The man who lost his life in Iraq, now lives in Birmingham.

Wars such as Iraq, Afghanistan, Kosovo, The Gulf and the Falklands have resulted in many victims. For some their battle scars are invisible psychological illnesses.

These casualties have experienced things few of us would want to imagine even in our worst nightmares and they carry the mental scars around with them, often adversely affecting their employment, family and friends.

Many become tragic victims of alcohol and drug abuse, homelessness, and some even become suicidal. These brave ex-Service men and women desperately need help and support.

If you are reading this as an ex-Service man or woman and you think, ‘this sounds like me’ or you know someone ex-Service who is suffering, please contact us on:

01372 841 680
or email us:
contactus@combatstress.org.uk

Charity Number England: 200602, Scotland SCO38828

www.combatstress.org.uk
Management of Mental Health in Veterans: The role of the Third Sector Charity Combat Stress

RCPsych Presentation
14th May 2010
Dr Walter Busuttil
Medical Director & Consultant Psychiatrist
Combat Stress
walter.busuttil@combatstress.org.uk
British Veterans

- A veteran is someone who has served at least one day in the military
- Distinguish between Veterans and Combat veterans
- Around 25,000 leave the military each year
- There are about 5 million Veterans in the UK and 7.5 million first degree dependents.
Why is Working With Veterans Complicated?

Mental health problems can arise from a variety of causes in Veterans:

- **Pre service vulnerabilities** – many join to escape a difficult life situation, poor education levels, IQ?

- **Military life itself** – institutionalization, alcohol, family issues; bullying, non-operational occupational mental health injury; Operational service – traumatic exposure: single / multiple

- **Earlier onset of physical disorders related to military life** – mainly orthopaedic including chronic pain / ENT problems; Physical disorders associated with mental health illness

- **Leaving the service and adjusting to civilian life** – institutionalisation

- **Help seeking issues** – Issues surrounding being macho, avoidance of seeking help, lack of understanding of and by civilians, shame, stigma, guilt, you were not there etc

- **Combination of the above**
Incidence of Mental Health Problems in Veterans

1. No UK Population Studies

2. Need National Vietnam Veterans Readjustment Study (NVVRS) equivalent studies

3. KCL OP Telec (Iraq Invasion and occupation) Studies will help as long as population is followed up as veterans (longitudinal)

4. Population Studies being set up in Scotland and Wales (cross-sectional). Also in England

- Depression
- Anxiety
- PTSD
- Alcohol
- Drugs
- Personality problems
Combat Stress
Ex-Services Mental Welfare Society est1919

• Third Sector National Mental Health Charity for Veterans
• Funding: Charity, War Pensions, NHS
• Multidisciplinary community outreach service including welfare needs
• Multidisciplinary residential bespoke programmes
• Helplines / websites
• Self referral or through family (56%) or ex-service charities/agencies (37%) - NHS only 3%
• 1303 new referrals last year: increase of 66% over past 6 years
• 4380 active patients – receiving either welfare or clinical help or both; further 5617 ‘passive’ patients
New Referrals
1 April 2009 – 31 March 2010

1,303 cases

Average Age 42.8 years
Average Length of Service 10.9 years
Interval between discharge and first contact 14.3 years
Attributable War Disability Pension 9 (0.7%)
Veterans by Service

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

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

31.03.2010
Referrals Iraq & Afghanistan Veterans
New referrals six monthly intervals from October 2003 to Jan 2010

IRAQ total n=665
Afghanistan total n=165
## The Needs of the Combat Stress Population: Clinical Audit Data

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

Psychiatric Disorders
• VERY High levels of **CHRONIC** psychiatric disorder and co-morbidity
• PTSD Commonest diagnosis (75%)
• PTSD Co-morbidity in 62%: with Depression, Alcohol disorders commonest.
  • Pseudo-Psychotic and Dissociative presentations of PTSD common
  • Anxiety, anger, personality difficulties, Dissociative disorders
  • Very high rates of attachment / abuse problems related to childhood
  • Attachment problems regenerated after leaving military

Behavioural Disorders
• Aggression, violent behaviour
• Offending behaviours including Schedule 1 offences
Complex Bio-Psychosocial Presentations

Clinical Audit data (n=608); Psychometric Data Analyses (n=704) 2005-2009

Physical Disorders
• Chronic physical disabilities / illness especially orthopaedic and chronic pain problems and deafness
• Premature onset of common physical disorders – cardiac, diabetes, hypertension etc.
• Very high levels of psychiatric and physical co-morbidity

Social Exclusion
• Dysfunctional relationships Marital and family break down
• Unemployment (up to 75% of those of working age)
• High percentage live alone and have accommodation problems
• Isolation – very common problem
Multiple Traumatisation in Adults
Studies of Hostages and POWs (Busuttil, 1992)

**Stress Disorders** *(incl ASD & PTSD)*: pre-captivity experiences; initial captivity experience; torture; solitary & group confinement

**Depressive Disorders**: torture, loss events, captivity experience itself

**Cognitive Defect States**: weight loss, vitamin deficiencies, CNS infections

**Psychotic States**: isolation and confinement

**Personality - Character Changes**: captivity experience itself: coping style and locus of control (includes enduring personality change)

**Physical Illness** - Somatiform & Genuine

**Alcohol/illicit drugs**
Enduring Personality Change after Catastrophic Stress (ICD-10, 1992)

Prolonged exposure to life threat/s PTSD may precede the disorder

*features seen after exposure to threat:*

- hostile mistrustful attitude towards the world
- social withdrawal
- feelings of emptiness or hopelessness
- chronic feelings of being on edge or threatened
- estrangement
Multiple traumatisation in Children and young people before the age of 26:

Complex PTSD:

*Diagnostic framework (Bloom 1999)*

Three areas of disturbance -

- Symptoms
- Characterological / personality changes
- Repetition of Harm
Complex PTSD: Disturbance on Three Dimensions
(Herman 1992; Bloom, 1999)

- **Symptoms of:** PTSD
  - Somatic – cf GWS
  - Affective
  - Dissociation
    (psychotic presentations)

- **Characterological Changes of:**
  - **Control:** Traumatic Bonding
    - Lens of Fear
    - Relationships: Lens of extremity-attachment vs withdrawal

  **Identity Changes:**
  - Self structures
  - Internalized images of stress
  - Malignant sense of self
  - Fragmentation of the self

- **Repetition of Harm**
  - To the self - faulty boundary setting
  - By others - battery, abuse
  - Of others - become abusers, aggressors
  - Deliberate self harm
Typical New Referral 2009

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

1. Regional Welfare Officer
2. CPN
3. Mental Health Worker
4. Desk Officer
5. Sessions of Psychology and Psychiatry
Community Welfare Arm of Combat Stress

- Sixteen Regional Welfare Officers across UK and Eire
- Desk officers manage RWO
- Desk officers offer 9-5 telephone advice to veteran (*silent hours advice offered by nursing station – 24 hour access*)

**RWO:**
- Is ex-military officer who visits ex-serviceman and engages him
- Initial visit: helps with practical needs; referral report for Treatment Centre assessment and starts psychometric data gathering
- Liaises with War Pensions and other service charities & retraining for work
- RWO follows up and stays in touch as long as the patient’s case remains ‘active’: ie help delivered for Welfare or Clinical needs or both
Over £2 million promised by Government

Up to 22 Combat Stress Liaison Nurses based in the NHS to be appointed:

Initially:
London - Maudsley
Pennine Care (NW)
Newcastle
Sheffield
Leicester
Devon Partnership Trust
Kent & Medway

Education for GPs and Primary Care
Veterans Mental Health Helpline.
Three Residential Treatment Centres

• **Tyrwhitt House, Surrey**

• **Audley Court, Shropshire**

• **Hollybush House, Ayr**

• Sensitive to the military culture
• Therapeutic milieu
• Peer support
Combat Stress Treatment Strategy (Dec 2007)

Chronic Disease management as per 2005 NICE Guidelines for treatment of Veterans for PTSD

- Initial preparation
- Stabilisation and safety
- Disclosure and working through of the traumatic material and psychotherapy on an individual basis
- Rehabilitation and reintegration within society; normalising activities of daily living
**Medications:**

**Medication**
- Antidepressant (SSRIs; Mirtazepine)
- Neuroleptics
- Mood Stabilizer / Antiepileptic (Carbamazepine; valproate)
- Anxiolytic (Pregabalin)
- Anti-impulse (clonidine/ prazocin/ propranolol)

**Indication**
- PTSD & Depressive symptoms
- Pseudo-psychotic presentations; Dissociation; Tranquilization; comorbid psychotic depression
- PTSD Symptoms, dissociation & Mood stabilizing properties
- Severe anxiety/hyperarousal
- Impulse control - self-harm
Current Clinical Intervention

Community

- Initial Regional Welfare Officer assessment – ESSENTIAL PORTAL OF ENTRY INTO CARE
- CPN assessment / clinical outreach / outpatient

Residential

- Five day week admission for assessment - followed by:
- Three two week treatment admissions over one year period as a maximum
- *Or* Six one week admissions over one year
- Whole Person Care Plan
- Try to plug into NHS care
Current Rolling Programme

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

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

Upgrade existing residential services to work in conjunction with community interventions

• Bespoke Programmes – all are evidence based:
  1. **Intensive** (Australian veterans)
  2. **Alcohol Education** (Australian veterans)
  3. **Refractory chronic PTSD** (American Veterans Association)
  4. **Old age** (Australian veterans)
  5. **Enhanced Rolling Programme** (American Veterans Association)
  6. **Old age respite** Transfer this to other venue?
  7. **Carers Groups** (Australian veterans)

Expansion of Outreach & Community Services will allow:

• Residential programmes to be more effective
• Transfer part two of intensive programme to outreach
• Transfer refractory chronic PTSD programme to outreach
Maintenance

• Maintenance is an essential part of chronic disease model for those whose illness is ongoing

• The Community Outreach Service must be in place for the bespoke treatment programmes to work well
## Community outreach will:

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Programmes Offered</th>
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<tbody>
<tr>
<td>Reduce Stigma</td>
<td>Allow Joint residential and outreach programmes</td>
</tr>
<tr>
<td>Improve Engagement</td>
<td>Tailor make treatment to patient need</td>
</tr>
<tr>
<td>Reduce presentation time</td>
<td>Allow more family work / carers group treatments</td>
</tr>
<tr>
<td>Promote Joint management with NHS / PLUG IN</td>
<td>Allow outpatient work</td>
</tr>
<tr>
<td>Free residential beds allowing more intensive programmes to be developed for those who need them most</td>
<td>Allow more community liaison / education of NHS services</td>
</tr>
<tr>
<td>Allow smoother pathway for those who need alcohol / drug detox followed by trauma treatment</td>
<td>Allow more community group treatment ; re-training and rehabilitation</td>
</tr>
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Combat Stress: Liaison & Joint Working:

- Defence Mental Health Services (in-service)
- NHS CMHTs / IAPT / psychology services
- Six MOD Pilot Sites (Cornwall, South Shields, Camden & Islington, Edinburgh; Staffordshire; Cardiff).
- UK MAP / Chilwell (veterans & reservists).
- Military Charities (RBL; SAFFA; H4H; COBSEO etc)
- War Pensions – Benefits Trap: WPs should not be counterproductive to treatment and therapy
- Local forums eg In South West Local Armed Forces Forum
- Other services
NHS

• Services patchy

• Training needs:
  – Lack of expertise in assessment and management of psychological trauma cases and PTSD generally (eg GPs study - Elhers et al, 2009).
  – Lack of expertise in Military psychiatry / psychology
  – Lack of appropriate prescribing of medications for complex / chronic PTSD
Major Challenges for NHS and Combat Stress

- Complex Trauma Presentations (Complex PTSD)
- Acute alcohol / drug Detox – seamless plug into trauma work
- Schedule 1 Sex Offenders
- Forensic cases – imminent violence, severe behavioural disturbance.
- Veterans with mental ill health in the prison population
- Increasing population of Old Age Veterans in the general population – hidden psychiatric morbidity plus locked in chronic PTSD
- Growing number of in service families with psychological and mental health problems ongoing wars 180000 servicemen and women sent to Iraq/Afghanistan so far!!!
Recent Government Initiatives for Veterans

- **MOD/NHS mental health pilots** – six so far assessed / signposted around 500 patients (Cornwall, Shropshire, Camden & Islington, Edinburgh, Cardiff, South Shields)

- **Advice to NHS about priority treatment**

- **Command Paper** – promise of help to veterans

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

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

- NHS central funding in Scotland for Scottish residents
- MOD War Pensions
- Charity (55% of revenue!)
- The Enemy Within Appeal (£30 million target) launched March 2010
References


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


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