

Chapter 41

MENTAL HEALTHCARE IN THE UNITED KINGDOM ARMED FORCES

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INTRODUCTION

Defense mental health services (DMHS) in the United Kingdom (UK) are primarily community based and provide both operational and homeland services to all 200,000 of the personnel in the UK armed forces.

This chapter will examine the history of military mental health in the UK and bring readers up to date on important procedural and operational aspects of the DMHS today.

HISTORY

In keeping with its tradition as the senior military service in the UK, the Royal Navy first established formal services to manage and treat service personnel who suffered from psychological problems. In August, 1818, a lunatic asylum was opened at the Royal Naval Hospital Haslar¹; today a Royal Navy Department of Community Mental Health (DCMH) remains at Haslar Hospital. With the outbreak of World War I, British Army psychologists and neurologists deployed to France in 1914 in support of British troops. Operating from field hospitals, casualty clearing stations, and, later, "NYDN" (not yet diagnosed neurological) hospitals, these practitioners saw large numbers of personnel suffering from "shell shock," "disordered action of the heart," and related syndromes. Personnel deemed unfit for further combat, at least in the immediate future, were evacuated to rear areas or to the UK.² A large number of hospitals were established in Britain, including Craiglockhart³; Seale Hayne, a converted agricultural college; and Sir Edward Mapother's No. 2 General Hospital in Stockport.⁴ These institutions provided treatment for shell shock and other disorders, aiming, if possible, to return individuals to the front to continue fighting. Specialist training courses in military psychiatry were also established at the Maudsley Hospital in London and, by Gordon Mott, at Maghull Hospital in Liverpool. Specialist centers for the treatment of disordered action of the heart were also established at Mount Vernon in Hampstead and Sobraon House in Colchester.

Although the British Psychological Society had been founded at University College London in the 1890s, psychology was a largely experimental science in World War I; it was some years before psychotherapy and clinical psychology became disciplines in their own right. The first military psychological practitioners, such as Charles S Myers and William H Rivers, were mostly medical doctors. Myers later became consultant psychologist to the British Expeditionary Force, and Gordon Holmes was consultant neurologist. Myers established four forward NYDN centers modeled on the French system,⁵ and, later, five forward "disordered action of the heart" centers in France, in addition to the hospitals in Britain. These facilities were established well before Thomas Salmon, the American psychiatrist, visited France in 1917 and

influenced what has since become known as "forward psychiatry."⁶

Following World War I, the UK built up a network of special civilian treatment centers and hospitals to treat the ongoing casualties generated by the war, peaking in 1921. (At that time nearly 15,000 inpatients and 3,000 outpatients were still suffering with war-related psychological disorders.) Although the vast majority of those who worked throughout the war for the British military mental health services returned to civilian employment, some remained in the services, forming a core of psychological practitioners during the build up to World War II. For the additional practitioners necessary for the Royal Navy, Army, and new Royal Air Force (RAF), formed between the wars from the Royal Flying Corps (originally part of the Army), neurologists and psychiatrists were recruited from four main sources (all in London): the Tavistock Clinic (Army), the Maudsley Hospital (Royal Navy), Saint George's Hospital (Royal Navy), and Guy's Hospital (RAF).⁷

For the first time psychologists were also recruited to work in personnel selection. Otherwise, the pattern of British Army military mental health service provision in World War II nearly mirrored that in the earlier war. In addition to a number of forward hospitals, treatment facilities also operated in the UK, including No. 41 Neuropathic Hospital in Bishop's Lydeard (where the Tavistock Clinic psychoanalyst JA Hadfield, one of the first to use collective hypnosis and abreaction, was based) and the better-known centers at Northfield (where Wilfred Bion, John Rickman, and Michael Foulkes, the founders of group psychotherapy, worked). In addition, forward psychiatry began to be practiced, often by accident or through necessity, but increasingly by design, in North Africa, Italy, and northwest Europe.

Support for the psychiatrists was far from unanimous, however; many saw them as fifth columnists (a clandestine group seeking to undermine the government), and Winston Churchill referred to psychiatrists as "gentlemen asking odd questions."⁸ Stigma was still attached to patients with mental illness. The RAF Neurological Hospital at Matlock was established as the final treatment center for the growing number of "lack of moral fiber" (LMF) cases, an administrative category rather than a diagnosis. This category was

begun after 250 “breakdown” cases occurred after the Battle of Britain in 1940; by the end of the war the LMF category included nearly 3,000 cases of breakdown per year.⁹ It is believed that fear of being labelled as LMF was essential to keeping RAF pilots motivated to fly despite the high risk of being shot down (mission attrition rates of 50% were common, especially during the early days of the war).¹⁰ Sergeants labeled as LMF were reduced to the lowest rank and put to work shovelling coal, peeling potatoes, or even mining coal. LMF officers were asked to resign or transferred to desk jobs in administration. Many of those categorized as LMF had already completed a dozen or more operational raids, but the designation was deemed useful for encouraging continuous operational flying in the face of extreme risk.

By the end of 1943, the number of psychiatrists totalled 227 in the British Army, 43 in the RAF, and 35 in the Royal Navy.^{11–13} The majority of the 35 military psychologists¹⁴ worked with selection panels and designed aptitude tests to ensure that officers were up to standard. These World War II selection tests included the “leaderless group,” a method by which a group of potential officer candidates are encouraged to come up with a plan to deal with a mock incident without a leader being assigned in order to see what transpires (ie, does a “natural” leader emerge?). It remains the basis for selecting the officers’ cadre today. Unlike in the United States during World War II, mental health professionals were rarely used in screening for vulnerability to future breakdown. This aptitude testing policy represented a major “democratization” of officer selection, in keeping with the social transformations the war brought about across society. At the end of the war, however, all the psychologists were demobilized, leaving only the psychiatrists in the service.

In the late 1960s, the UK began deploying large numbers of forces to contain the increasingly unstable situation in Northern Ireland. The particular demands of this counterinsurgency operation—effectively asymmetric warfare with an unknown and unseen enemy—began to take its toll on the mental health of troops. The Northern Ireland “troubles” continued until the late 1990s. Although no concrete evidence suggests that the conflict was more traumatogenic than other military operations, many of its veterans suffered from posttraumatic stress disorder (PTSD) and other psychological injuries.

In 1982, Britain again went to war, this time thousands of miles away across the Atlantic,¹⁵ to recapture the Falkland Islands invaded by Argentina weeks before. Although the Royal Navy deployed psychiatrists to the conflict, the overall mental health burden was thought to be small. However, some current anecdotal evidence indicates that marines who sailed

back to the UK after the war fared better in mental health outcomes than their airborne colleagues and other infantry units that were air-trooped home. These stories suggest that the marines settled back into their day-to-day lives after talking through their experiences during the sea voyage, as there was no formal mental health support made available for the troops during the voyage home. The airborne paratroopers, in contrast, displayed violent and aggressive behavior at home because they missed the necessary time to “decompress.”¹⁶ However, no research has been carried out to support or refute these claims.

At the end of the 20th century, UK forces were deployed on a number of fronts. Operation Banner, the name given to the Northern Ireland deployment, continued, with troops rotated at regular intervals for 3-month “emergency” tours, 6-month tours, and 2-year “permanent” tours. In addition, British troops were deployed on United Nations and North Atlantic Treaty Organization peace and stabilization missions to Bosnia-Herzegovina, Kosovo, and Macedonia. Army field mental health teams (FMHTs) deployed in the majority of these operations, often led by psychiatrists in the initial “surge” phases, but increasingly relying on a pool of well-trained, highly skilled, and relatively autonomous mental health nurses drawn from the hospitals and community clinics to operational roles.¹⁷ At the same time, however, defense cuts and downsizing led to the closure of all but three military hospitals; these have since shut. Today, there is no dedicated military hospital in the UK, and military medical care is provided in military wings of civilian hospitals called “military district hospital units.”

In addition to these and other peacekeeping operations (eg, in Lebanon, Rwanda, and Sierra Leone),¹⁸ the UK was involved in two major, if short-lived, wars, followed by ongoing and increasingly intense operations in the hostile theaters of Iraq and Afghanistan. Saddam Hussein’s invasion of Kuwait in 1991 led to a rapid British military deployment—Operation Granby—as part of a multinational coalition led by the United States to reclaim the country from the Iraqi forces. British Army psychiatrists and mental health nurses deployed with the Army field hospitals as field psychiatric teams but, where possible, adopted a free-standing roving role providing mental health briefings, psychological debriefings, and mental health assessments as required throughout theater. A Royal Navy mental health team deployed with a hospital ship, offshore in the Mediterranean Sea, and RAF mental health teams supervised the aeromedical evacuation and repatriation of mental health casualties. This role continues outside times of major conflict, with RAF mental health nurses on standby to escort service personnel with mental health and other problems back to

the UK from anywhere in the world.

When British and American forces invaded Iraq in 2003 (the British component of the invasion and occupation is known as Operation Telic), FMHTs composed of psychiatrists and Army mental health nurses again deployed with the UK's air assault and armored brigades, and were part of two military field hospitals. Again, the Royal Navy supplied a mental health capability on the primary casualty-receiving

facility—Royal Fleet Auxiliary Argus—and the RAF continued to operate as before. All mental health aeromedical evacuations and repatriations went to Duchess of Kent's Psychiatric Hospital (since closed) for assessment, treatment, and, if necessary, admission. Those requiring outpatient treatment, including mobilized reservists (who made up a large percentage of some Operation Telic units, especially medical units), were referred to the network of DCMH.

CONTEMPORARY DEFENSE MENTAL HEALTH SERVICES

The goal of DMHS is to provide military personnel with speedy access to skilled, effective, flexible treatment based on individual needs.¹⁹ The DMHS approach aims to foster recovery and rehabilitation, ensuring that personnel are rapidly returned to duty whenever possible, or supported and enabled to make a smooth, seamless, and effective transition back into civilian life. Treatment, care, and rehabilitation are provided in close proximity to the person's work environment to maximize occupational recovery and in close partnership with primary and secondary care facilities. A clear understanding of the unique nature of military ethos, composition, and task underpins the effective delivery of mental healthcare to service populations. Delivery of this care is multidisciplinary, provided by a variety of skilled professionals, depending on individual needs.

The UK armed forces emphasize that stress management and day-to-day mental health hygiene are functions of the chain of command rather than medical or support services. The same principles apply for physical and psychological disorders; for instance, the management of hydration is directed by unit leaders in the same way as stress management. Both may need a subject matter expert to provide appropriate information and training; however, the subject matter expert does not assume responsibility for the process.^{19,20}

When the chain of command is unable to continue to support personnel, three levels of mental healthcare provision exist: (1) primary care, (2) community mental healthcare, and (3) inpatient care. Provision of mental healthcare has moved from a hospital-based to a community-based service, mirroring changes in the UK's civilian National Health Service. Care in the community, as the process is termed in the National Health Service, has been a key element of UK government health planning over the last 2 decades and is considered well-suited to both military and civilian mental healthcare delivery. A report by an independent team of experts led to the closure of the last military inpatient facility in early 2004. Currently all inpatient care is provided by an independent service provider (a private psychiatric hospital) on a pay-per-patient

basis. Military protocols advocate using inpatient care for the minimum amount of time possible because community management is seen as the key to effective occupational rehabilitation.

The "workhorse" of the system is the DCMH, which carries out all specialist mental health functions within the DMHS. There are 15 DCMHs in the UK, with additional units in Germany, Cyprus, and Gibraltar. The departments are tasked with treating service personnel, providing a range of mental health educational programs, liaising with the independent service provider, and facilitating medical discharges when appropriate. The current cadre of some 200 military mental health professionals across the services are primarily uniformed members of the Royal Navy, Army, or Air Force. However, social work and psychology services are provided by civil servants. Most of the service members (75%) are nurses, with the remainder composed of psychiatrists, clinical psychologists, and social workers. Presently occupational psychologists and occupational therapists do not form part of the uniformed cadre.

Policy and strategy for the DMHS comes from the surgeon general's department through executive and professional advisory committees. In the UK, the military surgeon general, who may be a member of any service, is the head medical officer of all three services. The head of DMHS is the defense consultant advisor, and each service has a consultant advisor and a senior nursing officer. Although DMHS care is delivered on a triservice basis (ie, mental health professionals from each service routinely provide care to personnel of all three services), each service is responsible for career development and personnel management of its members.

Operational Organization

The deployable uniformed mental health assets are composed of registered mental health nurses (also called community psychiatric nurses), and consultant psychiatrists. The consultant psychiatrists traditionally have deployed only during the initial surge phase

of operational deployments; at later stages, community psychiatric nurses form FMHTs with telephone supervision and a visiting service from a consultant psychiatrist. Experience has shown that the most effective FMHTs comprise one officer at captain-to-major level (or equivalent) and one senior noncommissioned officer. This structure helps remove barriers across the military rank structure and destigmatize military mental health.

Operational planning includes a casualty estimate, which, in conjunction with the size of the deploying force, dictates which mental health assets are deployed. In the majority of traditional war fighting scenarios, an FMHT consisting of a psychiatrist and two or three community psychiatric nurses is deployed at role 2 (role 2 is usually collocated with the dressing station in the region of 1-hour travel by road from the fighting troops). Traditionally based at role 3 (3–4 hours traveling time by road from the front line) and collocated with the field hospital is a further complement of mental health personnel including a consultant psychiatrist and community psychiatric nurses.

Predeployment

Before deployments, the DCMH and FMHT assess medically downgraded personnel or those undergoing mental health treatment to give a clear indication to commanders about whether these personnel might be fit to deploy, and if so, whether there are employability restrictions. Ideally, the deploying FMHT also assists with preoperational stress management presentations⁵ and meets the commanders of units they will support in the operational theater to clarify arrangements (mental health personnel are often logistically prevented from deploying with units they supported in peacetime locations). The provision of formal briefings to all deploying personnel is mandated by policy. Such briefings are intended not only to provide factual information on stress reactions but also to detail the mental health provision (and how to access it) during the forthcoming operation. Specific briefings on subjects such as body handling or dealing with prisoners of war may be given, depending on the nature of the forthcoming deployment.

During Deployment

Teams aim to travel to all units in theater seeing patients as required (usually referred from medical services) and undertake a command liaison role within the unit lines. Operational travel restrictions sometimes prevent this mode of operations, and mental health professionals can then find themselves stuck in one location, unable to respond to other needs. In

these instances patients may travel to the FMHT, but they will consequentially lose proximity support from their units.

Assessment of potential patients in theater loosely follows the flowchart in Figure 41-1, which explains the referral pathway according to the seminal work undertaken by Goldberg and Huxley concerning the pathways to care followed by psychiatric patients in the community.²¹ Mental health nurses work with unit commanders and medical staffs to provide occupationally relevant advice aiming to maintain the fighting force whenever possible. However, unit commanders hold the ultimate responsibility in assigning operational duties. These decisions are based on a number of factors including the operational situation, the unit support available, and the location of medical and psychiatric assets.

Postdeployment

In line with postdeployment operational stress management policy,²⁰ DMHS professionals assist with any decompression process. The level of decompression package is left to the brigade commander to decide in consultation with medical or psychiatric advisors. The surgeon general's policy dictates that some form of homecoming brief will be delivered to returning troops, which should be tailored to suit the intensity of the operation once the unit has returned to the decompression area (a low-threat location in theater or another base such as Cyprus) or peacetime location.

Ministry of Defence Posttraumatic Stress Disorder Legal Case

In 2002, a number of former military personnel sued the Ministry of Defence (MOD) over claims of psychological injury related to their operational service.²² The claimants did not dispute their assignment of operational duties but claimed that the MOD was negligent in failing to provide appropriate predeployment screening and training as well as appropriate postoperational care that might have prevented, or at least detected and treated, their disorders prior to discharge from the services. Judgment in the PTSD group action was handed down by Lord Justice Owen on May 21, 2003. The judge found for the MOD on almost all of the generic issues, despite criticizing the ministry in several areas. The judge found against the MOD in 4 of the 16 lead cases, but these cases turned on their individual facts and did not represent institutional failure.

During subsequent examination of the case, the judge made clear that the MOD has a duty to provide a safe system of work for its personnel where reasonable

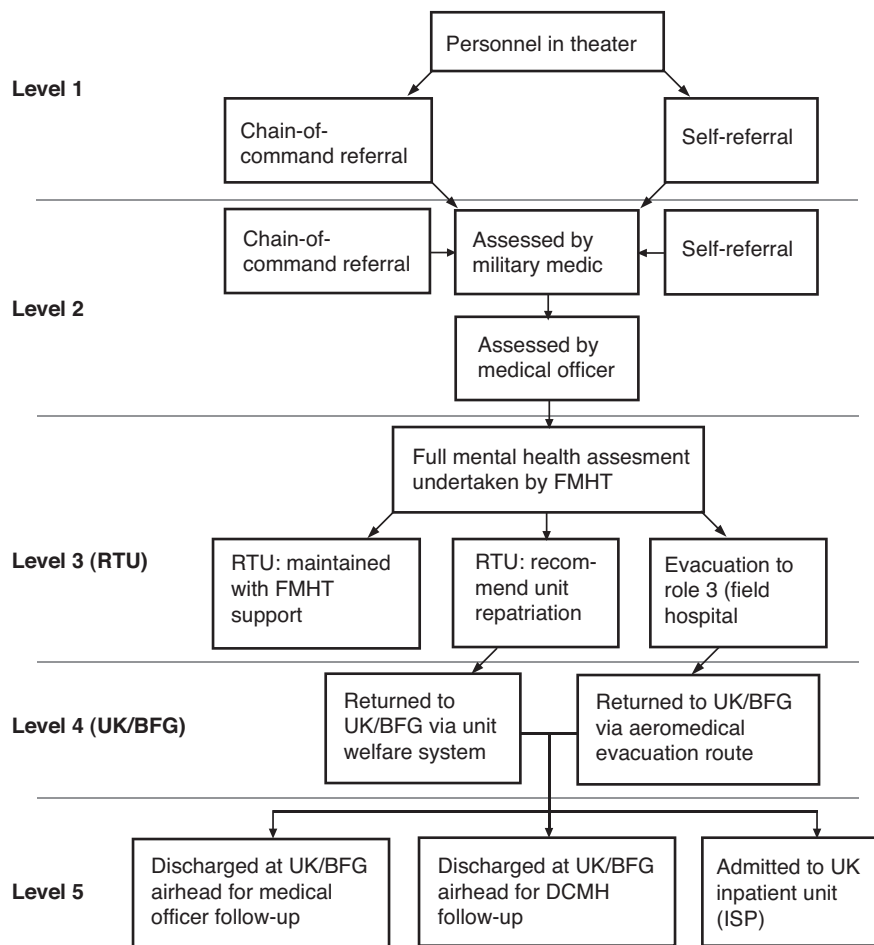


Figure 41-1. Operational mental health referral flowchart.

BFG: British Forces Germany

DCMH: Department of Community Mental Health

FMHT: Field Mental Health Team

ISP: inpatient service provider

RTU: return to unit

UK: United Kingdom

and practical. It does not, however, have a duty to do so in the course of combat, where the interests of personnel are subordinate to the military objective; this is known as “combat immunity.” The judge defined combat so that the immunity was not restricted to troops in the presence of the enemy but also all active operations against the enemy when personnel are exposed to the threat of attack, including attack and resistance, advance and retreat, pursuit and avoidance, and reconnaissance and engagement. Immunity extends to the planning of and preparation for operations in which there is the possibility of attack or resistance, including peacekeeping or policing operations in which personnel are exposed to the threat of attack.

The case was heated, and 16 subject matter experts from the UK, United States, Israel, and Australia gave evidence at the trial. Subjects discussed included screening before recruitment and before and after deployment, the potential use of critical incident psycho-

logical debriefings, preventative stress inoculation, and decompression or postdeployment briefings. None of these measures were found to be robustly effective in the prevention or treatment of psychological injury.²² An MOD internal report,²³ providing guidance for the future management of operational mental health issues, called for initiating a robust research program, training the chain of command to identify the signs of stress and assist anyone likely to “break down,” and instituting a stress awareness strategy to destigmatize mental health problems and encourage those who need help to request it.⁶

Trauma Risk Management

In the late 1990s, the brigadier in charge of the Royal Marines Commandos, an elite group of military maritime personnel who often form the UK’s rapid reaction force, tasked a staff officer to investigate ways

to improve his troops' mental health in response to operational stress. An initial critical incident psychological debriefing program was rejected within the robust culture of the marines. Staff subsequently developed a more successful peer support/psychological risk assessment program called Trauma Risk Management (TRiM), which has since been adopted by a number of UK organizations, including some of the emergency services and the diplomatic service.

The program, now fully integrated into the Royal Marines and many parts of the Royal Navy and Army, aims to equip nonmedical personnel with the skills to detect service members who might be suffering from traumatic stress problems. TRiM practitioners are trained to provide relevant mentoring and support in the aftermath of potentially traumatic events and deployments and, when necessary, to encourage persistently distressed personnel to seek referral from professional sources of mental health support.^{24,25} The program has been embedded within the existing personnel management systems. For example, during initial training young marines are instructed in field craft, shooting skills, and using TRiM support. Potential TRiM practitioners are selected for their interpersonal skills, experience, and common sense. Once trained, they provide basic psychoeducational packages to their units. Furthermore, all promotion courses within the Royal Marines Command provide

some detail on TRiM, ensuring that all marines, and especially those in leadership positions, are aware of TRiM and able to use the system. The training program has gained external certification and has also been considered by the US military²⁶ (preliminary training courses for US personnel were held in Washington, DC, in 2003, and San Diego, California, in 2005). The TRiM system is also to form part of the new US Army Psychological First Aid package designed for use by Army medical staff.

Among the TRiM program's strategic aims is to be a vehicle for organizational culture change. The course aims to destigmatize mental health issues and provide a pool of informed peers or mentors who are likely to be more acceptable than mental health professionals as sources of support. Research on UK military peacekeepers showed that more than 90% of personnel talked to peers about their deployments, whereas only 8% talked to medical or welfare staff.²⁷

A cluster randomized controlled trial is underway in the Royal Navy to ensure that TRiM does not suffer the same fate as the critical incident psychological debriefing program. The trial will attempt to identify any potential for TRiM to do harm, as well as any positive or negative cultural changes that occur on warships that have received TRiM training. A possible positive result of the trial would be an increase in referrals with no increase in mental health problems.

CURRENT RESEARCH AND FUTURE DIRECTIONS

The King's Centre for Military Health Research (KCMHR) is the primary UK military mental health research institution. Although numerous other academic centers conduct relevant research into both serving and retired UK military service personnel, none has a solely military orientation. The center boasts close links with an internationally acclaimed war studies department at King's College London and offers a master of science degree in war and psychiatry.

KCMHR has just completed a 3-year study on the health of about 12,000 randomly sampled UK military personnel, examining the recurrence of "Gulf War syndrome" problems and the rates of psychiatric injury following Operation Telic. Results so far show no rise in multisymptom conditions.^{28,29} Furthermore, regular military personnel have not been especially affected by service in Iraq in terms of posttraumatic stress or general psychological or physical symptoms. Veterans of Iraq deployments drink more alcohol and display more risky behaviors than those who did not deploy, but the absolute risk increase has been small. This result does not appear to be true for reservists, who are displaying significant changes in both psychological and physical health. The absolute risk increase is still

small (a doubling of PTSD symptoms from about 3% to 6%); however, the research has prompted MOD attempts to mitigate the problem (made more acute because veteran and reservist mental healthcare is not provided by the military).

With predeployment data on a subset of those deployed in Operation Telic, KCMHR was able to model the effects of predeployment mental health screening (when it had been conducted). The results showed that predeployment screening would not have reduced postoperational psychiatric illness, but would have had a significant deleterious effect on the numbers of personnel deployed.³⁰

Other work underway is investigating the impact of military service on family life, the usefulness of medical countermeasures to mental illness, and the effects of potential exposure to depleted uranium. KCMHR intends to follow the cohort for many years to gain relevant insights into the health of the UK service member in the 21st century. Preliminary results that have influenced strategic MOD policy include the finding that providing too much informed choice can adversely influence vaccine compliance³¹ and that predeployment mental health screening is likely

ineffective.³⁰

The recently established Academic Centre for Defence Mental Health is a small cadre of MOD mental health staff attempting to stimulate DMHS research. The center also provides the defense consultant advi-

sor in psychiatry, an advisor to the surgeon general, with regular reports on emergent research findings into potentially useful MOD policy actions. The MOD is increasingly realizing the need to use relevant research findings to inform future policy making.

SUMMARY

UK military psychiatry has a rich historical basis. Modern mental health provision is heavily community based, with operational provision being delivered by rendering appropriate support to the chain of command, which, in UK military doctrine, is primarily responsible for the psychological welfare of troops. The DMHS cadre of single-service uniformed and civilian staff provide triservice care, with a recently increased emphasis on research that is

already providing a plethora of useful data informing and influencing MOD policy. Having weathered a protracted legal case and the shrinkage of the armed forces, the DMHS will continue to focus on supporting the sailors, soldiers, and airmen of the UK armed forces, as well as personnel and operational commanders in their missions, while ensuring the use of the ever-increasing body of research evidence to inform future practice.

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