Veterans Services in the UK: The Role of Combat Stress

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Consultant Psychiatrist &
Medical Director Combat Stress
Military Psychiatry

- WHAT IS THIS?
Defence Medical Services

Military physical and psychiatric health is the responsibility of the Defence Medical Services (DMS).

- 15 multidisciplinary Departments of Community Health (DCMH) UK, Germany, Cyprus and Gibraltar.

- Rapid access to high standard of mental health care.

- Dual role – occupational and treatment

- Hospital based service contracted out to NHS Consortium

- In combat zones Psychiatric Field Teams: Uniformed CPNS (supported by) Military psychiatrists.

- 180,000 personnel in UK military.

- DCMHs: 5000 referrals or 4.5 referrals per 1000 per year

- Commonly: alcohol misuse (33%), depression (19%), anxiety (11%) adjustment disorders (10%); low rates of PTSD (DASA, 2009; McMannus, 2009; Fear & Wesseley, 2009)
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.

Suicide

• In service suicide rates unremarkable.
• Suicide rates for ex-serviceman under 24 years 2-3 times higher than civilian counterparts.
• Unclear reasons: possibly due to:
  a) pre-service vulnerability,
  b) trouble re-adjusting to civilian life and
  c) exposure to more adverse experiences.

(Kapur et al, 2009)
• Very few medical discharges are for mental health problems.

• Average of 150 of 1200 annual medical discharges for psychiatric disorders.
Military Psychiatry: Combat

Combat Stress Reaction (CSR) = War theatre breakdown.
Incorporates many features of Acute Stress Disorder (ASD);

Three phases: functional decompensation and symptom development.

1. **Premonitory Phase** starts **before** explicit exposure to psychological trauma occurs (pre-combat). *Symptoms of:* high arousal, restricted field of interest; severe psychological and physical symptoms of anxiety, emotional dysfunction, diminished social interaction and withdrawal, sustained criticism and mistrust.

2. Followed by **Acute Phase** precipitated by exposure severe psychologically traumatic event (combat). Characterised by gross psychiatric symptoms including cognitive impairment with dissociation, confusion and disorientation.

3. The final phase **Stabilisation Phase:** develops over several days or weeks. Characterised by affective symptoms (depression, guilt and shame), intrusive thoughts and vivid images of traumatic event/s; sleep disturbance, fatigue and irritability.
CSR can:

1. Resolve spontaneously;

2. Resolve following early intervention – rest, basic cognitive therapy based psychological interventions,

3. Progress to long term psychiatric illness: anxiety disorders, depression and alcohol misuse as well as PTSD
Risk factors for the development of CSR include:

**Primary factors:** dose response effect, including:

1. **Intensity of Battle** including unpredictability
2. **loss of the combat unit’s social cohesiveness**
3. **loss of; or, poor leadership.**

**Secondary Factors:**

1. **psychological deprivations** with those who take a passive role (for example drivers, technicians) being more at risk; a lack of adequate (military) training for the actual role;
2. **an inability to sustain denial** eg: over-exposure to casualties, atrocities, death of friend/relative;
3. **conflicts prior to combat**, including stress following separation from loved ones.
4. **physical deprivations**: with inadequate sleep, food, fluids; physical exhaustion and illness.
5. **Poor weather & field conditions**
6. **Support Deprivations**: leadership failure, death or replacement of the leader; isolation from unit; new soldier in a unit; lack of support from loved ones at home; poor unit cohesion/esprit de corps.
Prevention and Mitigation of CSR and PTSD.

Before, during and after combat.

(Little evidence that any of these prevent mental health difficulties):

1. Screening: Recruits; Pre deployment screening.
2. Realistic Professional Training
3. Stress Inoculation Training (SIT)
4. Pre deployment briefings
5. Induction Training
6. Prophylactic Medications
7. Leadership, Cohesion and Buddy/Buddy Care
8. Maintenance of social support networks and buffers.
11. Trauma Risk Management (TRiM)
12. Psychological decompression
13. Support by the public

• Many of the techniques incorporated into frame work of Battle Mind USA.
Alcohol

• Combat exposure associated with higher levels of alcohol misuse especially in the younger servicemen.

• In one study heavy drinkers (>30 units per week) were compared to light drinkers (<20 units per week). Heavy drinking associated with: current military service, being unmarried, separated or divorced and was commoner in younger personnel who had been deployed to Bosnia.

• Those who drank heavily were more likely to smoke. Heavy drinking was associated with poorer subjective physical and mental health.

• Op Telic / Herrick study - worrying rates of alcohol misuse as high as 13%. This study also demonstrated increased levels of PTSD of 4% (for in war theatre personnel overall – this percentage was no greater than comparable non-deployed personnel),
  5% for Territorial Army (with compared non-deployed levels of PTSD at 1%) and 6.9% (for front-line combat troops) in British personnel deployed to Iraq or Afghanistan.
• These figures are low compared to US and Australian studies which demonstrate levels of up to 20% in Combat veterans in some studies.
Alcohol

- Studies identify the range of co-morbidity between PTSD and alcohol disorders to be 41-85%. This far exceeds the 19-29% prevalence of alcohol abuse or dependence in the general male population.
- Alcohol disorders less likely in US Iraq / Afghanistan combat populations as compared to the UK Armed forces.
- Reasons:
  - Due to cultural differences: UK populations are likely to drink alcohol more heavily than US populations. UK populations are less likely to verbalise mental health problems compared to US population.
  - Other reasons due to differences in the methodology of studies;
  - A lower dose response effect following the implementation of ‘harmony guidelines’ that in comparison limit the duration and frequency of deployments for the British soldier. Psychiatric problems increase if these guidelines are breached, with particular difficulties in those whose tours are unexpectedly extended.


Alcohol and Delayed onset PTSD

- Ex-servicemen were twice as likely to develop delayed-onset PTSD as civilians and that 36% of veterans who suffer from delayed onset PTSD developed it within the first year of leaving the services suggesting that the loss of military support structures and adjustment to civilian life increase vulnerability.

- Many who developed delayed onset PTSD reported major depressive disorder and alcohol abuse prior to PTSD onset.
Alcohol

• Many with alcohol disorders cannot be treated psychologically until they undergo detoxification. *Some evidence some can be treated while drinking?? WOW!!*

• Psychological interventions need to be delivered seamlessly in order to reduce chances of relapse back into alcohol misuse.

• Ideal is to follow detoxification with intensive psychoeducation about PTSD and its interaction with alcohol and other substance misuse before further trauma focussed therapy is delivered.

• It has been noted that many who have sought help from local NHS services find that mental health professionals without experience of managing psychological trauma associated with the military service tend to focus on substance misuse, social problems, and anxiety and depression, while failing to tackle the root cause seldom recognising the problem as combat related PTSD.
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:

01372 841 680

or email us:

contactus@combatstress.org.uk

Charity Number England: 200602, Scotland SCO38828

www.combatstress.org.uk
Families and wives
Peace time cyclical separations:

**Intermittent Husband Syndrome**

- Anxiety,
- Depression
- Sexual difficulties

in wife
**Military Families**

**Psychological effects on families subjected to enforced and prolonged separations enforced under life threatening situations: a spectrum of disturbance**

Separation type I: cyclical separation and reunion: frequent cycles of partings and reunion

Separation type II: separations enforced under threat of death

Separation type III: indefinitely prolonged separations enforced under life threatening situations

Detachments

Going to war

POW MIA
Psychological effects on families subjected to enforced and prolonged separations enforced under life threatening situations:

• Initial shock, despair, detachment.

• Grief reaction – Anticipatory Grief (Lindermann 1944; Eliot 1946)

• If AG completes – wife becomes independent copes well with separation; but can cause problems for relationship – marriage at risk

• If AG does not complete: she will not cope during separation but marriage OK long term - reintegration of husband.

• Spectrum of disturbance: depends on nature and duration of separation: anxiety, PTS, psychosomatic, alcohol / drugs, social indiscretions and financial problems – (symptoms also reflected in children who cope as well as their mothers’ cope).

• Coping of the family members left behind determines the outcome for the family in terms of reunion and reintegration

• Treatment of psychological disturbance (may include psychosomatic, PTS and social disturbances) during separations may interfere with reunion and reintegration and longer term relationships.
Indirect Traumatisation: Living with the veteran suffering from PTSD: Characteristics of Impaired Veteran Families

- In **pre-war** marriages: Direct traumatisation of family- and separation and reintegration issues – followed by indirect traumatisation issues.

- In **post-war** marriages: Indirect traumatisation leading to ‘Ripple Effect’
- Most marriages of Vets are **post-war**:
  - Living with traumatised veteran
  - Children, spouse, parents
  - Extended families vs one parent families
  - Female veterans – little known
  - US Vietnam Veterans – 38% marriages broke up within six months of return from SEA (current problems in UK)
  - Divorce rates and loss of partner relationships much higher in Veterans

- **Wife brings veteran into care**
- **Carers groups family & couple therapy**
The man who lost his life in Iraq, now lives in Birmingham.

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British Veterans

- A veteran is someone who has served at least one day in the military
- Distinguish between Veterans and Combat veterans
- Around 25,000 leave the military each year
- There are about 5 million Veterans in the UK and 7.5 million first degree dependents.
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.
Op Telec Studies (KCL Studies)

N=25,000 representative sample of 180,000
TA more vulnerable = 5% PTSD (vs 1% in non-deployed)

Overall 4% PTSD (or 7200) – (4% non-deployed)
Combat Teeth Arms 6.9% PTSD
Alcohol related problems 13% (or 23,400)

UCL Studies

Delayed onset PTSD commoner in Veterans than in civilians and more likely to present in first year post discharge from military. – loss of support structures & adjustment to civilian life increase vulnerability.

PTSD is not the only mental health problem!!!
Fear et al, 2010
comparison between US and British Studies

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

• The National Probation Officers Association (NAPO) 8,500 veterans (10% of prison population)
• Department of Analytical Services and Advice (DASA) 2,500 (3% of prison population)
• Veterans In Prison Association (VIPA) - Military veterans in prison represent the largest occupational group among offenders.
• NAPO - 12,500 further veterans - on parole or subject to probation supervision - meaning that in excess of 20,000 veterans under correctional services control.
• NAPO – offences dominated by drug and alcohol misuse; propensity to violence, particularly domestic violence, many suffer depression and PTSD.
• Sexual offending??? Possibly slightly higher among veteran population
• Police Booking in desk surveys – higher than expected military and veterans presenting – violence and ??sexual offending.
Clinical Issues
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?
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

• 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 muscular relaxation
• Reduce stimulants caffeine, nicotine
• Thought stopping for intrusive mems / phenomena.
• Use of coping self statements / guided self dialogue (Meitchenbaum 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 and 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?
Combat Stress
Ex-Services Mental Welfare Society  est1919

• Third Sector National Mental Health Charity for Veterans
• UK and Ireland
• Funding: Charity, War Pensions, NHS
• Multidisciplinary community outreach service including welfare needs
• Multidisciplinary residential bespoke programmes
• Helplines / websites
• Self referral or through family (56%) or ex-service charities/agencies (37%) - NHS only 3%!
• 1303 new referrals last year: increase of 72% over past 6 years
• 4,380 active patients – receiving either welfare or clinical help or both; further 5617 ‘passive’ patients
Demand

New contacts are increasing year on year
72% over past 5 years

Not all convert to clinical cases:
Approximately 600 cases are assessed by clinical teams each year. This is increasing given the expansion of our clinical outreach services.
Referrals Iraq & Afghanistan Veterans
New referrals six monthly intervals from Oct 2003 to 09 Mar 2011

Numbers

IRAQ total n=926
active 517

Afghanistan total n=272
active 159

overlap = 125 (needs update)

or total of 1073 unique individuals (needs update)
3,809 ACTIVE CASES

England: 2,293
Wales: 230
Scotland: 495
Northern Ireland: 746
Elsewhere: 45

Where are they?
Veterans by Service

31.03.2010

<table>
<thead>
<tr>
<th>Service</th>
<th>Active</th>
<th>Passive</th>
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<tbody>
<tr>
<td>Army</td>
<td>4091</td>
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<tr>
<td>Royal Air Force</td>
<td>624</td>
<td></td>
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<tr>
<td>Royal Navy</td>
<td>602</td>
<td></td>
</tr>
<tr>
<td>Merchant Navy</td>
<td>63</td>
<td></td>
</tr>
<tr>
<td>Royal Marines</td>
<td>106</td>
<td></td>
</tr>
</tbody>
</table>

- Army: 82.1%
- Royal Air Force: 7.6%
- Royal Navy: 7.1%
- Merchant Navy: 0.4%
- Royal Marines: 2.8%
Theatres of Operation

India: 2
Rwanda: 3
Borneo: 3
Burma: 7
Suez: 10
Palestine: 11
Kenya: 27
Sierra Leone: 31
Korea: 43
Malaya: 59
Afghanistan: 101
Aden: 135
WWII: 172
Cyprus: 192
Other: 328
Iraq: 398
Falklands: 451
Balkans: 510
Gulf: 570
None: 763
Northern...: 2452

31.03.2010

EX-SERVICES MENTAL WELFARE SOCIETY
New Referrals
1 April 2009 – 31 March 2010

1,303 cases

Average Age 42.8 years
Average Length of Service 10.2 years
Interval between discharge and first contact 14.3 years
Attributable War Disability Pension 9 (0.7%)
Accessing Mental Health Care

- **Barriers:** Macho image, stigma, ‘trained to cope’, occupational issues, institutional issues – civvies will not understand;
- ‘they are men’! (Palmer)
- Vast majority must access NHS with no problems
- **BUT:** 80% of new patients accessing help via Combat Stress have tried to get help from the NHS – This either has not worked or there have been a failure to engage or there has been a failure of expertise.
Combat Stress acts as a main pathway back into care for a significant number

1 April 2009 to 31 March 2010

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>NHS / Social Services / Service Discharge Boards</td>
<td>13%</td>
</tr>
<tr>
<td>Service Charities, Welfare Organisations, VA / WPWS</td>
<td>24%</td>
</tr>
<tr>
<td>Self referral</td>
<td>56%</td>
</tr>
<tr>
<td>Other</td>
<td>7%</td>
</tr>
</tbody>
</table>
Clinical presentation:
Mental health problems can arise from a variety of causes

• Pre service vulnerabilities
• Military life itself
• Earlier onset of physical disorders
• Leaving the service and adjusting to civilian life
• Help seeking issues
• Combination of the above
The Needs of the Combat Stress Population: 
Clinical Audit Data  (backed up by psychometric data – n=704)

<table>
<thead>
<tr>
<th>Condition</th>
<th>All audits 2005-2009 N=608</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Physical illness</td>
<td>71%</td>
</tr>
<tr>
<td>Physical injury during military service</td>
<td>48%</td>
</tr>
<tr>
<td>History of Psychiatric illness diagnosed prior to contact with Combat Stress as a measure of chronicity</td>
<td>80%</td>
</tr>
<tr>
<td>Multiple exposure to military psychological trauma</td>
<td>92%</td>
</tr>
<tr>
<td>Present and past history of alcohol and drug dependence and abuse</td>
<td>69%</td>
</tr>
<tr>
<td>Significant attachment difficulties in childhood / adolescence incl CSA and other abuse</td>
<td>52%</td>
</tr>
<tr>
<td>Commonest diagnosis PTSD</td>
<td>75% (N=508)</td>
</tr>
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</table>
Clinical Audit data (n=608), Psychometric Data Analyses (n=704) 2005-2009

Psychiatric Disorders

• High co-morbidity: 75% have primary diagnosis of PTSD of which 62% have co-morbid PTSD, Depression, Alcohol misuse. *(ie approximately 30% of those referred to Combat Stress – clinical and non-clinical cases have PTSD)*

Behavioural Disorders

• Violence, aggression, schedule 1 offending

Physical Disorders

• Occupational
• Associated with Chronic PTSD: MIs, CVA.s Hypertension and Death 10 years prematurely!!

Social Exclusion

• Dysfunctional relationships, marriages.
• Isolation, living alone homelessness, unemployment.
Typical New Referral 2010

• Average age 44 year old (youngest aged 19 oldest 93)
• Ex Army
• Childhood trauma, neglect, poor care giving
• Multiple traumatic exposure. Service in many war theatres NI commonest
• Family Ultimatum – usually second marriage
• History of Multiple house moves, employers, long spells of unemployment or homelessness
• Many children mostly not in touch
• History of domestic violence
• Significant physical illness
• Classically diagnosed with PTSD, Depression; Alcohol misuse
• No prior intervention
• NHS has not helped (for a variety of reasons)
Phasic Treatment Strategy

Chronic Disease Management
2005 NICE Guidelines for treatment of Veterans with PTSD

1. Initial preparation
2. Stabilisation and safety
3. Disclosure and working through of the traumatic material and psychotherapy on an individual basis
4. Rehabilitation and reintegration within society; normalising activities of daily living and maintenance within the chronic disease model
5. Relapse Prevention / maintenance
Interventions

• Residential

• Outreach

• Move towards combined residential and outreach interventions
Short Stay Residential Treatment

Three centres providing a safe boundaries quasi-military therapeutic environment particularly well suited for the veteran patient unwilling to engage with therapy in a “civilian” NHS setting.

Audley Court, Shropshire
27 places inc 4 carers

Hollybush House, Ayrshire
25 places plus 4 – 6 carers

Tyrwhitt House, Surrey
30 places (being upgraded)
**Current Rolling Programme**

- Establish trust and rapport
- Unique therapeutic milieu
- Group Psycho education: incl PTSD, depression groups; anxiety management; anger management, coping skills training / mindfulness etc
- Stabilisation on Medication
- Engage in Individual therapy include activity centre, arts therapies, solution focussed therapy etc.
- Trauma Focussed therapies including TF-CBT and EMDR
- Rehabilitation – Occupational Therapy; Social Skills activities centre; retraining schemes
- Families and carers groups
- Liaison and plug in to local CMHTs/ Psychology etc
Rolling Programme Clinical Outcome Evidence

• Multi-Centre Outcome study (Lee et al, 2005)
• Inter admission study (Hart & Lyons, 2007)
• Exit Satisfaction Questionnaires (n=1681) (Bellwood, 2009)
• Warwick Edinburgh Mental Wellbeing Scale incorporated into exit surveys – longitudinal controlled study (n=49)(Bellwood & Busuttil, 2009)
• Two Year Follow-up Clinical Audit Outcome Data (n= 57) (Busuttil, 2009)
• Psychometric Data-Set Outcome study (ongoing)
Community Outreach Service: Teams

**PHASE 1**
1. Regional Welfare Officer
2. Desk Officer
3. Community Psychiatric Nurse
4. Mental Health Worker – psychotherapist, social worker

**PHASE 2:**
1. Sessions of Psychology and Psychiatry
<table>
<thead>
<tr>
<th>Community outreach will:</th>
<th></th>
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<tbody>
<tr>
<td>Reduce Stigma</td>
<td>Allow Joint residential and outreach programmes</td>
</tr>
<tr>
<td>Improve Engagement</td>
<td>Tailor make treatment to patient need</td>
</tr>
<tr>
<td>Reduce presentation time</td>
<td>Allow more family work / carers group treatments</td>
</tr>
<tr>
<td>Promote Joint management with NHS / PLUG IN</td>
<td>Allow outpatient work</td>
</tr>
<tr>
<td>Free residential beds allowing more intensive programmes to be developed for those who need them most</td>
<td>Allow more community liaison / education of NHS services</td>
</tr>
<tr>
<td>Allow smoother pathway for those who need alcohol / drug detox followed by trauma treatment</td>
<td>Allow more community group treatment ; re-training and rehabilitation</td>
</tr>
</tbody>
</table>
Community Outreach

Early impressions / initial clinical audits

• Very busy

• Identifying more patients with alcohol and drug problems and other complex presentations who have not been able to engage and be offered clinical intervention from Combat Stress before now.
Combat Stress Clinical Expansion

Move to combined residential – outreach interventions

(Pending application for National Specialist Commissioning Funding - NSC)

Bespoke Programmes – all are evidence based:

1. Intensive PTSD (Australian veterans) (NSC)??
2. Alcohol / PTSD Education (Australian veterans) (NSC)??
3. Refractory chronic PTSD (American Veterans Association) (Community)
4. Old age (Australian veterans)
5. Enhanced Rolling Programme (American Veterans Association)
6. Old age respite Transfer this to other venue ?
7. Carers Groups (Australian veterans)
Intensive PTSD Group Programmes

RN/ RAF / Australian veterans & Adult Survivors of CSA model

Clinical Components
• Psychoeducation
• Symptom management skills
• Trauma Focussed individual therapy
• Group therapy including trauma focussed work
• Cognitive restructuring
• Alcohol management
• Problem solving
• Family education / carer groups
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
Evidence base & Outcomes Research literature

Evidence base - >4000 Australian Veterans – & more from similar programmes & adult survivors of sexual abuse.

Outcome best if:

• Mix of individual and group interventions
• Mix of residential hospital / day centre and outreach
• Must include trauma focussed therapy not just ‘rehabilitation’
• Rule of thirds one third do well; one third get better, one third don’t do so well – need more help.
• Outcomes related to intensity of programme: this in turn is correlated with severity of disorder. The higher the severity the more intensive the therapy should be.
• If patient has mild disorder and intense programme delivered likely may not improve and might make worse.
• Patient Selection is critical.
Combat Stress Intensive Six Week PTSD Programme

• Based on Australian model
• Manualised – reviewed and standardised - supervision
• Work time 9am – 5pm five days per week
• Weekend homework
• Out of hours time – homework, support, key working, activities centre.
• Assessment Protocol
• Inclusion / exclusion criteria
• Pathways in
• Pathways out
• Outcome measurement
• Research literature
# Content: Intensive PTSD programme sessions

<table>
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<tr>
<th>Type of intervention</th>
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<tbody>
<tr>
<td>Group bonding</td>
</tr>
<tr>
<td>Psychoeducation</td>
</tr>
<tr>
<td>Cognitive restructuring</td>
</tr>
<tr>
<td>Individual therapy (TF – CBT)</td>
</tr>
<tr>
<td>Group therapy</td>
</tr>
<tr>
<td>Creative therapy</td>
</tr>
<tr>
<td>Skills training</td>
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<tr>
<td>Individual psychiatric review</td>
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<tr>
<td>Weekend stress inoculation training home work</td>
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<td>Family days / carer groups included</td>
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Alcohol and Illicit Substance misuse

CLINICAL PATHWAY

1. RWO
2. Outreach Assessment
3. Local NHS + other 3rd sector partners
4. Detoxification *followed immediately by* -
5. 10 day Alcohol/ substance misuse and PTSD education programme
6. Intensive PTSD programme
7. Outreach TF-CBT / EMDR
8. Rehabilitation
9. Relapse prevention
Detoxification – problems: relapse and timing

• Community vs residential
• Local – regional third sector partners?
• Local service variation
• ? NHS national centre partnerships
• ? Combat Stress – misuse of residential beds?
Government Initiatives

• Six MOD Pilots for veterans (Cornwall, South Shields, Camden & Islington, Edinburgh; Staffordshire; Cardiff).

• Evaluation – demonstrated vets friendly services; ex-service understanding; 30-50% also Combat Stress patients – residential –outreach approaches. U

• Improving Access to Psychological Therapies (IAPT) — low level input – has a place

• TA Chillwell

• UK Medical Assessment Programme (MAP)
30 embedded mental health nurses - approximately 1 per 2 trusts in England.

Locations to be determined.

Funded by DoH - likely to be a partnership arrangement including a third sector provider with expertise in veterans MH......we are naturally interested in this.

As a consequence of an earlier govt agreement, we are currently working with 4 trusts to embed a CS nurse in each....there is however funding for 7.

Recommendation of extension of partnership agreement with Combat Stress agreed in Jan 2010 be extended to ensure that resources and activity are deployed in a cohesive way.
Also:

- Incorporation of structured mental health systems enquiry into existing medical examinations performed while serving.

- PTSD screening tool to be developed for in-service and reserves.

- DCMH follow-up for exiting servicemen available for 6 months post discharge.

- Veterans Information Services (VIS) deployed 12 months after exit from Armed Forces – follow-up health surveillance.

- MHTs will be required to formulate a plan for managing cases referred by embedded mental health professionals, GPs or other agencies.

- National help line and Trial of online intervention service for service personnel and veterans. ‘Big White Wall’

- COMBAT STRESS HELPLINE Launched March 2011  0800 138 1619
• Strategic Networks NHS led – currently forming via strategic partnerships:
• DoH – Combat Stress
Partnership working

• Strategic Partnership agreement between Combat Stress and NHS and MOD signed in January 2010

• Partnership with RBL and other ex-service charities.

• Patients are jointly managed with NHS Primary and Secondary Care
• 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
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 230,000 servicemen and women sent to Iraq/Afghanistan so far!!!
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

- 2010 Murrison Paper

- Assessment services: UK Medical Assessment Programme (St Thomas’ Hospital for veterans), Chillwell Barracks Nottingham for reservists

- Advice about IAPT (Improving Access into Psychological Therapies)
Combat Stress Funding

• £30 Million appeal to fund outreach services

• Other Charity

• National Specialist Commissioning Application for most seriously unwell for residential phase of intensive programme

• NHS Scotland directly commissioned funding for brief residential treatment for Veterans living in Scotland.

• War Pensions
Without our help, for some the battle will go on forever!
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

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<thead>
<tr>
<th>Army</th>
<th>RAF</th>
<th>RN / Royal Marines</th>
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<tbody>
<tr>
<td>Army personnel Centre Secretariat Disclosure 3 (Medical) MP 525 Kentigern House 65 Brown Street Glasgow G2 8EX</td>
<td>PMA Medical (RAF) Room 040 Building 248 RAF Innsworth Gloucestershire GL3 1EZ</td>
<td>MDGN Medical Records Institute of Naval Medicine Alverstoke Hampshire PO12 2AA</td>
</tr>
</tbody>
</table>
References:


• Scheiner, N.S. (2008) Not ‘at ease’: UK Veterans’ perceptions of the level of understanding of their psychological difficulties shown by the National Health Service. Doctoral Thesis. City University London: Department of Psychology.


References:


