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Forces in Mind Trust's Response to the 'Informing the mental health strategy for England' Call for Evidence

Forces in Mind Trust (FiMT) was founded in 2011 to improve transition to civilian life for Service leavers and their families. Our mission is to enable successful transition to civilian life, and our strategy is to provide an evidence base that will influence and underpin effective policy making and practice.

The Armed Forces community is a significant population with distinct experiences that can shape mental health need, access to support and wider outcomes. As of 1 April 2026, there were 183,410 UK Service personnel, and Census 2021 data identified just over 1.85 million UK Armed Forces veterans living in England and Wales. This population is diverse in age, geography, Service history and family circumstances, and mental health need can be shaped by factors such as Service experience, transition, physical health, housing, employment, welfare, family life and social connection.

The Armed Forces Covenant sets out that those who serve, have served, and their families should face no disadvantage in accessing public and commercial services, and that special consideration may be appropriate for those who have given the most, such as the injured and bereaved. In healthcare, this means that the Armed Forces community should receive the same standard of, and access to, healthcare as the civilian population, with priority treatment for veterans where a condition is related to Service, subject to clinical need. The Covenant Legal Duty also requires relevant public bodies to have due regard to Covenant principles in specified functions, including healthcare, housing and education. The Government has announced an extension of the Legal Duty across all UK Government departments and devolved governments, and into wider policy areas including social care, welfare benefits, employment, criminal justice and pensions.

FiMT's response is informed by the research we have funded and the wider evidence base on the mental health and wellbeing of the Armed Forces community. Across this evidence, several consistent themes emerge:

1. the need to improve identification and recording of Armed Forces status across NHS service
2. the importance of Armed Forces-aware, trauma-informed and holistic care
3. the value of integrated pathways between primary care, Op COURAGE, NHS mental health services, local authorities, welfare, housing, employment and the voluntary sector
4. and the importance of earlier prevention, especially during Service, transition and post-discharge.

Our response therefore focuses on how England's Mental Health Strategy can better identify and understand the Armed Forces community, prevent need escalating, improve continuity of care, and embed the Armed Forces Covenant in commissioning, delivery and oversight.

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Q1. How can mental health services work more effectively across these areas? Please provide examples of cross-sector pathways in practice. (Optional, maximum 300 words)

FiMT's Call to Mind[1] set of reports found that low identification of veterans and family members in primary care, poor data collection and recording, and weak local needs assessments were core barriers to effective commissioning of support services. To better understand and identify this cohort, provisions need to be in place, such as the veteran-friendly GP practice accreditation scheme, through which practices pledge to deliver specific healthcare guarantees, including identification of the Armed Forces community.

There has been significant progress made in mental health initiatives and support for the Armed Forces community, including veteran-specific services such as NHS England's Op COURAGE. However, delivery is inconsistent locally, hampered by poor regional data on health and social care needs. Some ex-Service personnel can also experience the support landscape as confusing and have difficulty understanding which organisation is best suited to their needs or whether they are eligible. Additional challenges include long waiting times[2] and a lack of understanding of military experiences and the Armed Forces Covenant[3] by civilian healthcare professionals.

Our recent report Future Scenarios for Mental Health in the UK Armed Forces Community,[4] reinforces the need for services to plan collaboratively for future demand. It highlights that wider societal pressures and Service-specific factors will shape future mental health need, and that effective responses will require mental health services to work more closely with local authorities, the NHS, government and third sector organisations.

Cross-sector pathways should therefore be built around veteran identification, not only referral. The starting point should be a consistent identification question in primary care, secondary care and new neighbourhood health centres, coded in records to enable identification, referral and support that take account of Armed Forces community status and the needs that may come with it.

Q2. What further support should be provided for people with severe and enduring mental illness? (Optional, maximum 300 words)

For people with severe and enduring mental illness, support should be specialist where needed, in addition to what is received through primary and secondary care. FiMT evidence shows that service-related mental health needs often sit alongside other needs, for example, those associated with physical injury, alcohol or substance use, gambling harms, welfare, employment, housing and family pressures. Support, therefore, needs to be multidisciplinary, trauma-informed and Armed Forces-

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[1] https://www.fim-trust.org/wp-content/uploads/call-to-mind-united-kingdom.pdf
[2] https://s31949.pcdn.co/wp-content/uploads/stigma-barriers-care-service-leavers-mental-health-problems.pdf
[3] https://s31949.pcdn.co/wp-content/uploads/A-Decade-of-the-Covenant-Digital.pdf
[4] https://s31949.pcdn.co/wp-content/uploads/RR-A4652-1_Future-scenarios-for-mental-health_FINAL.pdf

aware. As such, support services need to be coordinated and collaborative across sectors such as the NHS, relevant Government departments and third sector support services.

Op COURAGE is an essential foundation, and its expansion to include specialist addiction support is welcome. However, people with treatment-resistant PTSD, CPTSD or moral injury could benefit from access to evaluated and emerging interventions, where standard interventions may no longer be effective. FiMT-funded work has supported UK trials of 3MDR[5] for treatment-resistant PTSD, MDMA-assisted therapy research[6] for chronic PTSD, ESTAIR[7] for complex PTSD, and Restore and Rebuild[8] for moral injury.

To address the delays in transferring medical records between Defence and civilian health care, which can impact support and treatment times, FiMT is aware of reported delays in Programme Cortisone and would urge NHS England, the Department for Health and Social Care and the Ministry of Defence to address these as a priority.

Q3. What are the main barriers to continuity of care across transitions between hospital and community services, and between different levels of care, including child to adult services?

Please provide examples from either side of the transition and outline how these barriers could be effectively addressed. (Optional, maximum 300 words)

Whether someone has served in the UK Armed Forces is not consistently recorded in healthcare records. This can make it harder for clinicians to understand whether military-related factors are relevant, whether someone is eligible for specialist support, and how to maintain continuity of care across services. Consistent recording of Armed Forces status would also improve research and local needs assessment.

FiMT-funded evidence shows that identification can be improved. University of Chester[9] research found that low-cost measures, including posters, text messages, community links and engagement with care homes, increased veteran registration in primary care by up to 218% in North West England. King's College London's FiMT-funded Military Service Identification Tool (MSIT)[10], tested at South London and Maudsley NHS Foundation Trust, also demonstrated that electronic records can identify ex-Service personnel in mental health services. It found that ex-Service personnel were more likely than those without military experience to have diagnoses of depressive, anxiety, personality and psychotic disorders. Complementing this, FiMT-funded Clinical Practice Research Datalink (CPRD) Aurum[11] research analysed records for over 122,000 former Service personnel and found higher

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[5] https://www.fim-trust.org/news-policy-item/new-film-explains-how-3mdr-can-help-veterans-with-ptsd/
[6] https://www.fim-trust.org/news-policy-item/new-research-further-progresses-mdma-assisted-therapy-for-ptsd-for-uk-veterans/
[7] https://www.fim-trust.org/news-policy-item/pioneering-intervention-for-complex-ptsd-shows-encouraging-early-results-for-ex-service-personnel/
[8] https://www.fim-trust.org/news-policy-item/new-moral-injury-treatment-shows-early-successes-for-uk-veterans/
[9] https://s31949.pcdn.co/wp-content/uploads/DIGITALWhere-Are-All-the-Veterans-June-2022.pdf
[10] https://s31949.pcdn.co/wp-content/uploads/20220930-FiMT-Report-2022-v12b.pdf
[11] https://s31949.pcdn.co/wp-content/uploads/20260224-CPRD_Aurum_Report_2025-FINAL.pdf

recorded prevalence of depression and PTSD, alongside some physical conditions, compared with a matched general population group.

Together, this evidence supports a standard Armed Forces connection question and coding approach across NHS settings, including through Veteran Friendly GP accreditation. Continuity also requires a holistic approach, with stronger links between NHS services, welfare, housing, employment, social care and the voluntary sector. FiMT research on ex-Service personnel's experiences of the benefits system found that navigating complex welfare processes can negatively affect mental health and contribute to disengagement from services.

Specific attention is also needed for Early Service Leavers, medically discharged personnel, and children in Armed Forces families, who may face disrupted transitions, relocation, or gaps between CAMHS and adult services.

Q4. What evidence and innovative examples are there of digital and AI tools being used to achieve these outcomes? Please provide examples. (Optional, maximum 300 words)

Digital tools can help when they complement, rather than replace. FiMT-funded examples include Drinks:Ration[12], which helped UK ex-Service personnel assess, understand and reduce alcohol consumption. MeT4VeT[13], a mental health toolkit designed to help veterans ecognize difficulties before reaching crisis level and engage with support earlier; and digital/teletherapy models[14] that can improve access for people who live far from specialist services or find face-to-face support difficult.

As set out previously in our response to Q2, investment is also needed to continue funding innovative treatments for ex-Service personnel, particularly for mental health difficulties related to their time in service and where current treatment has been shown to be less effective for ex-Service personnel, such as treatment for PTSD and complex PTSD. FiMT has funded several studies under our Mental Health Research Programme, including pilot studies and evaluations of new treatments for veterans and interventions to help identify and treat mental health concerns early on. This has included funding new treatments for PTSD and Complex PTSD as well as moral injury.

FiMT recommends that digital accessibility be treated as a design requirement, not an afterthought. Some veterans face specific barriers to digital access, including older age, sensory impairment, PTSD or CPTSD, lower socio-economic status, and low digital confidence. FiMT's position is that every digital offer should be accompanied by in-person, telephone and family-supported alternatives as standard.

Q5. How can data be used more innovatively to improve mental health and wider societal outcomes? Please provide examples. (Optional, maximum 300 words)

FiMT's Call to Mind work found poor population-based assessment and low identification of veterans and family members in primary care health needs assessments. Subsequent FiMT-funded projects showed how this can be improved. The University of Chester's primary care work demonstrated that

[12] https://s31949.pcdn.co/wp-content/uploads/RationAppReport-Final.pdf
[13] https://s31949.pcdn.co/wp-content/uploads/20220708-MeT4VeT-FiMT-Report-Final.pdf
[14] https://www.fim-trust.org/news-policy-item/novel-approach-sees-success-in-treating-former-service-personnel-with-ptsd/

simple measures such as registration prompts, posters, text messages and community links can increase veteran identification. The Military Service Identification Tool showed that electronic records can be used to identify ex-Service personnel in mental health services. The CPRD Aurum research provides a further step, using large-scale primary care data and military-related SNOMED codes to compare veteran and non-veteran physical and mental health outcomes.

FiMT's funded research spanning primary care identification, electronic health records and large-scale data analysis consistently demonstrates the need for a standard Armed Forces connection question across all NHS settings. DHSC should consider establishing a requirement for a standard Armed Forces connection question and coding approach across primary, secondary and community care, including for families where appropriate. Data should be linked with outcomes such as waiting times, treatment completion, crisis presentations, employment, housing, social participation and physical health checks. This dataset could help healthcare services and local authorities identify unmet needs and implement earlier intervention.

Q6. Which preventative approaches have the strongest evidence for reducing incidence or severity of mental health problems and promoting good mental health? (Optional, maximum 300 words)

The strongest preventative approaches for the Armed Forces community combine early identification, self-recognition and trusted access routes. FiMT-funded research on stigma and barriers to care[15] found that stigma is not the only, or always the primary, reason ex-Service personnel do not seek help. Barriers include not recognising a problem, believing they are not worthy of help, practical access issues, eligibility concerns, long waits and negative prior experiences. Prevention must therefore begin before crisis and make support easy to recognise, navigate and trust.

Practical measures include universal Armed Forces connection recording in health services; Veteran Friendly GP accreditation; routine screening for alcohol, gambling, physical health and social needs where mental health concerns are identified; and clear referral routes into Op COURAGE, local VCSE and social prescribing. Low-cost primary care identification initiatives funded by FiMT increased veteran registration by up to 218% in one North West England study, demonstrating that simple interventions can change access and behaviours.

Preventing severity also means intervening on co-occurring risks. FiMT'S response to the Men's Mental Health Strategy highlighted the links between hazardous alcohol use, smoking, gambling, diabetes, cardiovascular disease and mental health.. Digital tools such as Drinks:Ration and MeT4VeT can support self-monitoring and early action but should sit alongside face-to-face and family support.

Prevention should also begin during Service and transition. FiMT's Understanding the transition from Military to Civilian Life[16] highlights that Early Service Leavers, medically discharged personnel, and those with complex health or social needs, may face greater risk and may not engage early enough. Preventative approaches should therefore include personalised transition planning, family-inclusive support, peer connection, and practical advice on housing, employment, finances and health.

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[15] https://www.fim-trust.org/news-policy-item/new-research-finds-mental-health-stigma-not-main-barrier-ex-service-personnel-seeking-help/
[16] https://s31949.pcdn.co/wp-content/uploads/Transition-Study-Report_V5.pdf

Q7. Which preventative approaches have the strongest evidence for reducing the numbers of lives lost to suicide? (Optional, maximum 300 words)

Suicide prevention should be targeted, proactive and cross-sector. Evidence indicates that Veterans overall are not necessarily at higher risk than the general population, but risk is concentrated in particular subgroups. Compared to the general population, suicide risk is higher for ex-Service personnel under 25 and lower for those aged over 25 (MOD, 2025). A UK cohort study found[17] suicide risk was two to three times higher for veterans aged under 25 compared with the same age groups in the general population, and lowest specialist mental health service contact among the youngest veterans who died by suicide.

FiMT's funded research on stigma and barriers to care[18] found that some ex-Service personnel delay help-seeking because they do not recognise problems, feel ashamed or unworthy of help, or have had poor prior experiences. Prevention should therefore include outreach, peer support, and interventions and referral routes able to support the unique needs of the Armed Forces Community. Local suicide prevention partnerships should routinely include Armed Forces community data, and veteran-aware bereavement support such as the Beyond the Wire Hub[19].

Q8. How can services better support the 'missing middle' - those with sustained needs (that affect their participation in community life, for example, in education or work) who may not meet the criteria for NHS mental health services? Please provide examples. (Optional, maximum 300 words)

The missing middle should be supported through open-access, veteran-aware community offers that do not require people to reach a crisis point before help is available and integrate a 'no wrong door' approach.

To help prevent and address the health needs of ex-Service personnel, a holistic approach to the provision of care is required. This includes ensuring that services for ex-Service personnel with mental health concerns also encompass physical health and explore all contributory factors to poor mental health, including those related and un-related to service.

Veteran Friendly GP practices and other services should ask and code an Armed Forces connection, use holistic assessments, and refer to services able to support the specific needs of ex-Service personnel. Referrals should be made to Op COURAGE where thresholds are met, but also to VCSE, peer support and wider holistic support services such as employment and housing where clinical thresholds are not met. This would reduce the confusion many ex-Service personnel report about which organisation is right for them.

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[17] https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1004273
[18] https://s31949.pcdn.co/wp-content/uploads/stigma-barriers-care-service-leavers-mental-health-problems.pdf
[19] https://beyondthewire.org.uk/

Q9. What commissioning, funding and oversight or accountability arrangements (nationally and locally) best support safe and integrated mental health services that improve outcomes across mental health, participation in work, education and community life, and social functioning? Please provide examples. (Optional, maximum 300 words)

Commissioning, funding and oversight arrangements should make the Armed Forces Covenant a practical framework for integrated mental health support. The Covenant commitment is that the Armed Forces community should face no disadvantage in accessing public services, and that special provision may be necessary for some, such as the injured or bereaved. This should be embedded in local mental health commissioning and across all relevant mental health services.

FiMT welcomes progress through Veteran Friendly GP accreditation, Veteran Aware NHS Trusts and Op COURAGE. However, FiMT evidence also shows that low identification of veterans and family members, weak local needs assessment and inconsistent or fragmented local pathways remain barriers to effective support. The Covenant Legal Duty should therefore be used to require relevant public bodies to demonstrate how they have considered the Armed Forces community in mental health planning, commissioning and oversight.

Further action is needed to ensure consistency when the Armed Forces community access civilian mental health services. This should include:

- **Increasing participation in existing veteran health initiatives**, such as the veteran-friendly GP scheme, and extending them to families. FiMT-funded research, Where are all the veterans?, showed that low-cost, practical initiatives can improve veteran GP registration.
- **Health providers and commissioners should also work closely with partners** such as local authorities, social care, public health and wider well-being to deliver the Covenant locally. FiMT's The Decade of the Covenant report[20] provides insights into the core infrastructure needed to support the Armed Forces community.
- **Ongoing training of healthcare staff on the unique experiences of the Armed Forces community,** as well as specific support and services available to the community, particularly where front-line turnover is high.
- **Improved identification of veterans and their families** within primary and secondary healthcare to strengthen data, prevention and treatment planning.

[20] s31949.pcdn.co/wp-content/uploads/A-Decade-of-the-Covenant-Digital.pdf