

Understanding the needs of veterans seeking support for mental health difficulties

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INTRODUCTION

Since the late 1990s, studies have been conducted in the UK to monitor the health and well-being of military personnel. The bulk of this work has been conducted by researchers at King's College London, first after the 1991 Gulf War and then later by setting up a cohort study in the wake of the 2003 Iraq War.¹⁻³ This was later expanded to be representative of the wider military and so far has included three waves of data collection, the most recent of which reported results in late 2018.⁴ The third wave of data collection observed increases in the prevalence rates of post-traumatic stress disorder (PTSD) from 4% to 6% for the entire population (including serving and ex-serving individuals). However, this only told half the story, when the sample was restricted to veterans only, the prevalence rate for PTSD was 7.4%. For the first time, this suggested that veterans were at increased risk of PTSD compared with the general public in the UK.⁴ Further, when the sample was restricted to only veterans who had deployed within a combat role (approximately a third of all veterans), the observed rates of PTSD increased to 17.1%. These rates are worrying as until recently, evidence suggested that rates of PTSD in UK veterans from Iraq and Afghanistan were lower than their US, Canadian and Australian counterparts. However, this data suggests that for the most at risk groups of UK veterans the PTSD prevalence rates are comparable.⁵⁻⁷ In addition to PTSD, population studies of military populations typically report high rates of anxiety, depression, anger and alcohol problems.^{4,8}

Data suggests that veterans with PTSD profit less from therapy than their civilian counterparts and that the cost to society for veterans with PTSD is higher than for veterans with other mental health difficulties.⁹⁻¹¹ The reasons for this disparity are

unclear. Studies exploring treatment efficacy in veterans with PTSD suggest that individuals with higher rates of psychiatric comorbidity are at risk of poor treatment responses.^{12,13} Further, it has been suggested that veterans often take many years to seek help, by which time there is an erosion of resources around them that increases the risk of either dropping out of treatment or only making modest gains.¹⁴ Latent Class analyses have allowed researchers to model heterogeneity in PTSD treatment responses. These analyses show that comorbid depression, guilt associated with the traumatic event and combat exposure are related to treatment non-response.^{12,13,15} These studies suggest the importance of moving away from a one-size fits all treatment response for veterans to one that takes into account the idiosyncratic presentations of individuals.

In long-term follow-up studies, it has been demonstrated that Vietnam veterans report a higher prevalence of long-term health conditions compared with the general population.¹⁶ Studies have observed associations between mental health difficulties in veterans and a range of physical health problems such as chronic pain, cardiovascular disease, autoimmune diseases and gastrointestinal disorders.¹⁷⁻²¹ PTSD appears to be particularly problematic, with strong associations noted between PTSD and serious reductions in daily functioning.²² In US samples, veterans seeking support for PTSD were found to be at increased risk for both a range of physical health complaints and also earlier onset of physical health problems compared with veterans without PTSD.²³

Exploring the needs of treatment-seeking veterans

To date, there has been less published on the needs of UK treatment-seeking veterans. To go some way to address this, a study was setup by randomly sampling a representative population of treatment-seeking veterans from a national mental health veterans charity in the UK that provides clinical services.²⁴ Twenty per cent of all

veterans who had accessed services over a 12-month period were invited to participate in the study. Responses were elicited from 403/600 (67.2%) individuals, and no significant differences were found between responders or non-responders.²⁴ It is important to note that several limitations may be associated with this sampling strategy. These include that most of the population were male, had served in the Army and been in the lower ranks during their service, which may mean that minority groups were not well represented. While limitations may exist to the generalisability of this population, the charity covers the breadth of the UK and supports approximately 3500 individuals annually.²⁴ As such, the study was representative of a significant number of treatment seekers. In addition, the profile of mental health presentations of the sample for this study appears to be comparable to that of treatment-seeking veterans in the USA, Canada and Australia.^{5,6,25} The current issue of the *Journal of the Royal Army Medical Corps* includes a paper published from the study described above; reviewing levels of obesity in treatment-seeking veterans, and this editorial provided the opportunity to summarise the other key findings resulting from this data set. The aim of doing this was to document the profile of treatment-seeking veterans to help better understand their complex presentations.

Demographic characteristics

The 68.2% of the population of treatment-seeking veterans were aged 45 years or older; the majority were male (95.6%), had served in the army (86.1%) and reported being unable to work (68.1%). Treatment-seeking veterans endorsed exposure to a greater number of adverse childhood experiences than the wider military population.^{24,26} While the majority of the veterans sampled lived in England, comparison to the Royal British Legion's most recent household survey showed that there was a higher proportion of veterans residing in Scotland, Wales and Northern Ireland seeking support for mental health difficulties than might be expected from the distribution of veterans around the UK.²⁷ Compared with participants who resided in England, those living in Northern Ireland tended to be older and have more physical health needs, and those living in Wales and Scotland reported higher rates of alcohol problems and increased risk of living in areas of deprivation.^{27,28} On average, veterans reported taking 11 years between leaving

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the military and seeking formal support for mental health difficulties. Encouragingly, there appears to be evidence of a cohort effect, with veterans from more recent deployments seeking support more quickly than individuals deployed on historically older operations (eg, 2 years for those who went to Afghanistan vs 13 years for those deployed to Northern Ireland).¹⁴

Mental health profiles

PTSD appears to be the most frequently endorsed mental health difficulty in treatment-seeking veterans.²⁴ This contrasts with the wider veteran population where common mental health difficulties such as anxiety and depression are the most prevalent reported mental health difficulty.⁴ However, this is perhaps unsurprising as evidence clearly demonstrates that individuals experiencing symptoms of PTSD are at greater risk of social exclusion, functional impairment and poorer physical health, which may explain why these are the individuals accessing support from a specialist veteran mental health service.^{22 23} PTSD has also been reported as the most prevalent disorder that veterans seek support for in US, Canadian and Australian samples.^{5 6 25} Reporting comorbid mental health difficulties appeared to be the norm rather than the exception. For example, only 4.8% of participants met case criteria for only PTSD, compared with 79.3% of individuals with PTSD who also met case criteria for two or more other mental health difficulties (eg, common mental health difficulties, difficulties with anger or problems with alcohol). No significant relationships were found between the severity of mental health difficulties and suicidal ideation. It is important to note that this finding was within a clinical population who had been diagnosed with a mental health difficulty, as suicidal ideation has previously been associated with mental health status. As such, rates of suicidal ideation would be higher in veterans with mental health difficulties compared with veterans without such difficulties. Rather, within this specific population, the following demographic characteristics were associated with higher levels of suicidal ideation: currently being unemployed, being an early service leaver (defined as completing less than 4 years service), taking less than 5 year to access support and higher levels of childhood adversity.²⁹

PTSD presentations

The use of symptom network and latent profile analyses allowed us to explore the

heterogeneity in PTSD symptom profiles. Symptoms of PTSD were recorded using the PTSD checklist for Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) (PCL-5). The PCL-5 is a 20-item self-completed measure of PTSD that explores the symptoms of PTSD as defined by the DSM-5. The PCL-5 has been validated for use within UK veterans.³⁰ A network analysis was fitted to evaluate the relationships between the PCL-5 symptoms of PTSD.³¹ It was observed that recurrent thoughts, frequent nightmares, negative emotional state, exaggerated startle response and a sense of detachment were the most central symptoms to the network. Further, PTSD symptoms of detachment and diminished interests were most strongly associated with higher levels of functional impairment. Advocates for applying network analysis to mental health symptoms suggest that targeting the most central symptoms in a network may help more efficiently support individuals to overcome these difficulties and meet the individual needs of particular populations.

Latent profile analysis models were fitted and a six-profile model was found to best describe the variation of PTSD presentations within treatment-seeking veterans.³² Higher rates of common mental health difficulties, childhood adversity and taking longer to seek support were observed to be associated with more symptomatic profiles. Finding evidence of different profiles of PTSD symptoms suggests the importance of developing interventions tailored to the specific profile of PTSD symptoms and comorbid difficulties rather than applying the same treatment to all individuals.

Alcohol misuse

The increased risk of alcohol misuse in military populations compared with the general public is well documented.³³ When restricted to males only, comparison between treatment-seeking veterans, the wider UK military and the UK general public showed that treatment-seeking veterans were more likely to report drinking at higher levels (16+ on the Audit; 22% for treatment seekers, 17% for the military and 6% for the general public). Differences emerged between the pattern of drinking between treatment seeking veterans and the wider military. The wider military appeared more likely to report binge drinking, while treatment seekers more likely to endorse patterns of drinking that suggested alcohol-related harm or alcohol dependence.³⁴

Physical health

A relationship between mental health status and smoking has previously been reported in military personnel which was confirmed within the current study by just under 40% of treatment-seeking veterans stating they were current smokers.^{24 35} Over three-quarters of veterans had a body mass index (BMI) showing they were either overweight (39%) or obese (37%).³⁶ These rates are higher than in the general public and suggested that treatment-seeking veterans were 2–4 times at increased risk of being obese. Common mental health difficulties, anger and mobility issues were all associated with higher BMI scores. In a separate paper, the top five physical health complaints reported by veterans who had sought support for mental health difficulties were, chronic pain (41%), mobility issues (34%), hearing impairment (30%), cardiovascular problems (25%) and gastrointestinal problems (22%).³⁷

Potential areas of research

The needs of treatment-seeking veterans appear to be complex, chronic and poorly understood. It is hoped the above data may elucidate some issues for veterans, but many questions remain. While it is hard to prioritise these, for the authors of this editorial, three potential areas of research stand out. The first of these areas that warrants further investigation is around complex PTSD. When the International Classification of Diseases, 11th edition (ICD-11) was released in 2018, it contained, for the first time, a new diagnostic category for complex PTSD. Given the poorer response to treatment that are observed in veterans with PTSD, being able to understand their needs within the framework of complex PTSD may lead the development of new interventions to support this vulnerable group. For example, this may include the use of more robust techniques to support high levels of emotional deregulation or interpersonal difficulties encapsulated by the ICD-11 complex PTSD diagnosis. Associated with this is the concept of moral injury in trauma. Moral injuries have been hypothesised to include events where individuals have witnessed or perpetrated actions that are contrary to their belief system.³⁸ It has been speculated that applying traditional PTSD treatments may be inadequate to support individuals who have experienced more complex emotions potentially associated with moral injuries.³⁸ Treatment-seeking veterans appear to present with multiple chronic health difficulties and a further potential area

of research could be to better understand how to integrate treatments for physical and mental health difficulties.

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