

UK extended Medical Assessment Programme for ex-service personnel: the first 150 individuals seen

Ian P. Palmer¹

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¹The Baird Medical Centre, Gassiot House, St Thomas' Hospital, London

Correspondence to Ian Palmer (ianpalmer@doctors.org.uk)

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Aims and method To describe an interim service set up to examine the breadth of UK ex-service personnel's concerns in relation to their mental health and military service and provide a record of the first 150 individuals assessed following conformation of military service and examination of all available military and civilian medical records.

Results The majority of attendees were White male ex-soldiers. Average age, service and time to assessment were 44.5, 15.8 and 11.7 years respectively. Two-thirds were receiving help from the National Health Service and ex-service non-governmental organisations. Rates of post-traumatic stress disorder were similar to previous UK studies. Obsessional symptoms were of relevance to the clinical presentation in a third. Fabrication and/or exaggeration occurred in about 10%.

Clinical implications The spread of diagnoses and delay in help-seeking are similar to civilians. The link between mental disorders and military service is seldom straightforward and fabrication or exaggeration is difficult for civilians to recognise. Verification and contextualisation of service using contemporaneous service medical records is important given the possible occupational origin of mental health conditions.

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Each nation has a unique relationship with its armed forces. In Britain the relationship has never been straightforward and even today continues to influence how veterans are viewed.^{1,2} The term 'veteran' is defined differently by different nations.³ The UK government has opted for a socially inclusive designation whereby a UK veteran has to have served 1 paid day alone; thus even those who do not complete basic training are included. The US military has a large body of research on veterans, but caution is required in interpretation and its lessons may not be transferable to the UK.^{4,5} Currently, UK veterans are 'thought' to number 3.8 million, a figure expected to decline by over 50% by 2027 through death of veterans over 65.⁶ Approximately 20 000 individuals leave UK armed forces annually, around 5000 from the untrained staff. Roughly 2000 receive medical discharges, of which about 150 are for mental illness, including about 20 for post-traumatic stress disorder (PTSD).⁷ The term 'veteran' is value-laden with personal, social, cultural, spiritual, financial, legal and political dimensions and ageist overtones. It is disliked by many ex-service personnel. I shall therefore use the term ex-service person/personnel (ESP) in this paper.

Few pause to consider potential bias in popular media and literary narratives that inform civilian understanding of

the military world.⁸ In addition to current psychological fashions and paradigms, professional understanding of mental health problems in ESP is also shaped by sources which may fuel media speculation about the inevitability of psychological damage in soldiers returning from operations,^{9–11} despite clear evidence that the majority of UK military personnel, although enduring arduous operational duties, neither develop psychiatric injuries¹² nor are more prone to violent crime resulting in a custodial sentence.¹³ Some do, however, develop mental health or behavioural problems such as alcohol misuse, risk-taking and depression as well as experiencing social exclusion.^{14,15}

To add to our knowledge of the physical or mental health of this heterogeneous population, the government set up six National Health Service (NHS) pilot sites; created the Reserves Mental Health Programme (RMHP); developed an interim extension of the Medical Assessment Programme (MAP); extended priority NHS treatment for ESP; and highlighted mental health issues of serving, reserve and ex-service personnel in its publications *New Horizons*¹⁶ and *NHS Choices*.⁷ The Health and Social Care Advisory Service (HASCAS) estimated that, on the basis of discharge rates from the armed forces, a general practitioner (GP) is likely to see one new ESP with a mental health problem every 3 to

7 years;¹⁶ the evaluation of the six Community Mental Health Pilots for Veterans of the Armed Forces is available online.¹⁷

Since 1993, the MAP has been a free national service aiming to provide a 'foundation for developing research questions and hypotheses' through clinical assessment.¹⁸ It has always been the role of the MAP to add detail to the epidemiology. Until 2006, the MAP was staffed by consultant physicians who sent individuals identified with possible mental health problems elsewhere for assessment. Telephone advice and guidance has always been available free of charge. The MAP offers a mental health assessment and a pledge to 'listen' actively to ESP who believe their mental health problems may have been affected by military service since 1982, to get a better understanding of their needs, demography and any relationship with service. Ex-service personnel have become a politicised group and a number of them had involved their Member of Parliament in their plight. Assessments are currently undertaken by an ex-military consultant psychiatrist. The service is unique, in that there are no constraints, other than physical, on the duration of the consultation, in an attempt to understand the breadth of ESP narratives which can span the personal, social, political, spiritual and even philosophical domains.¹⁹

Method

This paper is a descriptive clinic-based study of the first 150 British military ESP from 1982 who believed their mental health problems may have been attributable to operational military service. They represent ESP seeking help for an identified need. Access to the service is limited to UK veterans. Proof of service is sought from the appropriate manning and records services in all cases. Referral is through a health professional alone and in all cases the individual's GP is involved; there is no self-referral. All ESP contacting the MAP were asked to get their GP to refer them. All military and NHS medical records were obtained and reviewed before consultation. All individuals were offered a consultation without constraint of time by an experienced ex-military clinician. Partners/carers were encouraged to attend. Physical conditions encountered had already been competently examined, investigated and treated by the GP. The same report was sent to the individual and their GP and included the appropriate ICD-10 diagnoses based on the history alone. For the past 12 years the same anonymous exit questionnaire has been given at completion of the consultation about the users' experience.

At the time of writing this paper, there have been three studies of UK ex-service personnel by the 'King's group' at King's Centre for Military Health Research, King's College London.^{14,15,20} Unlike the self-selecting MAP cohort, these studies have the benefit of being random samples on defined cohorts. Where there are data from the King's 2005 study¹⁴ they are included for interest and comparison in the tables.

Since 1993, all MAP attendees have been asked to give written consent to their anonymised data being used in research for the benefit of other veterans. No individual veteran can be identified from data in this paper and none declined to give written consent. Although the MAP has been funded by the UK Ministry of Defence since 1993, it is

an independent service and not part of the UK Defence Medical Services (DMS). All records are held separate from any Ministry of Defence, DMS or NHS service and conform to the Data Protection Act.

Results

Telephone and email contact with the service increased 95% over the period of 18 months, unrelated to the 150 cases. Enquiries and advice were sought by ESP, their friends and families, GPs, mental health professionals, researchers and non-governmental organisations (NGOs). As individuals came from across the UK, the average consultation lasted 2.9 h, attempted in one setting. Each consultation required an average administration time of 3.7 h (total 6.6 h). The response rate to the anonymous exit questionnaire was 95%. Response was diminished when forms were taken home to complete. Almost all service users (99%) stated that their concerns had been addressed to their satisfaction during the consultation. When individuals were contacted by letter and invited to update the MAP about their situation 6 months after attendance, the response rate was in the order of 15%, which was still better than an earlier response rate from GPs for information on attendees' progress (~10%). A random selection of 15% of the cases was reviewed with colleagues and discussion confirmed the diagnostic categories in those cases studied. The individuals seen did not require extensive telephone contact with GP or other agencies, which may relate to the time taken to identify their concerns and the provision of a formulation for both ESP and GP.

General demographics

The sample was predominately White male (97%), average age 45 years, of whom 62% were in a stable relationship (Table 1). Over half were employed (52%) and in contact with service charities (51%); 55% had a war pension. An equal number had either no or higher qualifications (25%). Nearly a third (27%) had contact with civil or military criminal justice systems, of which 53% were in combat arms (infantry, armour) and 3% (5/150) in prison. Of the 80% with alcohol misuse, a quarter had resulting problems in relationships (24%) and problems with the law (23%). Further, 20% of the sample had self-harmed, 97% had mental health problems with or without physical health problems, and 3% had physical health problems alone. The time from discharge to assessment was on average 12 years. Only a third had not sought help for their problems before the referral. Two-thirds were receiving help from primary or secondary care services and/or ex-service NGOs, for example Combat Stress. About 45% of those had seen a psychiatrist and 26% a clinical psychologist; 54% had received antidepressants and 24% cognitive-behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR). The majority (65%) had received two or more psychiatric diagnoses, of which 42% were unrelated to service; in only 20% was the link unequivocal. About one in five individuals had unequivocal record of involvement with military mental health services before discharge, of whom 67% had received NHS follow-up.

	MAP, n = 150 n (%)	King's group study, ¹⁴ n = 315, %
Gender		
Male	145 (97)	87
Female	5 (3)	12
Mean age, years	45	39
Mean time from leaving service, years	12	
Marital status		
Married	70 (47)	52
Partnership	23 (15)	9
Separated/divorced	24 (15)	23
Single	33 (23)	16
Employment status		
Employed	78 (52)	84
Unemployed	67 (45)	16
Retired/other	5 (3)	
Qualifications		
High	37 (25)	18
None	34 (23)	
Military mental health input	27 (19)	8
Subsequent NHS follow-up	Corroborated 18 (67)	Uncorroborated
Current mental health input (n=150)	89 (59)	58
Psychiatrist	65 (43)	29
Clinical psychologist	38 (25)	8
Treatment offered		
Antidepressants	78 (52)	70
CBT/EMDR	35 (23)	4
Ex-service NGO involvement	77 (51)	28
War pension	82 (55)	
Criminal justice system involvement	41 (27)	
Civilian record alone	25 (61)	
Combat arms (army)	23 (53)	
In prison	5 (12)	
Alcohol misuse	120 (80)	
And problems with criminal justice system	27 (23)	
And problems in relationships	29 (24)	
Self-harm	30 (20)	
Number of diagnoses of psychiatric disorder		
1	53 (35)	
≥2	97 (65)	'Many'

CBT, cognitive-behavioural therapy; EMDR, eye movement desensitisation and reprocessing; MAP, Medical Assessment Programme; NGO, non-governmental organisation; NHS, National Health Service.

Military demographics

Of the 150 MAP service users, 87% were army; half (55%) were non-commissioned officers, a third were enlisted ranks (35%) and 10% were officers (Table 2). The majority had left voluntarily (63%) after an average service of 15.8 years. With regard to operational experience, 11% had never deployed operationally, but 32% had deployed three or more times. Whereas 38% of the operations were combat operations, 62% were operations other than war (e.g. peacemaking, peacekeeping, humanitarian aid, aid to the civil powers).

	MAP, n = 150 n (%)	King's group study, ¹⁴ n = 315, %
Service		
Army	130 (87)	79
Royal Navy/Marines	8 (6)	6
RAF	12 (8)	12
Rank on exit		
Officer	15 (10)	13
NCO (senior and junior)	82 (55)	65
Other ranks	53 (35)	22
Mode of exit		
Voluntary	94 (63)	
Involuntary	56 (37)	
Average length of service, years	16	14
Operational deployments		
Nil	17 (11)	11
1-2	85 (57)	89
≥3	48 (32)	
Types of operations (n=191)		
Combat operations	73 (38)	
Operations other than war ^a	118 (62)	
Theatres of operations		
Iraq (all operations)	95	83
Northern Ireland	82	
Balkans	69	32
Falklands conflict	25	
Afghanistan	8	
Others	31	
Operational exposure (n = 133)		
Direct combat and related action	21 (16)	
Violent action short of combat	27 (20)	
Witness to comrade's death or corpse	38 (29)	
Injury/illness on operations	19 (14)	
Trade (n = 130)		
Combat and combat support arms ^b	89 (69)	
Combat service support arms ^c	41 (32)	

NCO, non-commissioned officer; RAF, Royal Air Force.

a. Peacemaking, peacekeeping, humanitarian aid, aid to the civil powers.

b. Infantry, armour, signals, engineers, air corps, intelligence, medics.

c. Logistics, electrical and mechanical engineers, administration, medical, etc.

Iraq, Northern Ireland, the Balkans and the Falklands were the most frequent operational theatres, and 5% of the sample had been to Afghanistan. Of the 133 individuals who had been involved in various operations, 16% had been involved in direct combat and 20% in violent action short of combat; 29% witnessed the death or the body of a comrade and 14% had been unwell or injured on operations.

Diagnoses

Most attendees had two or more diagnoses (Table 1). Nearly half the diagnoses were anxiety based (48%) and a fifth were related to alcohol or substance misuse (19%) (Table 3). About 15% of the diagnoses were of PTSD, of which 89% had a comorbid diagnosis: 48% depression, 40% alcohol misuse/

dependency, 13% obsessive–compulsive disorder (OCD). Approximately 11% had OCD alone, of whom 38% had depression, 28% alcohol misuse and 16% comorbid PTSD. Finally, 38% (9/24) of the personality disorders were anankastic. Obsessional traits, particularly rumination, were of relevance to the clinical presentation in up to 30% of the cohort and were coded under *Z* in the table. A number of individuals had histories suggestive of dyslexia. Psychotic and organic disorders were uncommon.

Discussion

This is a clinic-based study on a self-selecting group of ESP seeking help. It adds detail to the first examination of a random cohort of British ex-service Gulf War ESP from the First Gulf War by Iversen *et al* in 2005 (the King's group study).¹⁴ Attendees of MAP received a face-to-face interview, without constraint of time, from an experienced military psychiatrist after prior scrutiny of civilian and military medical records. In contrast, the King's study was a structured phone interview by civilian research staff supported by serving military medical personnel.

The demographic details give a clearer picture of the sort of ESP seeking help through the NHS. Despite the army being half of UK armed forces, 87% of the MAP users were ex-soldiers. The mode of exit and length of service give valuable information as to resilience as well as personality difficulties. The theatres, types and tempo of operations

change with time. In a few years it is unlikely that any British soldiers will not have deployed to both Iraq and Afghanistan. Even on current operations, although not every soldier engages in combat action, they may witness the injury, death or dead body of a colleague. Only a minority of the MAP patients were injured on operations, but this may change with time. The majority of those in trouble with civil or military criminal justice systems were from the army, particularly those in combat arms. Alcohol misuse remains a common issue for serving and ex-serving soldiers. In this sample, ESP engaged with health services – nearly half had seen a psychiatrist or clinical psychologist and an increasing number received psychotherapy. Attributions of a clear link between military service and subsequent mental disorder are problematic.²¹ Consultations revealed high levels of negative stereotyping of civilian health practitioners and services.

The MAP sample reflected the 2005 King's study in age, marital status, service, rank on exit, average length of service, number of operational tours and being in receipt of mental health input. In terms of diagnoses both cohorts were similar: most had more than one diagnosis²² and the majority had not been seen by a mental health professional before leaving service. The diagnostic rates of PTSD were similar to both the King's and previous MAP studies.²³ Unlike the King's 2005 cohort, however, diagnoses were more commonly neurotic, stress-related and somatoform disorders (ICD-10 F4) rather than mood disorders (ICD-10 F3). Substance misuse and obsessive–compulsive symptoms were common. Personality difficulties and/or disorders were not uncommon and seldom mentioned by referrers. More MAP attendees had been in contact with defence psychiatric services before leaving; more had received CBT; more were unemployed and more were in contact with service charities, as one might expect. Fewer women attended the MAP and fewer individuals had received antidepressants.

This is a continuous sample, unlikely to be representative of the whole UK ESP population, although likely to reflect those already seeking help from the NHS, including the UK pilot sites, and the ex-service NGO Combat Stress. It includes those seeking compensation or other benefits. It is likely to have missed those who isolate themselves from society, those who feel ashamed at their condition, those who preclude themselves from attending out of pride or who minimise their difficulties. Socially excluded ESP, those without GPs, those unable to travel to London, those who do not want to be seen by a government service, those who do not want their service record to be scrutinised, those with paranoia and those with 'difficult' personalities may all be missed. The MAP has been used to identify areas for further research and hypotheses. There was no specific design as the extension was not a scientific study, rather an information-gathering exercise. The use of psychometrics and diagnostic instruments would be desirable in future and would improve diagnostic reliability, but extra time would have to be factored in and repeat appointments funded. Screening measures could be sent by post in advance of assessment, which is now being trialled. A measure of personality would be particularly helpful and exploration into obsessive–compulsive spectrum symptoms would seem to be warranted. Although subject to all the usual caveats in

	MAP, <i>n</i> = 305 <i>n</i> (%)	King's group study, ¹⁴ <i>n</i> = 313 (%)
Organic (F0)	2 (0.7)	
Psychoactive substance use (F1)		
Misuse	33 (11)	
Dependency	15 (5)	37 (12)
Substances	11 (4)	
Schizophrenia, schizotypal and delusional disorders (F2)	4 (1)	
Mood (affective) disorders (F3)		
Bipolar affective disorder	6 (2)	
Depressive-spectrum disorders	44 (14)	167 (53)
Neurotic, stress-related and somatoform disorders (F4)		
PTSD	147 (48)	18 (18)
Obsessive–compulsive disorder	45 (15)	51 (16)
Somatoform disorders	32 (11)	
9 (3)		
Non-organic sleep disorders (F51)	8 (3)	
Disorders of adult personality and behaviour (F6)		
Anankastic	24 (8)	
9 (3)		
Disorders of psychological development (F8)	7 (2)	
Factors influencing health status and contact with health services (Z73) (<i>n</i> = 150)	45 (15)	

PTSD, post-traumatic stress disorder.

regard to clinical evaluation, unlike usual consultations, on average 3 h was spent with individuals after all service and NHS medical records were read. This allowed a wide-ranging discussion and evaluation of needs. Unfortunately, a non-responder bias analysis for either exit questionnaire or 6-monthly follow-up was not undertaken.

Issues unique to ex-service personnel's narratives

There are over 140 trades in the British Army and, in most armed forces, an individual's job is integral to their identity. It is therefore important to contextualise ESP narratives. Different trades put different individuals and groups into differing brackets of risk. Each operational theatre provides unique physical and psychological threats, which vary across the geographical area of an operation and change with time. Those most frequently in dangerous situations are the combat arms and combat service arms. These are the infantry soldiers, tank crews and their direct supporting arms such as artillery, medics, signallers, engineers and air support at 'the sharp end'. They are serviced by combat service support arms that include logistics, administrative, transport, electrical and mechanical engineers. The combat arms form about 25% of the army but less in the Royal Navy and the Royal Air Force (RAF). Although members of UK armed forces are frequently 'in harm's way', only a minority 'close with the enemy'. In this cohort, of those who had had operational exposure, 16% had been in direct combat-related action and 20% in violent action short of combat. Nearly a third (29%) reported witnessing the death or the corpse of a comrade.

It is believed by most in the ex-service community that most individuals serve their time, are proud of their service and leave in good health. The social structure of military service acts as a potent 'container' of individuals with difficulties.²⁴ In situations when this internal, horizontal and vertical support structure fails or is lost on leaving, individuals may have problems. Some end up in civil or military criminal justice systems, some in civilian and/or defence medical services. The mode of exit from UK armed forces can give valuable information about an individual's relationship with the military: 37% of the MAP cohort was involuntarily separated from service, not necessarily against their will. Involuntary separation means discharge on either medical or administrative grounds. Administrative discharge includes imposed redundancy, compassion, poor work, criminality, other disciplinary reasons and behavioural problems. Only 3% of MAP users were assessed in prison, which reflects the Defence Analytic Services and Advice (DASA) statistics,¹³ and about a third reported involvement with civil and/or military criminal justice systems.

Medical discharge only occurs after a full occupational medical assessment and medical board. Some conditions may not be serious, although they may interfere with an individual's ability to undertake their workplace duties, but are likely to improve on exit, yet others will be severe and enduring. It is important that those individuals entitled receive their due. In this study, 55% of the MAP cohort were in receipt of a war pension. Those medically discharged are entitled to financial recompense when their condition is 'attributable to service', some of which may be exempt of tax, and medications for the condition are free.

Obsessive-compulsive symptoms

The important finding for those involved in assessing and treating serving and ex-serving personnel is the frequency of obsessive-compulsive symptoms and personality traits in these populations which, to date, seem to have been underexplored. Slater²⁵ noted that obsessional neurosis in soldiers seemed to be more closely associated with pre-existent personality traits than most other neurotic disorders. Of occupationally successful submariners in the US Navy cohort, 9% met criteria for obsessive-compulsive personality disorder,²⁶ and one study found that officers may be more likely to possess obsessional 'features' than other ranks.²⁷ In another study, obsessive-compulsive, depressive and anxiety symptoms were more common in a cohort of Chinese officers over 30 years of age.²⁸

The lifetime prevalence of OCD in the general population is about 2%,²⁹ whereas a study of inductees into the Israeli Army revealed a point prevalence of 3.6% for OCD.³⁰ No figures exist for the UK military. Most recruits join in late adolescence when obsessional symptoms, although common,³¹ may not be precursors of OCD.³² Those attendees of MAP who enlisted at age 16 or 17 were no more likely to have obsessive-compulsive symptoms than attendees who joined at a later age. Currently, there is a debate as to how to conceptualise and classify this spectrum of symptoms.³³ Although it has long been accepted that obsessive symptoms may be triggered by traumatic events in childhood and adulthood, or exacerbated by a mental disorder,^{34,35} there is increasing cognitive psychological interest in the direction of the relationship.³⁶⁻³⁹ It is well known that obsessional symptoms may be part of other mental disorders such as depression, but it became increasingly clear in this cohort that obsessional personality traits and accompanying symptoms were independent of the mental disorder and particularly prominent in those who had problems readjusting to civilian life. Rumination was of particular relevance to the clinical presentation in up to 30% of the MAP cohort and the rate of anankastic personality disorder was similar to a cohort of combat veterans with both PTSD and depression.⁴⁰ The relationship between PTSD, obsessional personalities and symptoms in serving and ex-service personnel is complicated.^{41,42} In the MAP cohort, 16% of those with OCD had comorbid PTSD. Rumination needs to be distinguished from intrusive re-experiencing thoughts and when they coexist treatment can be difficult.⁴³ Guilt, shame and remembrance of dead comrades were common ruminative themes in MAP attendees.

Obsessionality and service

All those who have served understand how success in the military requires acculturation to a society which has clear supra-ordinate goals, where hard work, trust, mutual support, interdependency and integrity matter and attention to detail can be the difference between life and death for peers, superiors and subordinates. All military forces therefore require certain levels of obsessionality to achieve their mission. Practically, those with obsessional traits would appear to form a 'good fit' with the military structure and organisation that provides them with

unambiguous and transparent structure, routine, job descriptions, roles, measures of success and paths to advancement. Obsessional traits are particularly welcomed in logistics, engineering, administration, bomb disposal, accountancy, information technology, military police, intelligence collation, etc. At this time, it is a moot point whether some individuals are attracted, by dint of temperament, to such a life. Obsessive cognitions may be 'introceptive', in that obsessional rituals sooth internal anxieties, or 'extroceptive', where the hierarchical construction of an organisation, in this case the military, soothes the individual who feels safe in it and who may be keen that others 'conform' to likewise benefit.

As found in this study, MAP attendees' histories reveal that, years after leaving service, some individuals continued to ruminate over issues of guilt and/or shame at real or imagined sins of omission or commission and of not wanting to 'let the side down'. Remembering was a key issue for many who seemed to be 'unable to let go' of events for fear of forgetting, as opposed to intrusively remembering. One can imagine how those with obsessional patterns of thinking are more likely to be troubled by the nature of some military tasks, the context in which such tasks were accomplished and, for some, the existential dimension of such tasks.

Obsessionality and readjustment to civilian life

Personal clinical experience over 30 years and MAP attendees' histories reveal that those with obsessive-compulsive traits are often rapidly promoted to positions of increasing responsibility. For some this can lead to increasingly unmanageable stress with the resultant belief they have become 'unfit for purpose'. Some individuals, rather than seeking help in service, choose to 'do the right thing' and leave service prematurely (premature voluntary redundancy). On leaving, although those with obsessive-compulsive symptoms may find a job with an introceptive component, they are unlikely to find the same extroceptive organisational structure even in the police, prison, fire service, civil services or the like.

Observers, mainly civilian, talk of 'institutionalisation', implying that the military imposes its values, mores and working practices on (presumably) passive individuals, ignoring the raft of interactive social psychological processes and benefits involved in enlistment and acculturation⁴⁴ as well as extensive help and advice available to every individual who runs into problems whether in service or after they have left. Although it is believed that the majority of ESP transit to civilian life without difficulty, every soldier who has acculturated to service will feel the 'loss' of family on leaving; those with obsessive-compulsive symptoms may perhaps feel this loss more keenly.

This unique study highlights the frequency of obsessive-compulsive symptoms in the ESP population seeking help and the complicated relationship of obsessive-compulsive symptoms with post-service mental ill health. It would seem important to look for details of obsessive-compulsive symptoms in those who experience difficulty readjusting to civilian life, have problems engaging with services or fail to benefit from psychological interventions. Dyslexia, educational and literacy issues, particularly in

soldiers, may add to the burden of readjustment and an individual's ability to benefit from written material given to all before discharge from the services.

Recommended treatments

The psychopathology of the MAP cohort was complicated and reflected the frequency of childhood adversity known to exist in this population.⁴⁵ Further NHS mental health service assessment and/or treatment was recommended in 86% of cases of which 57% were for CBT; 21% individuals required further medical assessment.

Criminal justice system

Of those who had been involved with the criminal justice system, 90% were in the army and of those 41% were infantry. Five individuals were assessed in prison and although there is no excess of violent crimes by ESP in prison, sexual offences are more common.¹³ Additionally, 20% of the MAP cohort had self-harmed at some point.

Help-seeking

Despite the barriers,^{46–48} serving personnel's help-seeking and treatment seem similar to the general population.²⁰ The average time from leaving service to MAP attendance was 12 years, similar to civilians.⁴⁹ Engagement with service was hampered for some by real or imagined guilt or shame at acts of omission or commission and remembrance of dead comrades. The average age of MAP cohort was 45 years, which suggests accepting the need for help may improve with age.⁵⁰ All military medical records were available and 19% of the cohort had a record of in-service mental health involvement, 67% of whom had subsequent NHS follow-up.

Attribution

For hundreds of years British forces have undertaken war fighting and operations other than war. About 30% of the British army are combat arms (infantry, armour, artillery). Combat support arms work directly with combat troops, for example signallers, engineers and medics, and combat service support arms sustain them all. The threat differs with each type of operation, location, trade and the phase of the operation. Popular misconceptions about mental breakdown on war fighting operations exist.⁵¹ Only about a third of attendees were directly involved in combat and/or violent action. About 1 in 10 had never deployed operationally. Roughly half said they had witnessed death and 1 in 4 reported having witnessed the death or dead body of a comrade. Two of the cohort had mental health problems while on duty.

The MAP was extended to examine concerns that ESP's mental problems were consequent on military service. The assumption that military service is the major aetiological factor may be erroneous.⁵² Only 20% of diagnoses had an unambiguous link to military service, whereas 42% were unquestionably not attributable to service. The Howard League for Penal Reform²⁰ and the leading UK NGO for homeless ex-service personnel, Veterans Aid, consider that their clients' situation is 'hardly ever' a direct consequence of their military service (H. Milroy, 2012, personal communication) and PTSD is uncommon in this population.⁵³

Stories of military imposters regularly turn up in the British media,⁵⁴ yet fabrication and exaggeration in the ex-service population is particularly difficult for those without military experience to identify. Although mental health professionals may seek to understand such behaviours, many in society, particularly military and ex-military personnel, see it as reprehensible, dishonourable and, at the very least, tarnishing the integrity of the ex-service community. This type of behaviour is not uncommon in the US veterans' population,^{55–57} and it was found in 13% of the only British survey of ESP seeking treatment for combat-related PTSD.⁵⁸ The figure for fabrication and/or exaggeration in MAP attendees is at least 10%. For example, being 'unable to remember' their service number (currently, army: other ranks 8 numbers, officers 6 numbers; Royal Navy: all ranks 6 numbers prefaced and ending with a letter; RAF: other ranks 8 numbers prefaced with a letter, officers 8 numbers ending with a letter) is most suspicious, particularly without organic brain damage or syndromes, as are vague and/or changing narratives. Some attendees said they 'didn't want to' or 'couldn't' talk as they had signed the Official Secrets Act, not in itself an impediment to therapeutic intervention. Some had been offered, yet not engaged with, evidence-based interventions, others had received evidence-based help which, unsurprisingly, had not helped them. Those of the MAP patients who fabricated their stories told of units or missions that did not exist, of tasks for which they could never have been trained (given their service history), of being 'identified' for 'special duties' or operations such as political assassinations, all narratives that are difficult for those without military experience to recognise as false.

Fabrication and exaggeration is commonplace in psychiatry but is seldom contemplated or discussed in consultations outside medico-legal, forensic, military and liaison practice.⁵⁹ Although DSM-IV warns that 'Malingering must be ruled out in those situations in which financial remuneration, benefit eligibility or forensic determinations play a role' (p.427),⁶⁰ it would be wrong to equate fabrication with malingering as such behaviours are multifactorial in their genesis, from the fraudulent to the delusional. Examination of military and NHS records can be invaluable in identifying these behavioural patterns and corroboration of military service is recommended in the report into the UK Veterans' Pilot Sites Study.¹⁷

Final comments

Ex-service personnel currently involved with NHS mental health services are likely to be middle-aged ex-soldiers (men). The overwhelming majority of those in contact with military or civilian criminal justice systems come from the army; however, the link between mental disorders and service is seldom straightforward. Although very few ESP will have psychotic illness, their needs are complicated, frequently falling short of entry criteria for many mental health teams yet outwith GPs/GP counsellor skills, which can reinforce ESP's stereotypes about civilian mental health services. Common psychiatric conditions occur in this group and the treatment is the same for civilians and ESP alike; it is not all PTSD, but alcohol misuse is high and, in a substantial number, obsessive-compulsive symptoms seem

to be relevant to problems of readjustment to civilian life and could be screened for before leaving service.

Delay in seeking help is similar to that of civilians and barriers to care include male gender, pride, guilt, shame and remembrance of lost colleagues. Partners are frequently key in getting ESP to services. Those ESP who engage with services are as likely to do well as any other service user. Ex-service charities are helpful in pathways to care and offer many services unavailable to civilians. Understanding this population's needs is particularly important given their putative occupational antecedents and financial implications (for both the individual and the state). It is important to identify those individuals who are entitled to pensions and services so that scarce resources can be managed appropriately; corroboration of service is integral to this, aided further by service medical records.

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About the author

Ian P. Palmer is head of the Medical Assessment Programme for UK Veterans, The Baird Medical Centre, St Thomas' Hospital, London, UK.

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