SUPPORTING VETERANS

DOMINIC MURPHY DETAILS THE CLINICAL PATHWAYS AT COMBAT STRESS FOR VETERANS WITH POST-TRAUMATIC STRESS DISORDER

Post-traumatic stress disorder (PTSD) is a normal reaction to an abnormal experience; when we are exposed to an extraordinary situation – something far outside the norm – our mind may struggle to make sense of it. If your brain repeats a traumatic event day after day, it's not hard to understand how the impact on the mind can be utterly devastating.

At Combat Stress, the UK's leading mental health charity for ex-servicemen and women, we treat more than 6,000 veterans suffering from mental ill health following a career in the UK armed forces. Approximately 75 per cent of those we treat have a diagnosis of PTSD.

In 2011, Combat Stress was commissioned by the NHS to provide a specialist Intensive Treatment Programme (ITP) for veterans suffering from severe PTSD. The ITP, which runs over six weeks, is free to veterans as part of their recovery and rehabilitation. The programme consists of a mixture of individual and group sessions, including trauma-focused cognitive behavioural therapy (TF-CBT) sessions.

Over two years, we conducted a study on the efficacy of this innovative programme. Our results were published earlier this year in *BMJ Open*.[1] We were pleased that the results showed that the treatment we offer is effective. The veterans who completed the programme had significant improvements in PTSD and other mental health conditions. These improvements were maintained when we followed the veterans up six months later.

Between 2014 and 15, we saw a 28 per cent increase in veterans seeking help – this increase is mainly accounted for by a marked rise in those who served in Iraq or Afghanistan coming to us. To explore this increase in referrals further, we recently published a study in which we looked at the changing nature of referrals to Combat Stress over the last 20 years.[2]

The largest group of veterans seeking support are those who served in Northern Ireland, followed by veterans from the conflicts in Afghanistan and Iraq. Over this period, we have also seen the time lag between leaving the Armed Forces and seeking help reduce. In 1994, the average time lag was 24 years, but by 2014, this had gone down to 11.8 years. Encouragingly, it appears that veterans who served in Afghanistan and Iraq are seeking help sooner than their colleagues from previous deployments.

WHAT IS A 'VETERAN'?

My aim in this article is to provide some information about mental illness in ex-members of the UK armed forces and then detail the clinical services that Combat Stress offers. However, before I do, I thought it would be helpful to share what is meant by the term 'veteran'.

In Britain, a veteran is defined as an individual who served in the armed forces for at least one day and has now left the forces. This differs from many countries, where being a veteran often refers to having served on deployment to a conflict.[3] Each year, approximately 20,000 to 24,000 service personnel leave the UK armed forces, and it has been estimated that there are approximately 3.8 million veterans living in England.[4]

We have always known that fighting in conflicts is risky, and researchers have documented examples of mental illness in veterans of conflicts dating back to the Crimean War.[5] Historical evidence from conflicts dating from the First World War to modern day shows an association between the number of military personnel killed or wounded and the number of mental health causalities.[6] It has been suggested that the Vietnam War was the conflict that focused attention on the psychological consequences of warfare,[7] in particular the prevalence of PTSD in veterans following this conflict.[8–11] Studies following up Vietnam War veterans who experienced mental illness found they were at increased risk of employment difficulties, low earnings, substance misuse, and imprisonment.[12] Similarly, studies following veterans of the 1991 Gulf War also observed that those who returned from this conflict experiencing mental illness were more likely to be unemployed, have alcohol problems and have served a prison sentence.[13–16]

Studies of veterans from the recent conflicts in Iraq and Afghanistan have demonstrated that significant numbers of ex-service personnel are experiencing mental illness. For example, studies of US veterans have reported prevalence rates of PTSD to be 13 per cent after personnel returned from Iraq or Afghanistan, rising to 18 per cent four months later.[17,18]

In the UK, researchers at King's College London have been conducting a longitudinal epidemiological survey of military mental health that was set up shortly after the 2003 Iraq conflict. The first wave of data collection was published in 2006 and reported rates of PTSD to be four per cent and anxiety and depression to be 20 per cent.[18] The second wave of data collection was published in 2010 and reported similar rates.[19]

The authors then repeated their analyses, but this time restricted their sample to either combat personnel (those on the front line) only, or reserve personnel (for example the Territorial Army) only, and observed an increase in rates of PTSD to seven per cent and six per cent respectively.[17]

Those most at risk of experiencing mental illness include younger age groups, women, those with lower educational achievement, singletons, members of the army, individuals with a shorter than average enlistment period, and those with a history of childhood problems.[20,21]

As previously discussed, veterans from the Vietnam conflict and onwards have often found it difficult to adjust back to civilian life. More recently, research has been conducted with UK veterans from the Iraq and Afghanistan conflicts that showed individuals who reported experiencing mental illness prior to leaving the armed forces were at increased risk of being unemployed and still suffering from mental illness when followed up three years later.[22] Importantly, the researchers noted that, while anxiety and depression were the most common mental health problems, individuals with PTSD were more likely to be socially excluded.[23]

Figures released by the Ministry of Defence demonstrate a disparity between reported rates of PTSD and the rates of those seeking help – while four per cent of the UK armed forces experience PTSD at any one time, only 0.8 per cent are coming forward to ask for support.[23] This is supported by research that observed that only 23 per cent of UK veterans suffering from symptoms of PTSD had accessed services for support.[24] Given what we know about the longer-term consequences of experiencing mental illness within veteran populations, this difference between prevalence rates of PTSD and help seeking is concerning.

When an individual is employed by the armed forces, the military is responsible for their mental health service provision. Once they leave, the NHS is responsible for looking after the mental health of veterans. However, as detailed above, the majority of veterans who experience mental health difficulties find it difficult to engage in help seeking behaviour.

To address this, in 2011 the NHS commissioned Combat Stress as a national specialist service to provide clinical services to treat veterans experiencing symptoms of PTSD.

ABOUT COMBAT STRESS AND THE VETERANS IT SUPPORTS

Combat Stress was founded at the end of the First World War to support ex-servicemen returning from the front line with shell shock. Since then, the charity has helped more than 100,000 veterans.

We provide specialist clinical treatment at our three treatment centres (Ayrshire, Shropshire and Surrey), an outpatient psychiatric service, a UK-wide network of community and outreach teams delivering treatment and welfare support, and a 24-hour helpline (0800 138 1619).

A recent audit of new referrals to the charity showed that 75 per cent of veterans seeking support were experiencing the symptoms of PTSD. Of these, 92 per cent reported exposure to multiple traumatic events, and 52 per cent reported childhood traumas.

It is very common for veterans with PTSD to also be suffering from a range of other difficulties; for example, 69 per cent also present with alcohol difficulties and 62 per cent with depression.[25] Eighty per cent of the veterans we treat tell us they previously sought help from their local NHS services but, for a variety of reasons, failed to engage. The above findings demonstrate the complexity of the difficulties experienced by veterans presenting to Combat Stress.

CLINICAL PATHWAY

We have adopted a phase-oriented model for the treatment of complex PTSD.[26,27] This encompasses three different phases of treatment, though there is some necessary overlap between them.

The first phase is stabilisation and aims to help individuals understand their difficulties and find strategies to more adaptively manage their symptoms. The second phase is trauma therapy, which aims to help individuals process their trauma memories. The final phase goes beyond the trauma to help individuals

reconnect with their lives, and aims to help individuals work on other life issues such as improving their relationships or engaging in leisure activities.

Each phase and how they fit into our clinical pathway will be discussed below. Treatment is delivered in a stepped care model; this means that the exact pathway a veteran takes is based upon clinical need and is decided in partnership with the veteran.

PHASE ONE: STABILISATION

We offer stabilisation interventions at different stepped levels. The first level is a 24-hour helpline, set up in 2011 in partnership with the mental health charity Rethink and the Department of Health.

The aim of this phone line is to provide support and advice to veterans, service personnel and their families, as well as helping them to access the clinical services at Combat Stress and signposting them to other organisations.

The helpline receives approximately 800 calls a month. An audit over the first year of its use[25] reported that, while the majority of calls were from veterans, 667 were made by family members and 504 by mental health professions working with veterans.

Combat Stress has established 15 community and outreach teams across the UK. The teams support veterans to feel comfortable enough to engage in treatment by performing initial assessments, providing welfare support, delivering low-intensity mental health interventions and, where needed, referring veterans to our treatment centres for high-intensity treatment. In addition, the community and outreach teams run monthly support groups for veterans. Those being supported by the teams are offered psychiatric outpatient support which aims to stabilise veterans and treat co-morbid mental health difficulties.

The next step up is to offer inpatient stays at one of our three treatment centres. These services are staffed by multidisciplinary teams and include psychiatrists, psychologists, nurses, occupational therapists, art therapists and support workers. Initially, veterans are offered a two-week residential stay on what we have named a 'transdiagnostic programme'. This is for veterans who may be experiencing a range of mental health difficulties. The programme is structured around veterans attending a range of different psychoeducational and symptom management groups. Examples of these include psychoeducational groups about PTSD to increase awareness and understanding of the disorder, and symptom management groups aimed at tackling rumination.

In addition, we offer residential treatment for anger management and a stabilisation programme for PTSD. Both of these are two weeks long and include psychoeducational groups, symptom management groups and individual key-working sessions.

PHASE TWO: TRAUMA THERAPY

If further support specifically for PTSD is required, veterans' care is stepped up to the PTSD Intensive Treatment Programme (ITP). The ITP is based on the Australian Department of Veterans Affairs funded treatments, which have treated over 4,000 Australian veterans suffering from PTSD with a range of co-morbid presentations, as well as social and occupational problems, since the early 1990s.[28]

As part of this referral process, veterans are assessed independently by a psychiatrist and psychologist based at a Combat Stress treatment centre. The eligibility criteria for the ITP include a diagnosis of PTSD, exposure to multiple traumatic events related to an individual's military service (two or more events), being stable and compliant if on psychiatric medication, and being a veteran of the UK armed forces.

The ITP consists of a mixture of group and individual work. The programme runs on weekdays from 9am to 5pm. In total, veterans are invited to attend 55 group sessions and between 15 to 18 TF-CBT sessions. At weekends, veterans are encouraged to practise the behavioural and cognitive coping strategies they have been developing.

Group sessions can be broadly characterised to fit within three areas – psychoeducational groups, CBT groups, and wellbeing programme groups aimed at supporting veterans with the third phase of treatment which helps reconnect them with their lives. The programme is outlined in a therapist manual and is run by a team of psychologists.

The psychoeducational groups cover topics such as understanding a psychological model of PTSD, the relationship between PTSD and memory, grounding strategies to cope with flashbacks and nightmares, sleep hygiene, managing pain and medications, and relaxation strategies. The CBT groups cover topics including introducing CBT, coping with anxiety, anger management, and coping with depression. The wellbeing groups will be discussed in the next section. In addition, throughout the ITP, veterans are offered the opportunity to attend six art therapy sessions.

PHASE THREE: RECONNECTING VETERANS WITH THEIR LIVES

During the ITP, veterans are invited to attend a wellbeing programme. This is led by both psychologists and occupational therapists with the aim of supporting veterans to re-integrate into their community. The wellbeing groups cover topics such as strengthening relationships and developing more adaptive communication styles, mindfulness, and resilience groups.

Where appropriate, the occupational therapists also offer support to develop practical skills such as cooking healthy foods and engaging in recreational activities. In addition, veterans are encouraged to invite family members to a half-day group providing psychoeducation about PTSD. The aim of this group is to reduce stigma and, where appropriate, involve family members or carers in the veterans' treatment.

Following the ITP, veterans are offered continuing welfare support by the community and outreach teams. This is to support veterans with practical issues as well as helping them use their new skills to re-integrate into society. As part of this process, veterans are supported to engage in local services.

While more work is needed, it is encouraging that we have found strong evidence that the treatment for PTSD delivered by Combat Stress supports vulnerable veterans to overcome the debilitating effects of their mental ill health.

In conclusion, while the majority of veterans do well once they leave the armed forces, the ones who leave with mental health difficulties often struggle to make the transition to civilian life. In this article, I have described the clinical services that are freely available from Combat Stress to support veterans. It is important to remember that this is a vulnerable population that often needs additional support to overcome barriers to seek help. ■

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REFERENCES

1 *Murphy D, Hodgman G, Carson C, Spencer-Harper L, Hinton M, Wessely S et al. Mental health and functional impairment outcomes following a six week intensive treatment programme for UK military veterans with post traumatic stress disorder (PTSD): a naturalistic study to explore dropout and health outcomes at follow-up. [Online.] BMJ Open 2015: e007051 (accessed 13 November 2015).*

2 *Murphy D, Weijers B, Palmer E, Busuttil W. Exploring patterns in referrals to Combat Stress for UK veterans with mental health difficulties between 1994 and 2014. International Journal of Emergency Mental Health and Human Resilience 2015; 17(3): 652–658.*

3 *Dandeker C, Iversen A, Ross J, Wessely S. What is a veteran? Armed Forces and Society 2006; 32(2): 161–177.*

4 *Woodhead C, Sloggett A, Bray I, Bradbury J, McManus S, Meltzer H et al. An estimate of the veteran population in England: based on data from the 2007 Adult Psychiatric Morbidity Survey. Population Trends 2009; 138: 50–54.*

5 *Jones E, Wessely S. Psychiatric battle casualties: an intra- and interwar comparison. British Journal of Psychiatry 2001; 178(3): 242–247.*

6 *Wessely S. War syndromes: the impact of culture on medically unexplained symptoms. Medical History 2005; 49(1): 55–78.*

7 *Dohrenwend BP, Turner JB, Turse NA, Adams BG, Koenen KC, Marshall R. The psychological risks of Vietnam for US veterans: a revisit with new data and methods. Science 2006; 313(5789): 979–982.*

8 *Anderson K, Michelle J. Effects of military experience on mental health problems and work behaviour. Medical Care 1992; 30: 554–563.*

9 *Savoca E, Rosenheck R. The civilian labor market experiences of Vietnam-era veterans: the influence of psychiatric disorders. Journal of Mental Health Policy and Economics 2000; 3(4): 199–207.*

10 *Bremner JD, Southwick SM, Darnell A, Charney DS. Chronic PTSD in Vietnam combat veterans: course of illness and substance abuse. American Journal of Psychiatry 1996; 153(3): 369–375.*

11 *Yager T, Laufer R, Gallops M. Some problems associated with war experience in men of the Vietnam generation. Archives of General Psychiatry 1984; 41(4): 327–333.*

12 *Murphy D, Iversen A, Greenberg N. The mental health of veterans. Journal of the Royal Army Medical Corps 2008; 154(2): 136–139.*

13 *Unwin C, Blatchley N, Coker W, Ferry S, Hotopf M, Hull L et al. Health of UK servicemen who served in Persian Gulf War. Lancet 1999; 353(8148): 169–178.*

14 *Wolfe J, Proctor SP, Erickson DJ, Hu H. Risk factors for multisymptom illness in US Army veterans of the Gulf War. Journal of Occupational and Environmental Medicine 2002; 44(3): 271–281.*

15 *Cherry N, Creed F, Silman A, Dunn G, Baxter D, Smedley J et al. Health and exposures of United Kingdom Gulf war veterans. Part I: the pattern and extent of ill health. Journal of Occupational and Environmental Medicine 2001; 58(5): 291–298.*

16 *Fukuda K, Nisenbaum R, Stewart G, Thompson WW, Robin L, Washko RM et al. Chronic multisymptom illness affecting Air Force veterans of the Gulf War. JAMA 1998; 280(11): 981–988.*

17 *Riddle JR, Smith TC, Smith B, Corbeil TE, Engel CC, Wells TS et al. Millennium cohort: the 2001–2003 baseline prevalence of mental disorders in the US military. Journal of Clinical Epidemiology 2007; 60(2): 192–201.*

18 *Smith TC, Ryan MAK, Wingard DL, Slymen DJ, Sallis JF, Kritz-Silverstein D. New onset and persistent symptoms of post-traumatic stress disorder self reported after deployment and combat exposures: prospective population based US military cohort study. British Medical Journal 2008; 336(7640): 366–371.*

19 *Fear NT, Jones M., Murphy D, Hull L, Iversen A, Coker B et al. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. Lancet 2010; 375(9728): 1783–1797.*

20 *Iversen A, Dyson C, Smith N, Greenberg N, Walwyn R, Unwin C et al. 'Goodbye and good luck': the mental health needs and treatment experiences of British ex-service personnel. British Journal of Psychiatry 2005; 186(June): 480–486.*

21 *Iversen A, Fear N, Simonoff E, Hull L, Horn O, Greenberg N et al. Influence of childhood adversity on health among male UK military personnel. British Journal of Psychiatry 2007; 191: 506–511.*

22 *Iversen AC, van SL, Hughes JH, Browne T, Greenberg N, Hotopf M et al. Help-seeking and receipt of treatment among UK service personnel. British Journal of Psychiatry 2010; 197(3): 149–155.*

23 *Defence Analytical Services Agency. Rates of mental health disorders in UK armed forces (2007–2011). London: Ministry of Defence; 2011.*

24 *Iversen AC, van SL, Hughes JH, Greenberg N, Hotopf M, Rona RJ et al. The stigma of mental health problems and other barriers to care in the UK armed forces. [Online.] BMC Health Services Research 2011; 11: 31 (accessed 13 November 2015).*

25 *Combat Stress. Combat Stress 2013 annual review of clinical services. Leatherhead: Combat Stress; 2013.*

26 *Cloitre M, Courtois C, Charuvastra A, Carapezza R, Stolbach B, Green B. Treatment of complex PTSD: results of the ISTSS Expert Clinician Survey on Best Practices. Journal of Traumatic Stress 2011; 24(6): 615–627.*

27 *Herman J. Trauma and recovery. The aftermath of violence – from domestic abuse to political terror. New York: Basic Books; 1992.*

28 *Creamer M, Morris P, Biddle D, Elliot P. Treatment outcome in Australian veterans with combat-related posttraumatic stress disorder: a cause for cautious optimism? Journal of Traumatic Stress 1999; 12(4): 545–558.*

READER RESPONSE

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