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Safeguarding the military against mental health issues

Rhicha Kapila considers what more can be done to identify and treat service personnel with PTSD to ensure a better outcome

The prevalence of military mental health issues, and the stigma attached, has been brought to the fore by the Iraq and Afghanistan conflicts. But the question remains: what more should be done by the Ministry of Defence to safeguard British servicemen and women against the chronic and debilitating long-term effects of mental health disorders, particularly post-traumatic stress disorder?

Combat situations are likely to give rise to military PTSD, as servicemen and women are often exposed to life-endangering events. This can involve a direct threat to service personnel themselves, serious physical injury, or witnessing at close hand the death or serious injury of another. Psychiatrists advise that there are various ways in which symptoms of PTSD have been categorised over the years since the diagnosis first appeared in modern psychiatric literature in the 1980s. The most recent approach suggests that there are four main groups of symptoms complained of:

- Re-experiencing phenomena such as nightmares and flashbacks, intrusive memories, and symptoms of psychological and physiological arousal at reminders of the index trauma;
- Avoidance behavior, such that individuals avoid reminders or triggers of the index incident, and tend to withdraw into themselves and shy away from social contact;
- Symptoms of mood change and cognition; and
- Symptoms of heightened arousal and reactivity.

In recent discussions relating to screening, it has been debated whether, if performed early, it would be of any benefit. On the one hand, some argue that the effects of trauma can be latent and symptoms may not therefore manifest until weeks, if not months, later, once soldiers have transitioned into everyday life outside of combat.

On the other hand, it would certainly encourage those suffering to speak up and, once identified as symptomatic, be referred to the appropriate military mental health services. My own view is that early intervention will almost always result in an eventual better outcome.

Military doctors are now much better at diagnosing PTSD, but in the past doctors have misdiagnosed the condition as 'battle stress,' 'anger management,' 'alcohol misuse', and even 'personality disorder'. The delay in diagnosis inevitably prolongs the commencement of treatment, which can then often result in the development of other co-morbid complications such as depression, anxiety, and marital break-ups which mask the primary condition, making it more difficult to treat.

If it becomes apparent during military service that an individual is symptomatic, military doctors should be downgrading that individual to avoid re-exposure. An immediate referral should be made for an assessment at a Department of Community Mental Health. If servicemen and women are no longer fit for service, the MoD's own internal policy is to ensure that any soldier suffering with ongoing PTSD at the point of discharge should be:

- Designated a key case worker to support an individual deemed likely to be medically discharged due to mental illness; and
- Thereafter put on a structured programme of support following discharge for a period up to 24 months.

This is not always happening. In recent discussions, civilian GPs' understanding of the complexity of military PSTD has been questioned. This, coupled with the stigma of mental health issues, will quite often result in soldiers losing their military careers and employment, and struggling to integrate into civilian society, without an adequate support network in place. Charities such as Combat Stress and ABF The Soldiers' Charity are well placed to provide support but require more funding to meet our personnel's needs. **SJ**

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