Document Title: **Position Statement on Military Personnel and Veterans' Mental Health**
Document Type: Position Statement
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Date Created: 2024

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FOREWORD

This Position Statement on the military personnel and veterans' mental health has been prepared on behalf of the WPA Military Psychiatry Section by the above Working Group of clinicians and researchers by agreement of Prof. Thomas G. Schulze, President Elect of the WPA.

WHAT THE POSITION STATEMENT AIMS TO ACHIEVE

In this Position Statement, we aim to summarise the updates on:

- the current global conflict situation
- the unique mental health risks associated with military roles
- the range of mental health concerns in military and veteran population
- most common mental disorders in military and veteran population
- the specific issues related to stigma and suicide

Regarding these trends and issues, the aim is to provide recommendations to:

- improve awareness of the mental health problems related to military service
- enable and improve access to mental health care
- develop military leadership and clinical governance structures to support access and availability of the mental health care
- develop the evidence-based policy for prevention, early intervention, treatment, and reintegration into society after recovery of the military personnel and veterans with mental health problems

BACKGROUND

The current armed conflicts are an important reminder about of how combat, war, and mass violence result in adverse psychological and behavioural effects on military service members that impair functioning, diminish military readiness, and may negatively affect well-being long after a service member has left the military.

According to the International Institute for Strategic Studies (IISS), there are around 27 million active members of the armed forces worldwide (1,2). This number is even higher and could be multiplied many times if all three categories of personnel: active-duty soldiers, reserves, or paramilitary members are included (1). Obtaining an exact number of veterans worldwide can be even more challenging due to variations in definitions of "veteran". Nevertheless, it is estimated that there are tens of millions of veterans globally. The largest numbers of veterans are typically found in countries with large militaries or significant military involvement historically or currently (e.g. in 2023, there were 18.1 million US veterans (3), about 5.4% of the population, and in 2021 in the UK there were 1.85 million veterans, representing approximately 3.8% of the population (4). These data indicate the utmost importance of recognizing the significance of mental health issues and providing comprehensive measures to address their needs as military personnel often face challenging and demanding situations that can have profound effects on their mental health.

In recent years, there has been a notable escalation of global conflicts and their associated death rates as one of the most tragic consequences. The number of deaths from armed conflicts almost doubled between 2021 and 2022 (5). Recent global conflicts have seen military personnel exposed to not only the death of their own combatants, but mass death and intentional harm to civilians as well. Directly witnessing and hearing stories from civilian victims about torture, rape, and other violent acts by enemy forces intended to instil fear are often uniquely distressing experiences for service members. While traumatic brain injury (TBI) has been increasingly recognized as a

significant adverse outcome from combat exposure, recent conflicts have required service members to remain in combat even after experiencing multiple TBIs. This requirement to keep people „in the fight“ by any means necessary may have significant negative effects on the health and well-being of not only service members, but also their families and broader societies.
The transformation in warfare, driven by technological advancements, presents both opportunities and challenges (5,6). Autonomous weapons, remote warfare, cyber weapons, artificial intelligence (AI), and the persistent threat of nuclear conflict are reshaping how wars are fought and have significant implications for mental health, particularly for military personnel. Those operating and gathering intelligence from drones can experience psychological stress similar to front-line soldiers. These remote operators are effectively “deployed in place”, carrying home daily the stressful images and sounds of war, which have often been unacknowledged by society. Personnel engaged in cyber warfare face unique stressors, including the pressure of defending critical infrastructure and the constant threat of cyberattacks, which can lead to high levels of anxiety and burnout. The rising usage of autonomous weapons systems raise ethical concerns and moral dilemmas for operators and commanders, potentially exacerbating feelings of guilt and moral injury (7).
In addition to combat-related stressors, military personnel face a range of unique challenges and non-combat stressors that can significantly impact their mental health and well-being. Military sexual trauma (MST) encompasses experiences of sexual harassment and assault occurring during military service strongly associated with higher rates of depression and PTSD as well as harmful alcohol use, particularly among women (8,9). Separation from family due to deployments can strain relationships and lead to feelings of isolation, loneliness, and anxiety, and reintegration challenges such as difficulty transitioning back to civilian life, substance abuse, and suicide (10).
Understanding the range of adverse effects, including how this manifest across different cultures, the ways negative mental health effects unfold over time, and the factors that create risk and foster resilience, are essential to optimize policies, programs, and practices that protect military and veterans to foster global health security. Protecting military and veteran mental health is optimized through preparedness, response, and recovery actions by individuals, peers, organizations, and leaders.

SHORT- AND LONG-TERM MENTAL HEALTH CONSEQUENCES AMONG MILITARY PERSONNEL AND VETERANS

1. RISK AND PROTECTIVE FACTORS RELATED TO MENTAL HEALTH

Besides universal risk factors for negative mental health consequences of exposure to trauma, military personnel face unique military-related challenges that increase the risk for negative mental health consequences. Direct combat exposure can lead to significant stressors and trauma. Frequent deployments increase the likelihood of exposure to traumatic events and prolonged separation from family, leading to stress, feelings of isolation and loneliness (11). Intense deployment schedules, demanding physical requirements and high-pressure environments contribute to stress and mental health challenges (12). Within the military culture, personnel still face stigma surrounding mental health issues, which may discourage personnel from seeking help (13). Those with pre-existing mental health conditions may experience exacerbation under the unique military stressors. On the other hand, there are unique protective factors that can mitigate the effects of exposure to the war stressors. Loyalty and unit cohesion among members may provide emotional support and a sense of belonging (14). An immediate access to support services

including counselling and peer support groups also help in preventing worsening of mental health (15). Proper training in stress management, resilience, and coping skills, leadership support, routine and structure may lessen the risk for negative mental health problems in military personnel (14).

2. EARLY RESPONSES TO COMBAT AND OPERATIONAL STRESSORS

Combat and operational stress reactions (COSR) is the military analog of Acute Stress Reaction, and refers to “physical, emotional, cognitive, or behavioral reactions, adverse consequences, or psychological injuries of service members who have been exposed to stressful or traumatic events in combat or military operations.” (16). Between 42 and 52 percent of U.S. Army soldiers report having witnessed COSRs among fellow soldiers, with the most commonly observed symptoms including the soldier “freezing” in mission duties or becoming mentally detached (17). Because direct combat is an exposure few individuals experience in their lifetime, COSR is often described as a “normal” reaction to an “abnormal” experience, rather than a psychiatric disorder (18). When COSR occurs in high threat situations, it can impair functioning and jeopardize the safety of unit members. Promising practices have emerged to address COSR, which have been adapted across multiple nations, that involves a buddy aiding the individual experiencing COSR to reconnect, focus, and resume actions to support the mission and protect people around them (19,20).

The armed forces maintain combat and operational stress control (COSC) programs to improve service members' ability to manage combat and operational stress (18). Interventions to address COSR emphasize the principles of proximity, immediacy, expectancy, and simplicity (16) to meet basic needs, provide safety and possible comfort, ensure calming and stabilization, normalize observed psychological reactions to the chain of command, educate about the broad range of normal stress-related reactions, and provide expectancy of recovery (18). Teleconferencing offers a promising solution for managing COSR among military personnel, providing accessible, timely, and continuous mental health support (21). By overcoming logistical challenges and ensuring proper training, the military can further enhance the effectiveness of telehealth services in supporting the mental well-being of its members (22). Several mobile applications for self-management of psychological symptoms in military settings have been developed, with good results in empirical evaluations (23).

3. POST-TRAUMATIC STRESS DISORDER (PTSD) AND COMPLEX PTSD

Post-traumatic stress disorder (PTSD) is a significant mental health issue among military personnel and veterans due to the intense and often prolonged exposure to traumatic events. In 2021, 2.1% of active-duty U.S. Service members were diagnosed with PTSD. At some point in their life, 7 out of every 100 veterans (or 7%) will be diagnosed with PTSD (16). The prevalence of PTSD depends on the intensity and nature of deployment experiences and specific population studied. Reviews of first line treatments for PTSD in uniformed personnel have been disappointing in terms of reliable prevention of PTSD (24). For most people diagnosed with PTSD, trauma-focused psychotherapy which includes exposure rather than other forms of therapy delivered on site, is recommended as initial treatment. A secure video teleconferencing to deliver treatments are recommended when a therapy has been validated for use with video teleconferencing or when other options are unavailable (16). Regardless of the care setting, therapeutic approach to combat-related PTSD should be evidence-based, holistic, patient-centered (i.e., treatment based on patient needs, characteristics, and preferences optimizing the individual’s overall health and wellbeing), and culturally appropriate. Providers should practice shared decision making and leadership within

units should create an environment that supports help seeking to maintain a trauma-informed setting to appropriately respond to the effects of trauma (25).

Of those who suffer from PTSD, a significant subset may meet criteria for complex PTSD (cPTSD) due to the chronic and pervasive nature of their trauma exposure (26). CPTSD is perhaps the most common form of PTSD in veterans particularly those who seek treatment, as recent European studies revealed rates ranging from 54.3% to81 % among treatment-seeking veterans (27,28). In the ICD-11 (ICD-11; World Health Organization, 2018), hierarchical classification structure, PTSD and cPTSD are 'sibling' disorders, meaning that the diagnoses follow from the parent category of traumatic stress disorders. The inclusion of cPTSD to the ICD-11 is based on the evidence that individuals with the disorder have a poorer prognosis and may benefit from different treatments as compared to individuals with PTSD (29). CPTSD may require a longer treatment duration and benefit from a more diverse range of interventions compared to PTSD, particularly those that address disturbances in self-organization (30). Furthermore, these findings highlight the importance of adapting and tailoring interventions to accommodate ongoing stressors and the nature of chronic trauma.

4. DEPRESSION

Depression is a major issue among military personnel and veterans and frequently co-occurs with other mental health disorders such as PTSD. Among veterans with clinical depression, the rates of comorbid PTSD ranges from 36% to 51% (31,32). A meta-analysis of 25 epidemiological studies estimated the prevalence of recent MDD based on the DSM-IV criteria at rates of 12% among currently deployed U.S. military personnel and 13.1% among previously deployed (33). Military personnel with depression often report physical health problems, such as chronic pain or fatigue and alcohol and drug use can be a coping mechanism that exacerbate the condition and lead to additional health problems. Major depressive disorder is a major risk factor for suicide among military personnel and veterans (34). Treating depression in military personnel requires a comprehensive and multi-faceted approach due to the unique stressors and experiences associated with military service. The recent guidelines recommend integration of mental health services into primary care settings to ensure military personnel receive comprehensive care. Evidence-based treatment include cognitive-behavioural therapy, interpersonal therapy and antidepressants. Studies have shown that teletherapy can be as effective as in-person therapy for treating depression, providing flexibility and convenience for service members. Peer support programs and support groups provide a sense of community and shared experience. Wellness programs, mindfulness and stress reduction tailored to the interests and abilities of military personnel can enhance both physical and mental health (33).

5. ACOHOL AND SUBSTANCE USE DISORDERS

Throughout history, alcohol has held a prominent position in military culture, serving as a common method for managing stress among service members worldwide, both during active duty and in the post-conflict period (35). Substance use disorders (SUDs) among military personnel are significant concerns that can have profound effects on individuals, families, and society (36). SUDs are particularly prevalent among veterans experiencing chronic pain, traumatic brain injury, trauma, and homelessness, and is associated with increased risk for suicide. It is estimated, that around 53% of Veterans have experienced an SUD at some point in their lives (37). Military-specific characteristics and experiences, including service type, rank, and deployment status, have been consistently associated with elevated levels of alcohol use within military populations across

various countries (38). Despite ongoing efforts to address this issue, rates of SUDs among veterans continue to rise (37). Long-standing social and cultural traditions in the military, as well as idealized portrayals of alcohol use, need to be actively addressed by promoting a more balanced perspective on alcohol use. Treatment for substance use disorders in the military context should include specialized approaches tailored to the unique challenges and dynamics of military life. The aim is to provide comprehensive support addressing the addiction and underlying psychological or social factors, and often incorporates elements such as leadership involvement, peer support, and integration with existing military healthcare systems to ensure a holistic and effective approach to recovery.

6. STIGMA

Mental health stigma is a significant barrier to seeking mental health treatment, and even more so among military personnel and veterans than civilian counterparts, with profound implications for the well-being and quality of life. Approximately 60% of military personnel who experience mental health problems do not seek help, yet many of them could benefit from professional treatment (39). Stigma can lead to isolation and increased suicide risk. Service members who do not seek help may struggle with daily functioning and experience a decline in their physical and mental health. A hallmark of military culture is an ethos of “service before self”, which places great value on qualities such as toughness, self-confidence and resilience. Admitting mental health issues is often perceived as a sign of weakness, which contradicts these cultural values. Service members may fear judgment from peers and superiors if they disclose mental health problems with perceptions of how leaders view mental health care as a significant predictor of stigma beliefs and help-seeking behaviour by military personnel (40). This fear can lead to concerns about being seen as unfit for duty or less capable compared to their peers (41). Addressing mental health stigma in the military requires concerted efforts across multiple levels, from individual service members to leadership and institutional policies. Education and training to enhance mental health literacy resilience training, and peer support can help lower barriers to care. In addition, leadership that fosters a help-seeking culture through policies, procedures, and role modelling that destigmatize mental health care will enhance care utilization and foster military readiness (41).

7. SUICIDE

Worldwide, military personnel are considered as a high-risk subgroup for suicide. In response, several countries and organizations have initiated or strengthened their monitoring of suicide deaths and attempts within the armed forces (42). The results of a meta-analysis show that the prevalence of suicidal ideation and attempts within the military community is 11% (43). For military personnel with substance use disorders, the prevalence of suicidal ideation and attempts was significantly higher. The pooled prevalence of suicidal ideation among veterans was higher than that among active military personnel (14% vs. 10%) (43). Furthermore, suicidal ideation was more common among women than men within these populations (43). The use of firearms was found to be among the most prevalent suicide methods in the military population across nations (42). Educational programs on mental health and suicide prevention play a crucial role in increasing awareness, enhancing mental health literacy, and fostering positive attitudes (42). While suicide and related behaviours have historically been considered primarily a mental health issue, peers, organizations, and leaders exert significant influence on military service members with respect to suicidal behaviours. Many interventions for suicide have also focused primarily on treating suicide in clinical settings, but those impacted by suicidal behaviours are influenced by

factors before, during, and after a suicidal act occurs. New conceptualizations of suicide as an event that unfolds over time encourage the application of risk management models that encourage planning and interventions that address a range of factors relevant to individuals, communities, and systems, in the pre-event, event, and post-event time periods to create a comprehensive approach to suicide prevention and response (44).

It is of utmost importance to overcome barriers to care both before and after the onset of suicidal ideation. An example of best practice at a policy level could be the implementation of the requirements laid out under the Brandon Act. The Brandon Act named after Petty Officer 3rd Class Brandon Caserta, who died by suicide in 2018, allows service members to request a mental health evaluation just by making the request to their supervisor (45). Implementing systematic follow-up for suicide attempters, restricting access to lethal means during periods of heightened risk, and ensuring media engagement adheres to guidelines for responsible suicide reporting may be effective measures for reducing suicide rates (42). Large scale universal education and training programs on suicide prevention have been largely ineffective in altering the trajectory of suicide in the military. Any program, policy, or procedure should consider specifically which individuals are at risk for suicide and when the risk is greatest, and then provide screening and interventions tailored to these identified populations and time periods. Use of big data analytics increasingly allows for a precision medicine approach to better identify who is at risk for various adverse outcomes and when the risk is highest (46). Suicide prevention in military organizations is also a collective responsibility involving committed and engaged leadership, an accessible healthcare system that provides evidence-based care, and an educated and empowered membership.

SUMMARY

Military personnel face unique risk factors for mental health problems, such as direct combat exposure, frequent deployments, intense work schedules, and a high-pressure environment. Stigma surrounding mental health issues within the military culture often discourages seeking help. Protective factors like unit cohesion, immediate access to support services, and proper training in stress management can mitigate these risks. Combat and operational stress reaction (COSR) is a common reaction to high-stress events, and interventions emphasize addressing basic needs, providing safety, normalizing psychological reactions, and educating about stress-related responses. Telehealth services and mobile applications offer promising solutions for managing COSR. Post-traumatic stress disorder (PTSD) and depression are major mental health issues among military personnel and veterans. A significant portion of these populations suffer from PTSD, with a subset meeting criteria for complex PTSD. Effective treatment includes trauma-focused psychotherapy which may be delivered via secure video teleconferencing. Depression frequently co-occurs with other mental health disorders and physical health issues, with evidence-based treatments including cognitive-behavioural therapy, antidepressants, and teletherapy. Substance use disorders (SUDs) are prevalent among military personnel and veterans, often related to stress management and coping with trauma. Comprehensive treatment approaches should address addiction and underlying psychological or social factors, involving leadership, peer support, and integration with military healthcare systems. Stigma is a major barrier to seeking mental health treatment, leading to isolation and increased suicide risk. Efforts to reduce stigma include education, resilience training, leadership involvement, peer support programs, and policy changes. Military personnel and veterans are a high-risk subgroup for suicide. Suicide prevention efforts

include enhanced monitoring, educational programs on mental health, and initiatives like the Brandon Act, which allows service members to request mental health evaluations, and precision medicine approaches that more effective identify individuals and time periods where risk is most concentrated, while also conceptualizing suicide as an event influenced by multiple factors across time. Effective prevention requires identifying where risk is most concentrated, committed leadership, a high-quality healthcare system, and an educated and empowered military membership.

CONCLUSION

Addressing mental health and suicide prevention in military personnel and veterans requires comprehensive and coordinated efforts. The adverse effects of combat and non-combat stressors significantly impact the mental well-being of service members and veterans. High rates of PTSD, depression, substance use disorders, and suicidal ideation highlight the urgent need for targeted interventions and support systems. Effective mental health care in the military context must integrate early detection, access to evidence-based treatments, and a culture that encourages seeking help without fear of stigma. Protective factors such as unit cohesion, peer support, and proper training in stress management play essential roles in mitigating the risks associated with military service. Suicide prevention requires effective methods of identifying individuals and time periods of greatest risk, a collaborative approach involving committed leadership, accessible healthcare systems, and educational programs to enhance mental health awareness. Ultimately, safeguarding the mental health of military personnel and veterans not only enhances individual well-being but also contributes to military readiness and global security. By fostering a supportive environment and addressing mental health comprehensively, we can reduce the incidence of mental health issues and suicides within these populations.

RECOMMENDATIONS FOR ACTION

Recommendations for Military Personnel and Veterans

1. Participate in mental health education and training and suicide prevention if provided in basic and ongoing military training programs.
2. Increase awareness and understanding of mental health issues to reduce stigma and encourage help-seeking behaviour.
3. Utilize peer support networks and buddy systems to provide emotional support and early intervention among peers.
4. Engage in self-care that promotes resilience: avoid alcohol and substances, exercise, take meals regularly and maintain a regular sleep routine, spend time in nature, spent time with family and peers etc.

Recommendations for Military Leadership

1. Promote awareness and understanding of mental health issues among leaders to reduce stigma and encourage help-seeking behaviour.
2. Improve leaders' willingness to talk openly about mental health, share personal experiences and promote a culture of support.
3. Provide management of combat and operational stress reactions within the unit applying the principles of proximity, immediacy, expectancy, and simplicity.
4. Build partnerships with civilian mental health organizations to share best practices and resources.

Recommendations for Psychiatric Prevention and Care

1. Integrate mental health into primary care and ensure mental health screenings and services are available in primary care settings to facilitate early detection and treatment.
2. Expand the use of secure telehealth platforms to provide accessible mental health care, especially for those in remote or deployed locations.
3. Apply targeted interventions by implementing specialized programs for groups at higher risk, such as those with a history of trauma, with substance use disorders, and women.
4. Provide comprehensive support addressing underlying psychological and social factors contributing to mental health issues through holistic treatment approaches.
5. Ensure access to counselling to help personnel process their experiences and reduce feelings of guilt or moral injury.
6. Collaborate with civilian organizations to facilitate better integration of veterans into civilian communities through joint programs and initiatives.
7. Keep pace with the recommendations and guidelines for assessment, diagnosing and treatment of the mental health conditions in military personnel and veterans.

Recommendations for Policy and Governance

1. Implement stigma reduction measures that encourage people to speak openly about mental health issues without fear of reprisal or career repercussions
2. Ensure educational programmes to reduce stigma and regular workshops and seminars to raise awareness about the importance of mental health and reducing stigma.
3. Enhance suicide prevention strategies that allow monitoring and surveillance of suicidal behaviours (ideation, attempts, deaths) to identify trends and develop targeted prevention strategies.
4. Restrict access to lethal means by measures to control access to firearms and other means of suicide within the military.
5. Ensure systematic follow-up care for those who have attempted suicide or exhibited suicidal ideation.
6. Support the transition to civilian life by developing reintegration programs and family support services.
7. Promote research by funding and supporting research on mental health issues in the military population to develop evidence-based interventions.
8. Promote data collection by establishing comprehensive data collection systems to track mental health outcomes and the effectiveness of interventions.

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