Developing Mental Health Services For Veterans In England

Royal British Legion Consultation Response

1.0 About us

1.1 The Royal British Legion was created as a unifying force for the military charity sector at the end of WWI, and still remains one of the UK's largest membership organisations. We are the largest welfare provider in the Armed Forces charity sector, providing financial, social and emotional support, information, advice, advocacy and comradeship to hundreds of thousands of Service personnel, veterans and their dependants every year. In 2014, we responded to over 450,000 requests for help – more than ever before – and spent £1.4m every week on welfare support. For further information, please visit www.britishlegion.org.uk

1.2 The Legion is grateful for the opportunity to respond to NHS England's consultation on 'Developing mental health services for veterans in England'. The Legion has collated its consultation response on the basis of feedback received from beneficiaries through our 16 Area Offices and from Legion staff with direct experience of working with NHS mental health services. Additionally we have included the most up to date research with regards to veterans and their families' mental health needs from Legion commissioned research and from engagement with different research bodies addressing veterans mental health needs.

1.3 We commend the Government, Department of Health and NHS England on their work to address veteran mental health treatment services, based on the recommendations arising from the Murrison report, 'Fighting Fit', in 2010. Specifically we believe the creation of the 12 veterans mental health services, in tandem with supporting commissioned services such as, The Big White Wall, the Combat Stress 24 hour mental health helpline and the Combat Stress specialised PTSD treatment service, all work conjointly to support Armed Forces mental healthcare needs.

1.4 The Legion however believes there are areas for improvement in the way the NHS delivers veterans mental health services which would fulfil the obligations towards the Armed Forces community enshrined in the NHS constitution that states, '***the NHS will ensure that in line with the Armed Forces Covenant, those in the armed forces, reservists, their families and veterans are not disadvantaged in accessing health services in the area they reside'***. The accompanying handbook additionally states: ***'For those with concerns about their mental health who may not present for some time after leaving Service, they should be able to access services with health professionals who have an understanding of Armed Forces culture.'***

1.5 These areas for improvement are discussed below and include issues of access such as: identification of veterans in healthcare services, priority treatment, referral methods and waiting times, barriers to care such as stigma, negative attitudes towards NHS providers, awareness of NHS veteran services, provision for families and treatment of comorbid illnesses. More broadly we believe there are problems of adequate funding and provision of

veteran mental health services, as well as issues veterans and their families face accessing mainstream NHS mental health services where no veteran specific pathway has been specified.

1.6 To understand the health needs of the veteran community, we detail below specific research data on mental health needs and potential groups who may be more at risk of experiencing mental health problems. These groups should be a prime consideration within any mental health service commissioning plan.

2.0 The Size And Health Needs Of The Ex-Service Community

2.1 In 2014 the Legion's household survey (Royal British Legion, *A UK Household Survey of the ex-Service Community*, 2014) estimated that the adult ex-Service community in the UK was 2.8 million veterans, 2.0 million adult dependents and 990,000 dependent children. It is estimated that 83% of the ex-Service community resides in England, which equates to 4.2 million individuals. The ex-Service community's profile varies regionally from the general population in that there is a substantially lower proportion living in London and a slightly higher proportion living in the South West, Yorkshire and Humberside and in rural areas.

2.2 The UK's ex-Service population is an elderly population. 64% are over the age of 65, which reflects those who served during the Second World War or who undertook post-war National Service. However there are specific health needs related to different age groups.

2.3 Mental health needs:

- In the Legion's household survey, one in ten of the ex-Service community reported feeling depressed, which equates to 480,000 individuals. The age group most likely to report being depressed are those aged 35-64 (14%). Reporting depression was more common for those unemployed, those not seeking work that were under retirement age, and those who reported problematic alcohol consumption.

- Working age members of the ex-Service community were more likely than the general population to report having depression (10% v 6%).

- Military personnel who have deployed are at high risk of experiencing traumatic events (Hoge et al., 2004), particularly those who deploy in a combat role. UK research has found an association between holding a combat role and PTSD (Rona et al., 2009, Fear et al., 2010). There is an increased risk of PTSD and relationship problems in deployed Reserve personnel compared to non-deployed Reserves (Harvey et al., 2012). The prevalence of common mental health disorders (CMD) in the UK Armed Forces is estimated at 20%, alcohol misuse 13% and PTSD 4% (Fear et al., 2010).

- Recent research by Goodwin et al. (2015) comparing UK Service personnel and the English working general population suggests that odds of CMD were double in the military compared to the general population (which approximates the Legion's Household survey finding regarding depression).

- Longer deployments, deployment extensions and PTSD in military personnel are associated with psychological problems for Armed Forces spouses (De Burgh et al., 2011)

- Children of deployed parents have a higher risk of moderate to severe emotional and behavioural problems than their civilian counterparts (White et al., 2011)

- The mental health needs of the Armed Forces community should primarily focus on treating CMD and also provide targeted PTSD treatment. Equally resources should be focused on those most at risk (i.e. those who are unemployed, those with alcohol problems, those who have deployed, spouses and children of deployed Armed Forces members and Reserves).

2.4 Armed Forces Help-Seeking

- Help-seeking for mental health problems is low in the UK military population (Iversen et al., 2010, Hines et al.,2014).

- In a UK military sample including Service personnel, Reserves and ex-Service, only 23%, 50% and 64% of those with alcohol problems, depression/anxiety and PTSD respectively, had sought professional help (Iversen et al., 2010). A recent UK military study, Hines et al. (2014) found that out of 888 military personnel who reported a stress or emotional problem as a result of deployment, only 42% were seeking any help and only 29% seeking formal/professional help. Help-seeking for alcohol problems in this study (n=291) was again even lower with only 31% seeking any help and 17% seeking formal/professional help.

- In the UK military therefore, 46% - 83% of individuals with probable mental health disorders do not seek help and of those who do access help, most help sought is from informal sources (Iversen et al., 2010, Hines et al., 2014).

- In the Legion's household survey, reported mental health problems had doubled since 2005. Additionally only one in twenty had sought help for mental health problems. Even among those reporting psychological problems, only 16% had accessed help.

- The Legion Household Survey found that time since military discharge was a factor in help-seeking attitudes. Those discharged within the last five years from Service were less likely to seek medical advice and were more likely to ignore their own health problems assuming that their health problems would improve on their own. This group were also more likely to avoid seeking help because they worried what others might think about them.

- UK research has examined the barriers that impede help-seeking behaviour and engagement with treatment in military populations; these barriers include **stigma** (Iversen et al., 2011, Sharp et al. 2015), **practical or logistic barriers to care** (Iversen et al., 2011), **negative attitudes related to mental health problems or mental health treatment** (Forbes et al., 2013), **poor recognition of the need for treatment** (Iversen et al., 2005, Momen et al., 2012), **the effect of military culture** and **gendered (masculine) help-seeking** (Iversen et al.2005, Langston 2007).

- Overall mental health services should assess how they can break down differing barriers to accessing their services and target positive help-seeking behaviour campaigns on those least likely to seek help. (i.e. young males, those recently discharged, and those with alcohol problems). Equally, veteran mental health services should expect more people to access their services as they advertise their treatment and as help-seeking

campaigns start to have an impact on behaviours, hence any future commissioned service must have capacity for increases in demand.

2.1 Comorbid Mental Health Problems, Long Term illness/disability and Alcohol Abuse

- Half of the ex-Service community have some long-term illness or disability, most often a physical condition. Prevalence of many conditions has increased in the last decade because of the ageing population (46% are now aged 75+, compared with 28% in 2005), especially musculoskeletal conditions, cardiovascular and respiratory problems, and sensory problems. The King's Fund reported in 2012 that individuals with long-term illnesses or disabilities were 2-3 times more likely to have a comorbid mental health problem. Individuals with comorbid physical illness and mental illness were more likely to face poorer clinical outcomes and a significantly lower quality of life than people with a physical health problem alone (The Kings Fund, *Long term conditions and mental health: the cost of co-morbidities*, 2012). Hence, this group of the Armed Forces community with long term illness/disability are particularly at risk of mental health problems and need their health addressed holistically.

- Research has found that 50% of those with a PTSD diagnosis in the UK Armed Forces also have an alcohol abuse or dependence problem (Rona et al. 2010, Brewin et al. 2012) Hence many of those with a diagnosis of PTSD will need alcohol detox and treatment support, often before they can engage with mental health care services.

2.2 Carers and Mental Health Needs

- The Legion's household survey found one in five of the ex-Service community has some unpaid caring responsibilities which is equivalent to 990,000 people. Compared to the general population, the ex-Service community are more likely to have a caring responsibility. The difference is most stark for the age group 16-24 where 18% of this ex-Service population have a caring responsibility compared to 5% nationally. Carers UK found that 92% of carers reported a negative impact on their mental health, including stress and depression (Carers UK, 2013, State of Caring 2013). Hence this group of the ex-Service community are also at risk of mental health problems.

3.0 Experiences of Good Practice

3.1 In our experience the best mental health services that are appropriate for Armed Forces mental healthcare needs have certain characteristics which include;

- Veteran/ex-Service, badged mental health services (irrespective of whether that service feeds into regular NHS mental health services).
- Have an understanding of military Service and veteran healthcare needs.
- Provide a service that has a specific healthcare pathway connected to other NHS healthcare services and works in partnership with supporting statutory or welfare organisations (such as Housing associations or Service charities such as The Royal British Legion, Combat Stress etc.)
- Services that are well publicised locally and have a user friendly website with clear information.
- Services that accept self-referrals and/or services that have a standardised referral form.
- Services that publicise their mental healthcare provision for ex-Service, families and Reserves.

Examples of Good Practice

3.2 The Royal British Legion's Pop-in Centre at Bristol specifically provides the South West Veterans' Mental Health Service with a spare desk, working space and access to their interview rooms to ensure Legion clients are well connected to NHS mental health services. Where appropriate we would encourage NHS providers of veteran mental health services to include in their service plans, specific strategies to increase points of access. This includes strategies to link up with relevant organisations where partnership and space sharing agreements would benefit the Armed Forces community who may need to access NHS mental health services.

3.3 South West Veterans Mental Health Service and Veterans First Service (North Essex Partnership University NHS Foundation Trust) – have been highlighted by Legion staff as having a simple referral process that supports veterans to engage with the service quickly. There are other veteran services that have less direct referral processes and many that do not accept self-referrals which act as a barrier to accessing care (these are discussed in point 4.7)

3.4 As discussed in more detail in section 4.0 and 5.0, the main challenge for veteran mental health services and NHS mental health services more generally, is one of access. There are social and psychological barriers as well as practical barriers that the NHS could usefully aim to address.

4.0 Issues of Access to Mental Health Services

'Asking the Question'

4.1 Routine and effective data collection is fundamental to both ensuring that GPs are able to meet veterans' needs and to veterans engaging in mental health services. The current Read code/SNoMed CT Code "Served in Armed Forces" is in place, yet anecdotal evidence suggests that it isn't always being routinely and uniformly used to identify veterans accessing health care. As a minimum we would expect the presentation of an Fmed 133 form to automatically result in the allocation of the Read code, however this alone will not guarantee universal coverage.

4.2 Progress in this area has been welcome but more work is needed. The Legion believes it is the duty of all statutory bodies and those delivering statutory services to 'ask the question' and ensure veterans are identified and therefore receive the services to which they are entitled. We recommend that NHS England take responsibility for encouraging primary care services to record veteran status.

Priority Treatment

4.3 The implementation of priority treatment in referral practices is not comprehensively enacted. The Legion believes there may be a problem with awareness, knowledge of what priority treatment means in practice, and misunderstanding of priority treatment or unwillingness of NHS providers to implement it as a policy.

4.4 Legion research has found that awareness of priority treatment amongst veterans and GPs appears to be very low. In response to a 2009 survey of 500 GPs across England and Wales, 81 per cent of respondents said they knew not very much or nothing at all about priority treatment (Ipsos-Mori, 2009). Although this may be improving, it is still a significant problem and more should be done to educate GPs and other medical professionals about military health needs once Service history is identified.

4.5 A small research study by Northumbria University investigating alcohol treatment pathways for ex-Service personnel found that some NHS alcohol treatment providers knew about priority treatment but were reluctant to implement it as a policy (Kiernan et al., 2015). The providers either did not believe veterans should be treated differently to other civilians or believed they were following priority treatment 'by treating everyone the same'. We believe there are misunderstandings as to what priority treatment is and what it means in practice.

4.6 The Legion believes the NHS should collate a short guidance document to healthcare professionals detailing what priority treatment is and provide examples of best practice. We believe this may help to rectify issues of awareness or misunderstanding in the NHS of what priority treatment is.

Referral methods and waiting times

4.7 Feedback from the Legion Area Offices and our beneficiaries detail that where referral pathways are not standardised in veteran mental health services i.e. through one standardised form and available online, that referrals can become more complicated than they need to be. These difficulties in referrals negatively affect veterans waiting times in accessing support or cause veterans to disengage with help-seeking.

4.8 For example within the East Midlands Veterans Liaison Service – Legion staff report that there is not a standardised form for referrals and that they have to individually contact veteran liaison champions in different areas (who are not full time) and often wait days/weeks to be able to refer a veteran to the service. It is requested that this service (as well as all future commissioned veteran mental health services) consider one referral point in their area, through a standardised form that would promote better access to treatment.

4.9 Due to the poor help-seeking profile of the ex-Service community and from feedback from Legion beneficiaries, veteran mental health services that do not accept self-referrals will dissuade many veterans from accessing services. We would encourage future commissioned veteran mental health services to have self-referrals as a standard part of their operating procedure. This referral method would substantially benefit a reluctant help-seeking group.

Barriers to Care

4.10 Stigma - Specifically in UK military literature, one of the most common reasons evidenced as to why UK Service and ex-Service personnel indicate they would not or have not accessed mental health services, was the influence of anticipated public stigma associated with consulting for a mental health problem (Gould et al., 2010, Iversen et al., 2011, Osório et al., 2013a, Jones et al., 2013, Sharp et al., 2015). Some of the top concerns endorsed in these studies were; (a) being seen as weak, (b) concerns members of their unit or work colleagues might have less confidence in them, (c) concerns unit leaders or work bosses would treat them differently if they sought help and, (d) it being too embarrassing to seek help.

4.11 Recent research by KCMHR assessing help-seeking outcomes for individuals with mental health problems also found that high anticipated stigma (concern about what others might think, say or do) and high self-stigma (an individual personally internalising negative stereotypes pertaining to individuals with mental health problems - such as them being bad, mad, dangerous or weak) were strongly associated with a reduced likelihood of Armed Forces seeking help (Sharp, KCMHR)

4.12 The Legion advises that a tailored help-seeking, anti-stigma campaign for the ex-Service community is conducted. This campaign should take best practice from other successful UK

stigma campaigns, such as the 'Time to Change' campaign to understand how best practice in the civilian sector can be adapted to impact on the stigma of seeking help for mental health problems in the Armed Forces community. The Legion advises that the NHS should take a lead in promoting and developing the help-seeking campaign for veterans that is currently being formulated by the Mental Health Round Table group.

4.13 Negative attitudes towards mental health care and NHS providers – Feedback from Legion beneficiaries and staff highlights that many veterans have a negative attitude toward NHS services. These negative attitudes are because individuals do not feel NHS practitioners understand their service history, military culture/language and will not understand what they have experienced. Whilst many of the veteran mental health services do well at addressing this need, it is felt that there could be improvements in these services in educating staff to understand military culture and service. Legion staff report that veterans have disengaged from NHS services where they believe their service history is not understood or taken account of in treatment.

4.14 The Legion believes that any future commissioned veteran mental health service must have NHS clinicians and providers that have an understanding of military culture and health needs of the ex-Service community. This education and understanding will build trust within the veteran community and encourage engagement in services.

4.15 Awareness of veteran mental health services - Research from KCMHR suggests that there is very low awareness of NHS veteran mental health services within the ex-Service population and low awareness of the Veterans and Reserves Mental Health Programme. In a sample of ex-Service personnel (n=274) only 30% knew about NHS veteran mental health services and only 25% were aware of the VRMHP (Sharp, KCMHR).

4.16 The Legion believes that specific funding should be made available to any commissioned veteran mental health service to be able to publicise their service and adequately promote the support available.

4.17 Families – Feedback from Legion beneficiaries identifies that there may not be adequate mental health support for veteran families. Including spouses, partners and children. Whilst some veteran mental health services accept referrals for spouses, generally spouses of veterans and children access mainstream NHS services.

4.18 The Legion believes that families of veterans should have a choice which type of mental health service they wish to access (whether NHS mainstream or veteran mental health services), however we believe there is a need to offer mental health services to spouses that will be sympathetic to their Service history and will understand their needs. We feel currently that families mental health support is an area that does not have adequate provision and we would like future commissioned services to take into account the mental health needs of veteran families, including children's mental health support.

4.19 Treatment of comorbid alcohol and mental health problems - As identified earlier, of those that have mental health problems, a large proportion may also have a concurrent alcohol problem. Currently the majority of NHS veteran mental health services are not equipped to treat veterans who have comorbid alcohol and mental health problems. NHS alcohol detox programmes are often oversubscribed and their coverage in England is patchy. There is therefore currently a group of veterans who are not able to engage with mental

health services until they have successfully detoxed, who are often left without support from any NHS service.

4.20 The Legion believes there is a need for all future commissioned veteran mental health services to have in place a referral route to and from alcohol treatment programmes on the NHS to support those with comorbid diagnoses. These individuals are at the acute end of the spectrum and need more specialised support and clear healthcare pathways. We believe as standard practice, veteran mental health services must have these in place.

5.0 Broader NHS Mental Health Treatment Service Issues

5.1 Despite the 12 NHS veteran mental health services across England, Legion beneficiaries and staff report that mental health service provision is variable across England. Many veterans only have the choice to engage with standard NHS mental health services who have no veteran liaison positions. Legion beneficiaries have reported dropping out from mental health treatment because of long waiting times and because they did not feel their service history was understood or catered for. In areas such as Hereforshire, Worchestershire and Hertfordshire, we have had feedback from Legion staff that there is a need to have specific veteran mental health service provision to cover gaps in the UK coverage.

5.2 There is therefore a need to extend veteran mental health service provision across England to cover areas where this is not currently being addressed. The Legion understands that this provision will look different in different local areas depending on the needs of the community and the current set up of NHS services. The Legion however believes there is a need for better service coverage for veterans and we believe that all clinical commissioning groups should be required to do an Armed Forces Joint Needs Assessment to be able to understand their community's needs and concurrent commissioning needs. This Armed Forces Joint Needs assessment should be carried out in partnership with Health and Well-being boards in local authorities alongside Joint Strategic Needs Assessments to ensure the health needs of the Armed Forces community are captured on a local level.

5.3 The Legion commends the Government, the Department of Health and the NHS Armed Forces team for their work in veteran's mental health, however we believe there is much more work that needs to be done to fully fund veterans services and to meet need, which currently receives variable provision across England. We recommend that current veterans mental health services with best practice should act as benchmarks for future standard service provision.

Key Recommendations

- In our experience the best mental health services that are appropriate for Armed Forces mental healthcare needs have certain characteristics which include;

    - Veteran/ex-Service, badged mental health services (irrespective of whether that service feeds into regular NHS mental health services).
    - Have an understanding of military Service and veteran healthcare needs.
    - Provide a service that has a specific healthcare pathway connected to other NHS healthcare services and works in partnership with supporting statutory or welfare

organisations (such as Housing associations or Service charities such as The Royal British Legion, Combat Stress etc.)
    - Services that are well publicised locally and have a user friendly website with clear information.
    - Services that accept self-referrals and/or services that have a standardised referral form.
    - Services that publicise their mental healthcare provision for ex-Service families and Reserves.

- Future commissioned veterans NHS services must also:
    - Target resources on those most at risk of mental health problems.
    - Pursue tactics to engage those most reluctant to seek help in the Armed Forces community.
    - Have specified budget allocated to publicising their service.
    - Provide mental health service support for Armed forces families or provide effective referral routes to treatment.
    - Specified referral routes to and from alcohol detox programmes.

- NHS England to take lead on encouraging primary care services to record veteran status as standard data capture.
- NHS England to reissue guidance document on priority treatment and provide examples of best practice to NHS healthcare professionals.
- NHS England to take a lead in promoting the help-seeking campaign for the Armed Forces community in partnership with the Mental Health Round Table group.

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References

CARERS UK, 2013, State of Caring 2013

DE BURGH, H.T., WHITE, C.J., FEAR, N.T. AND IVERSEN, A.C., 2011. The impact of deployment to Iraq or Afghanistan on partners and wives of military personnel. *International Review of Psychiatry*, *23*(2), pp.192-200.

FEAR, N. T., JONES, M., MURPHY, D., HULL, L., IVERSEN, A. C., COKER, B.,MACHELL, L., SUNDIN, J., WOODHEAD, C., JONES, N., GREENBERG, N.,LANDAU, S., DANDEKER, C., RONA, R. J., HOTOPF, M. & WESSELY, S. 2010. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. *The Lancet,* 375**,** 1783-1797.

FORBES, H. J., BOYD, C. F., JONES, N., GREENBERG, N., JONES, E., WESSELY, S., IVERSEN, A. C. & FEAR, N. T. 2013. Attitudes to mental illness in the UK Military: A comparison with the general population. *Military medicine,* 178**,** 957- 965.

GOODWIN, L., WESSELY, S., HOTOPF, M., JONES, M., GREENBERG, N., RONA, R., HULL, L. & FEAR, N. 2015. Are common mental disorders more prevalent in the UK serving military compared to the general working population? *Psychological medicine***,** 1-11.

GOULD, M., ADLER, A., ZAMORSKI, M., CASTRO, C., HANILY, N., STEELE, N., KEARNEY, S. & GREENBERG, N. 2010. Do stigma and other perceived barriers to mental health care differ across Armed Forces? *JRSM,* 103**,** 148-156

HARVEY, S. B., HATCH, S. L., JONES, M., HULL, L., JONES, N., GREENBERG, N., DANDEKER, C., FEAR, N. T. & WESSELY, S. 2012. The long-term consequences of military deployment: a 5-year cohort study of United Kingdom reservists deployed to Iraq in 2003. *American journal of epidemiology,* 176**,** 1177-1184.

HINES, L. A., GOODWIN, L., JONES, M., HULL, L., WESSELY, S., FEAR, N. T. & RONA, R. J. 2014. Factors Affecting Help Seeking for Mental Health Problems After Deployment to Iraq and Afghanistan. *Psychiatric Services,* 65**,** 98-105.

HOGE, C. W., CASTRO, C. A., MESSER, S. C., MCGURK, D., COTTING, D. I. & KOFFMAN, R. L. 2004. Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine,* 351**,** 13-22.

Ipsos-MORI GP questionnaire on Priority Treatment - online questionnaire completed by 500 GPs across England and Wales. Fieldwork was conducted between 13-23 March 2009.

IVERSEN, A., DYSON, C., SMITH, N., GREENBERG, N., WALWYN, R., UNWIN, C., HULL, L., HOTOPF, M., DANDEKER, C., ROSS, J. & WESSELY, S. 2005. 'Goodbye and good luck': The mental health needs and treatment experiences of British ex-service personnel. *The British Journal of Psychiatry,* 186**,** 480-486.

IVERSEN, A. C., VAN STADEN, L., HUGHES, J. H., GREENBERG, N., HOTOPF, M., RONA, R. J., THORNICROFT, G., WESSELY, S. & FEAR, N. T. 2011. The stigma of mental health problems and other barriers to care in the UK Armed Forces. *BMC health services research,* 11**,** 31.

JONES, N., TWARDZICKI, M., FERTOUT, M., JACKSON, T. & GREENBERG, N. 2013. Mental health, stigmatising beliefs, barriers to care and help-seeking in a nondeployed sample of UK Army personnel. *J Psychol Psychother,* 3**,** 1-8.

KIERNAN, M et al. Understanding why veterans are reluctant to access help for alcohol problems: Considerations for nurse education, 2015. Nurse Education Today

LANGSTON, V., GOULD, M. & GREENBERG, N. 2007. Culture: What is its effect on stress in the military? *Military Medicine,* 172**,** 931-935.

MOMEN, N., STRYCHACZ, C. P. & VIIRRE, E. 2012. Perceived stigma and barriers to mental health care in Marines attending the combat operational stress control program. *Military medicine,* 177**,** 1143-1148.
OSÓRIO, C., JONES, N., FERTOUT, M. & GREENBERG, N. 2013b. Perceptions of stigma and barriers to care among UK military personnel deployed to Afghanistan and Iraq. *Anxiety, Stress & Coping,* 26**,** 539-557.

RONA, R. J., HOOPER, R., JONES, M., IVERSEN, A. C., HULL, L., MURPHY, D., HOTOPF, M. & WESSELY, S. 2009. The contribution of prior psychological symptoms and combat exposure to post Iraq deployment mental health in the UK military. *Journal of traumatic stress,* 22**,** 11-19.

Royal British Legion, *A UK Household Survey of the ex-Service Community*, 2014

SHARP, M.-L., FEAR, N. T., RONA, R. J., WESSELY, S., GREENBERG, N., JONES, N. & GOODWIN, L. 2015. Stigma as a Barrier to Seeking Health Care Among Military Personnel With Mental Health Problems. *Epidemiologic reviews,* 37**,** 144-162.

SHARP, M-L. Social influences and barriers to healthcare for mental health problems among UK military personnel: qualitative and quantitative investigations, PhD, 2015.

THE KINGS FUND, *Long term conditions and mental health: the cost of co-morbidities*, 2012

WHITE, C.J., DE BURGH, H.T., FEAR, N.T. AND IVERSEN, A.C., 2011. The impact of deployment to Iraq or Afghanistan on military children: A review of the literature. *International Review of Psychiatry*, *23*(2), pp.210-217.