

original
papers

MATTHEW GOULD, JOHN SHARPLEY AND NEIL GREENBERG

Patient characteristics and clinical activities at a British military department of community mental health

AIMS AND METHOD

To describe patient characteristics and clinical activities at a British military department of community mental health (DCMH). Data were drawn from a clinical database over a 1-year period ($n=409$).

RESULTS

Mean age was 29 years, 50% were single and 76% were from the junior

ranks. Women were over-represented compared with the wider military population. Mean length of service prior to presentation was 5 years. The main presenting problem was alcohol misuse (33%) followed by depression (19%). Twenty-five per cent were referred for psychotherapy and 68% returned to full employment after treatment.

CLINICAL IMPLICATIONS

Patient characteristics of those treated at a DCMH differ from those in the wider military. An out-patient occupational mental health service returns a substantial number of patients to occupational fitness within the Armed Forces.

Background

In recent years, the UK Armed Forces have been involved in numerous operational deployments in both peace support (including humanitarian assistance) and war fighting roles. Service personnel are at risk of psychological distress following deployment (e.g. Jones *et al*, 2006, Hotopf *et al*, 2006), with military health in relation to military campaigns in Iraq and Afghanistan currently being a source of considerable political and media interest, especially post-traumatic stress disorder (PTSD) (Wessely, 2005). Meanwhile, defence healthcare in the UK has changed considerably over the past 10 years; all dedicated military medical hospitals have closed and a new centre of excellence for defence medicine has opened in Birmingham. Also, the UK Ministry of Defence (MOD) has recently faced a number of high-profile legal cases. For example, in 2002 ex-service personnel brought an unsuccessful class action against the UK MOD for failing to detect post-traumatic stress problems at an early stage and provide effective treatment (McGeorge *et al*, 2006).

In terms of mental health, the military take a number of steps to ensure the welfare of their personnel, for example, briefings on stress and trauma-related problems are provided before and after deployment. These briefings are also designed to address barriers to care, such as the stigma of mental health problems, which is a significant issue for the military (Wessely, 2005). However, it is noteworthy that, within the UK Armed Forces, the psychological welfare of troops is considered to be primarily a function of the chain of command, who are, in most cases, advised by mental health professionals rather than directed by them. Regular military personnel who may suffer with mental health problems are assessed first by a military general practitioner (GP) and, if required, referred to a military department of community mental health (DCMH); DCMH are the main providers of psychological care within the Defence Mental Health Service (Defence Medical Services Department, 2006). However, to date there are few published data on the

type of patients seen and the treatments offered by such services. Military community mental health services have been reported on in the past, but as far as the authors are aware not since 1982 (Anthony & Fowlie, 1982). This study describes the nature of work undertaken by one Royal Navy DCMH in terms of the patient profile and clinical activities provided.

Defence mental health and setting

Greenberg *et al* (2002) provide a comprehensive overview of military mental health services. Briefly, the Defence Medical Service is responsible for the health of 195 000 Armed Forces personnel and approximately 40 000 MOD civilians and families abroad. The Defence Medical Service runs 15 DCMHs in the UK and several abroad (Germany, Cyprus and Gibraltar). Naval Mental Health Services consist of three DCMH, located in three base port areas, which provide services to all military personnel (Royal Navy, Army, Royal Air Force) within their catchment area. Departments of community mental health carry out clinical, educational and advisory services to both primary care and the chain of command. Their aim is to provide timely assessment and treatment to maximise operational and occupational capability and, for personnel who cannot be rehabilitated, to ensure they receive a smooth transition to civilian life. They are multi-disciplinary in their approach to care delivery. The DCMH under study covers a population of approximately 25 000 and is staffed with military and civilian consultant psychiatrists, a civilian clinical psychologist, a nurse therapist, mental health nurses, a civilian social worker and administrative personnel. Out-patient clinics are held within the DCMH and medical centres at nearby military establishments. The DCMH runs a number of specialist activities, including a day support group, alcohol education and anxiety management courses. Previously, The Duchess of Kent's Psychiatric Hospital in Catterick, North Yorkshire, provided in-patient services. Since the closure of the Duchess of Kent's Psychiatric Hospital in April 2004, in-patient services have been provided by an



independent service provider. The DCMH operates an out-of-hours advisory service.

Method

For audit purposes all clinicians complete a one-page summary of their patient contact, which is entered into a clinical database. This includes socio-demographic data, service details, source of referral, treatments received, occupational functioning and presenting problem. Of note, not all patients are seen by a consultant psychiatrist so non-medical clinicians record the nature of the problem using a subset of ICD-10 (ICD-Light). Also, most patients meet with a mental health nurse who assumes key worker responsibilities, therefore the clinical activities recorded are in addition to meeting with a mental health nurse (where the mean number of contacts is seven). Data from our clinical database were drawn on 409 patients (52% of the population seen at the DCMH under study) over a 1-year period (1 November 2005 to 31 October 2006). Due to time constraints data were not collected on all patients. Data were entered into SPSS (version 12) and descriptive statistics were used to characterise the sample and clinical activities.

Results

Socio-demographic and armed service characteristics are reported in Table 1. Clinical activities are reported in Table 2. In brief, 82% were men, mean patient age was 29 years (range 17–54 years) and most were from the

Characteristics	<i>n</i> =409
Gender: <i>n</i> (%)	
Male	335 (82)
Female	74 (18)
Age, years: mean (s.d.)	29 (7.9)
Marital status: <i>n</i> (%)	
Single	204 (50)
Married	131 (32)
Cohabiting	33 (8)
Separated	41 (10)
Presenting problem: <i>n</i> (%)	
Alcohol	135 (33)
Depression	78 (19)
Anxiety	45 (11)
Adjustment disorder	41 (10)
Other	110 (27)
Service: <i>n</i> (%)	
Royal Marines	16 (4)
Royal Navy	294 (72)
Army	78 (19)
Royal Air Force	21 (5)
Length of service, years: mean	4.6
Rank: <i>n</i> (%)	
Junior	311 (76)
Senior	65 (16)
Officer	33 (8)

Table 2. Clinical activity

Clinical activity	<i>n</i> =409
Source of referral: <i>n</i> (%)	
Unit medical officer	327 (80)
Executive	41 (10)
DCMH	37 (9)
Other ¹	4 (1)
Appointment: <i>n</i> (%)	
Urgent	41 (10)
Routine	368 (90)
Attended: <i>n</i> (%)	315 (77)
Admitted to support group: <i>n</i> (%)	29 (7)
Admitted to independent service provider: <i>n</i> (%)	16 (4)
Prescribed medication: <i>n</i> (%)	57 (14)
Referral for psychological treatment: <i>n</i> (%)	102 (25)
Medical/occupational status at end of treatment: <i>n</i> (%)	
S2 ²	278 (68)
S7RA ³	37 (9)
S7RD ⁴	65 (16)
Other	29 (7)
Length of time downgraded, weeks: mean (s.d.)	12 (14.7)

1. Secondary care, independent service provider, Naval Personal Family Service (NPFS).
2. Fully employable.
3. Employable ashore or on a ship in harbour in own trade.
4. Employable in restricted duty ashore only.

junior ranks. The mean length of military service was 5 years. The main presenting problems were alcohol misuse (33%), depression (19%) and anxiety (11%). Eighty percent of referrals were from primary care and 10% were urgent. After the initial assessment, 25% were referred for psychotherapy and 4% were admitted to hospital. The mean length of occupational downgrade (medically incapable of carrying out their primary military duty) was 12 weeks (range 4–67 weeks). At the end of the treatment 68% returned to full employment.

Discussion

The main strength of this study is that it provides insight into the care of a patient group that is currently attracting considerable interest and about which there is little published data. Limitations are that data were collected on approximately half of all patients seen at our service and no psychometric data were centrally available.

As expected the majority of referrals come from the unit medical officer (primary care). Given the high patient numbers that are being referred to a limited number of busy clinicians, and the generally mild nature of problems (i.e. anxiety and depression), it is perhaps questionable whether some patients should be referred to specialist services or whether they can be maintained in primary care. In the UK National Health Service Plan (Department of Health, 2000), primary care graduate mental health workers (PCGMH workers) have been established with the aim of reducing the pressure from GP referrals by diverting patients away from secondary mental health



services. Primary care graduate mental health workers receive training in evidence-based brief therapies, guided self-help and signposting. The military may benefit from considering whether a similar role could be carried out by providing further training for unit medical assistants who currently administer paramedic-like services after a year of training. However, it is possible that the high referral rate reflects the inherent risks of working in the military environment where access to weapons is commonplace, combined with the onus on unit medical officers to ensure that those they care for are sufficiently capable of carrying out their duty so as not to let their colleagues down in ways that would have potentially disastrous consequences. For example, even apparently minor degrees of distress might lead to a nuclear submariner not spotting a safety critical warning light or effectively monitoring a mission essential navigational sonar.

Women were over-represented in our study (18%); women comprise approximately 10% of military personnel (Defence Analytical Services Agency, 2005). Existing data is limited and inconclusive as to whether women in the military are at an increased risk of developing mental health problems (e.g. Rona et al, 2006). That women are over-represented in the current sample is perhaps a reflection of gender differences in help-seeking, rather than an increased prevalence of psychopathology, as men are more reluctant than women to seek help for both mental and physical health problems (Moller-Leimkuhler, 2002). In addition, our findings showed only a minority (8%) of patients were of officer rank whereas approximately 17% of the military workforce are officers (Defence Analytical Services Agency, 2006). Previous research has suggested that older personnel are more resistant to mental healthcare perhaps because of the 'stiff upper lip' approach to coping (Greenberg et al, 2003). Therefore, a potentially important role for the DCMH is how to encourage reluctant but needy individuals to seek help. To this end, the Royal Navy actively engages in mental health promotion. As part of this activity the MOD is currently implementing a programme called Trauma Risk Management (TRiM); a peer-group delivered trauma-related psycho-educational and psychological 'first aid' management strategy (Jones et al, 2003). Trauma Risk Management aims to target specific negative attributions which are commonplace in the military, for example, that seeking help is a sign of weakness. Such health promotion campaigns may also have an impact on the substantial number of missed appointments (23%).

We found that younger personnel were over-represented in the DCMH sample although the age range was wide (17–54 years). It is possible that individuals at either end of this age spectrum are faced with adjustment issues, namely how to adapt to military culture for new recruits and in the case of leavers how to prepare for civilian life. Indeed, evidence exists which suggests that a small number of veterans will go on to have significant mental health issues after leaving the services (Iversen et al, 2005). The mean age in our sample was 29 years whilst the mean age of all service personnel is 34 years (Defence Analytical Services Agency, 2005). In the

main therefore, the DCMH needs to plan for young-adult focused interventions (e.g. drug and alcohol, relationships). Significantly, only 40% of our sample were married or cohabiting whilst in the military 79% are married or cohabiting. Military life can lead to family separation and strain as deployments are often for many months. It would seem therefore, that an important function of the DCMH is to support service personnel and their relationships with their families. The Armed Forces have welfare and family services and DCMH personnel liaise with them where required.

The main presenting problems in our study were alcohol misuse, depression and anxiety. Although caution is needed when interpreting our presenting problem data, as the database records the nature of problems treated rather than a diagnosis, our findings are consistent with military epidemiological research. For example, Hoge et al (2004) assessed the mental health of the US army and marines deployed to Iraq and Afghanistan, and found a high incidence of substance abuse (especially alcohol), major depression, PTSD and generalised anxiety disorder. Similar issues have been identified within the UK Armed Forces (e.g. Hotopf et al, 2006). There is considerable demand on the DCMH alcohol treatment unit, which runs 1-day alcohol education courses and extended week-long treatment programmes. Although service personnel can be ordered to attend the 1-day course their attendance at the longer course is optional.

Referral rates for psychological treatment (i.e. cognitive-behavioural therapy and eye movement desensitisation and reprocessing) were high. Currently, the UK Armed Forces have one clinical psychologist per 30 000 troops. However, within the UK Armed Forces mental health nurses are trained to provide trauma-focused psychotherapeutic skills, with the psychologists concentrating on complex cases and supervision of other personnel providing psychotherapy.

Evaluating the rate of return to full fitness following treatment is possible as every service person has a medical category which indicates the occupational effects of any medical condition. The mean duration of reduced occupational fitness was about 3 months with the majority of our sample returning to full employment after treatment, which suggests that either the mild presenting conditions resolved spontaneously or the DCMH interventions were successful. Indeed, these outcomes are consistent with guidelines which suggest that brief psychological interventions are effective for mild and moderate psychological problems, such as depression, over 10–12 weeks (National Institute for Health and Clinical Excellence, 2004). However, we suggest that further research is required to understand the long-term mental health and occupational outcomes following engagement with services. Personnel may not return to service for a number of reasons. For example, one of the peculiarities of service life is that, after the first 6 months of service, personnel cannot leave until they have served for approximately a further 4 years. This causes difficulties for some personnel who, understandably, feel trapped in the military. Some of these are referred to DCMH for assessment by a psychiatrist who

original
papers

might find the individual should leave the service as they are temperamentally unsuited to service life (often described as 'a square peg in a round hole') or to be suffering with a mental disorder that is incompatible with a career in the services, which would lead to medical discharge. Such individuals are likely to seek help early in their military career and it is perhaps because of this group that the mean length of service in our group was 4.6 years which compares with 12.4 years across the Armed Forces.

In conclusion, DCMHs form the backbone of mental health services in the UK Armed Forces. They must balance the needs of military commanders (to conduct military operations as tasked) with the therapeutic needs of the individual. Due to the current demand for mental healthcare within the military, there is considerable pressure placed on clinicians that is often exacerbated during military campaigns when healthcare professionals deploy to the front line. Assessing healthcare delivery and uptake of services across the three branches of the military, and patients' and professionals' experiences of the DCMH would be interesting areas for future research.

Acknowledgements

We are grateful to Dr J. Hacker Hughes (Head of UK Defence Clinical Psychology) and staff in the Defence Medical Services Department for comments on an earlier draft of this article, and Robert Lewis RN(MH) for his time and expertise with the department's database.

Declaration of interest

M. Gould, J. Sharpley and N. Greenberg are full-time employees of the Ministry of Defence.

References

ANTHONY, E. & FOWLIE, D. G. (1982) Community psychiatry in the Royal Air Force. *British Journal of Clinical and Social Psychiatry*, **2**, 23–28.

DEFENCE ANALYTICAL SERVICES AGENCY (2005) *UK Defence Personnel in Figures: A Statistical Commemoration of the Entente Cordiale*. HMSO.

DEFENCE ANALYTICAL SERVICES AGENCY (2006) *Rank structure of the UK Regular Forces* (<http://www.dasa.MOD.uk/natstats/tsp9/tsp9tab1.html>).

DEFENCE MEDICAL SERVICES DEPARTMENT (DMSD) (2006) *Surgeon General's Policy Letter: Provision and management of defence mental health services*, ref. 03/06. Whitehall.

DEPARTMENT OF HEALTH (2000) *The NHS Plan. A plan for investment. A plan for reform*. Department of Health.

GREENBERG, N., TEMPLE, M., NEAL, L., et al (2002) Military psychiatry. A unique resource. *Psychiatric Bulletin*, **26**, 227–229.

GREENBERG, N., THOMAS, S. L., IVERSEN, A., et al (2003) Do military peacekeepers want to talk about their experiences? Perceived psychological support of UK military peacekeepers on return from deployment. *Journal of Mental Health*, **12**, 565–573.

HOGUE, C.W., CASTRO, C., MESSER, S. C., et al (2004) Combat duty in Iraq and Afghanistan, mental health problems and barriers to care. *New England Journal of Medicine*, **351**, 13–22.

HOTOFF, M., HULL, L., FEAR, N.T., et al (2006) The health of UK military personnel who deployed to the 2003 Iraq war: a cohort study. *Lancet*, **367**, 1731–1741.

IVERSEN, A., DYSON, C., SMITH, N., et al (2005) 'Goodbye and good luck': the mental health needs and treatment

experiences of British ex-service personnel. *British Journal of Psychiatry*, **186**, 480–486.

JONES, N., ROBERTS, P., & GREENBERG, N. (2003) Peer-group risk assessment: a post-traumatic management strategy for hierarchical organisations. *Occupational Medicine*, **53**, 469–475.

JONES, M., RONA, R., HOOPER, R., et al (2006) The burden of psychological symptoms in UK Armed Forces. *Occupational Medicine*, **56**, 322–328.

MCGEORGE, T., HACKER HUGHES, J. G. H. & WESSELY, S. (2006) The MOD PTSD decision: A psychiatric perspective. *Occupational Health Review*, **122**, 21–28.

MOLLER-LEIMKUHLER, A. M. (2002) Barriers to help-seeking by men: a review of sociocultural and clinical literature with particular reference to depression. *Journal of Affective Disorders*, **71**, 1–9.

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE (2004) *Management of Depression in Primary and Secondary Care. Clinical Guidelines 23* (<http://www.nice.org.uk>).

RONA, R. J., FEAR, N.T., HULL, L., et al (2007) Women in novel occupational roles: mental health trends in the UK Armed Forces. *International Journal of Epidemiology*, **36**, 319–326.

WESSELY, S. (2005) Risk, psychiatry and the military. *The British Journal of Psychiatry*, **186**, 459–466.

Matthew Gould Clinical Psychologist, DCMH Portsmouth, Postal Point 6, SunnyWalk, HM Naval Base, Portsmouth, ***John Sharpley** Surgeon Commander, Consultant Advisor in Psychiatry, Royal Navy, DCMH Portsmouth, Postal Point 6, SunnyWalk, HM Naval Base, Portsmouth PO1 3LT, email: capsych@a.dii.mod.uk, **Neil Greenberg** Surgeon Commander, Royal Navy, DCMH Portsmouth, Postal Point 6, SunnyWalk, HM Naval Base, Portsmouth, and King's Centre for Military Health Research, Weston Education Centre, Cutcombe Road, London