Ministry of Defence

UK Armed Forces Mental Health: Annual Summary & Trends Over Time, 2007/08 to 2024/25

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Mental health care can be provided to serving UK Armed Forces personnel in the primary care setting by the patient's own Medical Officer, similar to a General Practitioner (GP), or by specialist mental health clinicians at MOD Specialist Mental Health Services; this includes community mental health services at MOD Departments of Community Mental Health (DCMH) for outpatient care or admissions to hospital as an in-patient.

This bulletin provides statistical information on mental health in the UK Armed Forces. The first section of this bulletin provides an overall summary of UK Armed Forces seen in any military healthcare setting for a mental health related reason. The second section provides a detailed summary of those seen by MOD specialist mental health clinicians.

Key Points

1 in 8 (12.3%)

UK Armed Forces personnel were seen in military healthcare for a mental health related reason in 2024/25

Females sought help **more** than **males**, similar to that seen in the UK general population.

Some patients seen by their GP may require a referral for specialist mental health treatment:

1 in 52 (1.9%)

UK Armed Forces personnel were seen by a specialist mental health clinician in 2024/25

The rate of **PTSD** among UK Armed Forces remains **low** at around 3 in 1,000 personnel

The rate of UK Armed Forces personnel seen in any military healthcare setting for a mental health related reason in 2024/25 was **12.3%** (n=18,522), **statistically significantly lower** than in 2023/24 (13.0%, n=19,929).

Some patients seen by their GP may require treatment from a specialist mental health clinician. The rate of UK Armed Forces personnel requiring specialist mental health services in 2024/25 was **1 in 52** (1.9%, n=2,887).

The overall rate of personnel seen for any mental health related reason remained **broadly comparable** to the UK general population. The rate of those needing specialist mental health treatment was **lower** in the UK armed forces than that seen in the UK general population.

Depressive episode, Anxiety and Adjustment disorder were the most common disorders seen among those requiring specialist mental health care.

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Background Quality Report

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Contents

Supplementary tables containing:

- all data presented in this publication
- figures presenting UK Armed Forces personnel PTSD by gender and Psychoactive Substance Misuse due to alcohol by gender.
- tables presenting UK Armed Forces personnel by assignment type Regular, Reservist and Other
- more detailed information regarding each Service

are available alongside this report on the mental health statistics page.

This publication forms the single source of mental health statistics for UK Armed Forces personnel and is used within the Ministry of Defence as well as by external users including the general public, the media, academics and the charitable sector.

This publication will be used within MOD to monitor rates of mental ill-health and assist with policy making. It will also be used to facilitate research and to ensure MOD's accountability to the British public.

These statistics include serving personnel only. Information around Veterans claiming compensation for mental health reasons can be found in the Armed Forces Compensation Scheme National Statistic. Research into Veterans mental health has also been conducted by the King's College Centre for Military Health Research

The Armed Forces Continuous Attitude Survey presents serving personnel's feedback on a variety of topics, including well-being.

Main Points

The rate of UK Armed Forces personnel seen by military healthcare services for a mental health related reason in 2024/25 was 12.3%, a significant decrease from the rate of 13.0% in 2023/24.

- **1 in 8** (12.3%, n=18,522) UK Armed Forces personnel were seen by military healthcare services for a mental health related reason in 2024/25.

- Rates of personnel seen in military healthcare for a mental health related reason have risen over time to 13.2% in 2022/23, however, in the last two years rates have fallen and were statistically significantly lower in 2024/25 compared to the previous year. This has been driven by a fall in presentations among those aged between 20 and 29 years.

- Most personnel seeking military mental health care go to their military GP in the first instance. **1 in 8** (12.0%, n=17,973) personnel were seen by their GP in the latest year.

- The majority of patients who seek mental health care are managed by their military GP, however some with more complex needs will receive treatment from specialist mental health care providers. The rate of personnel requiring specialist mental health services fell in 2024/25 to **1 in 52** (1.9%, n=2,887) compared to 1 in 50 (2.0%, n=3,082) in 2023/24.

- The overall rate of mental health in the UK Armed Forces was **broadly comparable** to that seen in the UK general population.

- However, latest data shows the rate for those needing specialist mental health treatment was **lower** in the UK armed forces than that seen in the UK general population.

- There were some conditions that were more likely to be managed by GPs such as sleep disorders, stress, low mood and sexual dysfunction. Other conditions such as PTSD and depression were more likely to be treated by specialist mental health clinicians.

- Personnel from **all age groups** accessed military mental healthcare, however those aged 30-49 years had statistically significantly higher rates than other age groups. **Females** sought help more than males, as seen in the UK general population.

- The rate of **PTSD** among serving personnel remains low at 0.3%, which represents **3 in 1,000** personnel assessed with the disorder in 2024/25.

Our statistical practice is regulated by the Office for Statistics Regulation (OSR). OSR sets the standards of trustworthiness, quality and value in the Code of Practice for Statistics that all producers of official statistics should adhere to.

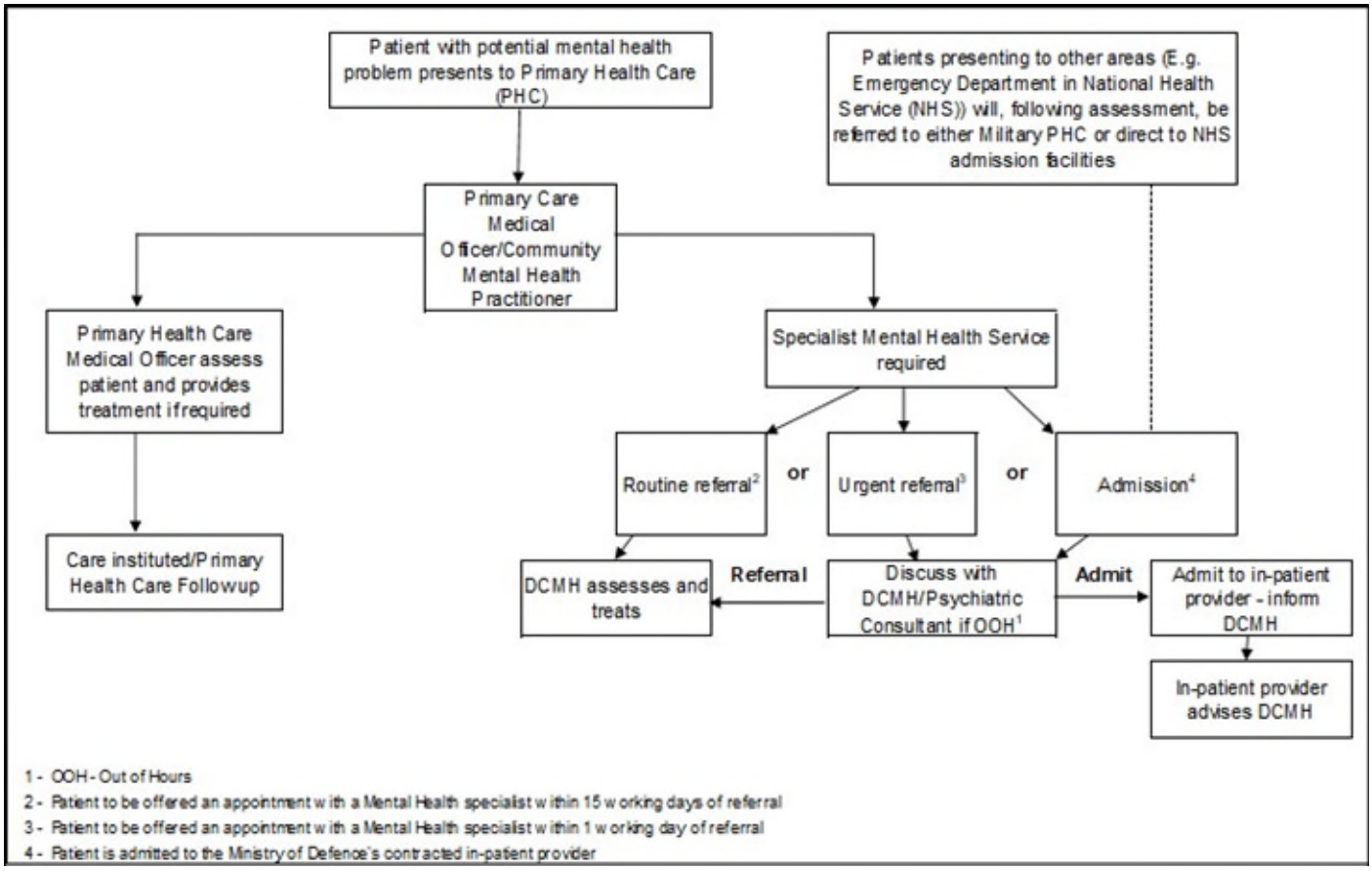
You are welcome to contact us directly with any comments about how we meet these standards. Please contact us at Analysis-Publications@mod.gov.uk. Alternatively, you can contact OSR by emailing regulation@statistics.gov.uk or via the OSR website.

Introduction

Assessment and care-management within the UK Armed Forces for personnel experiencing mental health problems is available at three levels:

1) In Primary Health Care (PHC), by the patient's own Medical Officer (MO), similar to a GP.
2) In the community through specialists in military Departments of Community Mental Health (DCMH).
3) In hospitals, either the NHS or the contracted In-Patient Service Provider (ISP).

The level of care a patient may require is determined by a number of factors, including the severity of symptoms and the degree of risk posed by the patient's current condition. The following diagram shows the pathways into mental health services in the UK Armed Forces:



The first section of this report summarises the totality of mental health in the UK Armed Forces by capturing those seen within any military healthcare setting for a mental health related reason; including by clinicians in primary care and/or by specialist mental health clinicians at MOD Departments of Community Mental Health (DCMH).

The second section provides a more detailed summary of initial assessments for care delivered by MOD Specialist Mental Health clinicians (MOD's DCMH for outpatient care, and all admissions to the MOD's in-patient care contractor).

The data is sourced from the MOD electronic medical records, entered by military clinicians. UK Armed Forces personnel who sought help from private practice were not included in this report.

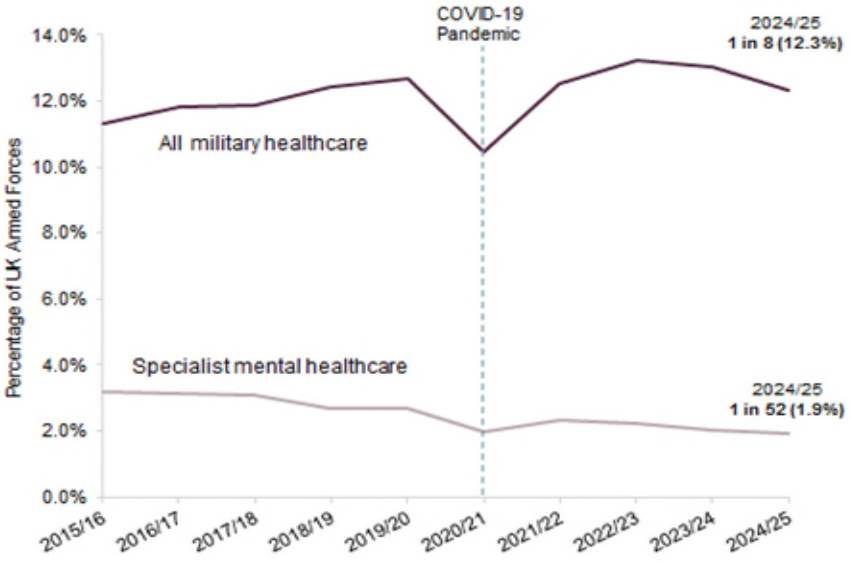
Section 1: All mental health in the UK Armed Forces 2012/13 to 2024/25

1 in 8 (12.3%, n=18,522)
UK Armed Forces personnel were seen in military healthcare for a mental health related reason in 2024/25.

Rates of personnel seen in military healthcare for a mental health related reason have risen over time, however, rates **significantly decreased** in the latest year.

Section 1 of this bulletin presents information on UK Armed Forces seen in any military healthcare setting for a mental health related reason. This includes those seen by clinicians in primary care (GP's) and/or by specialist mental health clinicians at a MOD DCMH. Please note, this includes signs and symptoms of mental health as well as all ICD-10 mental health disorders (a full list of the codes included in the analysis are detailed in the Background Quality Report (BQR) that accompanies this publication).

Figure 1: UK Armed Forces personnel seen in any military healthcare setting[1] for a mental health related reason[2,3]. Percentage of personnel at risk.
2015/16 to 2024/25



	UK Armed Forces personnel seen in military healthcare for mental health reasons[1]	UK Armed Forces personnel seen by a specialist mental health clinician[4]
	%	%
2015/16	11.3%	3.2%
2016/17	11.8%	3.2%
2017/18	11.9%	3.1%
2018/19	12.4%	2.7%
2019/20	12.7%	2.7%
2020/21	10.5%	2.0%
2021/22	12.5%	2.3%
2022/23	13.2%	2.2%
2023/24	13.0%	2.0%
2024/25	12.3%	1.9%

Source: DMICP
1. Personnel recorded in primary care or specialist mental health care at a MOD DCMH.
2. Mental health related reasons do include signs and symptoms of mental health as well as ICD-10 mental health disorders
3. The dotted line in 2020/21 represents the beginning of the COVID-19 pandemic.
4. Initial assessment at MOD Specialist Mental Health Services for a mental disorder

With the exception of 2020/21 when periods of COVID-19 national lockdown restrictions were in place, the rate of UK Armed Forces personnel seen in any military healthcare setting for a mental health related reason rose over time to 13.2% in 2022/23. Rates have since fallen to **12.3%** (n=18,522) and were statistically significantly lower in 2024/25 compared to the previous year.

Most personnel seeking military mental health care go to their GP in the first instance. **1 in 8** (12.0%, n=17,973) personnel were seen by their GP in the latest year.

The majority of patients who seek mental health care are managed by their military GP, however some with more complex needs will receive treatment from specialist mental health care providers. The rate of personnel seen for a mental disorder at MOD Specialist Mental Health Services has fallen since 2015/16 to a low of **1 in 52** (1.9%, n=2,887) in the latest year. This fall in referrals to specialist mental health services may be the result of a change to the management of low-risk patients with common mental health disorders within the MOD, introduced in September 2018. These patients are offered self-help and psychological interventions in primary care and may therefore be successfully treated without need for referral to MOD Specialist Mental Health Services.

It should be noted that all personnel seen for a mental health related reason in any military healthcare setting were counted in the overall rate of 12.3% (n=18,522). The majority were seen by their GP and included in the rate of 12.0% (n= n=17,973) and a small proportion were seen by specialist mental health clinicians and counted in the rate of 1.9% (n= n=2,887). Personnel can be counted in both the GP and specialist services rates and therefore these rates are not mutually exclusive and cannot be added together. Please also note it is not possible to identify and follow distinct episodes of care from first presentation to the GP through the care pathway due to the way data is collated in the electronic medical record and therefore a rate of those managed solely by their GP cannot be provided.

Section 1: All mental health in the UK Armed Forces 2012/13 to 2024/25, by demographics

Higher proportion of personnel seen in any military healthcare setting for a mental health related reason in:

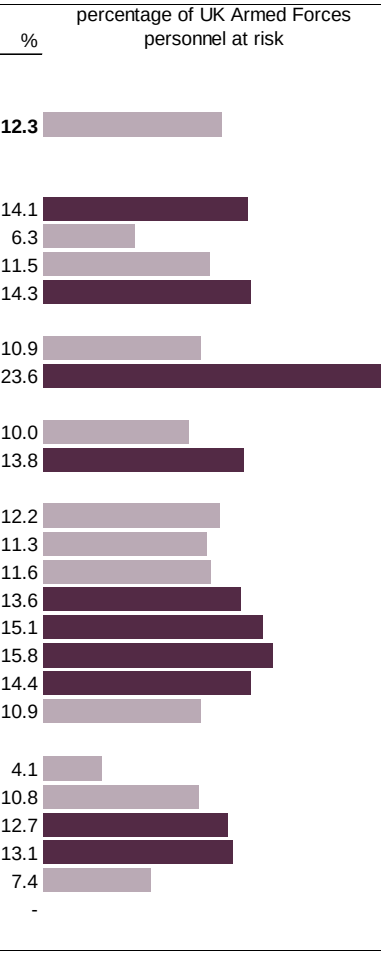
RAF and Royal Navy
Females
Other Ranks
Personnel from the mixed and white ethnic groups

Lower proportion seen in any military healthcare setting for a mental health related reason in:

Royal Marines
Personnel from the Asian ethnic group

Table 1: UK Armed Forces personnel seen in any military healthcare setting[1] for a mental health related reason[2] by demographics, number[3] and percentage of personnel at risk[4].
2024/25

	2024/25	
Number of UK Armed Forces personnel seen in a military healthcare setting for a mental health related reason	n	%
	18,522	**12.3**
Service		
Royal Navy*	3,716	14.1
Royal Marines	419	6.3
Army	9,804	11.5
RAF*	4,588	14.3
Gender		
Male	14,466	10.9
Female*	4,056	23.6
Rank		
Officer	3,008	10.0
Other Rank*	15,525	13.8
Age		
Aged <20	941	12.2
Aged 20-24	3,226	11.3
Aged 25-29	3,355	11.6
Aged 30-34	3,256	13.6
Aged 35-39	3,451	15.1
Aged 40-44	2,652	15.8
Aged 45-49	1,388	14.4
Aged 50 +	1,282	10.9
Ethnicity[4]		
Asian	382	4.1
Black	841	10.8
Mixed*	349	12.7
White*	16,713	13.1
Other	106	7.4
Unknown	131	-



Statistically significant differences in rates in 2024/25:

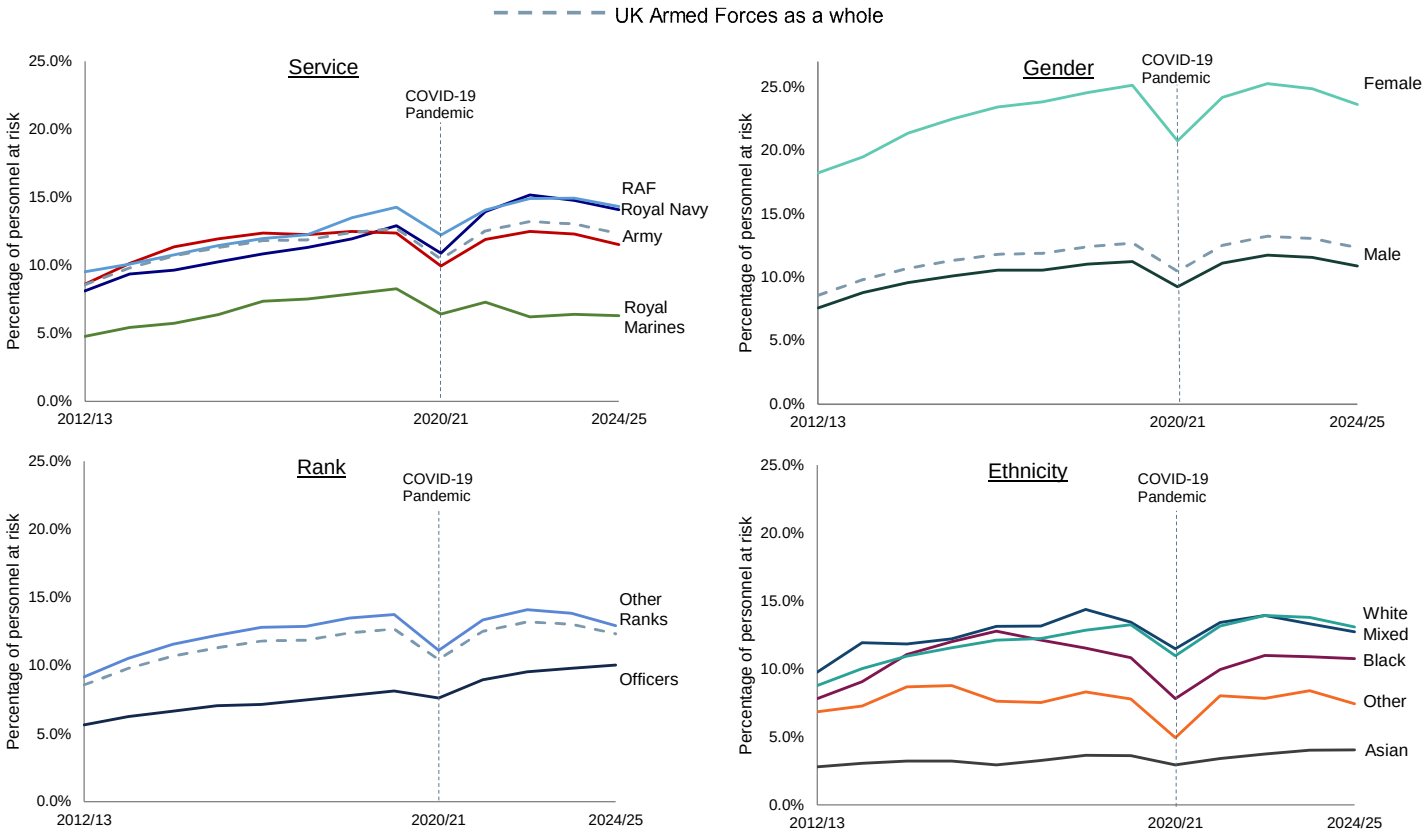
- **Higher in Royal Navy and RAF**
- **Lower in Royal Marines**
- **Higher in Females**
- **Higher in Other Ranks**
- **Higher in those aged 30 to 49 years.**
- **Higher in personnel from white and mixed ethnic groups**
- **Lower in personnel from the Asian ethnic group**

Source: DMICP

1. Personnel recorded in primary care and/or specialist mental health care at a MOD DCMH.
2. Mental health related reasons include signs and symptoms of mental health as well as ICD-10 mental health disorders.
3. Numbers within demographic groups may not sum the total. Personnel who have more than one episode of care in a year and whose age group, rank, service, gender or ethnicity records have changed will be counted once in each sub-category. Demographic information may be missing for some personnel at first presentation.
4. Unknown refers to where an individual preferred not to declare their ethnicity or where there was no ethnicity recorded. No rate has been calculated for this group.
5. '*' denotes significantly higher rates to comparison group(s).

The higher rate of presentation among the demographic groups seen in Table 1 were broadly similar to those seen in previous years. Figures 2 and 3 present trends over time in rates for personnel seen in military healthcare for a mental health related reason among each demographic group since 2012/13.

Figure 2: UK Armed Forces personnel seen in any military healthcare setting[1] for a mental health related reason[2], by demographics. Percentage
2012/13 to 2024/25



Source: DMICP

1. Personnel recorded in primary care and/or specialist mental health care at a MOD DCMH.
2. Mental health related reasons include signs and symptoms of mental health as well as ICD-10 mental health disorders.

Throughout the period presented:

- **Royal Marines had significantly lower rates** of personnel seen in military healthcare for a mental health related reason compared to the other three services.
- **Females had significantly higher rates** compared to Males.
- **Other Ranks had significantly higher rates** compared to Officers.
- **Personnel from the Asian ethnic group had significantly lower rates** compared to other ethnic groups.

Service
The rising trend in mental health presentations seen in the UK Armed Forces as a whole up to 2019/20 was also seen in each service with the exception of the Army, where since 2016/17 the rate remained stable at around 12.4% (excluding the COVID-19 period). In 2024/25, the rate of Army mental health presentations was statistically significantly lower compared to the previous year. Whilst rates fell across the other Services in 2024/25, there were no statistically significant changes.

In the latest year, the rate of **Royal Navy and RAF personnel** seen in any military healthcare setting for a mental health related reason was **significantly higher** compared to the other two services. Rates among the **Royal Marines were significantly lower** than all other services throughout the period presented.

The Royal Marines undergo rigorous training to ensure only the 'elite' go forward as Royal Marines (thus the selection process removes those that may be more susceptible to mental health problems). The tight unit cohesion that exists amongst the elite forces further supports the 'healthy worker' effect (personal communication with Def Prof Mental Health) and may also influence the lower rates of mental ill health in this service. In addition, high levels of preparedness may serve to lessen the impact of operational deployment experiences on mental ill health among the Royal Marines[b].

Gender
Rates among **Females were significantly higher than Males** throughout the period presented. This finding was replicated in the civilian population where females were more likely to have a common mental health condition than males (see Section 3 for further details).

In 2024/25, the rate of male mental health presentations statistically significantly decreased compared to 2023/24.

Rank
The rate of Other Ranks mental health presentations in 2024/25 was statistically significantly lower compared to the previous year, however the rate for Officers remained stable.

Rates among **Other Ranks were significantly higher** than Officers throughout the period presented. The differences between Other Ranks and Officers may be due to educational and/or socio-economic background, where both higher educational attainment and higher socio-economic background are associated with lower levels of mental ill health disorder[d]. Most Officers (except for those promoted from the Ranks) are recruited as graduates of the higher education system, whilst the majority of Other Ranks are recruited straight from school, particularly for the Army.

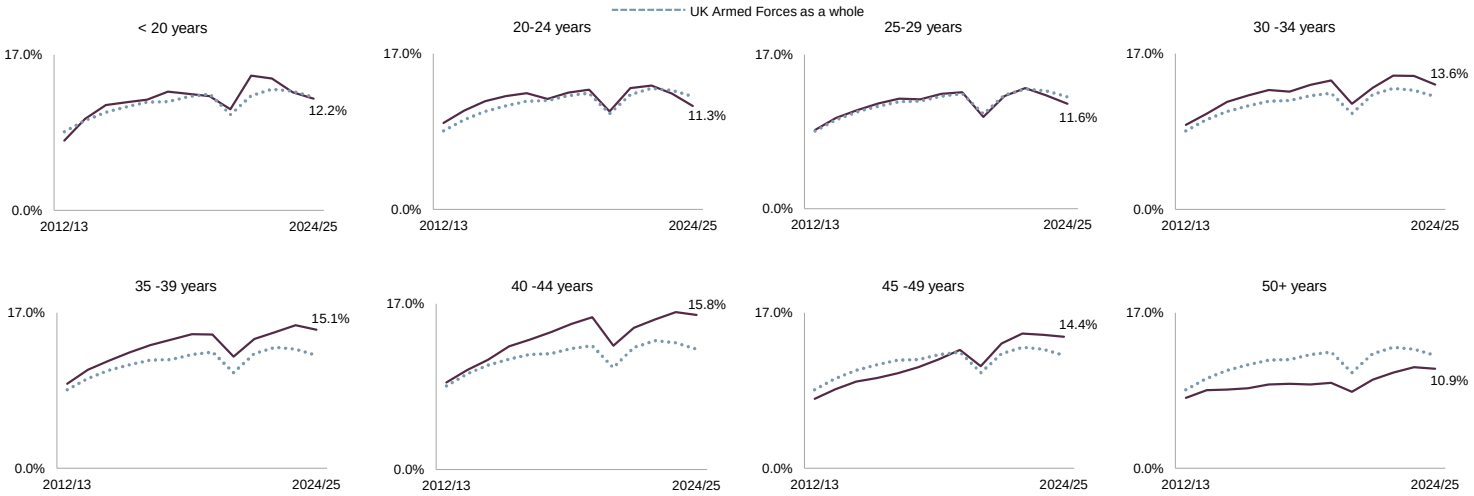
Ethnicity

In 2024/25, the rates of personnel from the **mixed** and **white** ethnic groups seen in any military healthcare for mental health reasons were significantly higher than other ethnic groups. Rates among **personnel from the Asian ethnic group** were significantly lower than all other ethnic groups throughout the period presented. In the UK general population findings show the white ethnic group (including white minorities) were most likely to report receiving treatment, but treatment rates did not differ between the black, Asian, mixed or other ethnic groups (see Section 3 for further details).

Section 1: All mental health in the UK Armed Forces, age and management of disorders

Age

Figure 3: UK Armed Forces personnel seen in any military healthcare setting[1] for a mental health related reason[2], by age group. Percentage.
2012/13 to 2024/25



Source: DMICP
1. Personnel recorded in primary care and/or specialist mental health care at a MOD DCMH.
2. Mental health related reasons include signs and symptoms of mental health as well as ICD-10 mental health disorders

Compared to the previous year, rates of personnel seen in military healthcare for mental health reasons in 2024/25 fell across all age groups. Rates for personnel aged 20 to 29 years were statistically significantly lower in 2024/25 compared to the previous year.

Personnel in every age group accessed military mental health care. In 2024/25, personnel **aged 30 to 49 had a statistically significantly higher** risk of being seen for mental health related reasons compared to other age groups.

Disorders

It is not possible to identify and follow distinct episodes of care from first presentation to the GP through the care pathway due to the way data is collated in the electronic medical record. Therefore, it cannot be determined whether mental health treatment was delivered solely by the GP or whether the patient went on to also receive specialist care at a MOD DCMH. However, crude exploratory analysis suggests that some conditions were more likely to be treated by a GP, such as sleep disorders, stress, low mood and sexual dysfunction. Other conditions were more likely to be treated by specialist mental health services, such as PTSD and Depression.

The following section of this bulletin provides more detailed analysis of those requiring the support of specialist mental health clinicians.

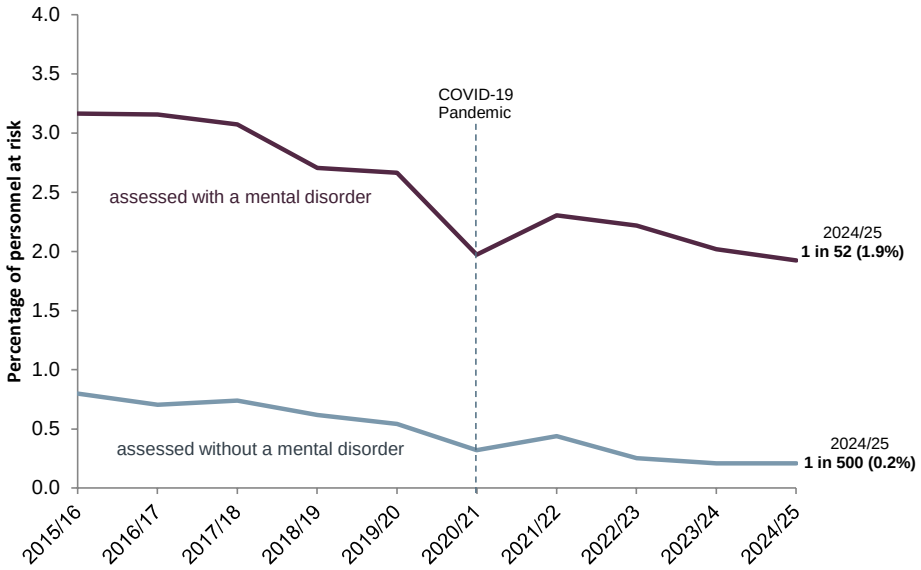
Section 2: Trends in UK Armed Forces mental health initial assessments at MOD Specialist Mental Health Services 2007/08 to 2024/25

1 in 52 (1.9%, n=2,887)
UK Armed Forces personnel were assessed with a mental disorder in 2024/25 at MOD Specialist Mental Health Services

The rate of those referred to specialist mental health care was **lower** than the UK general population.

Section 2 provides a more detailed summary of those patients requiring treatment by specialist mental health clinicians at MOD Specialist Mental Health services. UK Armed Forces personnel may access specialist mental health care as an outpatient in the community at a MOD DCMH and/or as an in-patient in hospital via the MOD in-patient care provider. Clinicians record the patient's initial mental health assessment based on the presenting signs and symptoms. Some patients are assessed by clinicians as having no specific and identifiable mental disorder.

Figure 4: UK Armed Forces personnel presenting at MOD Specialist Mental Health Services by initial assessment, percentage of personnel at risk[1].
2015/16 to 2024/25



	UK Armed Forces personnel seen for a mental disorder at MOD Specialist Mental Health Services
	%
2015/16	3.2%
2016/17	3.2%
2017/18	3.1%
2018/19	2.7%
2019/20	2.7%
2020/21	2.0%
2021/22	2.3%
2022/23	2.2%
2023/24	2.0%
2024/25	1.9%

Source: DS Database and DMICP

1. Percentages are based on the calculation of the absolute number and are presented to 1dp (refer to Data, Definitions and Methods).

There has been a declining trend in the rate of UK Armed Forces personnel assessed with a mental disorder at MOD Specialist Mental Health Services since 2016/17; in 2024/25 rates fell to **1 in 52** (1.9%, n=2,887).

The mental health care pathway model adopted by the MOD in September 2018 which aims to treat low risk patients with common mental disorders in primary care may explain the reduction in referral rates from military GPs to MOD Specialist Mental Health Services seen since 2018/19.

Please see Section 3 for comparisons to the UK general population.

Section 2: Demographic Risk Groups at MOD Specialist Mental Health Services

Higher presentations seen in:
Royal Navy personnel
Females
Other Ranks
Personnel from the mixed and white ethnic groups

Analysis in this section presents the number of UK Armed Forces personnel assessed with a mental health disorder at MOD Specialist Mental Health services by demographic groups: service, gender, rank, age and ethnicity. Table 2 presents the findings for 2024/25 collectively.

Table 2: UK Armed Forces personnel assessed with a mental disorder at MOD Specialist Mental Health Services by demographics, number and percentage of personnel at risk[1,2,3,4,5]. 2024/25

	2024/25		
	n	%	percentage of UK Armed Forces personnel at risk
Number of personnel assessed with a mental disorder at MOD Mental Health Services	**2,887**	**1.9**	
Service			
Royal Navy*	589	2.2	
Royal Marines	85	1.3	
Army	1,631	1.9	
RAF	582	1.8	
Gender			
Male	2,246	1.7	
Female*	641	3.7	
Rank			
Officer	414	1.4	
Other Rank*	2,473	2.1	
Age			
Aged <20	140	1.8	
Aged 20-24	514	1.8	
Aged 25-29	518	1.8	
Aged 30-34	524	2.2	
Aged 35-39	527	2.3	
Aged 40-44	379	2.3	
Aged 45-49	151	1.6	
Aged 50 +	140	1.2	
Ethnicity[4]			
Asian	56	0.6	
Black	133	1.7	
Mixed	62	2.3	
White	2,603	2.0	
Other	13	0.9	
Unknown	20	-	

Statistically significant differences in rates in 2024/25:

- **Higher in Royal Navy**
- **Lower in Royal Marines**
- **Higher in Females**
- **Higher in Other ranks**
- **Lower in personnel from the Asian ethnic group**

Source: DS Database, DMICP, SSSFT and BFG

1. Percentages are based on the calculation of the absolute number and are presented to 1dp (refer to Data, Definitions and Methods)
2. Excludes personnel where Initial diagnosis was not supplied (refer to BQR)
3. Numbers within demographic groups may not sum the total. Personnel who have more than one episode of care in a year and whose age group, rank, service, deployment status, gender or ethnicity have changed in JPA will be counted once in each sub-category. Demographic information may be missing for some personnel at first presentation.
4. Unknown refers to where an individual preferred not to declare their ethnicity or where there was no ethnicity recorded. A rate for this group is unavailable.
5. '*' denotes significantly higher rates to comparison group(s).

The demographic breakdown **(Table 2)** of those requiring specialist mental health care at MOD Specialist Mental Health services is similar to those being seen in all military healthcare for a mental health related reason presented in Section 1 of this bulletin **(Table 1).**

The rate for:

- **Royal Navy** personnel were significantly higher compared to the other three services.
- **Royal Marines** were significantly **lower** compared to the other three services.
- **Females** were significantly **higher** compared to Males.
- **Other Ranks** were significantly **higher** compared to Officers.
- **Personnel from the Asian ethnic group** were significantly lower compared to other ethnic groups.

Comparisons to previous year

The rate of all UK Armed Forces personnel requiring specialist mental healthcare at MOD Specialist Mental Health services continued on a downward trend, falling in the most recent year from 2.0% (n=3,082) to 1.9% (n=2,887). This was driven by a fall in the rates among Royal Navy and Army personnel and personnel aged under 30.

Previous deployment

To investigate whether there were certain mental health disorders associated with deployment on overseas operations, rate ratios (RR) were calculated. The rate ratios provide a comparison of cases seen between personnel identified as having previously deployed to Iraq and/or Afghanistan and those who have not been identified as having deployed there. A rate ratio less than 1 indicates lower rates in those deployed than those not deployed, whereas a rate ratio greater than 1 indicates higher rates in those deployed than those not deployed. If the 95% confidence interval does not encompass the value 1.0, then this difference is statistically significant.

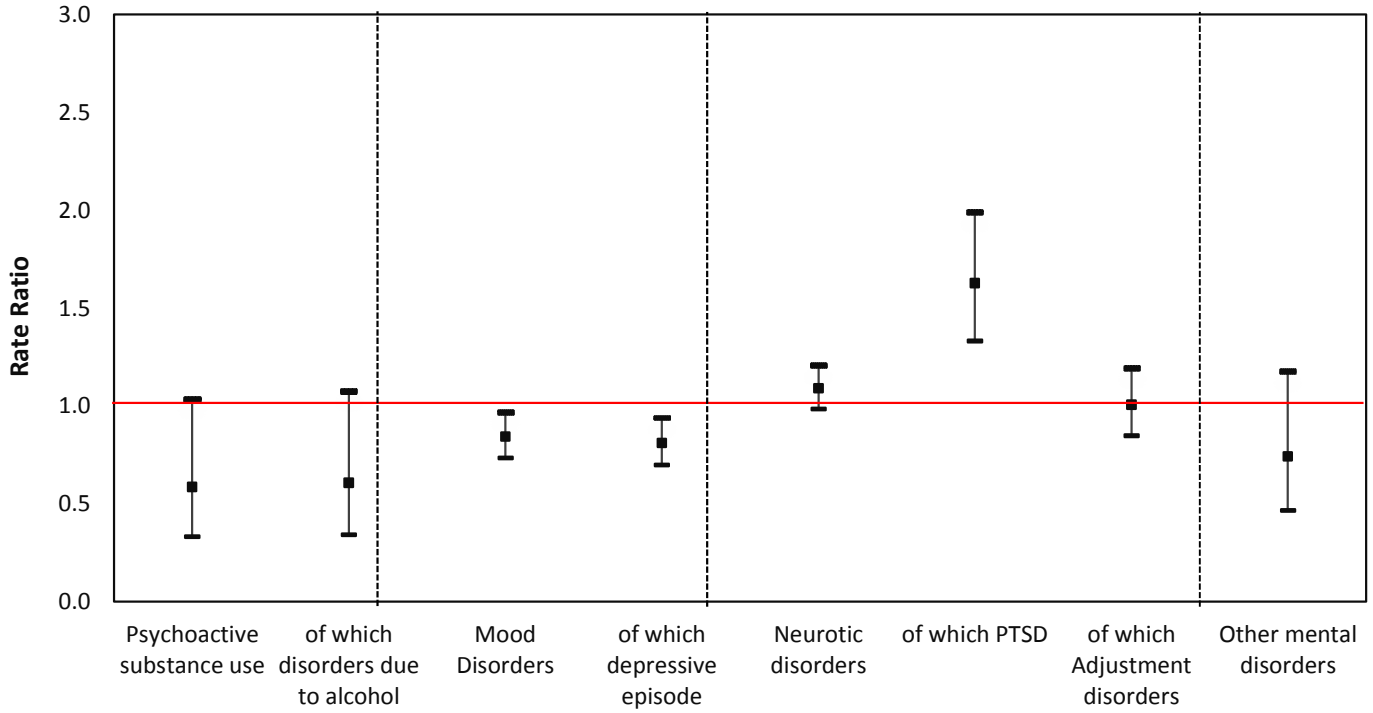
This comparison only includes deployment to Operation TELIC (Iraq), Operation HERRICK (Afghanistan) and Operation VERITAS (Afghanistan) and does not include deployment on recent operations to Operation SHADER (Iraq) and Operation TORAL (Afghanistan).

Historically, rates of depressive episodes and PTSD seen at MOD Specialist Mental Health services were statistically significantly higher among UK Armed Forces personnel who were previously deployed to Iraq and/or Afghanistan compared to those who had not previously deployed there (see Figure 12 in supplementary web tables).

Operations in Iraq ceased in 2011 and Afghanistan in 2014 and over time, as fewer personnel who had previously deployed to Iraq and/or Afghanistan remain in the armed forces, the increased risk for mental disorders among previously deployed personnel has fallen.

In 2024/25, PTSD was the only disorder with significantly higher rates among those previously deployed to Iraq and/or Afghanistan than those not deployed (a 63% increased risk) (Figure 5).

Figure 5: UK Armed Forces personnel seen at the MOD's DCMH's, for Iraq and/or Afghanistan by mental disorder. Rate Ratio, 95% Confidence Interval[1,2,].
2024/25



Source: DS Database and DMICP
1. Deployment to the wider theatre of operation (refer to BQR)
2. Data for Afghanistan between 1 January 2003 and 14 October 2005 were not available for person level deployment (refer to BQR).

Section 2: Trends in UK Armed Forces mental disorders at MOD DCMH 2007/08 to 2024/25

The most prevalent disorders diagnosed at MOD DCMH were:
Depressive Episodes
Anxiety
Adjustment Disorders

Rates of **PTSD remain low at 3 in 1,000 (0.3%)** UK Armed Forces serving personnel assessed at a MOD DCMH in 2024/25.

Clinicians at MOD Specialist Mental Health Services record the patient's initial mental health assessment based on the presenting signs and symptoms, categorizing to World Health Organisation's International Statistical Classification of Diseases and Health-Related Disorders 10th edition (ICD-10) mental disorders (more details can be found in the Glossary). A patient admitted to a MOD in-patient provider will be discharged to the care of a DCMH and therefore the data in this section presents the number of personnel assessed at a MOD DCMH by mental disorder.

In 2024/25, **Depressive episodes** continued to be the most common mental disorder assessed at a MOD DCMH, accounting for a third of all disorders assessed by specialist mental health clinicians (n=884, 0.6% of all UK Armed Forces personnel).

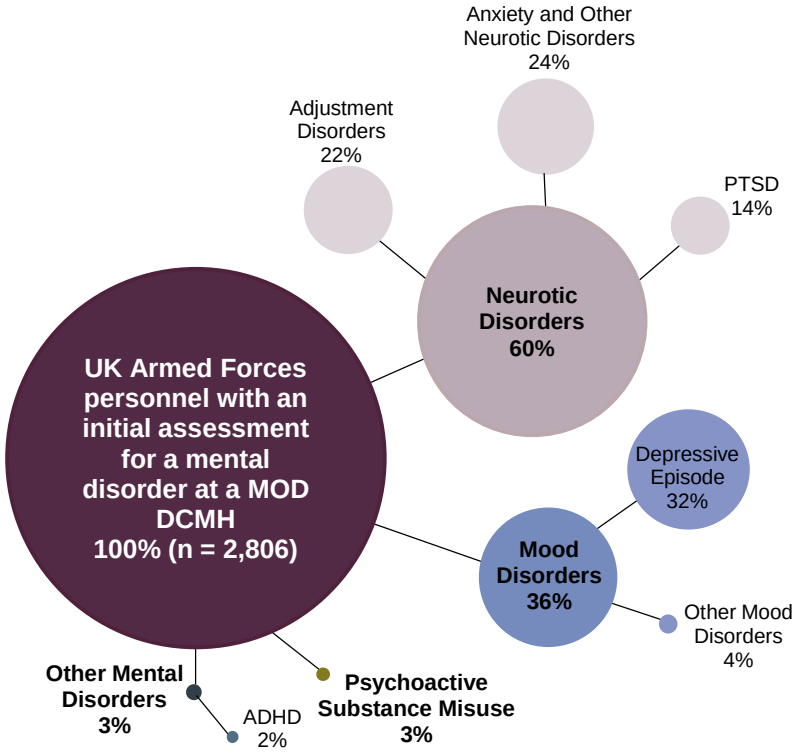
Anxiety and **Adjustment disorders** were the second and third most common mental disorders seen at MOD DCMH, representing around a quarter of all disorders seen by specialist mental health clinicians). (n=670 and 623 respectively, 0.4% of UK Armed Forces personnel).

In the UK general population, Mixed Anxiety and Depression and Generalised Anxiety disorders were also the most common conditions seen. The higher rates of Adjustment disorders seen in the UK Armed Forces compared to the UK general population may reflect the impact of Service life with routine postings every few years and operational tours. Adjustment disorder is a short-term condition occurring when a person has difficulty managing or adjusting to a particular source of stress such as a major life change, loss or event.

The proportion of initial assessments for **PTSD** and **Psychoactive Substance Misuse** in 2024/25 remained low at **14%** (n=393, 0.3% of personnel) and **3%** (n=70, <0.1% of personnel) of all mental disorders assessed at a MOD DCMH respectively.

Figure 6a: UK Armed Forces personnel mental disorders at initial assessment at MOD DCMH, number and percentage[1,2,3]

2024/25



Source: DS Database and DMICP

1. Percentages in the graphic may not sum 100% due to some personnel presenting with more than one disorder and thus are counted within each disorder they have presented with.
2. Excludes personnel where initial diagnosis was not supplied (refer to BQR).
3. The number of UK Armed Forces personnel assessed with a mental disorder differs from that presented in Table 2 as here only includes personnel assessed at a MOD DCMH in 2024/25, whereas Table 2 includes personnel assessed at both a MOD DCMH and/or an in-patient provider.

Figure 6b: UK Armed Forces personnel assessed with a mental disorder at a MOD DCMH in 2024/25, number and percentage of personnel at risk[1,2,3]

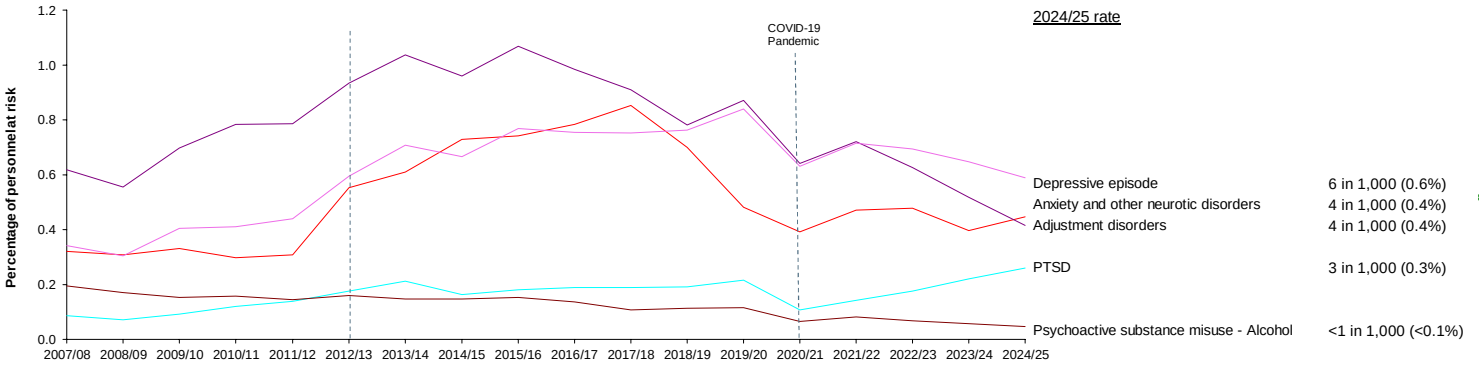
	%	n
All disorders	**1.9%**	**2,806**
Psychoactive substance misuse	**<0.1%**	**72**
of which disorders due to alcohol	*<0.1%*	70
Mood Disorders	**0.7%**	**1,000**
of which depressive episode	*0.6%*	884
Neurotic disorders	**1.1%**	**1,676**
of which PTSD	*0.3%*	393
of which Adjustment disorders	*0.4%*	623
of which anxiety and other neurotic disorders	*0.4%*	670
Other mental disorders	**0.1%**	**96**
of which ADHD	*<0.1%*	49

Source: DS Database and DMICP

1. Excludes personnel where initial diagnosis was not supplied (refer to BQR).
2. Percentages are based on the calculation of the absolute number and are presented to 1dp (refer to Data, Definitions and Methods).
3. The percentage of UK Armed Forces personnel assessed with a mental disorder may differ from that presented in Figure 4 as Figure 6b includes personnel assessed at a MOD DCMH only in 2024/25; Figure 4 includes personnel assessed at both a MOD DCMH and/or an in-patient provider.

Figure 7: UK Armed Forces personnel mental disorders at initial assessment at MOD DCMH, percentage of personnel at risk[1,2,3].

2007/08 to 2024/25



Source: DS Database and DMICP

1. Dotted lines on 2012/13 represent revised methodology to include electronic patient record data source (refer to Data, Definitions and Methods).
2. Percentages are based on the calculation of the absolute number and are presented to 1dp (refer to Data, Definitions and Methods).
3. Excludes personnel where Initial diagnosis was not supplied (refer to BQR)

There has been a downward trend in the rate for Anxiety and other neurotic disorders seen at MOD DCMH since 2017/18. This may be the result of the care model introduced in 2018 which sees low risk patients with less complex presentations of common mental disorders being offered self-help and psychosocial interventions in primary care before assessment for referral to MOD Specialist Mental Health Services. This may have had an impact on referral rates for specialist intervention for stress-related disorders that fall under the Other Neurotic Disorders category, with crude exploratory analysis suggesting these disorders were more likely to be treated solely within the primary healthcare setting.

Rates of Adjustment disorder have also seen a downward trend in recent years. In 2024/25, rates of Adjustment disorder were statistically significantly lower compared to 2023/24.

Despite media attention on the prevalence of **PTSD** and **Psychoactive substance misuse due to alcohol** in the UK Armed Forces, Figure 7 shows that these disorders remain **low.**

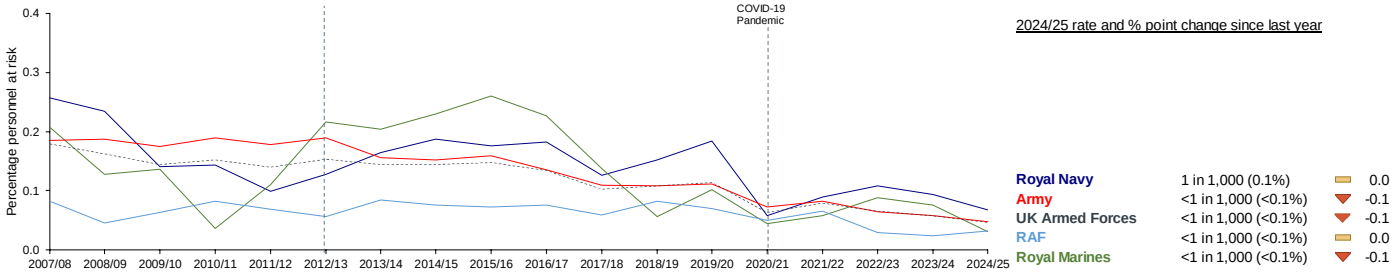
Rates of personnel seen for PTSD remain small and there was no statistically significant change in rates over time from around 2 per 1,000 in 2013/14 (n= 375) to 3 per 1,000 (n=393 in 2024/25).

Rates of personnel seen for psychoactive substance misuse due to alcohol at a MOD DCMH remained low throughout the period presented. Less than 1 in 1,000 (<0.1%, n=70) personnel were assessed at a MOD DCMH with psychoactive substance misuse due to alcohol in 2024/25.

Figures 8 and 9 present the differences in the percentage of UK Armed Forces personnel within each Service assessed with psychoactive substance misuse due to alcohol and PTSD respectively.

Psychoactive Substance Misuse due to Alcohol

Figure 8: UK Armed Forces personnel with an initial assessment at the MOD's DCMH, for psychoactive substance misuse due to alcohol, by Service, percentage personnel at risk[1,2,3].
2007/08 to 2024/25



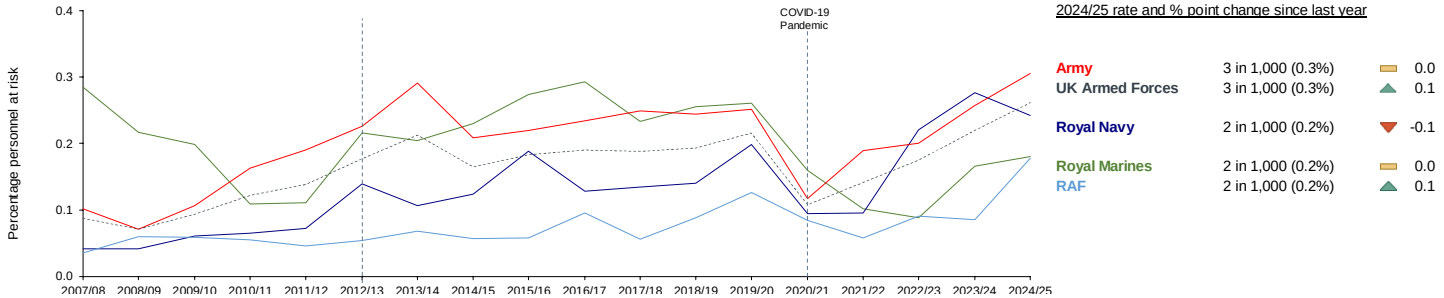
Source: DS Database and DMICP

1. Dotted lines on 2012/13 represents revised methodology to include electronic patient record data source (refer to Data, Definitions and Methods).
2. Percentages are based on the calculation of the absolute number and are presented to 1dp (refer to Data, Definitions and Methods).
3. Excludes personnel where Initial diagnosis was not supplied (refer to BQR)

In 2024/25, the rates of Psychoactive Substance Misuse for Alcohol were similar for each Service at less than 0.1% (1 in 1,000 personnel) or below.

Post-Traumatic Stress Disorder (PTSD)

Figure 9: UK Armed Forces personnel with an initial assessment at the MOD's DCMH, for PTSD by Service, percentage personnel at risk[1,2,3].
2007/08 to 2024/25



Source: DS Database and DMICP

1. Dotted lines represent 2012/13 revised methodology to include electronic patient record data source (refer to Data, Definitions and Methods).
2. Percentages are based on the calculation of the absolute number and are presented to 1dp (refer to Data, Definitions and Methods).
3. Excludes personnel where Initial diagnosis was not supplied (refer to BQR)

Historically, personnel deployed to Iraq and/or Afghanistan were at an increased risk of a subsequent assessment for PTSD in the UK Armed Forces. As greater numbers of Royal Marine and Army personnel were deployed, this may explain why rates of PTSD for these services have historically been higher than other services.

Section 2: Number of new episodes of care among UK Armed Forces personnel at MOD Specialist Mental Health Services, 2019/20 to 2024/25

Personnel may have more than one episode of care in a year. To understand clinical activity and prevalence of mental health disorders assessed at MOD Specialist Mental Health Services, it is important to present the total number of new episodes of care. This is of particular use to MOD's policy areas and other internal users of this bulletin.

Table 3: UK Armed Forces new episodes of care at MOD Specialist Mental Health Services by Service provider, initial assessment, numbers and percentage personnel at risk[1,2,3].
2020/21 to 2024/25

	2020/21	2021/22	2022/23	2023/24	2024/25
Number of new episodes of care					
New episodes of care at MOD Specialist Mental Health Services[1]	**3,996**	**4,830**	**4,263**	**3,667**	**3,608**
At a DCMH	3,779	4,569	4,003	3,453	3,406
At a MOD in-patient provider	217	261	260	214	202
Episodes assessed with a mental disorder[2]	3,458	4,071	3,823	3,319	3,232
Episodes assessed without a mental disorder[2]	523	730	405	326	342
Missing mental disorder information[3]	15	29	35	22	34
Percentage of personnel at risk					
New episodes of care at MOD Specialist Mental Health Services[1]	***2.5***	***3.0***	***2.7***	***2.4***	***2.4***
At a DCMH	*2.4*	*2.8*	*2.5*	*2.3*	*2.3*
At a MOD in-patient provider	*0.1*	*0.2*	*0.2*	*0.1*	*0.1*
Episodes assessed with a mental disorder[2]	*2.2*	*2.5*	*2.4*	*2.2*	*2.2*
Episodes assessed without a mental disorder[2]	*0.3*	*0.4*	*0.3*	*0.2*	*0.2*
Missing mental disorder information[3]	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*

Source: DS Database, DMICP, SSSFT, BFG
1. Percentages are based on the calculation of the absolute number and are presented to 1dp (refer to Data, Definitions and Methods)
2. Clinician's initial assessment based on presenting symptoms (refer to Data, Definitions and Methods)
3. Excludes personnel where Initial diagnosis was not supplied (refer to BQR)

The rate of new episodes of care at MOD Specialist Mental Health Services in 2024/25 remained the same as the previous year (2.4%) for UK Armed Forces personnel.

In 2024/25, **3,194** UK Armed Forces personnel had **3,608** new episodes of care at MOD Specialist Mental Health services. There were 3,406 new episodes at a MOD DCMH and 202 new episodes at MOD In-patient providers.

Breaking this information into initial assessments for mental health disorders at a MOD DCMH during 2024/25, there were:
1,676 personnel with 1,806 new episodes of care for Neurotic Disorders. Of which:
- 670 personnel with 712 new episodes of Anxiety and Other Neurotic Disorders.
- 623 personnel with 662 new episodes of Adjustment Disorder.
- 393 personnel with 432 new episodes of PTSD.

1,000 personnel with 1,081 new episodes of care for Mood Disorder. Of which:

- 884 personnel with 961 episodes of Depressive episodes.

96 personnel with 99 new episodes of Other Mental Disorders.

72 personnel with 78 new episodes of Psychoactive Substance Misuse. Of which:

- 70 personnel with 76 episodes of Psychoactive Substance Misuse due to alcohol.

Following a consultation in 2017 the production of more detailed tables presenting episodes of care data and rates have been ceased. Previous releases of the tables can still be found on the defence mental health statistics page.

Section 3: Comparison to the UK general population

Overall rates of mental health in the UK Armed Forces were **broadly comparable** to those seen in the UK general population.	The rate of those seen in specialist mental health care was **lower** than the UK general population.

Analysis in this section compares UK Armed Forces personnel seen by clinicians in military primary care (GP's) and/or by specialist mental health clinicians at a MOD DCMH to the UK general population.

UK Armed Forces personnel seen in any military healthcare setting

The rate of UK Armed Forces personnel seen in any military healthcare setting for any mental health related reason in 2024/25 (12.3%) was broadly comparable to those seen in the UK general population. As a crude comparison, the Adult Psychiatric Morbidity Survey 2023/24[a] (latest information available) carried out by NHS Digital shows that in England, 13.2% of adults reported discussing their mental health with a GP in the past year.

Gender

Within the UK Armed Forces, rates of personnel seen in military healthcare for any mental health related reason were significantly higher amongst females compared to males throughout the period presented.

This finding was replicated in the civilian population where females were more likely to have a common mental health condition than males. A study following up the mental health of adults suggested that this is because females were likely to have more interactions with health professionals[c]. MOD has not investigated whether females in the UK Armed Forces have more interactions with health professionals than their male colleagues.

Ethnicity

Within the UK Armed Forces in 2024/25, personnel from the white and mixed ethnic groups were significantly more likely to be seen in military healthcare for a mental health related reason, and personnel from Asian ethnic groups were significantly less likely to be seen than all other ethnic groups.

As a crude comparison, the Adult Psychiatric Morbidity Survey 2023/24[a] showed that in England, the white British and those from another White background ethnic groups were most likely to report receiving treatment, with 18.4% and 16.7% respectively reporting receiving treatment. Treatment rates among the black, Asian, and mixed or other ethnic groups, were significantly lower than those in the White British ethnic group.

UK Armed Forces personnel seen by MOD Specialist Mental Health Services

The rate of mental disorders among UK Armed Forces personnel seen by MOD Specialist Mental Health Services (1.9%) was **lower** than the rate of 6.3% of the UK general population who accessed secondary mental health services in 2023/24 (latest data available).

Published annual data for those seeking help from their GP for mental health related reasons and those referred to specialist mental health services in the UK general population for 2024/25 is

currently unavailable. However, published provisional monthly information on referrals to mental health specialist services among the UK general population suggests the number of referrals may be similar in 2024/25 to those seen in 2023/24.

Once published, if the annual 2024/25 UK general population rate remains in line with the published provisional monthly rates, the rate of mental disorder among UK Armed Forces personnel seen by Specialist Mental Health Services will be lower than the rate of the UK general population who accessed secondary mental health services.

It should be noted that comparisons with the UK general population are difficult for a number of reasons. Due to the nature of the role UK Armed Forces personnel undertake, in particular access to weapons; a patient's medical officer may refer at an earlier stage to specialised mental health services compared to the UK general population. In addition, the source of the UK general population statistic for specialist mental ill-health also covers services such as Adult Learning Disability which are not relevant to the UK Armed Forces population (this service accounted for approximately 5% of all secondary mental health service usage in 2023/24).

The lower rates seen among UK Armed Forces personnel accessing specialist mental health services compared to the UK general population may be due to the rigorous selection of individuals into the UK Armed Forces which may prevent those with more serious mental disorders joining the Services; as well as the role tight unit cohesion plays in maintaining good mental health. In addition, UK Armed Forces personnel who have a mental disorder which prevents continued Service in the military environment may be considered for medical discharge, thus more severe cases of mental health may not remain in the UK Armed Forces population.

Annex A1: Royal Navy personnel mental health 2007/08 to 2024/25

1 in 7 (14.1%) Royal Navy personnel were seen in military healthcare for a mental health related reason in 2024/25.	**1 in 45 (2.2%)** Royal Navy personnel were seen by a specialist mental health clinician for a mental disorder in 2024/25.	Higher presentations seen at MOD Specialist Mental Health Services among: **Females** **Other Ranks**	The most prevalent disorders at MOD Specialist Mental Health Services were: **Depressive Episode** **Anxiety**

In 2024/25, 14.1% of Royal Navy personnel (around 1 in 7, n=3,716) were seen in any military healthcare setting for a mental health related reason, a fall from 14.8% in the previous year. Rates of mental health among Royal Navy personnel were statistically significantly higher than the Army and Royal Marines.

In 2024/25, 2.2% (1 in 45, n=589) of Royal Navy personnel were assessed with a mental disorder at MOD Specialist Mental Health Services; a decrease from the previous year (2.4%). In 2024/25, Royal Navy rates were significantly higher than each other service.

For Royal Navy personnel seen in specialist mental health services:

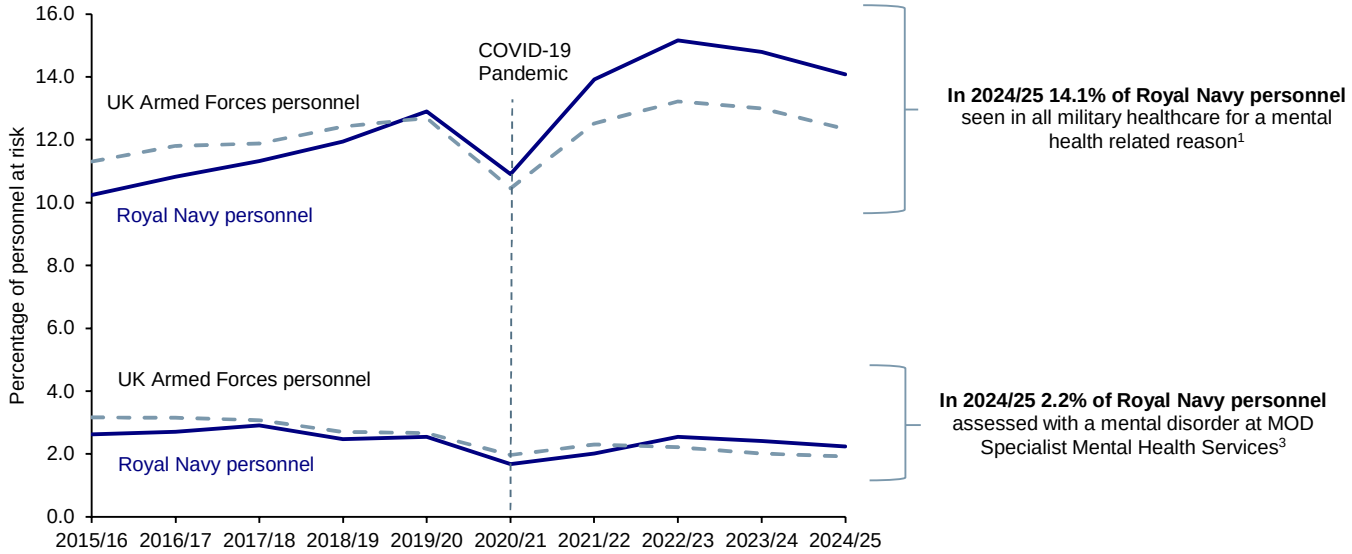
There were statistically significant higher presentations in certain demographic groups in line with the findings for the UK Armed Forces as a whole:

- Females
- Other ranks

Depressive episodes and Anxiety were the most prevalent condition among Royal Navy personnel assessed with a mental disorder.

More information regarding presentations in certain demographics along with numbers, rates per 1,000 personnel at risk and 95% Confidence Intervals are available in Excel tables at the defence mental health statistics page.

Figure A1.1: Royal Navy personnel seen for a mental health related reason, percentage of personnel at risk.
2015/16 to 2024/25



Source: DS Database, DMICP, SSSFT and BFG

1. Personnel recorded in primary care or specialist mental health care at a MOD DCMH.
2. Mental health related reasons do include signs and symptoms of mental health as well as ICD-10 mental health disorders.
3. Initial assessment at MOD Specialist Mental Health Services for a mental disorder.

Table A1.2: Royal Navy personnel assessed with a mental disorder at MOD Specialist Mental Health Services by demographics, number and percentage of personnel at risk[1,2,3,4].
2024/25

		2024/25		percentage of Royal Navy personnel at risk
		n	%	
Number of Royal Navy personnel assessed with a mental disorder at MOD Specialist Mental Health Services		**589**	**2.2**	
Gender				
	Male	448	2.0	
	Female*	141	3.9	
Rank				
	Officer	113	1.7	
	Other Rank*	476	2.4	
Age				
	Aged <20	26	2.0	
	Aged 20-24	101	1.8	
	Aged 25-29	106	2.1	
	Aged 30-34	113	2.9	
	Aged 35-39	110	3.0	
	Aged 40-44	69	2.4	
	Aged 45-49	37	2.2	
	Aged 50 +	28	1.2	

Source: DS Database, DMICP, SSSFT and BFG

1. Percentages are based on the calculation of the absolute number and are presented to 1dp (refer to Data, Definitions and Methods).
2. Excludes personnel where Initial diagnosis was not supplied (refer to BQR).
3. Numbers within demographic groups may not sum the total as personnel who have more than one episode of care in a year and change age group or rank will be counted once in each sub-category.
4. '*' denotes significantly higher rates to comparison group(s).

Annex A2: Royal Marine personnel mental health 2007/08 to 2024/25

1 in 16 (6.3%) Royal Marine personnel were seen in military healthcare for a mental health related reason in 2024/25.	**1 in 75 (1.3%)** Royal Marine personnel were seen by a specialist mental health clinician for a mental disorder in 2024/25.	The most prevalent disorders at MOD Specialist Mental Health Services were: **Anxiety** **Depressive Episode**

The overall rate of Royal Marine personnel seen in any military healthcare setting for a mental health related reason was significantly lower than the other three services across the entire period presented. In 2024/25, the Royal Marines rate was 6.3% of personnel (1 in 16, n=419), a fall from 6.4% in the previous year.

The rate of Royal Marine personnel presenting to MOD Specialist Mental Health Services with a mental disorder in 2024/25 remained stable at 1.3% (n=85).

For Royal Marines seen in specialist mental health services:

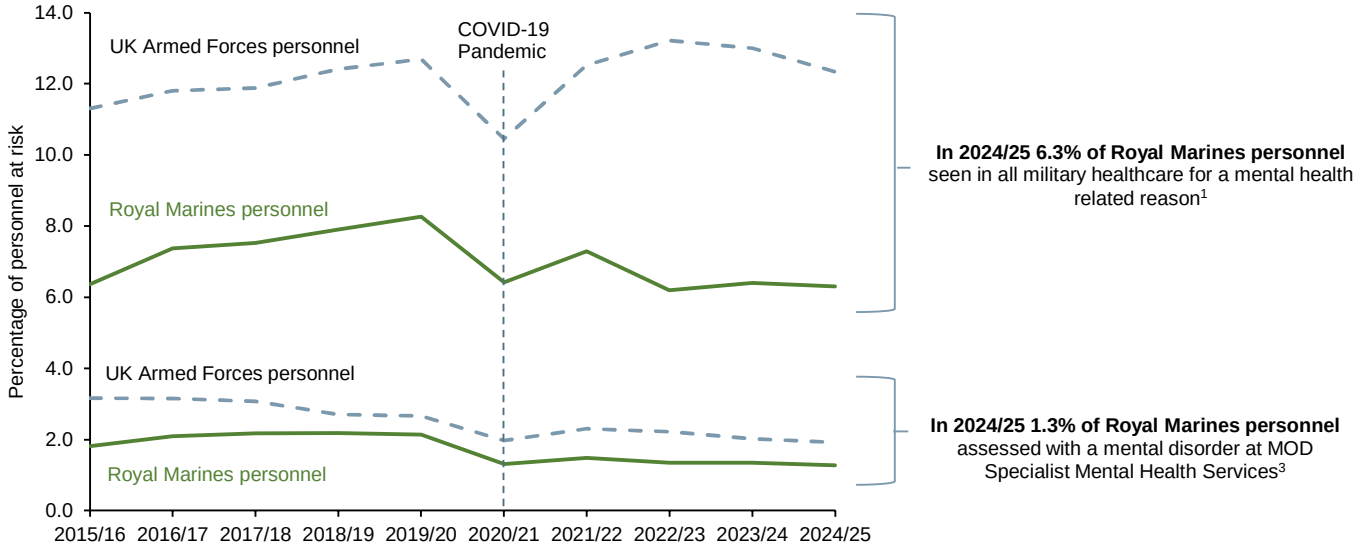
In 2024/25 rates of mental health disorders between Royal Marine personnel who were previously deployed to Iraq and/or Afghanistan was statistically significantly higher compared to those who had not previously deployed there (see supplementary tables for further information). This was also seen in the period 2014/15 to 2021/22.

Whilst rates of mental disorder was higher among females and Other Ranks compared to males and Officers for the Armed Forces as a whole, there was no significant difference in rates among Royal Marines.

Anxiety and Depressive Episodes were the most prevalent conditions among Royal Marines assessed with a mental disorder.

More information regarding presentations in certain demographics along with rates per 1,000 personnel at risk and 95% Confidence Intervals are available in Excel tables at the defence mental health statistics page.

Figure A2.1: Royal Marine personnel seen for a mental health related reason[1,2], percentage of personnel at risk.
2015/16 to 2024/25



Source: DS Database, DMICP, SSSFT and BFG

1. Personnel recorded in primary care or specialist mental health care at a MOD DCMH.
2. Mental health related reasons do include signs and symptoms of mental health as well as ICD-10 mental health disorders.
3. Initial assessment at MOD Specialist Mental Health Services for a mental disorder.

Table A2.2: Royal Marine personnel assessed with a mental disorder at MOD Specialist Mental Health Services by demographics, number and percentage of personnel at risk[1,2,3,4].
2024/25

		2024/25		
		n	%	percentage of Royal Marine personnel at risk
Number of Royal Marine personnel assessed with a mental disorder at MOD Specialist Mental Health Services		**85**	**1.3**	
Gender				
	Male	~	1.2	
	Female	~	3.3	
Rank				
	Officer	12	1.3	
	Other Rank	73	1.3	
Age				
	Aged <20	~	0.4	
	Aged 20-24	~	0.3	
	Aged 25-29	12	0.7	
	Aged 30-34	23	2.0	
	Aged 35-39	19	2.1	
	Aged 40-44	16	2.6	
	Aged 45-49	~	1.2	
	Aged 50 +	6	1.5	

Source: DS Database, DMICP, SSSFT and BFG

1. Percentages are based on the calculation of the absolute number and are presented to 1dp (refer to Data, Definitions and Methods).
2. Excludes personnel where Initial diagnosis was not supplied (refer to BQR).
3. Numbers within demographic groups may not sum the total as personnel who have more than one episode of care in a year and change age group or rank will be counted once in each sub-category.
4. '*' denotes significantly higher rates to comparison group(s).

Annex A3: Army personnel mental health 2007/08 to 2024/25

1 in 9 (11.5%) Army personnel were seen in military healthcare for a mental health related reason in 2024/25.	**1 in 53 (1.9%)** Army personnel were seen by a specialist mental health clinician for a mental disorder in 2024/25.	Higher presentations seen at MOD Specialist Mental Health Services among: **Females** **Other Ranks**	The most prevalent disorders at MOD Specialist Mental Health Services were: **Adjustment Disorders** **Depressive Episode**

In 2024/25, 11.5% of Army personnel (around 1 in 9, n=9,804) were seen in any military healthcare setting for a mental health related reason; a statistically significant fall compared to the previous year (12.3%). The rate of Army personnel seen in any military healthcare setting for a mental health related reason has been stable at around 12% since 2016/17.

The overall rate of Army personnel presenting with a mental disorder to MOD Specialist Mental Health Services was 1.9% in 2024/25 (n=1,631); lower than the rate of 2.0% in the previous year.

For Army personnel seen in specialist mental health services:

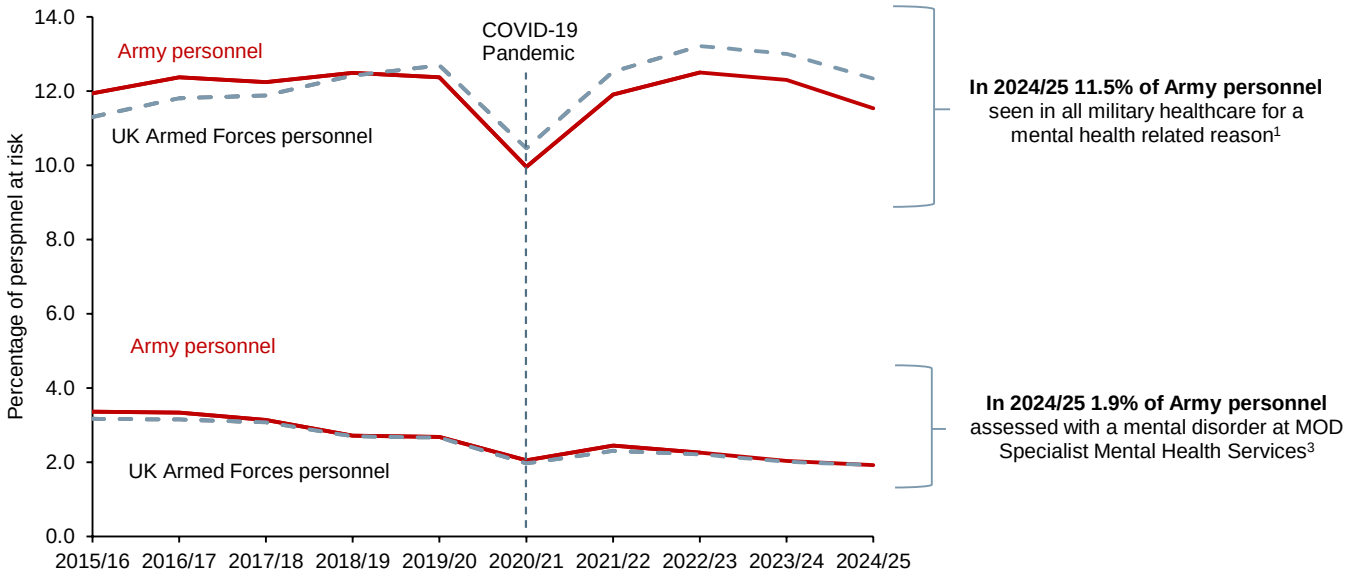
There were statistically significant higher presentations in certain demographic groups in line with the findings for the UK Armed Forces as a whole:

- Females
- Other ranks

Adjustment Disorders and Depressive Episodes were the most prevalent conditions among Army personnel assessed with a mental disorder.

More information regarding presentations in certain demographics along with rates per 1,000 personnel at risk and 95% Confidence Intervals are available in Excel tables at the defence mental health statistics page.

Figure A3.1: Army personnel seen for a mental health related reason[1,2], percentage of personnel at risk.
2015/16 to 2024/25



Source: DS Database, DMICP, SSSFT and BFG
1. Personnel recorded in primary care or specialist mental health care at a MOD DCMH.
2. Mental health related reasons do include signs and symptoms of mental health as well as ICD-10 mental health disorders.
3. Initial assessment at MOD Specialist Mental Health Services for a mental disorder.

Table A3.2: Army personnel assessed with a mental disorder at MOD Specialist Mental Health Services by demographics, number and percentage of personnel at risk[1,2,3,4].
2024/25

		2024/25		
		n	%	percentage of Army personnel at risk
Number of Army personnel assessed with a mental disorder at MOD Specialist Mental Health Services		**1,631**	**1.9**	
Gender				
	Male	1,302	1.7	
	Female*	329	4.0	
Rank				
	Officer	182	1.3	
	Other Rank*	1,449	2.0	
Age				
	Aged <20	102	2.0	
	Aged 20-24	340	2.1	
	Aged 25-29	295	1.8	
	Aged 30-34	286	2.0	
	Aged 35-39	258	2.0	
	Aged 40-44	208	2.3	
	Aged 45-49	74	1.4	
	Aged 50 +	72	1.3	

Source: DS Database, DMICP, SSSFT and BFG

1. Percentages are based on the calculation of the absolute number and are presented to 1dp (refer to Data, Definitions and Methods).
2. Excludes personnel where Initial diagnosis was not supplied (refer to BQR).
3. Numbers within demographic groups may not sum the total as personnel who have more than one episode of care in a year and change age group or rank will be counted once in each sub-category.
4. '*' denotes significantly higher rates to comparison group(s).

Annex A4: RAF personnel mental health 2007/08 to 2024/25

1 in 7 (14.3%) RAF personnel were seen in military healthcare for a mental health related reason in 2024/25.	**1 in 55 (1.8%)** RAF personnel were seen by a specialist mental health clinician for a mental disorder in 2024/25.	Higher presentations seen at MOD Specialist Mental Health Services among: **Females** **Other Ranks**	The most prevalent disorders at MOD Specialist Mental Health Services were: **Depressive Episodes** **Anxiety**

In 2024/25, 14.3% of RAF personnel (around 1 in 7, n=4,588) were seen in any military healthcare setting for a mental health related reason, a fall from 14.9% in the previous year. The RAF rate in 2024/25 was statistically significantly higher than the Army, Royal Marines and the UK Armed Forces as a whole.

The overall rate of RAF personnel presenting to MOD Specialist Mental Health Services with a mental disorder was 1.8% in 2024/25 (n=582), the rate remained the same as the previous year.

For RAF personnel seen in specialist mental health services:

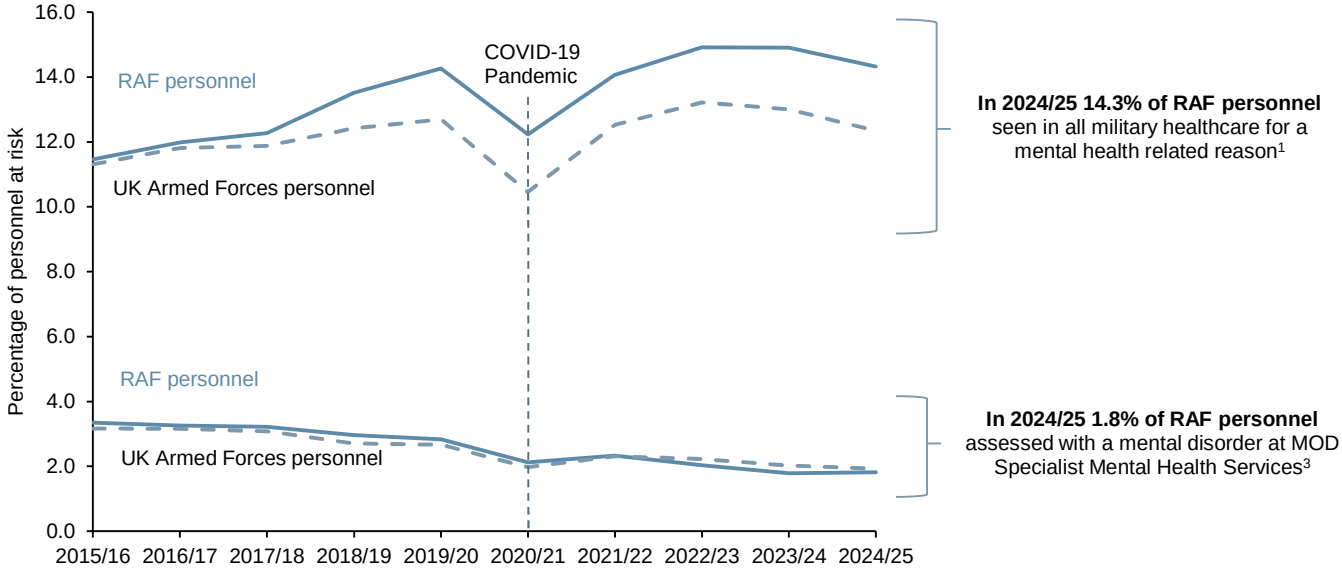
There were statistically significant higher presentations in certain demographic groups in line with the findings for the UK Armed Forces as a whole:

- Females
- Other ranks

Depressive Episodes and Anxiety were the most prevalent conditions among RAF personnel assessed with a mental disorder.

More information regarding presentations in certain demographics along with rates per 1,000 personnel at risk and 95% Confidence Intervals are available in Excel tables at the defence mental health statistics page.

Figure A4.1: RAF personnel seen for a mental health related reason[1,2], percentage of personnel at risk.
2015/16 to 2024/25



Source: DS Database, DMICP, SSSFT and BFG
1. Personnel recorded in primary care or specialist mental health care at a MOD DCMH.
2. Mental health related reasons do include signs and symptoms of mental health as well as ICD-10 mental health disorders
3. Initial assessment at MOD Specialist Mental Health Services for a mental disorder

Table A4.2: RAF personnel assessed with a mental disorder at MOD Specialist Mental Health Services by demographics, number and percentage of personnel at risk[1,2,3,4].
2024/25

		2024/25		
		n	%	percentage of RAF personnel at risk
Number of RAF personnel assessed with a mental disorder at MOD Specialist Mental Health Services		**582**	**1.8**	
Gender				
	Male	415	1.5	
	Female*	167	3.2	
Rank				
	Officer	107	1.3	
	Other Rank*	475	2.0	
Age				
	Aged <20	11	1.0	
	Aged 20-24	69	1.3	
	Aged 25-29	105	1.8	
	Aged 30-34	102	2.1	
	Aged 35-39	140	2.8	
	Aged 40-44	86	2.0	
	Aged 45-49	36	1.4	
	Aged 50 +	34	1.0	

Source: DS Database, DMICP, SSSFT and BFG

1. Percentages are based on the calculation of the absolute number and are presented to 1dp (refer to Data, Definitions and Methods).
2. Excludes personnel where Initial diagnosis was not supplied (refer to BQR).
3. Numbers within demographic groups may not sum the total as personnel who have more than one episode of care in a year and change age group or rank will be counted once in each sub-category.
4. '*' denotes significantly higher rates to comparison group(s).

Glossary

Admissions In-patient admissions to the MOD mental health in-patient care providers.

All mental health is defined as those seen for a mental health related issue in either primary care or specialist mental health care at a MOD DCMH.

Army the British Army consists of the General Staff and the deployable Field Army and the Regional Forces that support them, as well as Joint elements that work with the Royal Navy and Royal Air Force. Its primary task is to help defend the interests of the UK.

Assessed without a mental disorder A few patients present to DCMH with symptoms that require the treatment skills of DCMH staff, whilst not necessarily having a specific and identifiable mental disorder as defined under ICD-10.

Defence Medical Information Capability Programme (DMICP) is the MOD electronic medical record.

Department of Community Mental Health (DCMH) DCMH are specialised psychiatric services based on community mental health teams closely located with primary care service at sites in the UK and abroad.

Electronic medical record is where all UK Armed Forces healthcare data is stored. The system is known as DMICP.

FTRS (**Full-Time Reserve Service**) are personnel who fill Service posts for a set period on a full-time basis while being a member of one of the Reserve Services, either as an ex-regular or as a volunteer. An FTRS reservist on:
Full Commitment (FC) fulfils the same range of duties and deployment liability as a regular Service person;
Limited Commitment (LC) serves at one location but can be detached for up to 35 days a year;
Home Commitment (HC) is employed at one location and cannot be detached elsewhere.

Each Service uses FTRS personnel differently:

- The Naval Service predominantly uses FTRS to backfill gapped regular posts. However, they do have a small number of FTRS personnel that are not deployable for operations overseas. There is no distinction made in terms of fulfilling baseline liability posts between FTRS Full Commitment (FC), Limited Commitment (LC) and Home Commitment (HC).
- The Army employ FTRS(FC) and FTRS(LC) to fill Regular Army Liability (RAL) posts as a substitute for regular personnel for set periods of time. FTRS(HC) personnel cannot be deployed to operations and are not counted against RAL.
- The RAF consider that FTRS(FC) can fill Regular RAF Liability posts but have identified separate liabilities for FTRS(LC) and FTRS(HC).

Gurkhas are recruited and employed in the British and Indian Armies under the terms of the 1947 Tri-Partite Agreement (TPA) on a broadly comparable basis. They remain Nepalese citizens but in all other respects are full members of HM Forces. Since 2008, Gurkhas are entitled to join the UK Regular Forces after 5 years of service and apply for British citizenship.

International Statistical Classification of Diseases and Health-Related Disorders 10th edition (ICD-10) is the standard diagnostic tool for epidemiology, health management and clinical purposes. The following ICD 10 Chapters have been included in this report:

- **F10 to F19 Mental and behavioural disorders due to psychoactive substance misuse, including alcohol**. A wide variety of disorders that differ in severity (from uncomplicated intoxication and harmful use to obvious psychotic disorders and dementia), but that are all attributable to the use of one or more psychoactive substances (which may or may not have been medically prescribed).

- **F30 to F39 Mood affective disorders, including depressive episodes.** Disorders in which the fundamental disturbance is a change in affect or mood to depression (with or without associated anxiety) or to elation. The mood change is usually accompanied by a change in the overall level of activity; most of the other symptoms are either secondary to, or easily understood in the context of, the change in mood and activity. Most of these disorders tend to be recurrent and the onset of individual episodes can often be related to stressful events or situations. Includes Manic and Bipolar affective disorders, Depressive and recurrent Depressive episodes and other mood affective disorders.

- **F40 to F49 Neurotic Stress related and somatoform disorders, including PTSD and Adjustment disorders.** This includes mental disorders characterized by anxiety and avoidance behaviour, with symptoms distressing to the patient, intact reality testing, no violations of gross social norms, and no apparent organic aetiology. 'Other neurotic disorders' are mostly made up of reactions to stress and anxiety disorders that do not include adjustment disorders or PTSD.

- **F00 to F09**, **F20 to F29 and F50 to F99 are presented as 'Other mental health disorders'.** This includes, disorders grouped together on the basis of their having in common a demonstrable etiology in cerebral disease, brain injury, or other insult leading to cerebral dysfunction; schizophrenia, personality disorders and eating disorders.

In-patient services are provided through eight NHS trusts in the UK which are part of a consortium headed by the Midlands partnership Foundation Trust (MPFT) and at Gilhead IV Hospital, Bielefield, Germany under a contract with Guys and St Thomas Hospital in the UK up until April 2013 and from this date the Soldiers, Sailors, Airmen and Families Association (SSAFA) through the Limited Liability Partnership.

Mental health related diagnosis codes are the way mental health data is stored in the electronic medical record. The list of codes include all disorders under Chapter V (F00 to F99) of ICD-10 as well as other signs and symptoms of mental health.

Mental disorder Patients assessed by clinicians at a MOD DCMH or in-patient provider with a mental and behavioural disorder categorised under Chapter V (F00 to F99) in ICD-10.

Military healthcare setting represent primary care and MOD Specialist Mental Health Services.

Military Provost Guard Service (MPGS) provides trained professional soldiers to meet defence armed security requirements in units of all three Services based in Great Britain. M P G S provide armed guard protection of units, responsible for control of entry, foot and mobile patrols and armed response to attacks on their unit.

Mobilised Reservists are Volunteer or Regular Reserves who have been called into permanent service with the Regular Forces on military operations under the powers outlined in the Reserve Forces Act 1996. Call-out orders will be for a specific amount of time and subject to limits (e.g. under a call-out for warlike operations (Section 54), call-out periods should not exceed 12 months, unless extended.)

MOD Specialist Mental Health Services encompass the delivery of care through MOD's DCMH for outpatient care, and all admissions to the MOD's in-patient care contractor. It does not cover mental health care for patients treated wholly in the primary care setting by GP's.

New episodes of care New patients; or patients who have been seen at a DCMH but were discharged from care and have been referred again. This represents the level of clinical activity/prevalence and does not represent the number of personnel assessed as an individual may have more than one episode of care.

Non-Regular Permanent Staff (NRPS) are members of the Army Volunteer Reserve Force employed on a full-time basis. The NRPS comprises Commissioned Officers, Warrant Officers, Non - Commissioned Officers and soldiers posted to units to assist with the training, administrative and special duties within the Army Reserve. Typical jobs are Permanent Staff Administration Officer and Regimental Administration Officer. Since 2010, these contracts are being discontinued in favour of FTRS (Home Commitment) contracts. NRPS are not included in the Future Reserves 2020 Volunteer Reserve population as they have no liability for call out.

Number of Personnel represents the number of individuals with an initial assessment at MOD Specialist Services. An individual may have more than one episode of care, but the individual will only be counted once in the number of personnel.

Officer An officer is a member of the Armed Forces holding the Queen's Commission to lead and command elements of the forces. Officers form the middle and senior management of the Armed Forces. This includes ranks from Sub-Lt/2nd Lt/Pilot Officer up to Admiral of the Fleet/Field Marshal/Marshal of the Royal Air Force but excludes Non-Commissioned Officers.

Operation HERRICK is the name for UK operations in Afghanistan which started in April 2006. UK Forces are deployed to Afghanistan in support of the UN authorised, NATO led International Security Assistance Force (IASF) mission and as part of the US-led Operation Enduring Freedom (OEF).

Operation SHADER is providing military support to the US led Coalition to defeat Daesh in Iraq and Syria.

Operation TELIC is the name for UK operations in Iraq which started in March 2003 and finished on 21 May 2011. UK Forces were deployed to support the Government's objective to remove the threat that Saddam Hussein posed to his neighbours and his people and, based on evidence available at the time, disarm him of his weapons of mass destruction. The Government also undertook to support the Iraqi people in their desire for peace, prosperity and freedom.

Operation TORAL started 1 December 2014, is the UK's post 2014 contribution to operations in Afghanistan under the NATO RESOLUTE SUPPORT MISSION.

Other Ranks Other ranks are members of the Royal Marines, Army and Royal Air Force who are not officers but Other Ranks include Non-Commissioned Officers.

Personnel at Risk is defined as the number of serving UK Armed Forces personnel eligible for mental healthcare. This includes regular UK Armed Forces personnel, Ghurkhas, Military Provost Guard Staff, mobilised reservists, Full Time Reserve Service personnel and Non-regular Permanent Staff.

Primary care is the level of healthcare provided by a General Practitioner (GP) or medical officer. This does not include specialist mental health care.

Rate Ratio (RR) provides a comparison of cases seen between personnel identified as having deployed to a theatre and those who have not been identified as having deployed to either theatre. A rate ratio less than 1 indicates lower rates in those deployed than those not deployed, whereas a rate ratio greater than 1 indicates higher rates in those deployed than those not deployed. If the 95% confidence interval does not encompass the value 1.0, then this difference is statistically significant.

Royal Air Force (RAF). The Royal Air Force (RAF) is the aerial defence force of the UK.

Royal Marines (RM) Royal Marines are sea-going soldiers who are part of the Naval Service. RM officer ranks were aligned with those of the Army on 1 July 1999.

Royal Navy (RN) The sea-going defence forces of the UK but excludes the Royal Marines and the Royal Fleet Auxiliary Service (RFA).

Specialist mental health care clinicians are those that provide care at MOD Specialist Mental Health Services. These include; psychiatrists, psychologists, mental health nurses, mental health social workers and occupational therapists.

SSSFT, now MPFT, is the Midlands partnership Foundation Trust which heads up the consortium providing in-patient care through eight NHS trusts in the UK.

Strength is defined as the number of serving UK Armed Forces personnel.

Treated solely in primary care refers to those patients who have not been seen at a MOD DCMH in the 6 months before or the 9 months after being seen in primary care with a mental health related diagnosis.

UK Regulars are full time Service personnel, including Nursing Services, but excluding FTRS personnel, Gurkhas, Naval activated Reservists, mobilised Reservists, Military Provost Guarding Service (M P G S) and Non-Regular Permanent Service (NRPS). Unless otherwise stated, includes trained and untrained personnel.

Data, Definitions and Methods

Data Sources

Section 1 – All mental health seen in a military medical healthcare setting

All data has been sourced from MOD's patient electronic medical record (DMICP).

Section 2 – MOD Specialist Mental Health Services

Defence Statistics receive data from Department of Community Mental Health (DCMH) and in-patient providers for all UK regular Armed Forces personnel from the following sources:
For DCMH data:

- Between 01 January 2007 and 30 June 2014, the report captures data provided by DCMHs to Defence Statistics in monthly returns.
- For the period 01 April 2012 to 30 June 2014, new episodes of care data was also sourced from the electronic patient record held in Defence Medical Information Capability Program (DMICP) in addition to those provided by DCMH in monthly returns.
- Since 01 July 2014, DMICP was the single source of DCMH new episodes of care data.

For in-patient data:

- Since January 2007, SSSFT and Gilead IV hospital, Bielefeld have submitted relevant in-patient records.

Data Coverage

Section 1 – All mental health

This section includes all UK Armed Forces personnel, Regular and Reserves, who have a mental health related diagnosis code entered into their electronic medical record in any military healthcare setting, including primary care and specialist mental health care.

Mental health related diagnosis data entered into their electronic medical record is only available from April 2012. The data covers the period 1 April 2012 to 31 March 2025.

Mental health related diagnosis codes have been included if they sit within chapter V (Mental, Behavioural and Neurodevelopment disorders) of the International Statistical Classification of Diseases and Health-Related Disorders 10th edition (ICD-10). ICD-10 is the standard diagnostic tool for epidemiology, health management and clinical purposes. Some codes that fall outside of this chapter have been included in the analysis, these are signs and symptoms that can relate to mental health. These have been included on the recommendation of clinicians working within the MOD. The full list of codes included are presented in the Background Quality Report (BQR).

Section 2 – MOD Specialist Mental Health Services

The data in this section includes Regular UK Armed Forces personnel, Gurkhas, Military Provost Guard Staff, mobilised reservists and Full Time Reserve Service (Full Commitment) personnel as they have full entitlement to DCMH care. The data may also contain other Reservists (including non-mobilised and other FTRS status) as these individuals can be referred to a DCMH for an occupational opinion relating to their mental health problem.

DCMH staff record the initial mental health assessment during a patient's first appointment, based on presenting complaints. The information is provisional and final diagnoses may differ as some patients do not present the full range of symptoms, signs or clinical history during their first appointment.

A number of patients present to DCMH with symptoms that require the treatment skills of DCMH staff, whilst not necessarily having a specific and identifiable mental disorder. These cases are referred to as "assessed without a mental disorder".

Methodology

Section 1 – All mental health

It is not possible to identify and follow distinct episodes of care from first presentation to the GP through the care pathway due to the way data is collated in the electronic medical record and therefore a rate of those managed solely by their GP cannot be provided. A crude methodology has been used to enable exploratory analysis to identify patients treated solely in primary care for their mental health issue. This is those who have not been seen at a MOD DCMH in the 6 months before or the 9 months after being seen in primary care with a mental health related diagnosis.

Mental health related DMICP codes are used to identify UK Armed Forces personnel seen in any military healthcare setting for a mental health related reason. These codes are recorded in personnel's medical records by a primary care clinician and/or a specialist mental health clinician at a MOD DCMH and could be a continuation of mental health care as well as new episodes.

Section 2 – MOD Specialist Mental Health Services

DCMH are specialised psychiatric services based on community mental health teams closely located with primary care services at sites in the UK and abroad. All UK based and aero-medically evacuated Service personnel based overseas requiring in-patient admission are treated by one of eight NHS trusts in the UK which are part of a consortium headed by the Midlands partnership Foundation Trust (MPFT), was SSSFT; UK based Service personnel from British Forces Germany are treated at Gilead IV hospital, Bielefield under a contract with Soldiers, Sailors, Airmen and Families Association (SSAFA) through the Limited Liability Partnership. When presenting in-patient data in this report, the data include returns from both contract providers.

Due to the methodology changes implemented in July 2009 and in July 2013, when looking at trends over time for new episodes of care across the series of published reports, it is advisable to note:

- Prior to 2009/10, only an individual's first attendance at a DCMH or an in-patient provider were included in the data submitted by DCMHs to Defence Statistics.
- Since 2009/10, the report captures all new episodes of care provided by DCMH to Defence Statistics in monthly returns.
- Since 2012/13, the report captures all new episodes of care recorded in the MOD patient electronic record in addition to monthly submissions provided by DCMH to Defence Statistics.

Changes made to the methodology in July 2009 and July 2013 can be read in more detail in the Background Quality Report (BQR).

Rates

Rates enable comparisons between groups and over time, taking account of the number of personnel in a group (personnel at risk) at a particular point in time**. The number of events (i.e. mental disorders) is then divided by the number of personnel at risk per annum and multiplied by 1,000 to calculate the rate per 1,000 personnel at risk.**

Percentage

Previous publications of this report have provided rates alongside numbers to provide context and comparison between groups. This information is still available in the Excel file accompanying the release of this report, however, due to user feedback, this publication now provides a focus on the percentage of the population at risk. This is calculated in the same way as the rate per 1,000 but multiplying by 100 instead of 1000, i.e. **the number of events (for example mental disorders) is then divided by the number of personnel at risk per annum and multiplied by 100 to calculate the percentage of personnel affected.** The percentages presented have been rounded to one decimal place.

Confidence Intervals

Confidence Intervals use the standard error to derive a range in which we think the true value is likely to lie. It gives an indication of the degree of uncertainty of an estimate and helps to decide how precise a sample estimate is by giving a range of values likely to contain the given statistic. The wider the interval, the less precise the estimate is.

In order to calculate confidence intervals around an estimate we use the standard error for that estimate. The estimate and its 95% confidence interval are presented as: the estimate plus or minus the margin of error. The lower and upper 95% confidence limits are given by the sample estimate plus or minus 1.96 standard errors. The margin of error is calculated as:
Margin of error = 1.96 × standard error

In order to understand if a difference in rates is statistically significant, 95% confidence intervals are used. Statistical significance indicates that a finding is not due to chance. If a 95% confidence interval around a rate excludes the comparison value, then a statistical test for the difference between the two values would be significant at the 0.05 level. If two confidence intervals do not overlap, a comparable statistical test would indicate a statistically significant difference.

The information presented in this publication has been structured to release information into the public domain in a way that contributes to the MOD accountability to the British public, but which doesn't risk breaching individual's rights to medical confidentiality. In line with JSP 200 Statistics (April 2016), and in keeping with the Office for National Statistics Guidelines, all numbers less than five have been suppressed and presented as '~' to prevent the inadvertent disclosure of individual identities. Where there is only one cell in a row or column that is less than five, the next smallest number (or numbers where there are tied values) has also been suppressed so that numbers cannot simply be derived from totals.

Strengths and weaknesses of the data presented in this report

A key strength of this report is the presentation of the number of Service personnel who have been seen for a mental health related reason, as reported by clinicians. The inclusion in this report of data direct from the legal electronic patient record improves the robustness and integrity of the underlying data. As the data is held in a pseudo-anonymised format in the DMICP data warehouse, patient consent is not an issue. A further strength is the use of the pseudo-anonymised patient identifier to enable validation of data therefore improving accuracy and enabling linkage to deployment records to identify any effect of deployment on mental health in the UK Armed Forces. In addition, the tables in this report have been scrutinised to ensure individual identities have not been revealed inadvertently.

Mental disorder types reported here are the clinician's initial assessment during a patient's first appointment within military healthcare, based on presenting complaints, therefore final diagnosis may differ as some patients do not show full range of symptoms, signs or clinical history during their first appointment. It should also be noted that the clinician's primary diagnosis is reported here, however patients can present with more than one disorder. It is also not unusual for a patient to be given more than one diagnosis. For those seen in primary care, it was not possible to identify which disorders were the primary diagnosis and which were the comorbid conditions. Therefore, all diagnosis, regardless of whether it was the primary or comorbid condition, have been included in the all mental health analysis.

A further weakness with this data is that it is not currently possible to report those treated solely within primary care from those requiring specialist mental health services as it is not possible to identify and follow distinct episodes of care from first presentation to the GP through the care pathway due to the way data is collated in the electronic medical record.

Changes in methodology in 2009/10 and 2012/13 also make it difficult to compare data over time. In addition, DMICP is a live system and extracts for this report are taken six weeks after the end of the reporting period. Therefore, any amendments to records or late data entries may be excluded from this report.

More detailed information on the data, definitions and methods used to create this report can be found in the Background Quality Report (BQR).

References

a. Morris, S., Hill, S., Brugha, T., McManus, S. (Eds.), Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4. NHS England.

b. Sundin J., Jones N., Greenberg N., Rona R., Hotopf M., Wessely S., and Fear N. (2010) Mental Health among commando, airborne and other UK Infantry personnel Occupational Medicine, 60, 552-559.

c. Singleton N, Lewis G (2003). Better or Worse: A longitudinal study of the mental health of adults living in private households in Great Britain, *Her Majesty's Stationery Office (HMSO): London*.

d. Meltzer H, Singleton N, Lee A et al (2002). The social and economic circumstances of adults with mental disorders, *Her Majesty's Stationery Office (HMSO): London*.

e. Mental Health Bulletin, 2023-24 Annual report - NHS England Digital.

f. NHS Digital Mental Health Services Monthly Statistics

Further Information

Symbols

~ In line with JSP 200 (April 2016) to ensure individuals are not inadvertently identified suppression methodology has been applied to reduce the risk of disclosure, numbers fewer than five have been suppressed and presented as '~'. Where there was only one cell in a row or column that was fewer than five, the next smallest number has also been suppressed so that numbers cannot simply be derived from totals.

Revisions

There are no regular planned revisions of this bulletin. Amendments to figures for earlier years may be identified during the annual compilation of this bulletin. This will be addressed in one of two ways:

- Where the number of figures updated in a table is small, figures will be updated and those which have been revised will be identified with the symbol "r". An explanation for the revision will be given in the footnotes to the table.

- Where the number of figures updated in a table is substantial, the revisions to the table, together with the reason for the revisions, will be identified in the commentary at the beginning of the relevant chapter / section, and in the commentary above affected tables. Revisions will not be identified by the symbol "r" since where there are a large number of revisions in a table this could make them more difficult to read.

Occasionally updated figures will be provided to the editor during the course of the year. Since this bulletin is published electronically, it is possible to revise figures during the course of the year. However, to ensure continuity and consistency, figures will only be adjusted during the year where it is likely to substantially affect interpretation and use of the figures.

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Defence Statistics welcome feedback on our statistical products. If you have any comments or questions about this publication or about our statistics in general, you can contact us as follows:

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If you require information which is not available within this or other available publications, you may wish to submit a Request for Information under the Freedom of Information Act 2000 to the Ministry of Defence. For more information, refer to the FOI page on the gov.uk website.

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