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ARTICLE

What civilian psychiatrists should know about military psychiatry

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SUMMARY

Few of us have first-hand experience of military psychiatry. However, as a result of recent conflict and the imminent downsizing of the armed forces we will almost certainly be seeing increasing numbers of ex-servicemen in our clinics. This paper explains what civilian mental health professionals should know when dealing with service and ex-service men and women.

DECLARATION OF INTEREST

M.D. is a Colonel in the Territorial Army and a civilian consultant advisor to the Royal Air Force. He is also National Health Service clinical lead for the NHS network Joining Forces, which provides mental health in-patient services for serving military personal.

In an earlier article in *Advances*, McAllister *et al* (2011) described the structure and functions of the Defence Mental Health Services (DMHS), which are responsible for the care of approximately 200 000 service men and women (including reserves). Our article compliments and should be read in conjunction with McAllister *et al*, and sets out to describe what civilian clinicians should know about defence mental health when treating serving or ex-serving personnel. For purposes of readability the term servicemen will be used throughout, but it is important to appreciate that 10% of the armed forces are women, who, although not serving in front-line combat roles, nevertheless serve alongside combat troops and are exposed to the same risks and traumatic events as their male counterparts.

Civilian mental health professionals may encounter servicemen in diverse settings. First, they may, for a variety of reasons, register with a civilian general practitioner (GP), who may then refer on to a community mental health team (CMHT) or, in more dire circumstances, a crisis resolution and home treatment (CRHT) team or an emergency department, as with any other National Health Service (NHS) patient. At times of crisis or illness, servicemen often return home, where they may re-engage with NHS primary care services. They may wish to avoid military primary healthcare fearing, for example, the stigma of a mental health referral on their record and its possible career implications, or simply because of concerns that confidentiality may not be guaranteed in a close-knit military community.

Regardless of circumstances, the first priority is to ensure safety, treat the patient and minimise risk. Servicemen are no different to the general population: their presenting complaints (although nuanced by their experiences in the armed forces) and their response to treatment should be assessed and treated like any other patient. The prevalence of mental illness among serving personnel is shown in Box 1.

Department of Community Mental Health

The responsibility for medical care for serving personnel lies within the military, which, for mental health, is the Department of Community Mental Health or DCMH, in the region where the serviceman is based. Contact should be made with the nearest DCMH, which will ascertain exactly where and to whom the patient should be referred for further treatment.

There are key facts civilian clinicians should understand, particularly when a serviceman is ambivalent about seeking help within the military. Department of Community Mental Health personnel are colleagues, doctors and nurses who happen to wear uniform. They also include non-uniformed social workers and clinical psychologists (employed as Ministry of Defence civilians); they have the same capabilities as any CMHT. They adhere to the same professional standards and professional codes of conduct as the rest of us. Confidentiality is scrupulously observed and a DCMH will only liaise with an individual's unit chain of command when consent is explicitly given. Military medical records are held electronically with strictly controlled levels of access so there is no possibility of a patient's 'mates' seeing their medical record. Defence mental health personnel are non-judgemental and act in the interests of the patient. Many servicemen seeking help in the NHS are unhappy and embittered, wanting to leave the armed forces; not surprising, considering a private soldier on completion of basic training is tied into

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a 4-year contract. The 'unhappy soldier' wishing to leave is a common problem accounting for a large part of a DCMH's workload. The DCMH will not react negatively, but with sympathy and compassion. Military mental health professionals understand the administrative and medical routes out of service, and, with the patient's consent, will liaise and work with the chain of command to try to achieve the best outcome for the patient.

There are practical benefits for servicemen being treated by the DCMH. Apart from their better understanding of the military environment compared with NHS mental health professionals, the DCMH has considerably greater capacity than any NHS CMHT, shorter waiting times (less than 24 h in an emergency and less than 2 weeks for a routine appointment), and much more rapid access to clinical psychology and social work support. An individual can still remain 'sick' at home with their family and receive DCMH support. However, Departments of Community Mental Health have their limitations: out-of-hours care is generally unavailable and largely limited to telephone advice, and there are no alternatives to admission, such as CRHT.

Patients with predominantly social problems should be reminded that entirely independent organisations such as the Army Welfare Service are available to provide counselling and practical support, again outside the chain of command and defence medical services.

BOX 1 Mental health statistics for serving personnel

- During 2010, 3942 new cases of mental disorder were identified within UK armed forces personnel, representing a rate of 19.6 per 1000 strength.
- Among the 3942 personnel with a mental disorder, there were statistically significant findings:

  Rates for mental disorders in the Royal Navy are lower than the overall tri-service rate.

  Rates were higher for women than for men, for other ranks than for officers, and for those aged between 20 and 24 years. The army had a threefold increased risk of post-traumatic stress disorder (PTSD) following deployment to Iraq and a sixfold increased risk following deployment to Afghanistan. The army also had a threefold increased risk of depressive episodes following deployment to Iraq and Afghanistan.

  Rates for mental disorders in the Royal Air Force (RAF) are higher than the overall tri-service rate. Rates were higher for women than for men, and for other ranks than for officers. The RAF are at twice the risk of PTSD following deployment to Afghanistan, but they also saw a 40% decreased risk in mood disorders following deployment to either Iraq and/or Afghanistan.
- There were 315 admissions to the Ministry of Defence's in-patient contractor in 2010, including personnel based in Germany and treated as in-patients in that country. There were some statistically significant differences between subgroups of in-patients:

  Rates for the army were higher than the RAF and the Royal Navy.

  Rates for other ranks were higher than for officers.
- 158 armed forces personnel were seen at a field mental health team in Afghanistan, of which 133 had a mental disorder.
- In 2009, there were 164 medical discharges for a mental disorder out of a total of 1363 medical discharges.

(Defence Analytical Services and Advice 2011)

Admission to hospital

Compulsory admission

The one situation where treatment remains within the NHS is when a serviceman requires compulsory admission and detention under the Mental Health Act 1983. In this circumstance the patient should be treated exactly the same as any NHS patient and admitted to their local admission ward. However, the nearest DCMH should be contacted and made aware of the admission as soon as possible, as they may, according to circumstances, wish to divert the patient into the Ministry of Defence's dedicated in-patient services described below.

Informal admission

Patients requiring informal admission should be referred to their DCMH, who can arrange admission into a UK-wide network of eight NHS mental health trusts which currently hold the Ministry of Defence in-patient provider contract, each with dedicated facilities for military personnel (Box 2). The contract requires not only that a bed be made available within 2 h, but that patients are cared for in a ward environment with specific provision for military personnel and by dedicated staff who have a particular interest and experience in dealing with the military and who have built up a considerable understanding of the military ethos and culture (Deahl 2010).

Diverting patients into this care pathway not only reduces demand on local hard-pressed resources, but ensures that military personnel are admitted in a timely fashion into an environment where their particular needs and the service dimension is understood, and with a clinical team that works in close partnership with the DCMH. Any mental

BOX 2 Joining Forces Network: the NHS in-patient provider for the armed forces

- South Staffordshire and Shropshire Healthcare NHS Foundation Trust (prime contractor)
- Tees, Esk and Wear Valleys NHS Foundation Trust
- Lincolnshire Partnership NHS Foundation Trust
- Cambridge and Peterborough NHS Foundation Trust
- Southern Health NHS Foundation Trust
- Somerset Partnership NHS Foundation Trust
- NHS Grampian
- NHS Greater Glasgow and Clyde

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health professional wishing to obtain first-hand clinical experience with military personnel should contact the Joining Forces Network, who will be able to advise and assist wherever possible.

Admission criteria

Admission criteria differ markedly from those in the NHS; the military are understandably more risk averse than civilian colleagues given the nature of the military environment (replete with firearms, etc.) and, together with the lack of any alternatives to admission, thresholds to admit are much less than those in the NHS (McAllister 2011).

Whatever the reasons for an individual choosing to present to the NHS, particularly when they are deliberately seeking to avoid treatment 'in house', seldom are these anxieties justified and they should be persuaded to be redirected to their DCMH wherever possible. Formal responsibilities notwithstanding, this does not mean that service personnel should be denied treatment or hospital admission, particularly in an emergency.

Transitions

Whether it is returning home from operations or leaving the armed forces, transitions are emotionally demanding for military personnel and their families (Lincoln 2008). On return from operational service, personnel face a dramatic change in lifestyle, from the adrenaline-fuelled 'high' of combat to the realities of a more pedestrian domestic life and the 'day' job. Everyday life may seem monochrome and dull to many whose operational experience has been one of the most formative and rewarding periods of their life, prematurely triggering an existential mid-life crisis. A returning spouse expects life to continue as usual; all too often this is not the case: families have learnt to become more self-sufficient and independent. Respective expectations of families and returning service personnel may differ widely resulting in tension, discord and uncertainty (Faber 2008), and young children may show ambivalence towards a returning parent (e.g. Sayers 2009). Likewise, media and public hostility towards government and foreign policy may emotionally undermine service personnel who, as a result, may feel their effort and suffering have been nugatory and unappreciated, further contributing to family discord (Pinder 2009).

This 'transition gradient' is all the more steep for members of the reserve forces and Territorial Army who part company with comrades and return to an environment in which few, if any, can understand or empathise with their experience. All of the above may be compounded by the effects of alcohol, frequently used to excess by returning service personnel (Rona 2010), with greatly reduced tolerance having been largely abstinent while deployed. An association between the steepness of the transition gradient and psychopathology is an as yet untested hypothesis, but one with considerable face validity that resonates with clinical experience and helps explain the increased rates of psychopathology seen among reserve forces compared with regular personnel (Iversen 2009).

The transition from serving to veteran status may be as administratively problematic as it is psychologically challenging. Around 20 000 service personnel leave the armed forces annually. Private soldier or general alike, an individual must adjust from being a 'somebody' (with rank and status) to a 'nobody', from a highly structured and regulated environment, to a world of *laissez-faire* 'do as you please', from a secure world where all needs are met, to one of insecurity, self-help and uncertainty. Adjustment issues on leaving the armed forces are arguably responsible for far more psychopathology than post-traumatic stress disorder (PTSD) and the 'horrors' of war.

Pathways out of military service

Civilian practitioners should have a basic understanding of the pathways out of military service. An individual diagnosed with a psychiatric disorder may (after unsuccessful attempts to treat) be medically discharged (an S8 discharge in the parlance of the military medical grading system). This discharge will have been recommended by a uniformed consultant psychiatrist and endorsed by a consultant occupational physician at a medical board – the military forum for formal decision-making in such matters. Because of the bureaucracy and administrative complexities surrounding this process, an individual may wait as much as 1 year, sick at home, before their last day of paid service. The soldier will receive a pension and treatment at their nearest DCMH, who will refer on, as necessary, to local NHS services as the release date approaches.

Responsibilities have become somewhat more confused following recent changes in government policy. One recommendation of the Murrison (2010) report *Fighting Fit* (see later) is that the DCMH should continue to provide care to a serviceman for 6 months following their release from service. Although popular with service users, the potential for confusion surrounding responsibilities and duty of care is evident: what, for example, will happen when a DCMH, faced with a deterioration in a

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patient's mental state, attempts to refer to a local CRHT when the NHS has had no previous contact with the patient? Moreover, what will happen when they want to admit (accustomed to their low risk thresholds) to a local NHS unit that would never contemplate admission under other circumstances (these individuals will be out-with the Ministry of Defence's current in-patient contract)? Clearly, there needs to be close liaison between defence medical services and the NHS, with a mutually agreed care plan in individual cases. Ideally, a period of shared care and a seamless handover should take place, but it is not uncommon in the current economic climate for hard-pressed local NHS services to demur from engagement with a serviceman (i.e. 'not our responsibility') until the last possible moment. Although this is technically correct, it is arguably unethical, puts patients at risk, is bad practice and should stop.

Physically disabled servicemen

Physically injured and disabled servicemen are particularly vulnerable, and their mental health needs often eclipsed by their physical disability. Recent operations in Iraq and Afghanistan have created a large number of blinded and limbless individuals, often with multiple, complex disabilities. They have been fêted and received world-class care and the fulsome praise of society. Charities such as Help for Heroes (www.helpforheroes.org.uk) have elevated their public profile and raised enormous amounts of money to support them. They have walked to the Poles, crossed the Atlantic and performed countless other acts of extraordinary heroism.

From a psychological perspective this looks like displacement activity by any other name and creates a powerful emotional shield. Once the shield has lowered, the public attention waned and society's focus shifts elsewhere, these individuals settle down to face a very uncertain future. The world-class military medical care will be no longer available, their disabilities will be at the extremes of what the NHS can cater for, and although the voluntary sector will continue to support them as best they can, they will ultimately rely on local statutory services. Their mental health needs will be considerable and it behoves us to start planning for their future needs as quickly as possible.

The 'temperamentally unsuitable' serviceman

A further category of patient is that of servicemen discharged administratively as 'temperamentally unsuitable' or 'TU', usually within their first 3 years of service; these are individuals who are unable to adjust to the rigours of service life. They receive no pension and often part company with the military with ill feeling and hostility. Although not mentally ill, they are vulnerable and may well develop mental health problems in the future.

Mental health problems after discharge

Servicemen may, of course, complete their contract and leave the service fit and well, only subsequently developing mental health problems. Alternatively, they may conceal a mental disorder and be released from service, invisible to the DCMH and military mental health authorities, only to present subsequently to psychiatric services. For some individuals a combat-related disorder does seem to announce itself only some time after the alleged trauma: the National Institute for Health and Care Excellence reports that 10–15% of PTSD cases are delayed in onset (National Collaborating Centre for Mental Health 2005). No matter how efficiently the DMHS attempt to screen or encourage distressed individuals to come forward, there will always be some who evade detection and present unannounced to the NHS.

Veterans – the lost tribe?

Service veterans are a diverse and heterogeneous group which broadly reflects the demographics of society (with, of course, proportionately fewer women), and may equally present to substance misuse and older people's services as to adult mental health services. Veterans typically deny popular stereotypes. Old and bold, or young and immature, they may present to any psychiatric subspecialty, as indeed may their families and children. Their needs are disparate, as are their attitudes towards the provision of dedicated services for veterans. Some veterans will insist that only those who have served themselves and worn a uniform can possibly understand their needs. Others, on the other hand, have no desire to have any further contact with anyone remotely associated with the armed forces or affiliated organisations and prefer to receive care in a civilian environment. Some veterans are extraordinarily ambivalent – complaining bitterly about perceived injustices and the way in which they have been treated by the armed forces while living in surroundings embellished with treasured mementoes and memorabilia of their military career. There are no hard and fast rules and an important question in any assessment is to ascertain whether the patient wishes to receive support and treatment in the more military setting of services dedicated to veterans.

Veterans may be ambivalent about their disorder. To some, a diagnosis of PTSD is a serious disability, isolating and alienating from

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TABLE 1 **Where to get help for servicemen and ex-servicemen**

Service personnel	Intervention
Serving regular personnel	Unit medical officer or nearest Department of Community Mental Health (DCMH)
Serving reservist	National Health Service (unless deployed on operations since 2003 and mental health problems appear attributable to deployed operational service)
Reservist (serving or ex) and deployed on operations since 2003	Veterans' and Reserves Mental Health Programme (VRMHP) (previously Reserves Mental Health Programme) (www.army.mod.uk/welfare-support/23247.aspx): will assess and arrange out-patient treatment at a DCMH if mental health problem is judged attributable to service
Any ex-service personnel who have served on operations since 1981	Veterans' and Reserves Mental Health Programme (VRMHP) (www.veterans-uk.info/map/faq.html): GP referral necessary, diagnosis, advice, signposting, but no treatment
Any service personnel or veteran	Service Personnel and Veterans Agency (www.veterans-uk.info/about_us/about_us.html): provides advice on pensions, compensation and support

society and loved ones; for others, PTSD is worn almost as a badge of courage and may bring with it status and recognition in the local community – successful 'treatment' may undermine this and assault an individual's core identity. Likewise, the threat of any potential loss of benefits is a powerful disincentive to recovery and it is hardly surprising that some veterans remain entrenched in the 'sick role'.

Without doubt, a 'one size fits all' approach is unlikely to be effective. In general, younger veterans, particularly those having seen service since 2003 and deployed on operations in Iraq (Operation Telic) or Afghanistan (Operation Herrick) and who have an acute disorder of more recent onset, are likely to benefit from evidence-based treatments and psychiatric care, whereas older veterans, more entrenched in the sick role, are less likely to respond to treatment and more likely to respond to welfare and social support (Table 1). Most will benefit from accurate signposting given the confusing plethora of third-sector organisations offering help to ex-servicemen.

Presenting problems

Veterans may present with any disorder. However, regardless of diagnosis, in addition to mental illness they are more likely to suffer:

- domestic (Erbes 2008) and occupational breakdown (Iversen 2009)
- social exclusion (Murphy 2008)
- criminality (van Staden 2007)
- homelessness (Dandeker 2005)
- self-harm (Crawford 2009)
- substance misuse (Iversen 2009).

It is also important to be alert to the phenomenon of medically unexplained symptoms (Greenberg 2009), which have been reported during and after all modern wars (Jones 2002) and came into particular prominence following the 1991 Gulf War. These symptoms, such as fatigue, dizziness, nausea and gastrointestinal complaints for which there is no known aetiology, frequently veil underlying psychopathology.

These disparate presentations make estimates of veterans' psychopathology very difficult to quantify, let alone attribute to service-related factors. Indeed, there is little more than anecdotal evidence to suggest that these problems are specific or likely to occur more often in the veteran population. One study, however, from the University of Manchester UK Centre for Suicide Prevention (Kapur 2009), which examined all discharges from regular military service between 1996 and 2005, demonstrated a threefold increase in suicide rates in the under-24-year-old age group (compared with the age-matched general and servicing populations). Suicide was most likely to occur in army veterans of low rank who had served for only a short time (i.e. generally within their 4-year engagement). Most worrying was the observation that this was also the very group that had the lowest rate of contact with mental health services following release from service. This mirrors suicide statistics from serving personnel showing that army (only) personnel under the age of 20 years are the highest risk and suggests that these individuals carry their risk with them on leaving the service (and may have brought the risk with them into service too) (Fear 2009).

Treating mental disorder in veterans

The treatment of mental disorder in veterans is no different from treatment in any other patient. However, it is important to deliver this in context, being mindful of the military background which may have precipitated, perpetuated or exacerbated a particular disorder. Without doubt, a few individuals may fabricate or (more often) embellish a military history and 'military Munchausen's' syndrome is well recognised (Baggaley 1998). It is important for civilian clinicians not to take a history at face value, particularly when this is dramatic, extreme or contains any reference to secret operations, the Special Air Service or special forces; a call to the local DCMH will enable appropriate checks to be made and confirm (or otherwise) a story.

The problem of attribution

It is part of our nature to seek an external locus on which to blame our problems and the concept of effort after meaning has long been recognised

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(Bartlett 1916). It is hardly surprising therefore that ex-servicemen developing mental health problems may, entirely understandably, be quick to attribute these to their former military service (fuelled by potential financial incentives such as pensions or compensation). In some cases this may indeed be the case, be it PTSD, alcohol dependency or an affective disorder. However, it is important to bear in mind that for most, military service is formative, some of these individuals may have brought their vulnerability and problems into service with them, and others simply succumb to life's vicissitudes that befall all of us. There is little empirical evidence to suggest that military service *per se* is a significant cause of mental health problems.

The problem of identification

Many clinicians are oblivious to the fact that their patients have served in the armed forces (Box 3). Even when a service history is identified, it is seldom explored in depth. When taking a history it is important not only to ask whether an individual has served but to explore further and ascertain what the patient did in the armed forces, whether they served on operations and whether they feel their service has any bearing on their current problems. Data such as GP registration and care programme approach (CPA) documentation are only just beginning to be sensitised to record an individual's veteran status.

Organisations such as Combat Stress (www.combatstress.org.uk) argue that there is an iceberg of untreated morbidity among the veteran community, in particular a delay of more than 14 years between release from service and first contact with mental health services (Fletcher 2007). It is difficult to know to what extent this is true. Epidemiological studies are difficult to conduct, not least because individuals can be very difficult to track once they have left the armed forces.

Service veterans frequently cross conventional boundaries of care. Their diverse needs may include relationship and family problems, accommodation, occupation, criminal justice and financial issues. Thoughtful and informed care planning is needed to achieve the best outcomes. Many organisations are dedicated to catering for veterans' needs, but their services often overlap, and it can be very difficult for the concerned professional to know which is the most appropriate resource for a particular individual. Veterans have an unhappy history of raised expectations; organisations (including the NHS) either offering services that they fail to deliver or 'passing the parcel' and sending the veteran on a wild goose chase from one organisation to another, wasting time, effort and achieving little or nothing.

> **BOX 3** Practice points
>
> - Know which of your patients are service veterans
> - Know where your local DCMH is, and how to make contact
> - Be aware of the NHS veterans mental health network and identify your local veterans mental health therapist

Veterans' mental health has been a particular priority of the present UK government, who commissioned Dr Andrew Murrison MP to prepare a report suggesting ways of making improved access to services and treatment for veterans. The report, *Fighting Fit* (Murrison 2010), covers a number of elements of the care pathway (Box 4).

In response to these recommendations, the Department of Health has allocated £1.5 million to establish a national NHS Veterans' Mental Health Network with 30 dedicated veterans' mental health therapists covering all the English NHS regions. The therapists are (mostly) experienced mental health nurses, often with military experience. Their role is to educate fellow mental health professionals and liaise with the care coordinators over individual cases, offering advice, signposting to the plethora of service charities, co-working. They also have a small individual case-load of individuals with the most complex problems.

Conclusions

Wherever we work and whatever our specialty, we will doubtless in the future be seeing more servicemen and veterans. Although recent conflict dominates the headlines, it is important not to forget the veterans of the Second World War, Korea, Malaya, Suez, the Falklands, Northern Ireland, and Bosnia. Their disorder may be just as relevant to military service in the distant past as that of the younger veteran of conflict in Afghanistan and Iraq.

Services for veterans are many and often overlapping. They can appear muddled and confusing to civilian health professionals, let alone the service user. A basic understanding of the needs of servicemen and veterans and where to obtain help and advice should be integral to continuing professional development – indeed, it could be argued that it should be included as an element of equality and diversity mandatory training (Box 5).

> **MCQ answers**
> 1 b 2 b 3 c 4 b 5 c

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BOX 4 Improved care pathway for veterans

Theme 1: Improving the consistency of approaches to mental health across the military veteran life cycle, with an emphasis on ensuring continuity of care

- One armed forces minister specifically responsible for serving members, veterans and families.
- Recognition of the need for disparate government departments to work together to ensure that the needs of veterans are reflected in wider public policy and support arrangements.

Theme 2: Improving the process of transition out of the military, aiming for a seamless handover to the NHS

- *Strategy for Veterans* (Ministry of Defence 2006) – plan for continual improvement in in-service training, healthcare, treatment and rehabilitation; where appropriate, applying lessons learnt from studies of veterans' health.
- Defence mental health services for veterans – information about services and benefits for veterans on the Ministry of Defence website (Murrison 2010).
- Fast-track career transition services for medical discharges, and possibility of deferring services for up to 2 years post discharge for veterans unable to participate sooner because of their medical condition. In extreme cases, transition services can be transferred to a spouse/partner.
- Veterans Information Service – part of *Fighting Fit* (Murrison 2010). Some members may be at risk of developing mental health problems after discharge as military support structures are no longer available. Personnel will be advised at their discharge medical assessment to expect a 12-month follow-up, which will contain a questionnaire relating to health (including but not limited to mental health and alcohol use), and will explain the range of services available locally.

Theme 3: Improving the engagement of serving members, veterans and their families in psychological health and well-being initiatives

- Trauma Risk Management (TRiM) – peer mentoring and support programme, where at-risk personnel are identified, monitored and, if necessary, assisted in referral to specialist help.
- Veterans UK – telephone helpline and online service providing information on entitlements and support available.
- *Strategy for Veterans* (Ministry of Defence 2006) – aim to develop strategies and initiatives for raising veterans' awareness (especially hard-to-reach veterans) of the benefits, help and support available.
- Evaluation of Veterans Mental Health Pilot Projects – Recommendation that mental health services for veterans should accept self-referrals: experience with Improving Access to Psychological Therapies programme showed no inappropriate use or 'flooding' of services, and that the existence of mental health services for veterans be publicised widely, including to all discharging service personnel.
- Technological innovations (e.g. Big White Wall, www.bigwhitewall.com) – online mental well-being service, free for serving members, veterans and their families.

Theme 4: Optimising the quality of mental healthcare provided to serving personnel, veterans and their families

- Departments of Community Mental Health – provide out-patient mental healthcare to serving members. Staffed by psychiatrists and mental health nurses, with access to clinical psychologists and mental health social workers.
- Collaboration between Ministry of Defence, UK health departments and ex-service organisations to achieve effective delivery of appropriate mental health services for veterans.
- *Strategy for Veterans* (Ministry of Defence 2006) – plan to work with civilian healthcare professionals to raise awareness of armed forces' and veterans' health issues.
- Ministry of Defence Medical Assessment Programme – offers mental health assessments for veterans who have served since 1982 (via GP referral).
- Community Mental Health Pilot Projects – collaboration between Ministry of Defence, UK health departments and charities (particularly Combat Stress) in response to the perception that the NHS does not understand veterans or always provide a good service for them. Evaluation found the following successful features (not all pilot sites offered them):

  option of self-referral

  availability of staff who were themselves veterans, and group work with other veterans

  provision of multi-agency services, with advice on pensions, employment, housing, physical health, etc.

  task- and information-sharing with other agencies (such as NHS/Combat Stress) to support one another and prevent duplication

  routine access of armed forces' service records of new referrals

  combined assessment/treatment, with no wait in between.

BOX 5 Learning points

- A patient's history of military service, particularly in the reserve forces, is often overlooked. Mental health professionals are bad at asking whether an individual has served and taking a service history.
- The treatment of psychiatric disorder in serving and ex-service personnel is no different from that in civilians, although their problems must be seen in context.
- Post-traumatic stress disorder is not the most common mental health problem affecting servicemen and veterans. Depression, other anxiety and adjustment disorders and alcohol misuse are much more prevalent.
- The treatment of PTSD, including military PTSD, should be within the competency of CMHTs.
- Veterans' mental health therapists will soon be in post, giving nationwide advice on the resources and services available to veterans. Each mental health trust should have a page on its website giving details of these services and how to make contact.

We have a duty and particular moral obligation to serve those, who, after all, have served and made sacrifices for us, by providing a flexible, needs-led, high-quality standard of care. To achieve this, we will need to understand the capabilities, strengths and weaknesses of the voluntary sector, working with them in an unprecedented collaboration to achieve the best outcomes for this special group. If in so doing we raise standards for all, we will indeed have achieved a worthy goal.

Further reading

An issue of the *International Review of Psychiatry* is devoted to military mental health: 2011, **23**(2) 'Military mental health – modern developments'.

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MCQs

Select the single best option for each question stem

1 The Veterans' and Reserves Mental Health Programme:
- a is available to any reservist
- b is only available to reservists who have deployed on operations since 2003
- c is synonymous with the Medical Assessment Programme
- d requires a GP referral
- e provides treatment and case management.

2 The most common presentation to defence mental health services is:
- a PTSD
- b unhappy soldiers
- c conversion hysteria
- d alcohol misuse
- e malingering.

3 Service veterans:
- a only want treatment with clinicians closely allied with the military
- b have high rates of PTSD
- c may, under certain circumstances, be entitled to treatment within the military
- d their mental health problems are usually attributable to military service
- e have unique mental health problems that only clinicians who have served themselves can properly understand.

4 The *Fighting Fit* report:
- a recommends pension and compensation arrangements for veterans
- b advocates free access to the Big White Wall to servicemen and veterans
- c suggests Combat Stress provide exclusive mental healthcare for veterans
- d recommends veterans receive in-patient treatment in private hospitals
- e suggests more NHS clinicians should receive training in the treatment of PTSD.

5 Transitions:
- a are mostly welcomed and a minor source of mental health problems
- b are an important cause of PTSD
- c probably cause more mental health problems than traumatic exposures in combat
- d are well managed by the military
- e usually involve the seamless handover of care to the NHS.

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