

LIFE AS A MILITARY COMMUNITY PSYCHIATRIC NURSE

R Lewis¹, B Mushonga², A Simpson¹

¹DCMH Portsmouth, Sunny Walk, HM Naval Base, Portsmouth, Hants. ²DCMH Catterick, Horne Road, Catterick Garrison, North Yorkshire.

Introduction

Although conflict has changed considerably over the decades and bears little resemblance to that of the World Wars, it continues to require the presence of the 'Medical Team'. It is important to remember that military operations and campaigns are not simply won or lost as a result of machines or evolving technology, but also depend on a range of human factors. The battlefield can be one of the most stressful, threatening, violent and dangerous places on earth, one that can test the limits of the men and women who are the primary players within the battlespace. These are the men and women upon whom the ongoing operation and maintenance of the actual tools of conflict such as tanks, ships and aeroplanes depend. Without this human input, there would be no successful prosecution of conflict. Human factors are thus amongst the most critical elements in any war, conflict or operation and it is this factor upon which success depends. It is after all "*not numbers or strength that brings victory in war; but which ever army goes into battle stronger in soul*" [1]. The human component must be given due consideration whether in time of war or in operations other than war.

This recognition can be seen as a result of the lasting legacies of World War II psychiatry which identified and acknowledged the fact that the prevalence of psychiatric injuries within the various units at times had more to do with the makeup of the unit itself than with the idiosyncrasies of the individual casualty [2]. This was a fact that became apparent to one WWII psychiatrist who was assigned to the Allied Expeditionary Force in North Africa. What proved most puzzling to him was not why men broke down but rather their enduring ability to contend with and function in unrelentingly miserable conditions. He believed that it was consideration for comrades, respect for higher authority, the units' reputation and the drive to ensure the success of the unit which kept them fighting [3].

Other psychiatrists came to similar conclusions. One described a particular patient as a "*frightened, lonely person whose interpersonal relationship had become disrupted.... whose efforts to protect himself were doomed to failure*" [4].

The actual event which finally overwhelmed an individual varied but the common denominator identified was that the individual had lost their place as a member of the team. Whether this was as a result of the individual changing or the group, was to some extent immaterial, it none the less left the individual feeling overwhelmed and disorganised [5].

All of this serves as essential background to a consideration of life as a military Community Psychiatric Nurse (CPN). History has shown that whilst conflict can last a long time it does not last forever. As a result the lessons which are identified during conflict are not always learnt and remembered. For most, the human element of conflict is quietly set aside in favour of more definable,

measurable and perceptible analysis of the mechanical processes which can be used to identify the road ahead for future conflict, in short the human component in conflict is the first casualty of peace [6]. For the military CPN this is not and cannot be the case.

In order for a military CPN to function it is important for them to understand their role, both within the peacetime environment and during conflict. For the most part CPNs in the field will, dependant upon circumstance either work within singleton posts or alternatively in a team of two or three. Whilst supervision can be sought via various communication routes, CPNs frequently deploy without a psychiatrist and as such in order to provide a viable service within the wider military context, must understand the implications of the decisions made in relation to both patients and to the individuals unit. Whether deployed in the field or working in units back home in the UK the role of the CPN largely remains the same, being to balance the needs of the patient with the needs of the service [7].

The military, as with most organisations, recruits its CPNs from all walks of life, some have no previous experience of the military and join direct from school, others have been part time members of the Armed Forces through either the RNR or TA or as is the case with a significant number of Naval CPNs, have been full time serving members of the service who have transferred from other branches. All military CPNs, whether qualifying whilst members of the armed forces or having undergone training within the NHS, follow the same training pathway, spending time working within Primary Community Mental Health Care Teams and in ward environments. Irrespective of service, all CPNs go through Basic Training with the other Sailors, Soldiers or Airmen and women.

Although the CPNs' peacetime role will undoubtedly include single service work, inevitably a great deal of work is carried out together on a triservice basis as a unified team. CPNs provide both a re-active and pro-active service. Re-active in so far as dealing with referrals from Unit Medical Officers, the Chain of Command, welfare services and chaplaincy. Pro-active in spending time both at home and in the field 'getting out and about' educating both medical and non-medical agencies on mental health issues and the various ways in which to deal with them. Anecdotal evidence tends to suggest that the perceived purpose of CPNs as far as the wider service is concerned is to 'send people home' or 'stand them down' thus 'making everyone's life difficult' when in fact one of our aims is to assist the wider service in the management of their personnel. Perhaps this anecdotal evidence is due to a lack of understanding of the value of CPNs to the service as a whole.

The role of CPNs as nurses is principally that identified in the title: for the greater part all CPNs are based within the wider service community. Within the field environment, unlike a large proportion of our Adult Nurse counterparts, CPNs can frequently be found 'running the gauntlet' in order to achieve the aims of providing the wider service community with support. Two examples of what "Life as a Military CPN" is like are given in the boxes.

Corresponding Author: Chief Petty Officer Naval Nurse Rob Lewis, Shackleton Division, Lancelot Building, HM Naval Base, Portsmouth, Hants PO1 3NH
Email: robert.lewis386@mod.uk

Sergeant Brian Mushonga - On being a CPN

My Role

My role is to assess and provide care to service personnel who have been referred by their Medical Officers' because of psychological problems. As a Sergeant my responsibilities extend to staff management, the supervision of junior members, facilitating personal and professional development and undertaking military duties.

I am in my final year of BSc studies in Practice Development (Mental Health) at Northumbria University funded by the Army. The degree programme includes modules such as Leadership, Brief Intervention Therapies and Cognitive Behavioural Therapy, suited to military needs with an emphasis on a 'talk therapy model' as opposed to a 'medication model' which was common and largely ineffective in my early experiences in the civilian setting. I have found the Defence Mental Health Services emphasizes personal and professional development and have not had any difficulty getting funding for training.

My Day

As an experienced clinician I work autonomously with patients, from recruits to experienced personnel from the three services. The nature of the work is largely Occupational Mental Health, most patients presenting with depression, anxiety, adjustment problems, marital disharmony, self harm, unhappiness with continued military service and alcohol related problems. The DCMH concentrates on treatability, prognosis and retention by relating presentation, to past and likely future patterns of thought, feeling and behaviour. Communication between the multi-disciplinary team and the Chain of Command is essential in ensuring patients are managed appropriately and in confidence. DCMH Catterick is a good environment to work in, with a transformational style leadership that promotes initiative, innovation, openness and professional development.

My Experience

I qualified at Thames Valley University in March 2001, and initially worked in an NHS inpatient acute mental health unit before joining the Army in 2002. My first posting was to the Mental Health Hospital Unit Wegberg, Germany 2002-05, including a three months tour in Bosnia 2003/04, and another three months tour in Iraq 2005 on Op Telic 5. I have been in my current post at DCMH Catterick since July 2005 and was promoted to Sergeant 2008.

Petty Officer Naval Nurse Andy Simpson - on deployment as a CPN

As with everyone else in the military, CPNs deploy to operational theatre, and the days of joining the Navy and expecting only to go to sea are long gone. The blurring of services is here to stay for the foreseeable future. As a result a CPN will often deploy to an operational theatre where there may be very limited numbers of personnel from their service. Therefore "non-green" CPNs may have a steep learning curve to adapt to serving with another service for those months away.

A CPN's operational role differs from the role of other nurses in the fact that CPNs rarely stay stationary in theatre. Travelling around theatre (using any means possible) can be hazardous but is essential in order to ensure that patients are seen in their own environment. Although getting away from the clinic-area may sound strange in reality it makes case management much easier. Going to the patient means that CPNs can speak to the patient's line manager face-to-face without having to rely on the military phone system! Also if

changes need to be implemented, then the CPN can witness any changes, and indeed adjust any care-packages.

Another difficulty a CPN faces in theatre is the disparity between rank held and the decisions we make. Whilst such decisions are only advisory they remain difficult at times; for instance there is no standardised risk profile that makes allowances for the patients to bear arms.

The CPN doesn't just look after UK personnel when deployed. They will often see patients from other allied nations and provide input into the care of the local population too. So with that in mind, it is advantageous for the CPN to have a basic understanding on how lifestyles differ between nations and of cultural aspects of mental health problems.

It is a common misconception that the best way to get out of a deployment is to see a CPN who will put you on a plane home. However our main aim during a deployment is to keep personnel in theatre and to maintain the effectiveness of the fighting force. Because CPNs have more time to spend with patients and a smaller caseload (usually) than in the UK, it means that they can provide a lot of input, where needed, to those they see. Thus there is rarely a need to send personnel home. Rarely casevac cannot be avoided as some personnel require treatment which is not suitably provided in a conflict zone.

A CPN spends a lot of time promoting Mental Health and breaking down the barriers which prevent people from accessing care; this is encompassed in the briefs that they give. Pre-deployment psycho-education is the norm and this information is repeated in a condensed form when in theatre as part of the RSOI package. In addition, when its time to leave theatre the CPN usually delivers a going-home brief. If the personnel have access to a decompression package, a CPN will brief all troops during this stage too. The aim is that everyone should be aware of their own mental preparation before going to theatre and before going home.

Conclusions

It is hoped that this article will have provided the reader with a broader understanding of the role of a military CPN. Both personal accounts provided here have outlined that 'Life as a military CPN' is varied and have illustrated that CPNs in the military perform a wide variety of roles both as part of a multi-disciplinary team and as relatively independent practitioners on operational taskings. As the 'workhorse' of the Defence Mental Health Services the military CPN plays a vital role in ensuring the highest level of mental health of the UK Armed Forces personnel.

References

1. Richardson FM. *Fighting Spirit: A study of Psychological factors In War*. London: Leo Cooper, 1978
2. Stouffer SA, Lumsdaine AA, Lumsdaine MH. *The American Soldier*. Princeton NJ: Princeton University Press 1949
3. Spiegel HX. Psychiatry with an infantry battalion in North Africa In WS Mullens & AJ Glass, eds. *Neuropsychiatry in World War II, Vol. 2: Overseas Theatres*. Washington: Government Printing Office 1973
4. Weinstein EA. The Function of Interpersonal Relations in the neurosis of combat. *Psychiatry* 1947; **10**:307-14
5. Bartemeir LH, Kubie LS, Menninger KA, Romano J, Whitehorn JC. Combat Exhaustion. *Journal of Nervous Mental Disease* 1946; **104**:358-89
6. Spiller RJ. The Tenth Imperative. *Military Review* 1989; **LXXIX No 4**:2-13
7. Surgeon Generals Policy Letter 11/05. *Provision and Management of Defence Mental Health Services*. Defence Medical Services Department 10 August 2005