Behavioural Health and Women's Health in the Armed Forces of the United Kingdom

The Defense Health Board – Monday 10th February

Colonel Chris Wright

MB, ChB, DIMC, FRCEM, MA

Colonel in the Royal Army Medical Corps, part of the Defence Medical Services, Full time, Regular since 1997

Consultant in Emergency Medicine
St Mary's Hospital, North-West London's Major Trauma Centre

Consultant in Pre-Hospital Emergency Medicine
Kent, Surrey, Sussex Air Ambulance

UK Surgeon General's Advisor in Pre-Hospital Emergency Medicine
Everything from point of injury through to the front door of the hospital

93% of healthcare is provided by the NHS

Government expenditure is on NHS is £197.4 billion

9.6% of gross domestic product (GDP)*

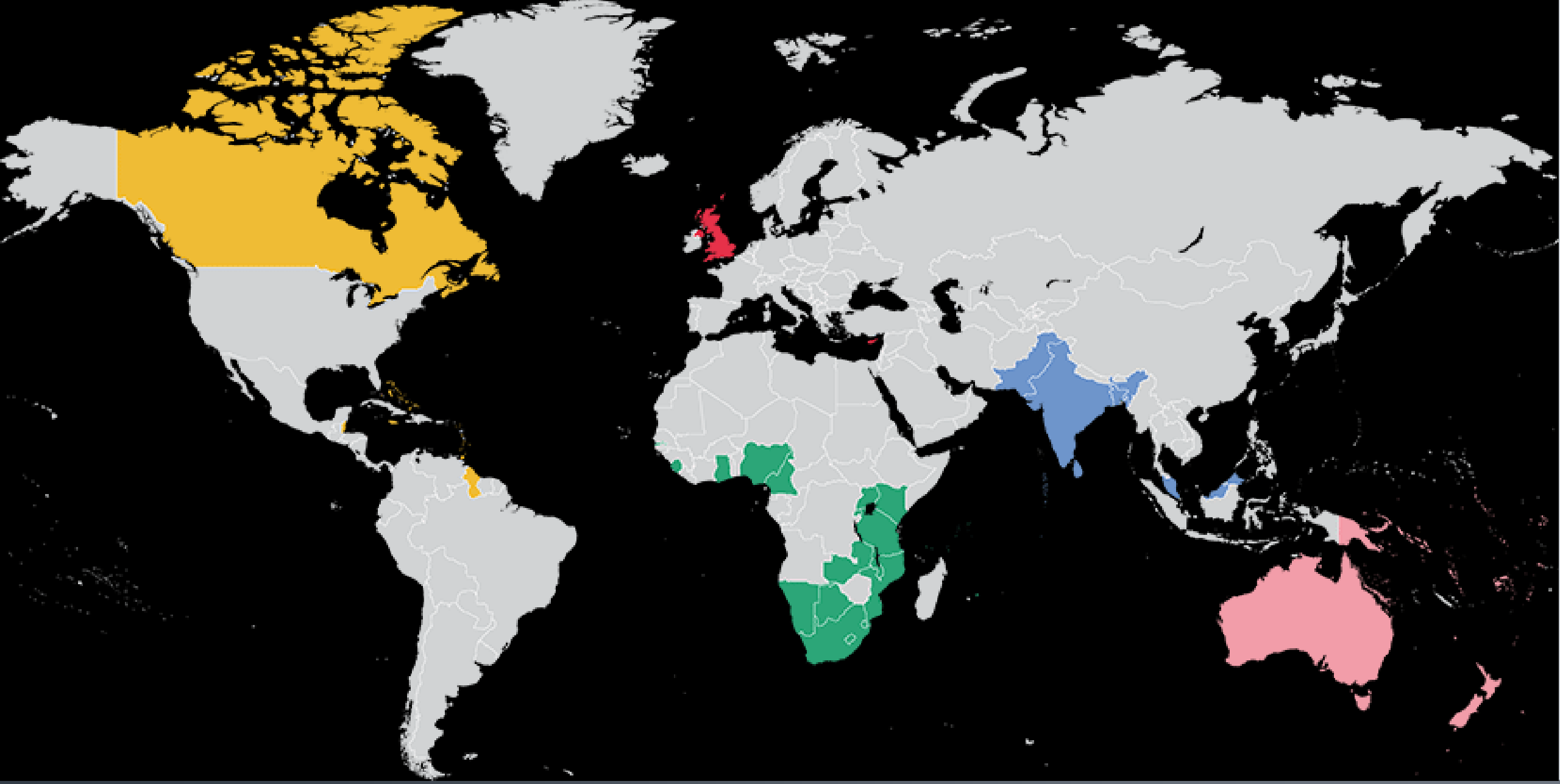
Spending is increasing between 1.1% - 3.4% per annum.

11,200 service personnel and 2,200 civilian personnel

Provide healthcare to 135,360 UK Armed Forces personnel

Since 1999, most secondary care for the UK military is provided by the NHS

*UK Office for National Statistics: www.ons.gov.uk



The Defense Health Board – Monday 10th February

Behavioural Health

Behavioural Health

No screening on entry

But we do require full access to health records

Behavioural Health

Overall rate of ALL diagnosed mental health conditions: 2.7%
(5.1% in women)

Behavioural Health

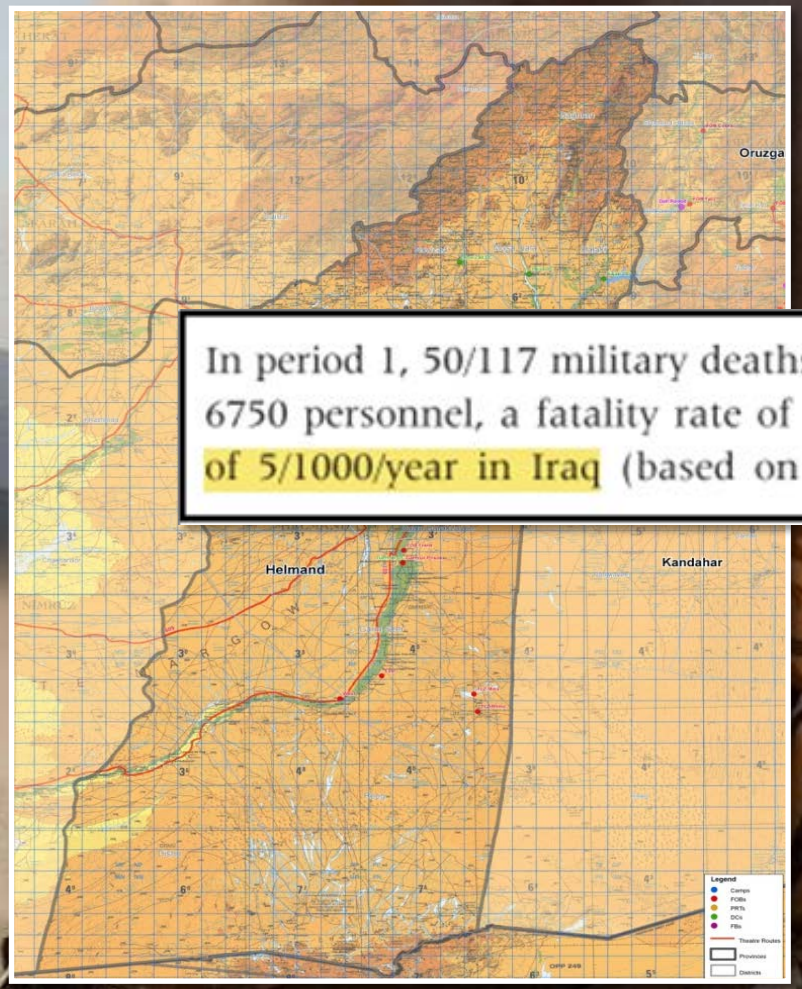
The rate of PTSD remains low at **0.2%**

This represents 2 in 1,000 personnel assessed with the disorder in 2018/19.

COMBAT STRESS
THE VETERANS' MENTAL HEALTH CHARITY

The Defense Health Board – Monday 10th February

Operation Herrick: Helmand Province



WAR

Military fatality rates (by cause) in Afghanistan and Iraq: a measure of hostilities

Sheila M Bird[1*] and Clive B Fairweather[2]

Accepted 16 April 2007

Background Military fatalities occur in clusters, and causes differ between theatres of operation or within-theatre over time.

Iraq and 17, 2006, nd others' years. Take vice (IED)

e as listed hostile or d Canada, and for US to Iraq.

Findings Out of 537 coalition fatalities in Iraq in 2006 to September 17, 2006, 457 (85%) were hostile, but only half were in Afghanistan (October 2001 to September 17, 2006: 52%, 249/478). Air losses accounted for 5% fatalities in Iraq, but 32% in Afghanistan. IEDs claimed three out of five hostile deaths in Iraq, only a quarter in Afghanistan. Deaths per fatal IED incident averaged 1.5.

In period 1, 50/117 military deaths in Afghanistan were UK or Canadian from 6750 personnel, a fatality rate of 19/1000/year, nearly four times the US rate of 5/1000/year in Iraq (based on 280 deaths). Sixty out of 117 fatalities in Afghanistan occurred as clusters of two or more deaths.

In period 2, fatality rates changed: down by two-thirds in Afghanistan for UK and Canadian forces to 6/1000/year (18 deaths), up by 46% for US troops in Iraq to 7.5/1000/year (416 deaths).

Interpretation Rate, and cause, of military fatalities are capable of abrupt change, as happened in Iraq (rate) and Afghanistan (rate and cause) between consecutive 140-day periods. Forecasts can be wide of the mark.

Keywords Military fatality rates, specific causes of death, clusters, short-term projections

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International J Epidemiology 2007;36:841-846

Behavioural Health

ORIGINAL PAPERS

TRAUMA RISK MANAGEMENT (TRiM) IN THE UK ARMED FORCES

N Greenberg, V Langston, N Jones

Academic Centre for Defence Mental Health, King's College London.

Abstract

Trauma Risk Management (TRiM) is a novel system of post incident management which intend to allow commanders to provide appropriate support to their subordinates in the aftermath of traumatic events. Given the current very considerable operational tempo being experienced by the majority of the UK Armed Forces, it is perhaps not surprising that TRiM has been in use in both Iraq and Afghanistan. Although TRiM originated from within the Royal Marines, it is now widely used in both the Royal Navy and Army; there are also plans to introduce it into specific components of the Royal Air Force such as for the RAF Regiment. This paper aims to explore the basis behind the TRiM system and to explore the evidence for its growing popularity within hierarchical organisations such as the military.

Background

The Armed Forces exist in order to carry out operational duties in support of UK interests around the globe. The nature of such duties, be they combat, peace support or humanitarian, often leads to military personnel being placed into potentially traumatic environments. Although the majority of such personnel who are exposed to traumatic events will deal with them without suffering undue distress or indeed developing any formal psychiatric illness, it is inevitable that a small proportion of personnel will become unwell or suffer with sufficient sub-syndromal symptoms that their operational efficiency might be less than is desirable. The principles of battlefield management of operational stress reactions are simple; treat the person without evacuation if at all possible, intervene quickly, normalise symptoms and encourage the expectation of recovery and make use of avoid overly complex solutions or immediate recourse to psychotherapy. These techniques are often referred to as PIES which stands for proximity, immediacy, expectancy and simplicity [1].

However, as was pointed out in a recent legal case against the MoD by ex-service personnel who claimed to be suffering with psychological injuries as a result of their military service, stigma is a very real and significant issue [2]. Stigma has been defined as something which sets the affected individual apart from others [3]. Stigma can be split into internal, or self stigma, and external stigma. An example of the former is the belief that asking for help for mental health problems will lead to a premature end to a military career and an example of the latter is the belief that people who suffer from mental health problems are universally weak and cannot be trusted. As a result of stigma, many personnel who suffer as a result of their military service are often hesitant to seek help. This is somewhat of a concern as the reality is being effectively treated for a mental health problem will most definitely not limit someone's career. In fact the contrary is true in that poor performance, secondary to mental health problems or otherwise, will limit someone's career progression.

Therefore given that exposure to traumatic events can lead to the development of psychological distress, lowered morale and organizational difficulty it follows it would be useful if a system could be put in place to mitigate the difficulty with help seeking which occurs as a result of stigma as described above. This paper aims to examine the development of Trauma Risk Management or TRiM, a system that was pioneered with the Royal Marines [4], and to explain the validation study that is now underway to investigate what place, if any, TRiM has in the routine management of traumatic events that effect naval personnel.

A Historical Perspective

Systems to prevent trauma related psychological injury are not new. In the early 1980's Critical Incident Stress Debriefing (CISD) was developed by Jeffrey Mitchell a former fire-fighter in the USA [5]. Mitchell claimed that CISD prevented post traumatic stress disorder (PTSD) and other similar systems of post incident emotional catharsis have made similar claims. Nevertheless the research that has been carried out on "single session psychological debriefing", including a Cochrane systematic review of randomised controlled trials of early single-session psychological interventions, has shown that preventing post incident psychological change is far from easy [6]. Such single session debriefings have now been shown to be at least of no use and at worse harmful. Consequently, in 2000 within the UK military the Surgeon General banned the use of single session psychological debriefing [7] and the Department of Health has recently stated that single session debriefing appears unhelpful [8]. This negative view regarding the usefulness of single session psychological debriefing has been confirmed by the publication of the National Institute of Clinical Excellence's guidelines on the treatment of PTSD [9]. However, even though debriefing is not effective at preventing psychological injury, more complex early psychological therapies, including cognitive behavioural therapy, applied some weeks following the traumatic event appear likely to be beneficial [10] for the few people who require them.

Prevention of Psychological Injury

Whilst the Armed Forces continue to undertake operational duties then personnel will be exposed to trauma and stress. Some of those exposed will develop psychological distress as a result. Whilst realistic training may reduce the impact of

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JR Army Med Corps 154(2): 124-127

1. Perception that they were out of control during the event
2. Perception that their life was threatened during the event
3. The person blames others for what happened
4. The person reports shame/guilt about their behaviour
5. The person experienced acute stress following the event
6. Exposure to substantial stress since the event
7. Problems with day to day activities since the event
8. History of previous traumatic events
9. Poor social support, (family, friends, unit support)
10. The person has been drinking alcohol excessively to cope with distress

Behavioural Health

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Art & science

If you would like to contribute to the Art & science section, email gwen.clarke@rcnpublishing.co.uk

The synthesis of art and science is lived by the nurse in the nursing act
JOSEPHINE G PATERSON

Role of the military community mental health nurse

Kiernan MD *et al* (2013) Role of the military community mental health nurse. Nursing Standard. 27, 51, 35-41. Date of submission: March 28 2013; date of acceptance: April 29 2013.

Abstract

Aim To understand the role and effect of a community mental health nurse (CMHN) deployed to work with military personnel during sea-based operations.

Method Semi-structured interviews were conducted to ascertain Royal Navy aircraft carrier military unit commanders' perceptions and experiences of the CMHN's role.

Findings Three mutually inclusive components are necessary to ensure successful integration of the CMHN: familiarity, trust and credibility.

Conclusion For CMHNs to function successfully and provide mental health care to sea-based military personnel, they need to demonstrate familiarity, trust and credibility. This will enhance uptake of mental health services among military personnel and ensure they are fit for service.

Authors

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Correspondence to: matt.kiernan@northumbria.ac.uk

Keywords

Community nursing, mental health, military nursing, Royal Navy

Review

...e-blind peer review and ...software.

...available at ...uk. For related articles visit the archive and ...ing the keywords above.

SINCE THE EARLY 1990s, mental health care for British military personnel deployed to areas outside of the UK for land-based operations has been delivered predominantly by community mental health nurses (CMHNs) supported by visiting military psychiatrists. It is now common for CMHNs to be deployed as lone practitioners based in primary health care to support military personnel. However, there is a lack of research about the role of CMHNs deployed to work with military personnel during sea-based operations, in other words onboard ships.

Literature search

Conflict and war, and the need to provide clinical and nursing care to injured military personnel, have shaped healthcare services throughout the world. The lessons learned from managing the mental health and welfare of military personnel have influenced assessment and clinical practice in civilian mental health services, with interventions such as assertive outreach, community-based care, crisis intervention and group psychotherapy now considered routine (Harrison and Clarke 1992, Artiss 1997).

Military-related mental health problems

Well-motivated military personnel, whether during peacetime or deployment, generally have good mental health (Hughes *et al* 2005, Finnegan *et al* 2011). Serious mental illness is rare and out of the 1,600 people leaving the military each year on medical grounds, only around 150 leave as a result of a mental health-related problem (Busuttil 2010). The most common mental health disorders affecting British military personnel are depression, alcohol misuse and anxiety (Iversen *et al* 2009).

"…familiarity, trust and credibility…"

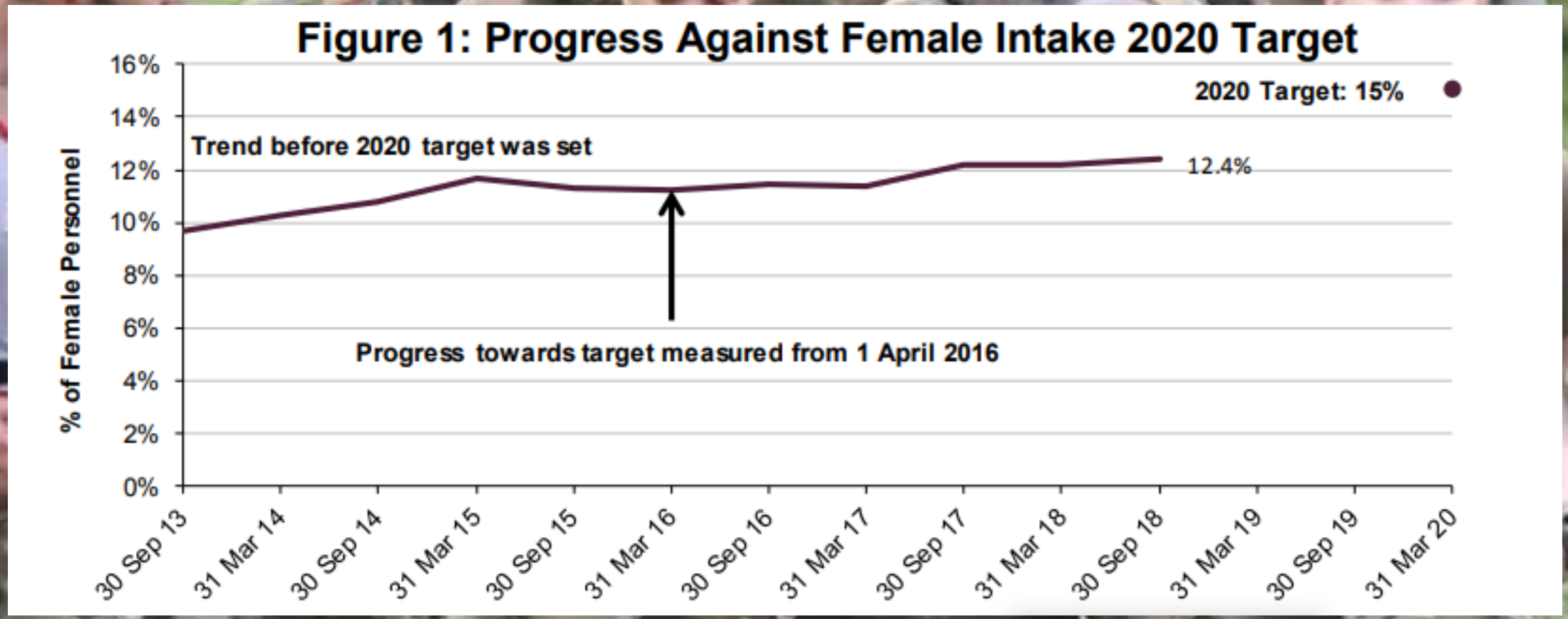
Behavioural Health

Behavioural Health

Women’s Health

Women's Health

10.5% of the force



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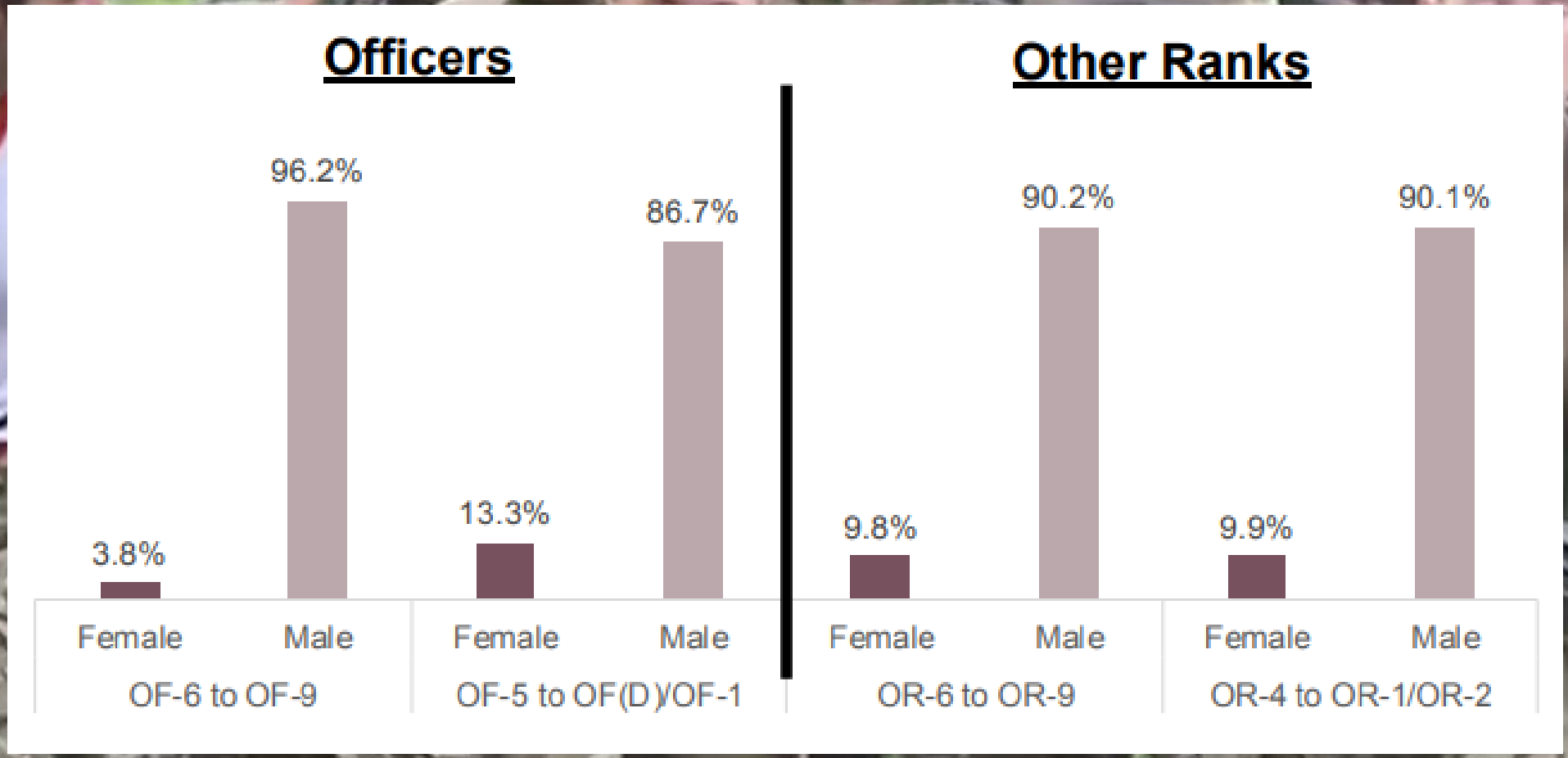

Women's Health

Ban on women serving in ground close combat roles lifted in July 2016

British Army fitness test

Age	Press-ups in two minutes		Sit-ups in two minutes		Run 1.5 miles	
					mins sec	mins sec
29 and under	44	21	50	50	10 30	13 00
30 - 34	41	19	46	46	11 00	13 30
35 - 39	39	16	43	43	11 30	14 00
40 - 44	35	15	37	37	12 00	14 30
45 - 49	29	13	34	34	12 30	15 00
50 - 54	25	11	32	32	13 30	16 00
55 - 59	21	9	27	27	14 10	16 40
60 - 64	17	7	23	23	14 40	17 10

LOADED MARCH

Infantry/RAC
4km/40kg march within 50 mins, followed by 2km/25kg in 15 mins

Para/16AAB
4km march/40kg within 35 mins followed by 2km/25kg in 12.30 mins

WATER CAN CARRY

Carry 2x 22kg jerry cans over 240m/2mins

FIRE & MOVEMENT

20x 7.5m tactical bounds
15m crawl
15m sprint/55secs

VEHICLE CASEVAC

70kg lift and 3 sec hold

CASUALTY DRAG

110 kg dragged over 20m in 35 secs

LIFT & CARRY

Moving 20kg bags, 20x over 30m in 14 mins

Women's Health

Latest research:

"Equality in value, but difference in function [between men and women]"
"Universal anovulation and suppression of reproductive axis function"
"vulnerability to stress fractures between 14 and 28 weeks of training"

Positive adaptation of HPA axis function in women during 44 weeks of infantry-based military training. Psychoneuroendocrinology Vol 110, December 2019, Gifford et al. https://doi.org/10.1016/j.psyneuen.2019.104432


ARMY
ICE MAIDEN
AECOM
aecom.com
TeamArmy
BLACKROCK
OPTIQ
AIRBUS

Women's Health

Unplanned or 'ambivalent' about pregnancy: **45%**

Baby birth shock for soldier on Afghanistan deployment

20 September 2012 Share

A team of doctors has flown to Afghanistan after a British servicewoman gave birth to a boy having not realised she was pregnant.

The MoD did not know the servicewoman was pregnant

Originally from Fiji, the unnamed Royal Artillery gunner is said to have only learned she was about to give birth on Tuesday after having stomach pains.

Mother and baby are "stable" in Camp Bastion, Helmand province, said the Ministry of Defence.

The woman went to Afghanistan in March and her baby was five weeks premature.

A specialist paediatric team from Oxford's John Radcliffe Hospital has left for Afghanistan, RAF Brize Norton has confirmed.

Women's Health

- Paid time off for antenatal care
- Maternity leave
- Maternity pay or maternity allowance
- Protection against unfair discrimination or dismissal

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20 September 2012 Share

D did not know the servicewoman gnant

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Women's Health

- On return to work the individual is assumed to be fully fit
- Cultural assumption that the mother will care for children rather than the father

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Summary

1. **Overall rates of mental health illness are 2.7%**. No screening tests on recruitment but history of mental illness does often preclude service.
2. **Trauma Risk Management (TRiM)**: using peers to go over the incident, and screen using a checklist.
3. **Women can serve in close combat**. And plenty of new research into effects of service, for example risks of stress fractures.
4. **Maternity benefits are good.** But women remain under-represented in senior officer positions.

Questions?

Questions?