required, accessing to treatment.

The charity sector plays a fundamental role in national-level mental health promotion. Charities can help to address many of the recognised determinants of health, including helping people to adopt and maintain healthy lifestyles, providing social support and maintaining positive living conditions. The MOD regularly seeks the support of the charity sector to address health issues where it may not otherwise be able to influence, in recognition that some people may prefer to seek alternative sources of support from specialist military or mental health charities. The MOD continues to build partnership activity in this area, in particular with anti-stigma campaigning.

'Contact' is a group of military charities working with the MOD, the NHS and leading academics to improve access to mental health support for members of the Armed Forces community. Members of the collaboration include: Big White Wall, Cobseo, Combat Stress, Help for Heroes, King's College London, Ministry of Defence, NHS England, NHS Wales, The Royal British Legion, The Royal College of Psychiatrists, Veterans First Point and Walking With the Wounded.

MOD-charity partnerships are an exciting area of opportunity and represent a new and innovative way to share best practice and combine knowledge and resource. Specifically, and at the time of writing, initiatives are being discussed with regards to collaboration for training and communication strategy/ publicity projects.

Research and Evaluation. The Defence Medical Services are committed to evidence-based best practice interventions in mental healthcare, as reflected in the peer reviewed scientific and medical literature and national clinical guidelines. Research and Evaluation underpins all Defence health and wellbeing-related activity and is coordinated by the Headquarters Surgeon General Medical Director. The Academic Department of Military Mental Health (ADMMH) provides the focus for high quality, cutting edge research with the aim of improving the health and wellbeing of service personnel, veterans and service families'. The research effort is dedicated to three main areas; the prevention of mental illness, the early detection and management of mental ill-health and restorative treatment via interventions. At Appendix 3 is a summary of key research findings.[59] Information on on-going research can also be found at: **https://www.kcl.ac.uk/kcmhr/research/admmh/index.aspx**

Although a vast number of academic providers commission research in mental health and wellbeing, of particular note is the Kings' College London military cohort study, established in 2003. This study incorporated military mental health information from personnel who had deployed to Iraq and Afghanistan, and was controlled against responses from personnel who had served at a similar time but had not deployed. Such large-scale cohort studies provide a powerful means of studying mental health and its determinants in the Defence population at risk; in areas such as tour length, deployment frequency, changes in symptoms or behaviours, barriers to help-seeking and time taken to request such help. Phase three of this study is due to report in late 2017.

59 Adapted from the Academic Department of Military Mental Health Summary, March 2017.

9. Conclusion

Much has been achieved since the first Armed Forces Mental Health Strategy in 2011, which recognised formally the importance of the need to place mental and physical health on an equal footing. It prioritised the need to encourage healthy lifestyles by reducing alcohol and smoking consumption, and improving diet and exercise routines; this would support the reduction of related physical and mental injuries and illnesses. The context was a period of sustained operations in Iraq and Afghanistan, where some unique challenges were being faced in the UK and worldwide by the medical and welfare communities in caring for their people.

The establishment of the Defence People Health and Wellbeing Board, its Strategy, Plan and Steering Groups, signified a marked change in the level of esteem in which health is now considered. The Board provided a coherent structure within which health agendas could be aligned. 'Health' and 'Healthcare' were represented together for the first time. This Strategy document builds on this success with a new ambition. It incorporates an entirely new population, acknowledging the wider impact it can effect. It states a need for genuine collaboration at all levels to achieve this; at the team, organisational and cross-Governmental level.

Our priorities, looking ahead to 2022, focus on promoting positive mental wellbeing, preventing mental illness, reducing the need for medical services and ensuring those in need of mental healthcare receive timely, safe and effective treatment. Ultimately, a healthier force will contribute directly to our military capability, and it will ensure a positive, long term impact on the lives of those who have served. Specific activity has been promised in areas such as anti-stigma campaigning, education and training, detecting symptoms of poor mental health in others and providing innovative approaches to healthcare.

The answer now lies firmly in a multi-organisational approach, where resources can be pooled and best practice can be shared. We must train our people at every level to have an awareness of mental health issues and to know what to do about them. We must also ensure all aspects of the organisation are aware of the vast amount of help and resources available to them, whether they are serving, ex-serving, service family members or part of the MOD Civil Service. Finally we should recognise where specific areas might benefit from increased or smarter use of resources.

This Defence People Mental Wellbeing Strategy 2017-2022 sets out a road map to drive future activity. A Mental Health Action Plan will be developed to assure progress, reporting through the Mental Health Steering Group to the Defence People Health and Wellbeing Board and Partnership Boards. Readers are encouraged to utilise and implement this Plan and associated policy references. The challenge ahead remains considerable, but is of paramount importance. Success will enable our Armed Forces and MOD Civil Servants to continue to defend the UK's national and overseas interests, help our families in supporting them and our veterans who have already contributed so much to society.

Appendix 1: Summary of Activity and Resource for Service Personnel, MOD Civil Servants, Service Families and Veterans

SERVICE PERSONNEL AND FAMILIES

On-going Activity	Future Activity (Resourced)	Future Activity (Requires Resource)
Medically assess recruits, pre-existing mental health taken in to account, trainees undergo selection training and if necessary deselected. MOD do not utilise mental health screening methods; research through ADMMH showed it ineffective in predicting PTSD. **Redeployment training:** Implemented joint policy on resilience, decompression, deployed welfare, deployment stress briefing, stress in the workplace briefings. **Stress and Resilience:** Established Stress and Resilience Training Centre at the Defence Academy; resilience training for regular, reserve and MOD Civil Servants including TRiM. The single services have taken this and made in to bespoke packages: ■ Launched START taking control (SRTC) ■ Launched Op REGAIN (RN) ■ Launched OP SMART (Army) ■ Launched SPEAR (RAF) **Defence Medical Services** deliver mental health care for service personnel and mobilised reservists via Primary Healthcare and regional Departments of Community Mental Health. There are 11 Departments of Community Mental Health (DCMH) and 4 smaller Mental Health teams across the UK. Also a MH team in Cyprus. Field Mental Health Teams routinely deployed on operations and exercises. The DCMHs are made up of psychiatrists, psychologists, nurses/ practitioners, mental health social workers and administrative staff. They provide outpatient care to personnel, with in-patient mental healthcare provided under contract by a consortium of eight NHS Trusts. **Piloting High Intensity outpatient psychiatry service**, providing direct access of up to 12 sessions of high intensity therapy to provide Defence Communities of Mental Health with surge capacity. **Launched Big White Wall in 2015**, an online platform that supports people experiencing common mental health related problems – accessible to serving personnel, veterans and families and in some Clinical Commissioning Groups, civilians. Established **Defence People Health and Well-being Board (DPHWB)** linking health and healthcare, Mental Health and Lifestyles, Preventative Health and Injury Prevention.	Work with the single Services to fully utilise expertise within the **Stress and Resilience Training Centre**; combining resource for coherent content for all. Continue with **alcohol reduction** strategies, measuring intake through the AUDIT-C work (defence stats to publish in July 17) given the link between alcohol and mental health. Work in collaboration with **Royal Foundation** to produce Mental Health training to embed within compulsory courses and work with them on communications material (joint Surgeon General and Royal Foundation funding identified). Continue to use the **Service Charities' Partnership Board**, and MOD's membership of the **Contact Group** (COBSEO's cluster of Mental Health charities) and the UK Department of Health Partnership Board as a forum for collaboration on best practice for Mental Health. Implement a **new mental healthcare operating model**, improving initial access to clinical assessment and prioritisation for treatment. **Commission a dedicated out-patient psychological therapy service** from an in-patient provider, with further plans for investment through in-house provision. Ensure **greater mobility of MH Practitioners** to reach the Defence population by trialling 'remote working' for Defence Medical Services Clinicians. Production of a **mental health and wellbeing plan and communication strategy**. Prioritising **research on resilience training** and monitor those risks groups already identified. Monitor evaluate and learn from defence statistics **mental health surveillance data**.	**Manning gaps** vary across the Services and in uniformed and civilian mental health professionals vary between 50% and full manning. This is in the context of a national shortage. An enhancement option for future increase in mental **healthcare staff numbers** will be considered but before that, MOD will need to examine our recruitment offer and look at efficiencies to deliver patient care. The aspiration for **STRC** is to provide tri-Service stress and resilience training relies on the identification of resources from RN, Army, RAF, MOD Civil Service, MOD or JFC to pool resources for greater effect. Consider how **families** can be more involved in our approach to anti-stigma and resilience; a core enabler for health and wellbeing.

SERVICE PERSONNEL AND FAMILIES

On-going Activity	Future Activity (Resourced)	Future Activity (Requires Resource)
As a subset of DPHWB, established a **Mental Health Steering Group** with a focus on stigma reduction; occupational stress; suicide and self-harm, culture and behaviours. **MOD/UK Department of Health Partnership Board**, working to a partnership agreement to govern how we commission and assure health provision for the Armed Forces Community. Launched **anti-stigma campaign** 'Don't bottle it up' across the Services and MOD civilian community. Engaged in **Mental Health Awareness week** with a series of onsite and online briefings; presentations and dial-ins. Initiated a **pilot professional exchange programme** between Departments of Community Mental Health and local NHS teams. Commissioned **resilience related research** through Academic Department of Military Mental Health (Kings College, London). **Deployment related briefings to families** are provided. Introduction of **Mental health awareness briefings for families**, aimed specifically at recognising symptoms of poor mental health in their loved ones.	Undertaking a research study to identify the **medical occupational outcomes of patients assessed in the Defence Medical Services**. **Programme CORTISONE**. Enhancing data capture and exploitation, aiming for improved efficiency and visibility along the care pathway and supporting access to services and transition to and from time in service. Online 2019. Member of **Cross-Government Director Level Steering Group** on Mental Health – incorporate initiatives from the NHS Five Year Forward Plan.	

VETERANS

On-going Activity	Proposed Activity (Resourced)	Proposed Activity (Requires Resource)
MOD **collaborates** with NHS and charity sector in the provision of mental health services. NHS (England) has introduced a Transition, Intervention and Liaison mental health service to include Armed Forces personnel approaching discharge and veterans. The service will seek to increase the access and treatment to appropriate and timely mental health services for serving personnel approaching discharge and veterans with mental health difficulties. There are three elements to the service: a. Service for those in transition, leaving the Armed Forces. b. Service for veterans with complex presentation. c. General service for veterans.	**Veterans Gateway**, formally launched 20 June 2017, provides a one-stop hub for veterans to seek advice on a full range of welfare matters. Continue to work in **partnership with NHS and third sector organisations** to align mental health promotion programmes (such as Breaking Down the Barriers). Developing **tri-service transition policy** to encompass: ■ Employment and education ■ Accommodation ■ Financial awareness ■ Substance misuse ■ Access to community support ■ Children and Family ■ Mental and Physical health	**Veterans declaring** that they are veterans so that they can receive targeted help (GP marker when they register but individual needs to declare). **Healthcare Professionals** being aware of veterans needs (Free Health Education E-learning).

VETERANS

On-going Activity	Proposed Activity (Resourced)	Proposed Activity (Requires Resource)
The **Scottish Government**, in partnership with NHS (Scotland), provided £1.2million to fund the provision of specialist mental health services for veterans across Scotland. The **Welsh Government** invested £650,000 to support improvements in psychological therapies. In **Northern Ireland**, the mental health needs of returning ex-Service personnel are dealt with either through the Ulster Defence Regiment and Royal Irish Aftercare Service, through Combat Stress, or directly within the mainstream primary care and mental health services. MOD provides a structured Mental Health Assessment prior to discharge from Service. **Veterans and Reserves mental health programme** provides assessment and treatment advice for veterans who believe that their deployment may have affected their mental health. Access to **Defence Medical Services' Departments of Community Mental Health** for up to six months post discharge to aid smooth transition to NHS care. Access to full range of **NHS mental health services** for all veterans, non-mobilised Reservists and families, in the local area in which they reside. Launched **Big White Wall** in 2014, an online platform that support people experiencing common mental health related problems – accessible to serving personnel, veterans and families. **Vets Trauma network** launched in Jan 17, comprising 22 major trauma centres that act as hubs for trauma; ten of which have been designated as Veterans Trauma Centres (VTCs) to co-ordinate veteran trauma care; linked in to DMS. **Veterans Welfare Service**, part of the MOD works with statutory and non-statutory bodies, local authorities and the third sector to provide continuous lifelong support. **Service Charities Partnership Board** and charities group Contact, working with RBL, Walking With The Wounded, Help for Heroes, Royal Foundation, Combat Stress. **MOD/UK Department of Health Partnership Board**, working to a partnership to govern how we commission and assure health provision for the Armed Forces Community.	**Contract with Kings College** London to track Iraq and Afghan deployees, against those who didn't deploy and produce research on: ■ The long-term legacy of deployment to Iraq, and Afghanistan (this will address the Chilcott Report). ■ Service leavers - transition issues, post-service mental health and lifestyle behaviours, social support, and social exclusion (e.g. post-service employment, job transience, accommodation problems, debt). ■ Occupational issues, health issues, social support and career intentions among reservists. ■ Persistence, new onset and remission in mental health difficulties (in particular persistent, delayed onset and successfully managed PTSD). ■ Physical health (injuries, disability, multiple physical symptoms). ■ Risk taking behaviours (e.g. risky driving, violence, anger). ■ The role of functional impairment. ■ Differences between the Services. ■ Comparisons of the UK Armed Forces with other militaries (in particular the US) and the UK general population. ■ Help seeking, perceived barriers to care and stigma, use of NHS and third sector services, treatment trajectories. We will review the **communications framework** for those leaving the service or demobilising, and their families, in order to ensure that they are aware of the resources available to them. Work with **NHS, DoH and third sector providers** to ensure seamless provision and sharing of best practice. Support the launch of **NHS (E) Transition, Liaison and Intervention Service** to provide Mental Health services for veterans Working closely with them to monitor its delivery.	

VETERANS

On-going Activity	Proposed Activity (Resourced)	Proposed Activity (Requires Resource)
	Launched free to access **e-learning packages** for health care providers to help them understand health needs of veterans. Delivery of programmes for veterans and their families through **CONTACT**, working with RBL, WWTW, H4H, RF, Combat Stress. **Refreshing the MOD / DoH / NHS partnership agreement** which governs how we commission and assure health provision for the Armed Forces Community. Support to **NHS(E) re-procurement programmes** for intensive services (commencing Apr 2018), developing a clinical commissioning framework to deliver best outcomes for patients. Continue to use the **Service Charities' Partnership Board** and MOD's membership of the Contact Group (COBSEO's cluster of Mental Health charities) as a forum for collaboration. Monitor usage and learn from the MOD **reservist and Veterans Mental Health Programme**.	

MOD CIVILIANS

On-going Activity	Proposed Activity (Resourced)	Proposed Activity (Requires Resource)
Published **Civil Service Operational Deployment Policy** to enable civil servants to benefit from equitable access to operational deployment support. Developed **e-learning package** 'Mental Health at work'. Launched **Mental wellbeing toolkit** to provide advice, support and training on mental health issues. Launched **MOD Civil Service employee wellbeing service**, incorporating helpline and wellbeing consultants based in regional hubs. Provide an **Occupational Health Service** to support managers and staff dealing with issues such as sickness absence, rehabilitation or reasonable adjustments.	Ensure **Civil Service Health and Wellbeing policy** is incorporated in to existing defence people health and wellbeing framework in order to pool resources and make best use of communication activity. Continue to **promote positive mental wellbeing** through the culture of defence and as an individual and leadership responsibility. Focus on **reducing stigma and non-medical** interventions. Member of **Cross-Government Director level Steering Group** on Mental Health – incorporate initiatives from the NHS Five Year Forward Plan	

Appendix 2: Facts and Figures

General

- Press narratives and public opinion are known to influence the mental health and wellbeing of military personnel.[60]
- PTSD prevalence is lower than perception might suggest. Studies show that following deployment, the overall prevalence for PTSD was 4%,[61] broadly comparable to the general population, compared with 20%[62] for common mental disorder (principally anxiety and depression). PTSD rates are around 7% in combat troops,[63] an area of on-going focus.
- Those at increased risk of any mental health problem include Reservists, combat troops, those with pre-existing social or childhood adversities and early Service leavers (leaving before completing four years of service).[64]

State of Mental Health

- The absolute numbers and rates of mental disorder among UK Armed Forces personnel assessed at MOD Specialist Mental Health services has increased from 1.8% in 2007/08 to 3.2% in 2016/17. Despite this rise, those with historically higher rates of mental illness (Army, RAF, Other Ranks, Females, 20-44 year olds) remained broadly similar.[65]
- The rate of mental disorder among UK Armed Forces personnel assessed within specialised psychiatric services (3.2%) was lower than the rate of 3.5% within the UK general population (based on access to NHS secondary mental health services in 2015/161 (latest data available)).[66]
- Comparison with the general population is difficult. Studies have assessed that the main mental health challenge facing UK Armed Forces is Common Mental Disorder,[67] and is broadly comparable to the general population,[68, 69] although some research suggests odds of common mental health disorder may be as high as double within the Armed Forces.[70]
- PTSD rates of Armed Forces personnel remained low at 0.2% in 2016/17.[71]
- Women are more likely to report symptoms of common mental health problems.[72]

60 King, L. A., King, D. W., Fairbank, J. A., Keane, T. M., & Adams, G. A. (1998). Resilience-recovery factors in post-traumatic stress disorder among female and male Vietnam veterans: hardiness, post-war social support, and additional stressful life events. J Pers Soc Psychol,74, 420-34.

61 Academic Department of Military Mental Health in Collaboration with the King's Centre for Military Health Research, Research Summary pg 6, 20 Mar 17.

62 Ibid.

63 Ibid.

64 The Royal British Legion Briefing Note, King's Centre for Military Health Research and Academic Department for Military Mental Health, October 2014.

65 Defence Statistics (Health) Annual Report 2016/17.

66 Ibid.

67 Academic Department of Military Mental Health in Collaboration with the King's Centre for Military Health Research, Research Summary pg 26, 20 Mar 17.

68 McManus S, Bebbington P, Jenkins R, Brugha T. (eds) (2016) Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014. Leeds: NHS Digital. Available.

69 NICE CG123 – Common Mental Health Disorders, May 2011.

70 L. Goodwin1, S. Wessely, M. Hotopf, M. Jones, N. Greenberg, R. J. Rona, L. Hull and N. T. Fear, Are common mental disorders more prevalent in the UK serving military compared to the general working population? Psychological Medicine, Cambridge University Press 2014.

71 Defence Statistics (Health) Annual Report 2016/17.

72 Better Or Worse: A Longitudinal Study Of The Mental Health Of Adults In Great Britain, National Statistics, 2003.

Families

- Military families are pivotal to successful transition from deployment.[73]
- Lower mental disorder symptom levels were associated with less post-deployment transition difficulties, family and relationship problems at follow-up.
- Good leadership appears to be crucial in maintaining mental health during deployment,[74] while family and home-front problems have a similar impact to combat exposures.[75]

Reserves

- Although baseline mental health of Reserves is considered better, deployed Reserves have reported higher rates of poorer mental health than deployed Regulars.[76]
- Three quarters of those Reserves assessed by the 'Reserves and Veterans Mental Health Programme' return to full fitness and experience substantial improvements in mental health.[77]

The Cost

- In the MOD Civil Service, the cost of sickness absence from 31 January 2016 to 30 Jan 2017 was £37.5million. This is lower than the £50 million quoted from 2014/15.
- For non-industrial MOD Civil Service personnel, mental health and behavioural disorders were the main cause of sickness absence at 22%, between 1 Apr 16 and 31 Mar 17.[78]
- The number of working days lost to mental health/behavioural disorders for MOD Civil Service non-industrial staff was 50,030 between 1 Apr 16 and 31 Mar 17.[79]
- Mental health and behavioural disorders are the second largest cause of medical downgrading within the UK Regular Armed Forces, behind Musculoskeletal Disorders and Injuries.

Operational Deployments

- There was a small but significant increase in PTSD symptoms among forward deployed medical personnel who also experienced more challenging homecoming transitions.[80]

73 Academic Department of Military Mental Health in Collaboration with the King's Centre for Military Health Research, Research Summary pg 24, 20 Mar 17.

74 Jones, N., Seddon, R., Fear, N. T., McAllister, P., Wessely, S., & Greenberg, N. (2012). Leadership, cohesion, morale, and the mental health of UK Armed Forces in Afghanistan. Psychiatry, 75(1), 49-59.

75 Mulligan, K., Jones, N., Davies, M., McAllister, P., Fear, N. T., Wessely, S., & Greenberg, N. (2012). Effects of home on the mental health of British forces serving in Iraq and Afghanistan. British Journal of Psychiatry, 201(3), 193-198.

76 Browne T, Hull L., Horn O, et al. Explanations for the increase in mental health problems in UK reserve forces who have served in Iraq. The British Journal of Psychiatry, 190: 484-489.

77 Jones, N., Wink, P., Brown, R. A., Berrecloth, D., Abson, E., Doyle, J., & Greenberg, N. (2011). A clinical follow-up study of reserve forces personnel treated for mental health problems following demobilisation. Journal of Mental Health, 20(2), 136-145.

78 Defence Statistics (Health) data 2016-7.

79 Ibid.

80 Cawkill P, Jones M, Fear NT, Jones N, Fertout M, Wessely S & Greenberg N. (2015). Mental health of UK Armed Forces medical personnel post-deployment. Occupational Medicine, 65:157-64.

- The mental health impact of a pre-deployment stress briefing is 'probably marginal'; however, it might still be a worthwhile activity given that the intervention is very low cost.[81]
- R&R taken during a six-month operational deployment continues to be a potentially important element of deployment mental health support.[82]
- Early (qualitative) evaluations of Post-operational Decompression indicated overwhelming support with around 91% of respondents finding it moderately or very useful, despite 80% being ambivalent or not wanting to go through it prior to arrival at the decompression facility.[83]
- Personnel deployed for periods of thirteen months or more within a three year period were more likely to fulfil the criteria for PTSD and Common Mental Disorder, somatic symptoms and severe alcohol problems, particularly when deployed in a combat role and when the length of deployment was longer than expected.[84] This evidence has been used in policy setting regarding deployment length and frequency.
- Following return from deployment, TRiM recipients were significantly more likely to seek help from mental health services than exposed personnel who did not receive the TRiM intervention. There is some evidence that TRiM interventions can help to promote help-seeking and may have limited positive occupational benefits; however, it is not a 'panacea'.[85]

Mental Health Screening

- Both pre and post-deployment mental health screening have been shown to be largely ineffective in predicting who will develop a mental health disorder following deployment.[86]

Leadership and Stigma

- Positive perceptions of leadership and better unit cohesion were significantly associated with lower stigma and barrier to care levels, while greater unit cohesion was significantly associated with awareness of and willingness to discuss mental health matters.[87]
- 25-50% of military personnel who require support for a mental health problem actually seek help.[88]

81 Academic Department of Military Mental Health in Collaboration with the King's Centre for Military Health Research, Research Summary pg 12, 20 Mar 17.

82 Ibid.

83 Jones, N., Burdett, H., Wessely, S. & Greenberg, N. (2011). The subjective utility of early psychosocial interventions following combat deployment Occupational Medicine, 61(2), 102-107.

84 Rona, R. J., Fear, N. T., Hull, L., Greenberg, N., Earnshaw, M., Hotopf, M., & Wessely, S. (2007). Mental health consequences of overstretch in the UK armed forces: first phase of a cohort study. Bmj, 335(7620), 603.

85 Academic Department of Military Mental Health in Collaboration with the King's Centre for Military Health Research, Research Summary pg 27, 20 Mar 17.

86 Rona, R. J., Burdett, H., Bull, S., Jones, M., Jones, N., Greenberg, N., .Wessely, S. & Fear, N. T. (2016). Prevalence of PTSD and other mental disorders in UK Service Personnel by time since end of deployment: a meta-analysis. BMC psychiatry, 16(1), 333.

87 Jones, N., Campion, B., Keeling, M., Greenberg, N. (2015). Cohesion, Leadership, Mental Health Stigmatisation and Perceived Barriers to Care in UK Military Personnel. Journal of Mental Health. (in press).

88 Hines, L., Goodwin, L., Jones, M., Hull, L., Wessely, S., Fear, N., Rona, R. (2013). Factors Affecting Help-Seeking for Mental Health Problems after Deployment to Iraq and Afghanistan. Psychiatric Services in Advance.

Suicide and Deliberate Self-Harm

- The UK regular Armed Forces have seen a declining trend in male suicide rates since the 1990s. Suicide remains a rare event, evidenced by the small number of deaths in each year.[89]
- For the 20-year period 1997-2016, the male suicide rate for the UK regular Armed Forces was statistically significantly lower than the UK general population; the UK regular Armed Forces as a whole were at a 57% decreased risk of suicide compared to the UK general population 37%.[90]
- Females and younger age groups are at greatest risk of presentation at a hospital with a self-harm episode. Suicide rates for females are too low for statistical analysis.
- The military population appears healthier with a lower lifetime prevalence of attempted suicide and self-harm, within the range of general population estimates.[91]
- Historically, the only age group with a statistically significant increased risk of suicide compared to the UK general population were Army males aged under 20 years of age. However, the number of suicides in this age group has fallen and for the latest five-year period, there was no significant difference in suicides among young Army males compared to males of the same age in the UK general population.[92]

Veterans

- Military veterans are as likely as the general public to be mentally unwell[93] or engaged with mental health treatments and therapies.[94]
- When analysed in context, the evidence suggests that the health needs of veterans do not represent a specific challenge to a community's health budget and that their routine health needs are not appreciably different to the overall age-matched patient base.[95]
- The NHS states that PTSD is not common amongst veterans but is nevertheless viewed as significant; PTSD rates are broadly the same in veterans as the general population, with the exception of certain groups such as 'combat arms' and Reserves.
- NHS figures state that common mental health problems such as anxiety, depression or alcohol/drug misuse are more common (20-25%) than PTSD (7%).
- At least 66,000 of those who served between 1991 and 2014 will need some form of physical and mental health support now or in years to come.[96]
- Research outcomes suggested that the mental health needs of blind veterans were substantial.[97]

89 UK regular Armed Forces suicide and open verdict deaths, August 2002 to 31 December 2016.

90 Ibid.

91 Ibid.

92 Ibid.

93 Ibid.

94 Woodhead, C., Rona, R. J., Iversen, A., MacManus, D., Hotopf, M., Dean, K., . K., McManus, S., Meltzer, H., Brugha, T., Jenkins, R. & Wessely, S. (2011). Mental health and health service use among post-national service veterans: results from the 2007 Adult Psychiatric Morbidity Survey of England. Psychological Medicine, 41(02), 363-372.

95 The Veterans Transitions Review, Lord Ashcroft, 2014, pg 104: http://www.veteranstransition.co.uk/vtrreport.pdf.

96 Counting the Costs Study, KCMMR, ADMMH and Help for Heroes, Diehle, J., Greenberg, N., November 2015: http://www.helpforheroes.org.uk/media/1438/counting-the-costs-november-2015-final.pdf.

97 Stevelink, S. A., Malcolm, E. M., & Fear, N. T. (2015). Visual impairment, coping strategies and impact on daily life: a qualitative study among working-age UK ex-service personnel. BMC Public Health, 15(1), 1118.

Appendix 3: Further Information

Policy

Air Publication 3394 The Royal Air Force Aeromedical Evacuation Service.

Joint Service Publication 375 Management of Health and Safety in Defence (Pt.2 Vol 1 (V1.0 Jan 16) Chapter 17, Stress).

Joint Service Publication 419 Adventurous Training in the UK Armed Forces.

Joint Service Publication 534 Tri-Service Re-Settlement Manual.

Joint Service Publication 770 Tri-Service Operational and Non-Operational Welfare Policy.

Joint Service Pubcliation 835 Alcohol and Substance Misuse and Testing.

Joint Service Publication 950 Medical Policy

Government

The NHS Five Year Forward View:
https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

The Government's response to the Five Year Forward View:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/582120/FYFV_mental_health__government_response.pdf

Department of Health/NHS

Department of Health Northern Ireland: https://www.health-ni.gov.uk/topics/mental-health-and-learning-disabilities

Department of Health UK: https://www.gov.uk/government/organisations/department-of-health

NHS Choices - Web based health information: www.nhs.co.uk/NHSEngland/Militaryhealthcare/Pages/Militaryhealthcare.aspx

NHS England Mental Health: https://www.england.nhs.uk/mental-health/

NHS HEE e-learning tool for professionals and wider Defence community: https://www.hee.nhs.uk/our-work/hospitals-primary-community-care/mental-health-learning-disability/learning-disability/workforce-capability

NHS Scotland Mental Health: http://www.healthscotland.scot/health-topics/mental-health-and-wellbeing

NHS Wales: http://www.wales.nhs.uk/healthtopics/conditions/mentalhealth

Charity Sector

Big White Wall online community: https://www.bigwhitewall.com/landing-pages/landingV3.aspx?ReturnUrl=%2f#.WPc-44TR-M8

Confederation of British Service Charities: https://www.cobseo.org.uk

Contact: http://www.contactarmedforces.co.uk/

Combat Stress: www.combatstress.org.uk

Forces Line:
UK - 0800 731 4880, Germany – 0800 1827 395, Cyprus – 800 91065, Falkland Islands - #6111, Rest of World - +44(0)1980 630854

Heads Together: https://www.headstogether.org.uk/

Help for Heroes: http://www.helpforheroes.org.uk/

Mental Health Foundation: www.mentalhealth.org.uk

Mind: https://www.mind.org.uk/

Rethink Mental Illness: https://www.rethink.org/about-us

Royal British Legion: www.britishlegion.org.uk

SSAFA – the Armed Forces Charity: https://www.ssafa.org.uk/

Samaritans – provide confidential, non-judgemental, emotional support for people experiencing distress and despair: www.samaritans.org.uk, tel: 0800 810722

Sane – aims to improve the quality of life for those affected by mental illness: www.sane.org.uk, Tel: +44(0)207 7375 1002

The Royal Foundation: www.royalfoundation.com

General

Armed Forces Covenant: https://www.armedforcescovenant.gov.uk/

Mental Health Foundation Fundamental Facts About Mental Health 2016: https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf

Royal College of Psychiatrists: http://www.rcpsych.ac.uk/

Service Personnel and Veterans Agency: www.veterans-uk.info, Tel: 0808 1914218.

Time to Change - pledge to end mental health stigma: www.time-to-change.org.uk

What Works Well online resource: www.whatworkswellbeing.org

World Health Organisation resources: http://www.who.int/en/

Veterans

NHS Choices for veterans: http://www.nhs.uk/NHSEngland/Militaryhealthcare/veterans-families-reservists/Pages/veterans.aspx

NHS Veterans Wales: http://www.veteranswales.co.uk/

Remploy - support with mental health and access to work: http://www.remploy.co.uk/

Veterans First Point: http://www.veteransfirstpoint.org.uk/

Veterans and Reserves Mental Health Programme: 0800 0326258 or email DPHCE-DCMHCHL-VRMHP@mod.uk

Veterans UK: Free helpline 0808 1914218 or www.veterans-uk.info/

Welfare

Army Families Federation: www.aff.org.uk

Army Welfare Service: www.army.mod.uk/welfare-support/

Cruse Bereavement Care – free confidential help for the bereaved: 0844 477940.

Hive Information Centre - provides important and valuable information to local communities and acts as referral point for other agencies, including counselling services: www.hive.mod.uk

Joint Casualty Compassionate Centre - emergency casualty and compassionate support (in case of death, injury or illness of soldier or immediate family): +44(0)1452 519951.

Naval Families Federation: www.nff.org.uk/

RAF Community Support: www.raf.mod.uk/community/

Relate – offer advice, relationship counselling and therapy workshops, face to face, on the phone or online: www.relate.org.uk, Tel: 0845 1304016, Northern Ireland +44(0)289 226 6008.

Royal Navy Royal Marines Welfare: www.royalnavy.mod.uk/welfare/welfare-teams