ForcesWatch

# The Last Ambush?

## Aspects of mental health in the British armed forces

**ForcesWatch**

ForcesWatch scrutinises armed forces recruitment and proposes changes in policy that we believe will better serve the interests of young people. We raise public awareness of the issues and seek to hold the armed forces to account on their recruitment practices, especially those aimed at the youngest and most disadvantaged groups.

October 2013.

Published by ForcesWatch (forceswatch.net).

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Clarifications and corrections from interested parties are welcome via office@forceswatch.net.

Citation: Gee, D. (2013). *The Last Ambush? Aspects of mental health in the British armed forces* (London: ForcesWatch).

*Vince Bramley was a machine-gunner with 3 Parachute Regiment at the night-time battle of Mount Longdon in the Falklands War. He describes it as 'combat at very close quarters, hand to hand, eye to eye, very bloody stuff' and recalls the scene at the top of the mountain after the battle in the early hours of the morning:*

> *'It wasn't until daylight, when I ran into the bowl on the summit and saw the number of dead people there, including my own friends and colleagues, that the shock hit me. Nobody touched me, but it was as if somebody had punched me in the stomach. And I just went into a state of shock. …*
>
> *'I remember looking around at some of my friends who had survived as well and were in this bowl, and I hadn't realised until then that I wasn't the only one crying. And there were Argentines who had been taken prisoner, and they were crying as well. I think all of us were shocked at the extent of what we'd done to each other. And then you begin to realise you're not the rough, tough British paratrooper that the programme of training had made you out to be. You realise you're human, and you have human feelings, and that the men beside you are no different.'*[a]

# CONTENTS

# EXECUTIVE SUMMARY

*This report investigates some of the main mental health effects of a career in the British armed forces during the last decade. It explores how widespread these effect are, whom they affect most, and why. It finds that harmful levels of drinking, as well as violent behaviour after deployment, are serious problems in the armed forces. Compared with the general population and with current personnel, former personnel are markedly more affected by post-traumatic stress disorder, harmful drinking, common mental disorders (types of anxiety and depression), and self-harming behaviour. Pre-enlistment adversity, exposure to warfare at close quarters, and loss of social support after leaving the forces are among the most potent risk factors. While many people in the armed forces have good mental health, some face substantially greater risks than others. The youngest recruits from socio-economically disadvantaged backgrounds are the group most at risk.*

## Measuring mental health in the armed forces

Research of mental health in military groups has developed appreciably since the Vietnam War but the problems of accurately defining and reliably measuring the mental health effects of an armed forces career have yet to be addressed satisfactorily. The limitations of research methods lead to substantial under-reporting of psychological ill-health in military groups. Narrow definitions of mental health problems, the common absence of anonymity for participants in studies, and the unpredictability and complexity of veterans' reactions to traumatic stress, are all significant limitations on the reliability and validity of the available evidence base. Despite this, research contributes important insights into which groups within a military population are most affected and why. [See page 12.]

Most of the quantitative research in the UK is directly funded by the Ministry of Defence, which has increased its contribution to this work in the last decade. This development, while welcome, also constrains the scope of the research: the Ministry of Defence is able to determine, through funding decisions, which research questions are investigated. [See page 16.]

Noting these limitations, this report draws on the available research of six indicators of mental health pathology in order to investigate the relative risks for different groups within the armed forces and with comparison to the general population. These indicators are: post-traumatic stress disorder (PTSD), common mental disorders (types of depression and anxiety), alcohol misuse ('harmful' levels of drinking), violent behaviour after deployment, self-harm, and suicide. [See page 18.] The evidence base is comprised of 41 quantitative British studies that have researched relevant aspects of the six mental health-related outcomes discussed in this report.[1-41] These sources are supplemented by the findings of 10 US quantitative studies[42-51] and around 100 further published sources, as well as informal interviews with veterans. [See page 59.]

## Prevalence

Although not all veterans are severely affected, a military career carries significant mental health risks, particularly at times of war when substantial numbers of psychiatric casualties are usual. Research from the last decade shows that certain mental health-related problems in the armed forces, particularly harmful alcohol use and post-deployment violent behaviour, are a serious problem. Those who have left the forces during the last decade show markedly higher rates of a number of mental health-related problems, particularly PTSD and harmful levels of drinking.

In the armed forces, harmful drinking has been found to be more than **twice** as common as in the general population (**13.0%** vs. **5.4%**); the problem is more common among deployed than non-deployed personnel. Studies have found the prevalence of PTSD among personnel deployed to Iraq and/or Afghanistan to be about **20% higher** than in the general population (**3.2%** vs. **2.7%**), whereas among those not yet deployed it was found to be **about the same** (**2.8%** vs. **2.7%**). The rate of common mental disorders in the armed forces as a whole has been shown to be about **30% higher** than in the general population (**19.7%** vs. **15.0%**), but the prevalence of self-reported self-harm has been approximately **50% lower** (**4.2%** vs. **8.0%**), as has the long-term incidence of suicide. [For sources and detail, see page 18 and also Figure 4 on page 25].

Among personnel who have left the forces in the last decade, the prevalence of PTSD, alcohol misuse, common mental disorders and self-harm is appreciably higher in each case than that found in either current armed forces personnel or the general population. Compared with the general population, studies of ex-armed forces personnel have found that PTSD (for those deployed to Iraq and/or Afghanistan) and alcohol misuse are both **more than three times** as common (Alcohol: **16.8%** vs. **5.4%**; PTSD: **9.2%** vs. **2.7%**); prevalence of common mental disorders has been found to be about **90% higher** (**28.3%** vs. **15.0%**); and self-harming behaviour approximately **30% higher** (**10.5%** vs. **8.0%**). The long-term incidence of suicide among ex-forces personnel is about **the same** as that found in the general population. [For sources and detail, see page 18 and also Figure 4 on page 25].

Although veterans are less likely overall to have a criminal record, lifetime offences of a violent nature are more common than in the general population (**11.0%** vs. **8.7%**). One study found that the rate of violent offending among Iraq and Afghanistan War veterans after they returned from their deployment was **twice** what it was before they enlisted. The rate of self-reported post-deployment violent behaviour is also high; one study found that **12.6%** of Iraq War veterans reported having behaved violently towards family members or others within weeks of returning from their tour of duty. [See page 21 for sources and detail].

The studies show a high degree of co-morbidity (symptoms of more than one problem at once), with strong associations found between the six mental health-related problems investigated in this report. For example, personnel screening positive for PTSD were found to be approximately **four times** as likely to report homecoming violent behaviour as those without such symptoms, [32]b about **three times** as likely to have committed a violent offence after deployment, [36]c and nearly **eight times** as likely to report a history of self-harming behaviour. [29]d [See page 23 for sources and detail.]

## Risk factors

Pre-military, military, and post-military factors all strongly affect the risks personnel face; consequently, distribution of mental health problems is highly uneven.

Principal pre-military risk factors are youth and factors associated with a socio-economic disadvantage such as a background of childhood adversity, a history of anti-social behaviour and/or under-achievement in school.

Youth and childhood adversity both predispose vulnerability to trauma. Iraq War veterans in the youngest age group have been found to be about **twice** as likely to screen positive for PTSD as those in the oldest (**5.7%** vs. **2.6%**). Although young age is associated with higher prevalence of mental health problems in the general population, the limited comparable data available show that young armed forces personnel are more affected than their civilian counterparts. For example, when comparing the youngest age groups in the armed forces and general population, harmful levels of drinking were around **three times** as common in the military group (**26.1%** vs. **8.4%**) and, after leaving the forces, the long-term suicide rate has been **between two and three times** as high. Elevated rates of mental health-related problems are also found in personnel who under-achieved at school, have a history of anti-social behaviour or had a troubled home life as a child. Proportionally nearly **four times** as many personnel with the highest levels of adversity in their childhood background were screening positive for PTSD as were those without such a background (**7.2%** vs. **1.9%**) and the disorder was more than **twice** as prevalent among those without GCSEs as among personnel who had A Levels (**8.4%** vs. **3.3%**). [See page 26 for sources and detail.]

Military factors affecting mental health risk include the stigmatisation of mental health problems, quality of leadership, in-unit social support, and the degree of control personnel experience over their own situation. Structural factors, such as rank and branch also matter. Problems are much less prevalent in the RAF and Navy than they are in the Army, for example: studies have found a **4.8%** rate of PTSD in the Army, vs. **2.8%** in the Navy and **2.5%** in the RAF; **6%** of the Army's deployed Infantry troops screened positive for PTSD. The most potent risk factor for the onset of mental health-related problems is the intensity and duration of a person's exposure to warfare when deployed. Of personnel deployed in a combat role to Iraq and/or Afghanistan, the rate of alcohol misuse was found to be **22.5%**, which compares with **14.2%** among troops in support roles and is about **four times** the **5.4%** rate found in the general population. Rates of PTSD and post-deployment violence have both been found to increase in proportion to the number of traumatic events a combatant has experienced. [For sources and detail, see page 30 and Table 3 on page 34.]

Risk factors affecting veterans after leaving the armed forces include social exclusion, negative life events and lack of social support. For example, a study of current and former armed forces personnel found that those who said they had few or no friends were **up to three times** as likely, and those with family problems **up to 2.5 times** as likely, to report self-harming behaviour as were veterans with access to good social support. Although exposure to combat is the most potent trigger of trauma-related mental health problems in general, the most important factor in their persistence is the loss of social support after leaving the forces. [See page 39 for sources and detail.]

Women remain a minority group in the armed forces (**9.8%**) and the factors impinging on their mental health are complex. In civilian life, women are more likely than men to screen positive for PTSD and common mental disorders but this difference is less pronounced in the armed forces. In common with the general population, in the armed forces fewer women than men drink heavily; even so, women in the military drink substantially more heavily than their civilian counterparts. Potential sources of traumatic stress for women in the armed forces include the behaviour of male peers; a 2006 study found that **20%** of women of low rank reported a 'particularly upsetting' experience of unwanted sexual behaviour directed at them from a colleague in the previous 12 months. [See page 32 for sources and detail.]

## High- and low-risk groups

Personnel to whom few of the major risk factors apply are likely to have good mental health and better than that found in the general population on average. Indeed, far from all veterans are significantly affected by mental health problems. Those to whom a number of risk factors apply – whether pre-military, military (especially

exposure to warfare) or post-military – are much more likely to suffer from a serious mental health effect of their military career. In particular, mental health problems in the armed forces are concentrated among those who have been most exposed to war stress and/or who carry the pre-traumatic vulnerabilities associated with a socio-economically disadvantaged background.

Higher- and lower-risk career pathways largely depend on the socio-economic status of personnel at the point of recruitment. The youngest personnel from the most disadvantaged backgrounds are: more vulnerable to trauma; more likely to be in a close-combat role and exposed to traumatic stress when deployed; and then less likely to be able to draw on the social support they need to manage a mental health problem after leaving the forces. This group is therefore disadvantaged before, during and after their military career in terms of the mental health risks they face. Infantry personnel, who are typically enlisted at younger ages from disadvantaged backgrounds and are most exposed to war zone trauma, carry a high concentration of these risk factors. [See Figure 6 on page 46 and page 56.]

It is impossible to know with certainty whether recruits from disadvantaged backgrounds would have fared better or worse had they not chosen to enlist, although there is evidence that a military career at a time of war exacerbates rather than ameliorates the effects that pre-existing disadvantage has on mental health. Research on PTSD, for example, shows that exposure to traumatic stress is particularly harmful to individuals who have certain psychological vulnerabilities associated with a socio-economically disadvantaged background. One complex study of British personnel found that PTSD and common mental disorders are more prevalent among combat-exposed personnel whether or not they had pre-existing disorders, but that those who did were most affected. Other studies have shown that although pre-enlistment factors partly account for elevated rates of PTSD and post-deployment violent behaviour, more important are post-enlistment factors, especially combat exposure. [See pages 22, 26 and following.]

## Recommendation: Review policy of recruiting from age 16

The report highlights a particular concern for the youngest recruits, who can enlist from age 16 and may be as young as 15 when they first apply. This group is unlikely to be aware of the mental health risks of their prospective career, unlikely to be told of them, and unlikely to be able consider seriously their real-life implications at that age. The youngest recruits are also heavily over-represented in roles most exposed to the risk of traumatic stress once they are deployed to war from age 18. In the last five years the Infantry, which is just **14%** of the armed forces but has suffered by far the highest fatality rate in Afghanistan, accounted for **31.7%** of all new armed forces recruits aged 16 or 17 (versus **24.1%** of all adult recruits). This and other evidence gathered in this report points strongly to the conclusion that those who enlist youngest face the highest mental health risks.

The report calls for the policy of recruiting from age 16 to be reviewed so that the greatest burden of risk is not left to the youngest, most vulnerable recruits to shoulder. Raising the minimum age of recruitment to 18 would ensure that recruits share the risks more equally and that they accept them at the age of adult responsibility. [See page 47 and page 57].