

A CAREER IN MILITARY PSYCHIATRY

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Introduction

Military psychiatry is a rather unique speciality. Unlike many other secondary care specialities, military psychiatrists work directly with military personnel and do not provide services to the National Health Service. The last article written in this Journal about Military Psychiatry was eight years ago [1] and since that time much has changed.

Following the Review of Defence Mental Health, carried out by the Northern Centre for Mental Health in 2001 [2], the emphasis shifted from inpatient services to the development of community services in the form of the Departments of Community Mental Health (DsCMH).

As a result, the in-patient services were outsourced and the Duchess of Kent's Psychiatric Hospital (DKPH), the Tri-Service in-patient facility in Catterick, North Yorkshire, was closed in 2003. In addition to fulfilling its role as the primary military psychiatric hospital it also acted as a focus for research, for the development of services and for the training of both medical and non-medical mental health professionals. However, the growth and influence of two academic centres in London; *Kings Centre for Military Health Research (KCMHR)* and the *Academic Centre for Defence Mental Health (ACDMH)*, in conjunction with the Postgraduate Deanery at the Royal Centre for Defence Medicine, Birmingham has ensured that a career in Military Psychiatry is still an exciting path to embark upon.

The current demands on the UK Armed Forces (AF) personnel are considerable. With changes in manning levels leaner Armed Forces are simultaneously involved in two major theatres of Operation; Iraq (Op TELIC) and Afghanistan (Op HERRICK), in addition to a variety of smaller operational commitments around the world. The potential consequences of more frequent and lengthy deployments, especially for those who breach harmony guidelines [3] are significant. High levels of work stress and traumatic exposures as a result of operational commitments have the potential to impact upon the individual sailor, soldier or airman. In spite of considerable evidence of the resilience exhibited by most Service personnel, conditions such as Post Traumatic Stress Disorder (PTSD), substance misuse, depression and anxiety continue to be a problem for a significant minority of AF personnel [4]. Furthermore the British public and media have become increasingly concerned regarding the mental health of service veterans, with their increased levels of homelessness, substance misuse and chronic psychological injuries. In the past the NHS has had difficulty in providing mental health services for these individuals and the DMHS have not been directly involved. The ex-servicemen's charity Combat

Stress has provided some care and has recently received an uplift in government funding. The DMHS are now involved in the care of reservists after they return from operations and prepare to demobilise or when referred to them by the Reservist Mental Health Programme after demobilisation. In essence, this is a busy time for the Defence Mental Health Services (DMHS).

This article attempts to provide a cross sectional picture of the current provision of Defence Mental Health Care, explain some of the challenges confronting the delivery of mental health care to a diverse and separated patient group and to highlight some of the possible future developments in defence mental health.

Structure and organisation

Community Mental Health Teams

As of 2004 the MOD had established 16 military Departments of Community Mental Health across the UK and Cyprus. The provision of mental health care to UK Forces in Germany was re-organised in October 07 along the same lines as in the UK; there are 4 DsCMH in Germany and in-patients are admitted to a German private provider. DsCMH staff include psychiatrists and mental health nurses, both civilian and military, and civilian psychologists and social workers. DCMH staffing varies depending upon the relative needs and size of its target population; small units may have several nursing staff with visiting psychiatric services whilst larger units are likely to have professionals from all mental health specialisations. As the DsCMH contain the majority of all DMHS personnel, the staffing levels fluctuate when uniformed staff deploy to a variety of operational roles around the world. Easy access to clinical psychology services and mental health social workers allows for the full needs of the patient, and where appropriate their family, to be met. Referrals for care are made in a similar way to the NHS, with the patient's Medical Officer, making the initial assessment of the patient's need and communicating with the local DCMH. In addition the DCMH is in a unique position allowing it to liaise closely with Chaplaincy services and military social and welfare services to place the individual on the appropriate pathway of care. Military mental health services must also maintain close links with patient's chain of command in order to effect suitable occupational adjustments as might be required to encourage a return to good psychological health.

In-patient facilities

Following the closure of DKPH in 2003, inpatient provision was outsourced to an Independent Service Provider (ISP) and the contract for this was awarded to The Priory Group as a result of a competitive tendering process. One advantage of The Priory Group is its wide UK coverage which potentially allows service personnel to access inpatient care close to their unit or home, thus conferring the practical advantage of allowing necessary military and social support to continue

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during a patient's admission. The Priory Group hospitals also have considerable experience in treating less severe mental health problems such as those encountered in military settings. The contract was set up to allow access to a formalised and centralised admission procedure and for there to be military input to patient care provided by an experienced Service Liaison Officer from a nearby Department of Community Mental Health (DCMH). The original independent sector provider contract is shortly due to be renewed, and the tendering process has attracted innovative bids from numerous possible providers, again including The Priory Group.

Hierarchy

The working environment of the military Consultant Psychiatrist at first glance appears to be very different from that of his NHS counterpart, but on closer evaluation there are a number of similarities. The military is traditionally a hierarchical organisation which can be thought of as having a pyramidal structure; the more experienced but less numerous heading up the organisation, with increasingly larger numbers of individuals working below them at various levels. In some respects this is similar to the NHS with consultants having responsibility for a team of varying skills and experience. One challenge confronting NHS psychiatry at this time is "New Ways of Working" [5] which encourages the increased development of multi-disciplinary team working. Whilst this has obvious advantages in terms of the delivery of patient health care and the reduction of repetitive work, to a degree the traditional medical roles appear to have been lost. Multi-disciplinary working has been adopted within DsCMH across the country, and the ease with which various professionals can communicate has undoubtedly improved patient care. The challenge facing the DMHS is how to manage to work clinically in a multi-disciplinary way whilst retaining and working effectively within the hierarchical structure in which it finds itself.

It is helpful to consider the structure of military psychiatry so that it is possible to understand the advantages and constraints of such a system.

At the highest level policy is dictated by The Surgeon General who is advised on mental health matters by the *Defence Consultant Advisor* (DCA) in Psychiatry. The Defence Professor provides academic input and liaison with the Royal Colleges. Each individual service also has a *Consultant Advisor* in Psychiatry whose role is to manage service specific mental health needs and policy. Each service has responsibility for a number of DCMH sites; however the individual patient is seen at the closest DCMH site to their unit regardless of service "colour".

The structure of DMHS allows policy directives to be implemented at a variety of levels whilst still retaining the flexibility for individual DsCMH to manage their workload in the most appropriate way for their situation. Regular meetings at both a service and tri-service level have allowed the development of a corporate identity and ethos as well as the communication of ideas. The highest level of direction for the DMHS comes from the *Mental Health Services Executive Committee* which is chaired by Director Healthcare who is a 1*.

Further changes are afoot with the introduction of the *Joint Medical Command*. The Army is also due to be given a 'lead service' role for the DMHS although the ramifications of this change for the other two Services are unclear. However there is no current or planned future intention to make DMHS all join one service as is the case for physiotherapists and pharmacists.

Workload

Referral Rates

According to the latest statistics produced by the Defence

Analytical Services Agency (DASA), during the 3-month period April-June 2007, 1,380 UK Armed Forces personnel attended a first assessment at one of the DsCMH [6]. Out of the 1,299 for whom information on the presenting complaint was supplied, 996 were identified as having a mental disorder (which equates to a rate of 5.0 per 1,000 strength). During this same period only 69 patients were admitted to the MOD's in-patient care contractor (11 Navy, 45 Army, 13 RAF personnel).

Spectrum of Disorder

Judging from the British media one could be forgiven for thinking that there was an epidemic of Post Traumatic Stress Disorder within the British military [7]. The impact of this condition is reflected by reports in the media of individuals' distress, the prominence that the scientific literature gives to military PTSD [8] and associated diagnoses and the concerns expressed by senior commanders. The 'culture of trauma' is a phenomenon affecting society at large [9], and the diagnosis and treatment of affected individuals is an important part of mental health provision despite the challenges of NHS funding. The responsibility to recognise psychological symptoms following trauma in service personnel and to treat them appropriately is a legal and moral obligation for the MOD as it is for other organisations that predictably place their personnel in hazardous environments. In 2003 an unsuccessful class action was brought by veterans against the MOD. The Judge found the MOD 'wanting in its commitment to maintain a corporate memory of military health and the lessons that can be drawn from it on how to deal with military health and related personnel issues' [10]. The imperative to manage stress from a Health and Safety Perspective has also served as a reminder of this corporate responsibility [11]. The Over-Arching Review of Operational Stress Management (OROSM) in 2004/2005 [12] has prompted the MOD to overhaul the existing single service stress/resilience policies. The formal implementation of *Trauma Risk Management* (TRiM) within the Royal Marines, Navy, Army and some RAF units provides an indication that MOD is indeed taking the issue of operational stress seriously. TRiM aims to provide non-medical serving military personnel with the skills to recognise symptoms of stress in their peers and subordinates so that they know how and when to refer those most affected [13,14]. With the spotlight on recognition of stress and the inevitable overlap between symptoms of overstretch, adjustment and mild mental disorder, there are exciting implications for DsCMH in terms of education and prevention strategies.

In terms of the spectrum of disorder which is encountered in everyday clinical practice within the DCMH, it is not PTSD which dominates the workload. In fact, KCMHR data shows a rate of only 4% of significant PTSD symptoms in a large tri-service cohort study carried out between 2003 - 2006 [15]. The majority of the presenting complaints fall within the ICD-10 categories of mood disorders, neurotic disorders and substance misuse (the latter almost entirely attributable to alcohol related disorders). Moreover, the major advantage of the lower threshold for referral is that it enables timely therapeutic interventions which can hopefully 'nip the problem in the bud'; this can be satisfying for both commanders and clinicians. Current DMHS policy suggests that all referrals should be offered an appointment within 20 working days of referral or within one working day for urgent cases. One advantage of the broad level of skill within the average DCMH is the ability of service personnel to access a range of brief psychotherapies to speed their return to health. In particular cognitive behavioural therapy (CBT) (which includes trauma-focused CBT), motivational interviewing and eye-movement desensitisation and reprocessing (EMDR) treatment are available readily in most DsCMH.

Psycho-Education

Apart from the daily clinical work, one of the most important functions of the DCMH and its staff is to promote protective mental health strategies through psycho-education [16]. Such educational activities occur in a variety of settings from military bases to a wide variety of deploying units. Examples of such interventions include alcohol awareness, stress management and pre-deployment briefs to both general and targeted populations. However although the evidence about the effectiveness, or not, of such briefs is not of high quality, what evidence there is suggests that psycho-educational briefings are marginally effective at best [17].

Occupational role

Working within the military requires a relatively high degree of psychological resilience especially in some roles such as combat troops, those working with sensitive information and aircrew. However the robust nature of military life is associated with significant levels of stigma being exhibited by military personnel [18]. Stigma surrounding mental health is an issue for society in general and not just the military. In order to overcome stigma being a barrier to accessing care peers, commanders or medical officers who become aware that someone is suffering from a psychological disorder need to have easy access to expert advice and in some cases referral.

The necessary close liaison between the military consultant psychiatrist and the 'Executive' in making sometimes difficult occupational decisions on medical downgrading and workplace limitations can be advantageous as occupational factors may often be acting as stressors or aggravating factors to a person's illness. However, the perception that a psychiatric consultation may be in some way damaging to one's career is a hurdle for the military to address. This was highlighted by the Judge, Mr Justice Owen, in his ruling on the Class action of 2003. He said that *"there can be no doubt that amongst serving soldiers and many NCOs and officers that there was a stigma attached to psychiatric/psychological disorder. It was seen to be a sign of weakness which, if revealed, would expose an individual to ridicule, and would be the 'kiss of death' to a military career"* [19].

Operational Role

Psychiatrists can deploy as part of a Field Mental Health Team which consists of a single psychiatrist and 2-4 psychiatric nurses [20]. The FHMT will usually be administered by the local medical unit but have a peripatetic role. The challenge of providing mental health support in an Operational environment involves deciding when to retain manpower at the front-line and treat patients in theatre (the principle of forward psychiatry and PIE) or when to CASEVAC them to the UK for in-patient care. However, outside of war-fighting operations it more usual for the FMHT to consist solely of psychiatric nurses and for psychiatrists to have only a visiting role every three months.

Other Roles

The competencies that military health clinicians have are also transferable to other environments. This gives them expertise which allows them to advise on the mental health effects of natural disasters, individual psychological traumas and the benefits of applying the military experience of successful groups to other organisations. As an example, military mental health professionals have been involved in providing support to the Foreign Office after the 9/11 bombings in New York and the 2002 bombings in Bali.

Research

King's Centre for Military Health Research (KCMHR)

Beginning life in 1996 as the Gulf War Illnesses Research Unit, KCMHR was launched in 2004. This academic hub has brought together researchers from epidemiology, neurology, anthropology, psychiatry, public health, sociology and history. The vast array of publications in peer-reviewed scientific journals serve as a foundation of evidence-based science on which to inform everyday clinical practice (for instance the prevalence of alcohol-related problems [21] or vulnerability factors for PTSD [22]); an objective antidote to media-fuelled anxiety (for instance the delineation of the extent of the Gulf War Illness problem and the various 'causation theories' [23]); and as a lever to influence policy (for instance the identification of an increase in mental health problems in Reservists after the war in Iraq led to a ministerial announcement of an extension in the provision of mental health support to this population [24]).

Academic Centre for Defence Mental Health (ACDMH)

ACDMH was created in 2004 to develop a research culture within Defence Mental Health. Its wide remit includes the organisation of the academic element of Annual DMHS Conference, co-ordinating audit and research activity within the DsCMH, preparing an annual review of all relevant mental health research for the Surgeon General and monitoring the decompression process for PJHQ. ACDMH personnel also provide tutors for the MSc in War and Psychiatry held at the Institute of Psychiatry and taught by Professor Edgar Jones which aims to explore and evaluate aspects of military psychiatry, both past and present. The concept of war-related psychiatric injury is considered within a historical, cultural and social framework. The development of a shorter Diploma in Military Mental Health is in the pipeline, which aims to provide a foundation in the core functions and organisation of Defence mental health services both in peace-time and on Operations.

Psychiatric Training in the DMHS

The path to becoming a consultant in Military Psychiatry is now the same as any trainee pursuing a career in psychiatry. The closure of DKPH in Catterick saw the end of 'in-house' training for the SHOs and SpRs. Whilst working within the NHS provides trainees with exposure to a wide range of psychopathology not routinely seen in military settings, encouraging trainees to spend some of their training time in military units ensures that they acquire the relevant occupational skills. As with other specialties, trainees join any of the Military Deanery approved NHS training schemes within the UK on a 'supernumerary' basis, this has enabled trainees to base themselves at geographically convenient hospitals, complete attachments at centres of excellence and even work abroad. The flexibility of military training can be advantageous for both professional and personal reasons and allows individuals to tailor their training to meet future specific military needs. The potential downside to a 'pick and mix' approach to training can be a sense of isolation and an increased burden of administration, although individual Services are working on methods to retain a service ethos for their detached personnel. An example of this is the recent initiative to bring military psychiatric trainees together for teaching at the Maudsley Hospital/Institute of Psychiatry in South East London where ACDMH and KCMHR are based.

The future

Tony Blair once famously said *'I don't predict the future, I never have and I never will'*.

The experience of armed conflict changes individuals and societies; when those changes are for the worse, military psychiatry has had to learn and relearn effective methods to help service personnel to recover and optimise the effectiveness of the Armed Forces [25]. The history of post-combat syndromes in the last century stretches from *'Shell Shock'*, *'Effort Syndrome'*, and *'PTSD'* to *'Gulf War Syndrome'*. Although there has been no evidence of a discreet Iraq War Syndrome, the emergence of other operational health issues, for instance mild Traumatic Brain Injury [26], is a reminder that the twenty-first century shows no signs of let up for all those involved in the provision of defence mental health services.

Military Psychiatry is essential to the effectiveness of the Armed Forces. The unique blend of occupational responsibility across a wide range of mental health issues, both in peacetime and in war, ensures that a career in this speciality guarantees challenge and reward.

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