A good soldier gone bad!

Workshop

A presentation by Veterans about Veterans

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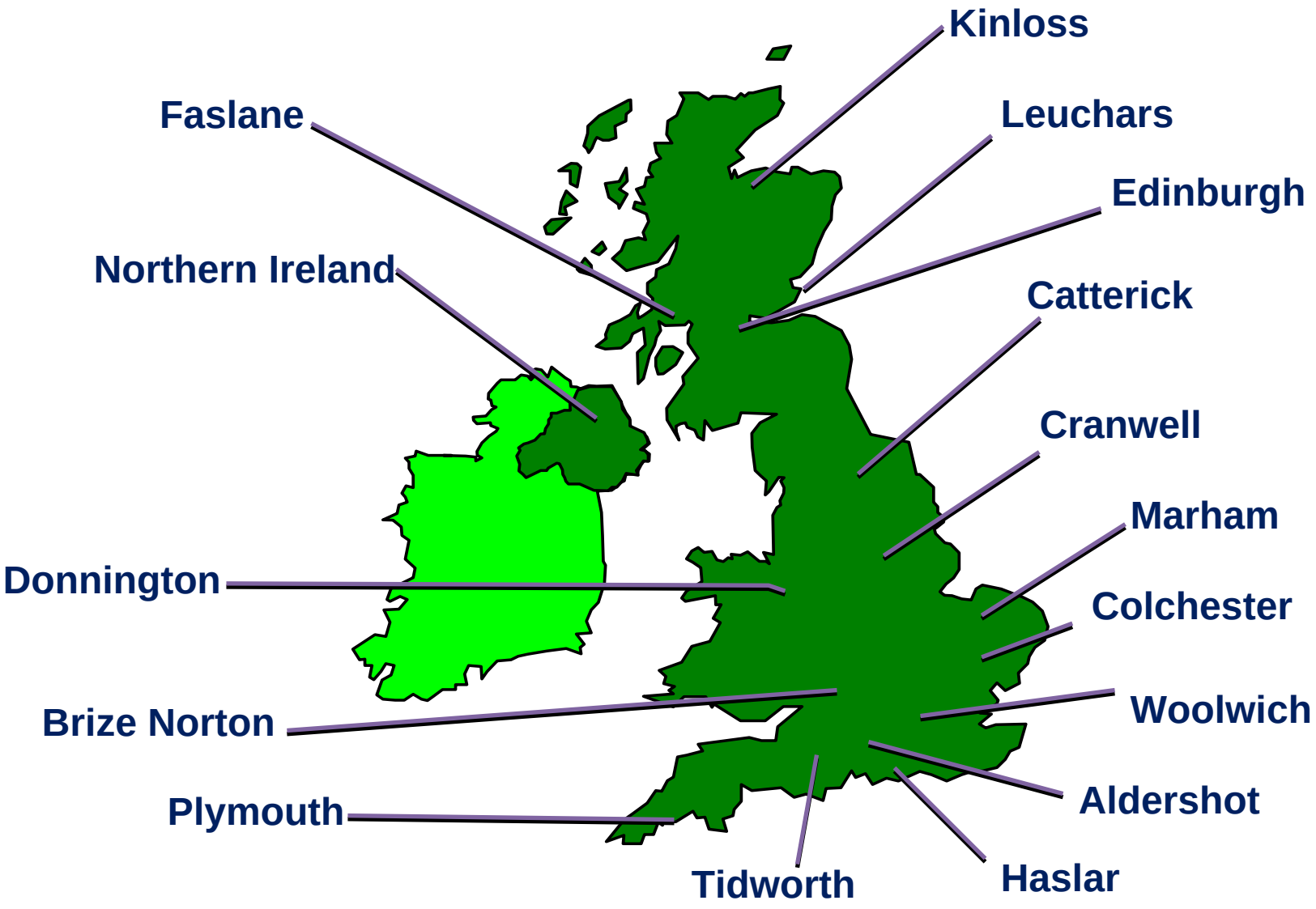
COMBAT STRESS

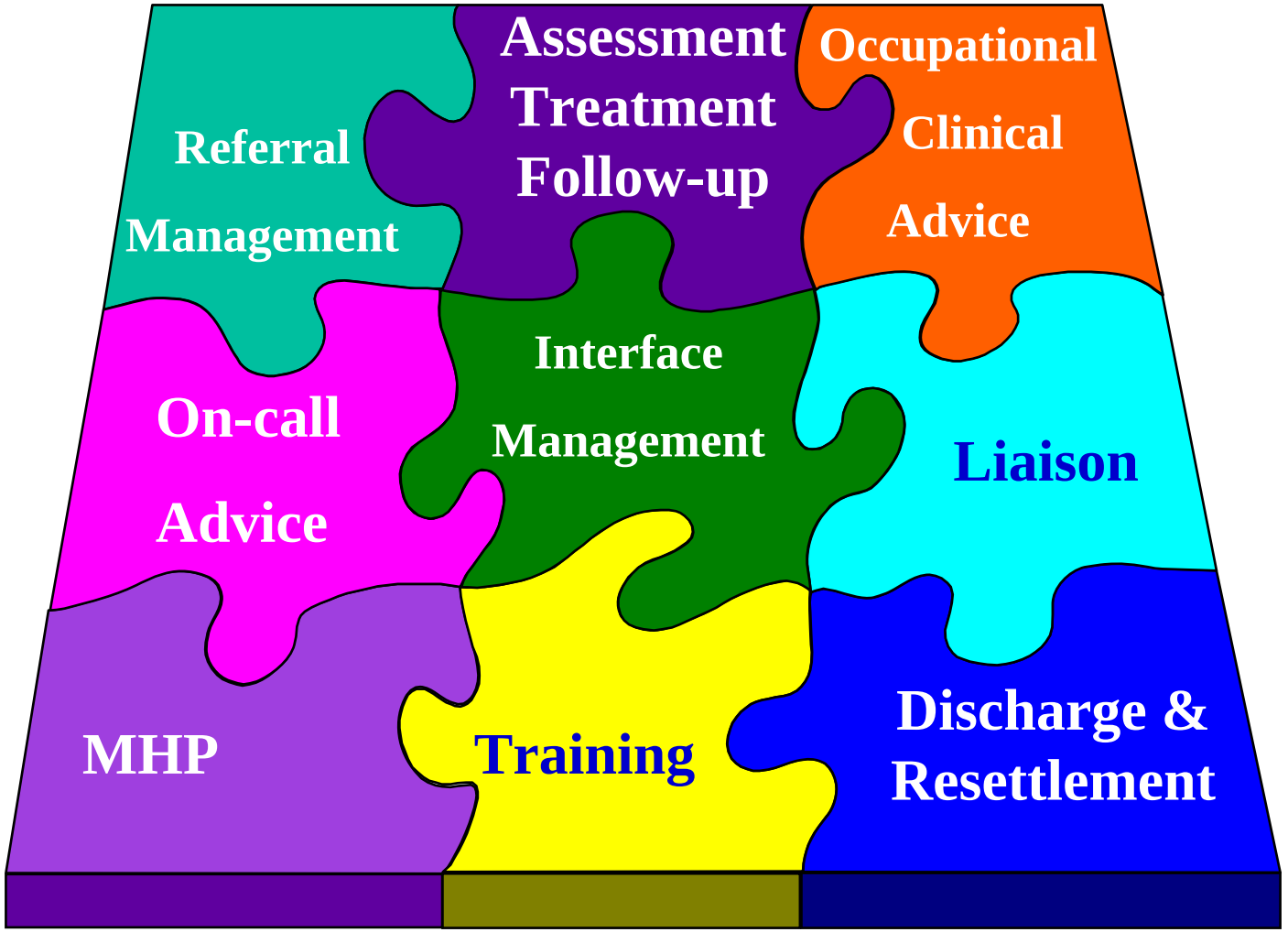
UK Departments of Community Mental Health



STRUCTURE OF A "TYPICAL" DCMH

Catchment Population:	10-20,000 Servicemen (Tri-Service).
Geographical Area:	Varies widely.
Location:	On a military base. Often co-located with Primary Care Centre.
Clinical Staff (Military & Civilian):	1/2 Psychiatrists (military and/or civilian MOD). 6 Community Mental Health Nurses. 1 Regional Clinical Psychologist. 1 Regional Psychiatric Social Worker.
Admin Support:	2/3 Secretarial/clerical.

DCMH SERVICE PROVISION OUTPUTS



CLINICAL WORKLOAD

- COMMUNITY - BASED
  - 5500 New outpatients seen per year (3% of military population).
  - 15000 Review appointments per year.

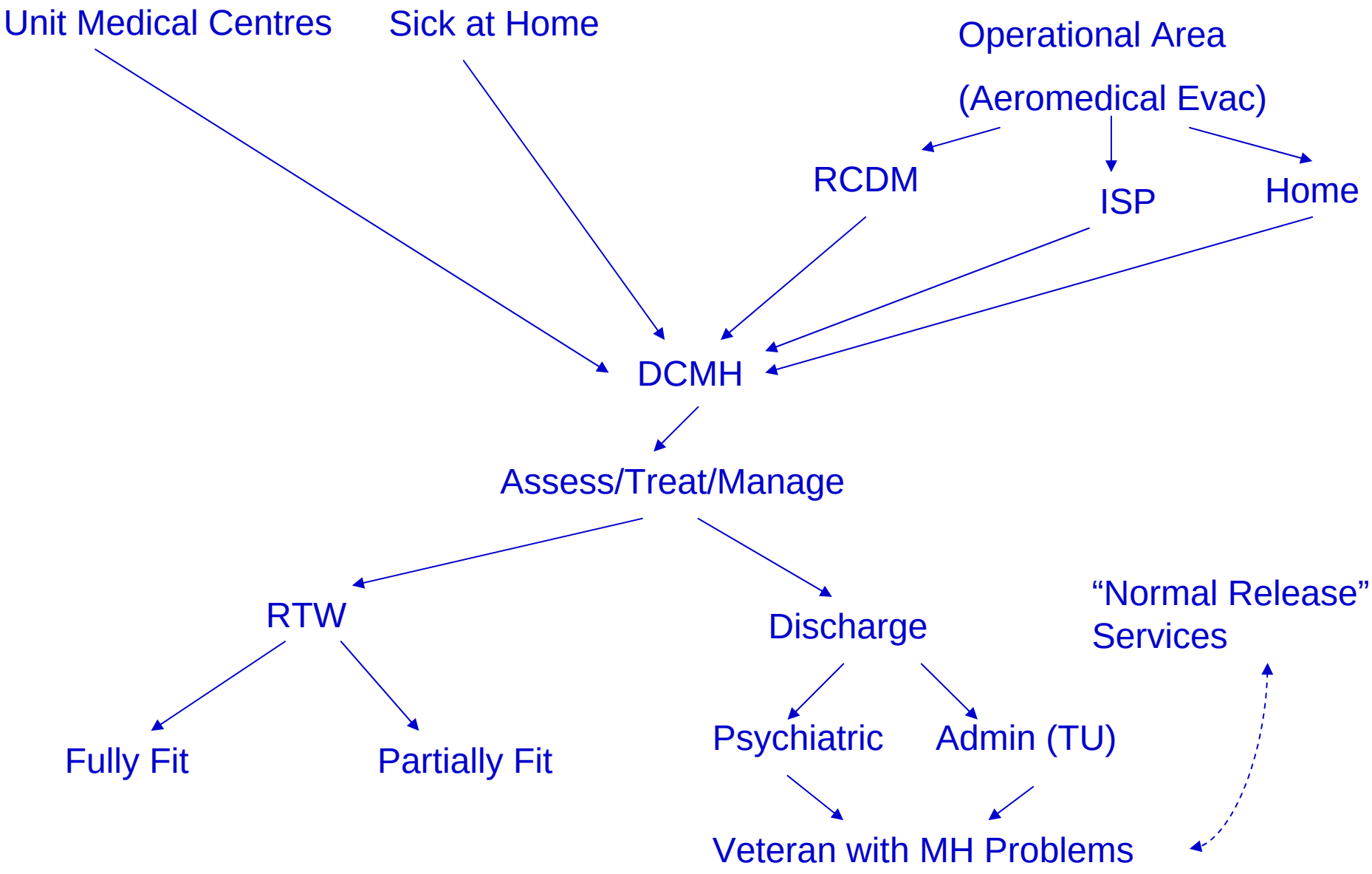
INPATIENTS

- Approx. 350 per year.

DCMH WORKLOAD/TARGETS

- 0830 - 1700 hrs
- No out of hours service except x1 National “On Call” CMHN for advice to GPs.
- All “cold” referrals seen < 20 working days.
- All “urgent” referrals seen < 24 hours.

PATIENT PATHWAYS



DIAGNOSTIC BREAKDOWN (COMMUNITY OUTPATIENTS)

Diagnosis	Percentage
Anxiety Related/Adjustment Disorders	25%
Mood Disorders	18%
Psychoactive Substance Misuse: Alcohol – Harmful Misuse Alcohol Dependence Other Drugs	25% 14% 10% 1%
Schizophrenia	5%
PTSD	3%
Personality Disorder	3%
Organic Mental Disorder	1%
No Diagnosis	20%

DIAGNOSTIC BREAKDOWN (INPATIENTS)

Diagnosis	Percentage
Mood Disorders	31%
Alcohol Problems	26%
Anxiety Related/Adjustment Disorders	17%
Psychotic Illness	9%
PTSD	6%
Deliberate Self Harm	3%
Other Substance Misuse	2%
Personality Disorder	1%
Eating Disorders	1%
OCD	1%
Organic Disorder	1%
No Diagnosis	8%

MILITARY MENTAL HEALTH MISSION

- To provide service personnel with speedy access to skilled, effective treatment/management that is flexible and based around individual needs.
- An occupational approach geared to recovery and rehabilitation, ensuring that wherever possible service personnel are returned to duty rapidly or supported and enabled to make a smooth seamless transition back into civilian life.
- Treatment, care and rehabilitation should be provided in close proximity to the person's work environment to maximise occupational recovery and in close partnership with primary care facilities.
- Emphasis is upon Force Generation i.e. to maximise numbers of service personnel available for their operational role at their highest level of mental health fitness.

MENTAL HEALTH SERVICES OPERATIONAL ROLE

- DMS MHS staff support military operations via deployment of psychiatrists and community mental health nurses.
  - Iraq.
  - Afghanistan.
- 2003 Psychiatrists and nurses deployed to all parts of the operational area.
  - Forward.
  - Divisional areas.
  - Rear areas.
  - UK.
- RAF MHS support aeromedical evacuation of service personnel from both operational and non operational areas.

CHALLENGES /PROBLEMS

- De-stigmatisation of mental ill health.
- Ethics and Doctrine of Forward Psychiatry in modern warfare.
- The problem of “unhappy soldiers”.
- Detecting psychological injury in Service Personnel.

CHALLENGES /PROBLEMS (contd...)

- Seamless transfer of care at time of S8 Discharge to:
  - NHS.
  - Local Authorities.
  - Combat Stress.
- Mental Healthcare of Veterans
  - DMS MHS should provide but is not resourced (and not likely to be).
  - ? Who will do it ? NHS? Private Sector.
  - Number of S8 Discharge=87 between Apr 2009- Mar 2010.

(MENTAL HEALTH) PROBLEMS OF SERVICEMEN ON DISCHARGE/RELEASE

- Ongoing mental health problems.
  - Traumatic injury (PTSD + Sub threshold PTSD + Complex PTSD).
  - Co-Morbidity Common (especially depression and alcohol misuse).
- Un-revealed mental health problems which present years post discharge.
- Unrecognised mental health problems present years post discharge.
- Psycho-Social problems.
  - Accommodation.
  - Work.
  - Relationship difficulties.
  - Personality disorder.
  - Substance misuse.

(MENTAL HEALTH) PROBLEMS OF SERVICEMEN ON DISCHARGE/RELEASE

- Love/hate relationship with the military.
  - Angry at military (justified/not justified).
  - Inability to fit into civilian life.
  - Inability to identify with NHS MHS (“they don’t understand”).
  - Social anxiety/ avoidance.
  - Paranoid ideation.

The man who lost his life in Iraq, now lives in Birmingham.

Wars such as Iraq, Afghanistan, Kosovo, The Gulf and the Falklands have resulted in many victims. For some their battle scars are invisible psychological illnesses.

These casualties have experienced things few of us would want to imagine even in our worst nightmares and they carry the mental scars around with them, often adversely affecting their employment, family and friends.

Many become tragic victims of alcohol and drug abuse, homelessness, and some even become suicidal. These brave ex-Service men and women desperately need help and support.

If you are reading this as an ex-Service man or woman and you think, 'this sounds like me' or you know someone ex-Service who is suffering, please contact us on:

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Accessing Good Mental Health Care

Many veterans say they had NOT accessed help during their military service.

Reasons:

- Loss of career, macho image, stiff upper lip, shame and guilt

- Many coped with mental health symptoms by drinking alcohol to excess.
- Heavy alcohol use can mask anxiety and other symptoms of PTSD.

- **Delayed onset PTSD** is common in British veterans.

- **Delayed onset PTSD** More 33% more likely in first year post military discharge – loss of support structures & adjustment to civilian life increase vulnerability .

(Hoge, et al 2006; Scheiner, 2008; Andrews & Brewin, 2009).

Veterans and Combat Veterans

- **Longitudinal study : Op Telec / Herrick study**
- Even small percentages of veterans with complex mental health needs amount to very large numbers. So far 180000 have been to Iraq and Afghanistan.

- **PTSD:** 4% - n= 8400

(6% reservists; 6.9% combat vets)

- **Alcohol misuse:** 13% n= 23400, higher levels than comparative civilian populations especially in the younger servicemen. **(Fear et al, 2010).**

Fear et al, 2010 Op Telic /Herrick study comparison between US and British Studies

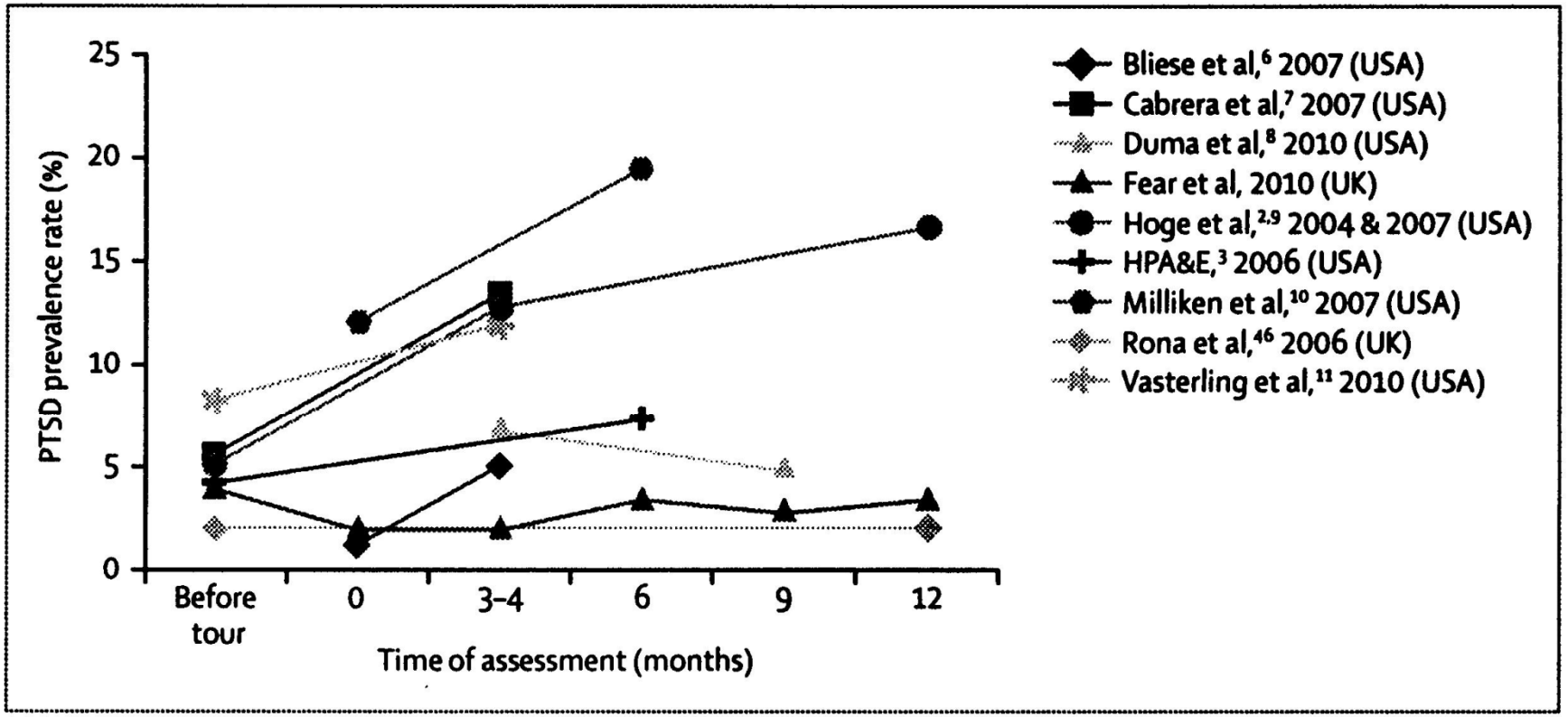

Figure 5: **Prevalence of probable post-traumatic stress disorder (PTSD) within the first year of return since deployment**

Assessment of Need: UK Veteran Population studies

- No studies.
- Estimated 5 million veterans in the UK and 7.5 million first degree dependents.
- Crossectional Population study: would provide a picture of bio-psycho-social needs: aid service planning, investment and target care.
- Gold standard set by the National Vietnam Veterans Readjustment Study (NVVRS, 1990).
- Before this study was performed, assessment and treatment facilities for veterans in the USA were dispersed, variable and inadequate.

Multiple Traumatisation in Adults

Studies of Hostages and POWs *(Busuttil, 1992)*

Stress Disorders *(incl ASD & PTSD):* pre-captivity experiences; initial captivity experience; torture; solitary & group confinement

Depressive Disorders: torture, loss events, captivity experience itself

Cognitive Defect States: weight loss, vitamin deficiencies, CNS infections

Psychotic States: isolation and confinement

Personality - Character Changes: captivity experience itself: coping style and locus of control (includes enduring personality change)

Physical Illness - Somatiform & Genuine

Alcohol/illicit drugs

Enduring Personality Change after Catastrophic Stress (ICD-10, 1992)

Prolonged exposure to life threat/s

PTSD may precede the disorder

features seen after exposure to threat:

- hostile mistrustful attitude towards the world
- social withdrawal
- feelings of emptiness or hopelessness
- chronic feelings of being on edge or threatened
- estrangement

Multiple traumatisation in Children and young people before the age of 26:

Complex PTSD:

Diagnostic framework (Bloom 1999)

Three areas of disturbance -

- Symptoms
- Characterological / personality changes
- Repetition of Harm

Complex PTSD: Disturbance on Three Dimensions

(Herman 1992; Bloom, 1999)

- **Symptoms of :** PTSD
  - Somatic – cf GWS
  - Affective
  - Dissociation
  - (psychotic presentations)
- **Characterological Changes of:**
  - **Control:** Traumatic Bonding
    - Lens of Fear
    - Relationships: Lens of extremity-attachment vs withdrawal
  - **Identity Changes:**
    - Self structures
    - Internalized images of stress
    - Malignant sense of self
    - Fragmentation of the self
- **Repetition of Harm**
  - To the self - faulty boundary setting
  - By others - battery, abuse
  - Of others - become abusers, aggressors
  - Deliberate self harm

Clinical Issues: handy hints

- Assessment – co morbidity
- Preparation essential
- Treat comorbidity first? Alcohol
- Safety, macho, trust in civvies?
- You were not there
- Female therapists
- Anger issues
- Families

Clinical Issues: handy hints

- Why are you looking after a veteran?
- NHS? Signposting? Any use?
- Private Practice?

- About you: have you any military background?
- Have you read any books to provide background?
- Terminology
- Military culture?
- Self disclosure?

Complex presentations:
Treatment Strategy (Herman, 1992)

- Initial preparation
- Stabilisation and safety
- Disclosure and working through of the traumatic material and psychotherapy on an individual basis
- Rehabilitation and reintegration within society; normalising activities of daily living

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Veterans' treatment programmes

- Bespoke Programmes – all are evidence based:
  1. **Intensive** (Australian veterans)
  2. **Alcohol Education** (Australian veterans)
  3. **Refractory chronic PTSD** (American Veterans Association)
  4. **Old age** (Australian veterans)
  5. **Enhanced Rolling Programme** (American Veterans Association)
  6. **Carers Groups** (Australian veterans)

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Intensive Australian Veterans' Programme

Time Limited 4-6 weeks intensive residential 'course' of group treatment comprising:

- **Psychoeducation**
- **Trauma focussed therapies**
- **Cognitive restructuring**
- **Rehabilitation**
- **Referral for Work Re-training**
- **Maintenance in community – follow-on therapies**
- **Follow-up 'top-up' brief residential reunions**
- **Outreach / NHS therapy incl TF-CBT**

Treatment of Anger

- Medications: anti PTSD / anti depressants, Mood stabilisers, Anti – impulse medications, *Anxiolytics* beware disinhibition

- **CBT Anger management** – a treatment adjunct to routine psychological intervention in the treatment of Combat and Veteran related PTSD

Anger Management
General Points

Forbes and Creamer (2003)

- Very common in chronic PTSD veterans.
- Important have skills to control anger before TF work is done.
- Psych ed – enables understanding
- Anxiety mgt – not in isolation – physical, cognitive, behavioural aspects
- Controlled breathing
- Progressive musc relaxation
- Reduce stimulants caffeine, nicotine
- Thought stopping for intrusive mems / phenomena.
- Use of coping self statements / guided self dialogue (Meichenbaum 1985)
- Non-specific Behavioural interventions for isolation, insomnia, incl activity scheduling, communication skills, assertiveness

Cognitive Behavioural approach to anger treatment (12 Sessions)

Chentomb et al, 1997 in Vietnam Vets (Hawaii study)

1. Client education about anger, stress & aggression
2. Self monitoring of anger frequency, intensity and situational triggers
3. Construction of a personal anger provocation hierarchy created from the self monitoring data and used for the practice and testing of coping skills
4. Arousal reduction techniques of progressive muscular relaxation, breathing focussed relaxation ands guided imagery training
5. Cognitive restructuring by altering attentional focus, modifying appraisals and using self instruction
6. Training in behavioural coping and respectful assertiveness as modelled and rehearsed with the therapist
7. Practicing the cognitive, arousal regulatory and behavioural coping skills while visualising and role playing progressively more intense anger arousing scenes from the personal hierarchies.
8. Imaginal provocation
9. Graded exposure
10. Stress inoculation techniques

DO NOT FORGET Dangerousness

Don’t forget to refer!! Forensic assessment

- Do you carry a weapon?
- Have you a weapon in the house, under the bed?
- Do you go out on patrol to check your neighbourhood before you retire for the night?

NHS

- Services patchy

- Training needs:
  - Lack of expertise in assessment and management of psychological trauma cases and PTSD generally (eg GPs study - Elhers et al, 2009).
  - Lack of expertise in Military psychiatry / psychology
  - Lack of appropriate prescribing of medications for complex / chronic PTSD

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Major Challenges for NHS and Combat Stress

- Complex Trauma Presentations (Complex PTSD)
- Acute alcohol / drug Detox – seamless plug into trauma work
- Schedule 1 Sex Offenders
- Forensic cases – imminent violence, severe behavioural disturbance.
- Veterans with mental ill health in the prison population
- Increasing population of Old Age Veterans in the general population – hidden psychiatric morbidity plus locked in chronic PTSD
- Growing number of in service families with psychological and mental health problems ongoing wars 180000 servicemen and women sent to Iraq/Afghanistan so far!!!

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Major Challenges for NHS and Combat Stress:

Physical Injury, severe wounding: psychological implications:

- Badge of courage vs hidden mental stigma
- Long term disability
- Acceptance
- Body image problems
- Sexual issues
- Phantom sensations / pain
- Pain
- Risks of Depression, anxiety, PTSD
- Most of the severely injured have not been discharged form the military - yet.

Recent Government Initiatives for Veterans

- **Partnership with the NHS, MOD & Combat Stress - three-way agreement Jan 2010**
- **MOD/NHS mental health pilots** – six so far assessed / signposted around 500 patients (Cornwall, Shropshire, Camden & Islington, Edinburgh, Cardiff, South Shields)
- **Advice to NHS about priority treatment**
- **Command Paper** – promise of help to veterans
- **Assessment services:** UK Medical Assessment Programme (St Thomas' Hospital for veterans), Chillwell Barracks Nottingham for reservists
- **Advice about IAPT** (Improving Access into Psychological Therapies)

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CASE STUDY

- 28 year old, served 11 years Army.
- Ex - Army airborne forces section commander infanteer – discharged SNLR
- Two Terms in military prison (Colchester) assault under influence of alcohol.
- Served NI 2 tours; Balkans (Kosovo); Sierra Leone; Iraq; Afghanistan.
- Separated, H/O domestic abuse (fuelled by alcohol) ; supervised access to kids (Jack and Jill aged 5 & 6)

- Currently living with a male ex-army friend.
- Unemployed since leaving Army has had 2 jobs – security and building site.
- No registered with a GP
- Found “collapsed” in the street; hiding underneath a car. – extremely frightened state
- Taken by police - seen by A&E Doctor
- Referred to your team

- What is going on!!

Solution

- Abused as a child
- Dysfunctional family
- Soft drugs as a teenager
- Petty crime stealing and fighting
- Joined as boy soldier
- Excellent professionally until Afghanistan
- PTSD (Complex Type), Alcohol, Depressed,
- Violence, Homelessness, unemployed, unskilled.

Case Presentation

Modes of Discharge from the Military

- S8
- SNLR / TU
- PVR
- Time Served
- Courts Martial
- Compassionate Discharge

Clinical Pathways –

military, NHS, 3rd Sector (Combat Stress)

(Obtaining military health records)

Medical Records Addresses

Army	RAF	RN / Royal Marines
Army personnel Centre Secretariat Disclosure 3 (Medical) MP 525 Kentigern House 65 Brown Street Glasgow G2 8EX	PMA Medical (RAF) Room 040 Building 248 RAF Innswirth Gloucestershire GL3 1EZ	MDGN Medical Records Institute of Naval Medicine Alverstoke Hampshire PO12 2AA

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