

Factors affecting mental health support to the British armed forces: part two

Alan Finnegan, Sara Finnegan, Mike Thomas

The first part of this series (*JCN*, 28(5): 30–32) provided the background to the study, which used semi-structured interviews with 18 nurses based in Afghanistan during 2013 to focus on factors affecting the delivery of mental health care in the field. This, the second part of the series, details the results of the study in the form of analysis of the interviewees' verbatim transcripts. The study offers an insight into the role of deployed mental health nurses and examines some of the challenges they face. The findings demonstrate that managing the mental health of armed forces personnel on an operational deployment requires the ability to develop trusting relationships, identify factors leading to stress, and help staff to feel supported.

KEYWORDS:

Mental health ■ British armed forces ■ Military mental health nurses

The first part of this series provided some background to the role of the British armed forces in deploying a capable workforce, while minimising the effect of mental health problems on its members as they perform their military duties. It went on to present the first qualitative defence nursing research to explore the views of mental health and other nurses based at Camp Bastion Hospital, Afghanistan in 2013.

The overall aim of the study was to advance the understanding of any predisposing factors that affect the delivery of nursing care during an operational deployment. This included analysis of academic preparation and clinical competency in preparing military nurses to provide high-quality care; the impact of multiprofessional and multinational boundaries; and the challenges of providing nursing care for both military and local nationals.

Colonel Alan Finnegan, defence professor of nursing, Academic Department for Defence Nursing, Royal Centre for Defence Medicine, Birmingham; Sara Finnegan, registered nurse, Eastham Group Practice, Wirral; Professor Mike Thomas, pro-vice chancellor (academic) and executive dean of Faculty of Health and Social Care, University of Chester

While the first article in this series looked at the theory, methods and initial results of this study, part two details the transcriptions obtained from interviews with 18 nurses (although a significant amount of information in this study was supplied by three nurses who formed the field mental health team). It was hoped that studying these factors would help to elucidate their impact on the delivery of nursing care and the wellbeing of nursing staff.

RESULTS

As detailed in part one of this series, the results were drawn from a grounded theory analysis of the interviewees' verbatim transcripts. Initial coding indicated 21 categories — for example, personal stressors; experience and confidence; mental wellbeing; battle tempo and tiredness, etc — which were identified due to certain similar characteristics. Analysis of these categories led to the identification of four major clusters (*Figure 1*):

- ▶ Autonomous practitioner
- ▶ Nursing care
- ▶ Warrior nurses
- ▶ Situational pressures.

These clusters in turn led to theoretical groupings under the headings of:

- ▶ The autonomous and competent defence nurse
- ▶ Operational stressors (such as expectations of the chain of command)
- ▶ Multidisciplinary and multinational nursing practice
- ▶ Mental wellbeing.

The findings discussed below were drawn from analysis of the participants' views on these four subject areas. Presentation of the findings is intended to protect the anonymity of respondents.

DISCUSSION

The autonomous and competent defence nurse

Field mental health team nurses have to be prepared to work independently as autonomous practitioners. On deployment, there may be limited or no access to clinicians from other disciplines and a lack of resources such as books or the Internet, as one respondent commented:

'Over here in a forward operating base you've got nothing other than what you have in your head.'

Defence Medical Services acknowledges the need for field mental health team nurses to act as autonomous practitioners and preparation for operational duties is provided during peacetime in community mental health departments and outreach services. This allows the field mental health team nurses to address soldiers' mental health issues in their own locality. Performing routine clinical tasks, as well as dealing with the most common military mental health disorders — depression and alcohol

misuse (Fear et al, 2010; Finnegan et al, 2010) — offer a robust grounding for the operational mental health role.

Field mental health team nurses have to assess, diagnose and develop independent treatment plans. Other members of the multidisciplinary team, in particular defence consultant psychiatrists, understand the operational requirement and in the field will transfer some of their traditional clinical responsibilities, such as diagnosis and prescribing, to nurses. Safe practice is underpinned by multidisciplinary supervision and educational preparation ensures personnel are clinically competent.

Field mental health team nurses are still soldiers and training for the role includes military preparation, as noted by one of the respondents:

'You are not going out as a clinician; you are going as a soldier.'

The field mental health team nurses must complete all their military educational and pre-deployment training and are required to be physically fit and able to adapt to often austere environments. While the focus is on developing them as autonomous practitioners, there is also considerable emphasis on providing a functioning team that is able to offer peer support. This focus on peer support stems from the recognition that the armed forces is built on teamwork — field mental health team nurses must be prepared to undertake non-clinical roles and become involved in routine military chores when required. Examples of this include members of the field mental health team acting as stretcher-bearers, for instance.

It was clear from their answers that members of the field mental health team believed that this willingness to get involved in tasks not necessarily related to mental health had far-reaching benefits in terms of fostering a positive identity within the wider military, and a better relationship with troops. In what is often regarded as a 'macho' military environment, this can reduce the stigma associated with mental health, which can have a negative impact on

help-seeking behaviour (Finnegan et al, 2014).

Currently, field mental health team nurses are trained in interventions such as cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) (a type of therapy that regards disturbing memories as the cause of some mental health problems and aims to alleviate the symptoms of post-traumatic stress disorder [PTSD]).

Respondents acknowledged that there were differences in the nursing role required on deployment, including an understanding of the different types of treatment needed. For example, there have been isolated anecdotal reports of field mental health team nurses performing intrusive treatments such as intensive psychotherapy in the field, but this is not conducive to the operational arena and is not ratified by the Ministry of Defence — soldiers requiring psychotherapeutic interventions should be evacuated back to their home base.

On deployment, where there may be an absence of psychiatric consultants to refer to, field mental health team nurses have to focus on risk assessment, risk management and patient maintenance. Every patient receives a full assessment — including a risk assessment — and a care plan is formulated with the objective of keeping the soldier 'in the field'. As one of the respondents commented:

'Although we have had some complex cases, there's little value in diving in and trying to fix them. It's more about supporting individuals to complete their tour and then posting them on ... It's a big plus to complete a tour then go home and get treatment — if they complete the tour they are more likely to recover.'

After an initial assessment, the team may see the patient on several more occasions to ensure their conclusions are correct. Knowing that they were being supported in the field was reported as instilling self-confidence and self-belief in soldiers,

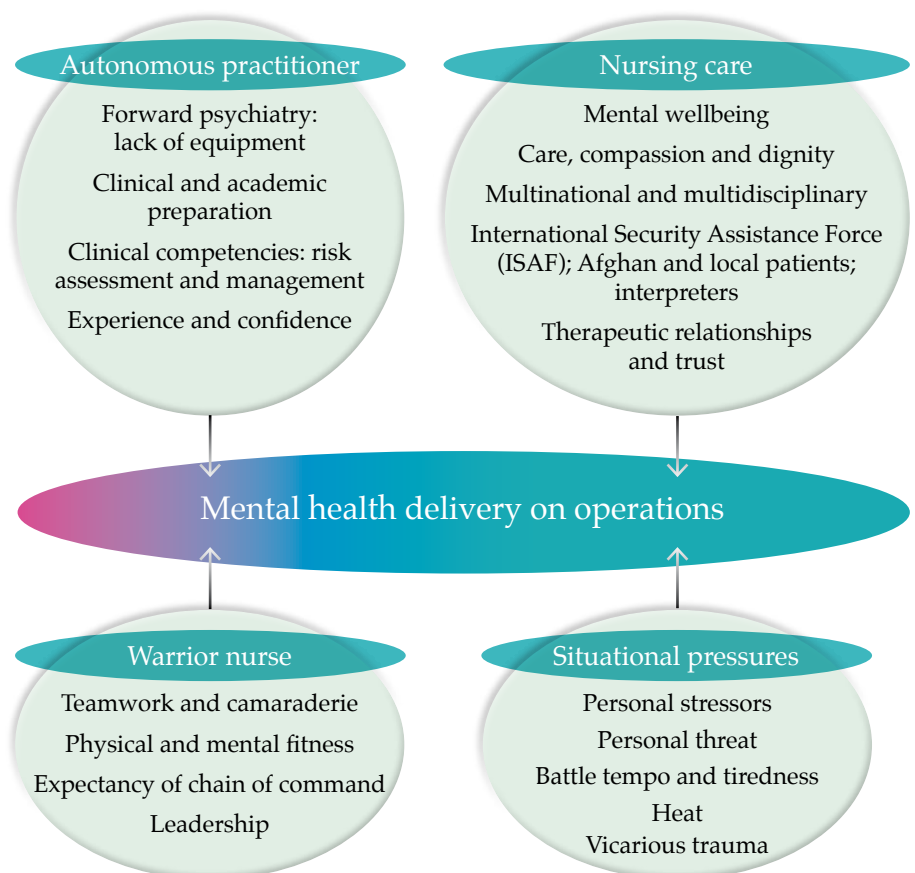


Figure 1. The graphic illustrates how the 21 categories were grouped into four major clusters.

resulting in improved functioning. Respondents also noted that reducing work stress and providing advice on health and nutrition were helpful, while the problems associated with alcohol are negated in the field as it is not available.

Any treatment needs to be flexible and being able to work within a therapeutic environment is more often an aspiration than a reality. However, field mental health team nurses still had to bear in mind the need for patient confidentiality and ensure discussions were not overheard. As one respondent commented:

'Any assessment has to be carried out to the best standard that it can be in the circumstances. You try to do it in the most secure area where people won't overhear. Some patrol bases simply can't provide that — they are the size of a shoebox.'

Operational stressors

Field mental health team nurses have to adjust quickly to whatever location the troops have been deployed to — often in particularly austere environments. Supporting soldiers who face operational stressors, which can affect them on a number of levels, is integral to the role. However, these stressors were also experienced by members of the field mental health team, who could be targeted by enemy soldiers and fired on, for example. Shifts can be long with no allocated spare time and the working day routinely lasts for 12 hours or more, with the potential to be called upon at any other time. This means that field mental health team nurses are often tired and they have to be skilled in time management to make sure they get enough rest.

Respondents noted that in the field there may be a lack of commodities such as telephones and running water and, in the case of Afghanistan, the temperature can rise to 50°C. There was also the stress of supporting other clinicians in dealing with severe polytrauma casualties — a vicarious trauma that can have a direct bearing on the mental wellbeing of deployed personnel (Monson et al, 2009).

Another factor noted by respondents was that while high activity levels could be stressful, they did reduce everyday worries about home, such as relationship difficulties (although these often resurfaced once the operational tempo was reduced). The field mental health team also supported experienced soldiers who reported mental health issues related to residual problems — on deployment, soldiers faced many of the same stressors that they would at home, with relationship problems and family issues being particularly amplified.

What was not anticipated in the study was that some initiatives aimed at assisting personnel could actually result in additional stress. This included tour leave, or 'rest and recuperation' (R&R), which is supposed to support the troops. However, this was not universally beneficial or always welcomed — for example, soldiers with young families who returned home for short periods reported that this could confuse and distress their children. Short periods of leave could also have a deleterious affect on relationships, as one comment revealed:

'If you and the wife are getting on badly you are going to be asking for a divorce at the end of a period of R&R. Quite often when you are out here [deployed in the field] a home visit just stokes the fire. R&R is very good for some people; but very bad for others.'

Respondents reported that mental health referrals often increased after a period of R&R and that the wellbeing of the whole 'service

family' is extremely important — any perception that this is threatened can negatively affect the troops on tour. In Camp Bastion, there are excellent opportunities for communication with family and friends, yet this presents both benefits and challenges. Many respondents reported cases of disputes over social media forums such as Facebook, for instance, which in one respondent's opinion:

'...can be really good, but probably makes them more homesick'.

Expectations of the chain of command

When soldiers have mental health problems, this can cause significant anxiety about their wellbeing and ability to function within the regimental chain of command. Similarly, senior personnel can be distressed by casualties sustained by their troops, as one respondent observed:

'Senior lads can be markedly damaged [by casualties]. If their team has lost somebody, then it is pretty hard for them.'

Field mental health team nurses need to recognise the military hierarchy's concerns and must possess the clinical competencies necessary to address any issues. They also need experience in dealing with serious risk, such as a soldier's capability (or otherwise) to handle a live weapon. Therefore, while nurses will assess the patient's mental health, the reality of the soldier's role — as well as the necessity of maintaining operational capability — mean that, in some cases, the nurse will inform the chain of command



THE SCIENCE — WHAT IS PTSD?



According to the National Institute for Health and Care Excellence (NICE, 2005), post-traumatic stress disorder (PTSD) 'develops following a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. PTSD does not, therefore, develop following those upsetting situations that are described as "traumatic" in everyday language, for example, divorce, loss of job, or failing an exam. PTSD is a disorder that can affect people of all ages. Around 25–30% of people experiencing a traumatic event may go on to develop PTSD'.

about a soldier's condition before returning him or her to the unit.

It is important to have a good working relationship with the military chain of command, and the field mental health team nurses took a proactive role to achieve this, as noted by one respondent:

'We try to link-in quickly and they [the commanders] have reacted to us positively.'

Of course, some soldiers remain concerned that medical information provided in confidence will not be kept secure and may delay seeking support. Therefore, one of the roles of the mental health team was to reduce stigma and try to persuade the chain of command to view interventions positively. As one respondent, commented:

'We have tried to pass on the message that rather than break somebody, we would rather give them an MOT and get them back to work.'

The military chain of command has an important role in promoting positive mental health and wellbeing, and an accessible commanding officer can be invaluable in supporting the mental health team's work.

Multidisciplinary and multinational nursing practice

The respondents were positive about multidisciplinary practice and relationships with other clinicians when on deployment. However, as the field mental health team's base is inside British Military Camp Bastion Hospital, it was felt that the close proximity resulted in unrealistic expectations, namely an over-reliance on the team to deal with routine stress-related issues and an expectation that team members should provide hospital care.

A certain amount of stress is normal in field situations and when encountering someone in distress, non-mental health clinical staff naturally feel that something must be done. However, on occasion rather than providing support themselves they can unnecessarily refer the patient to specialist mental health services.

To counter this, educational mental health programmes extended into the hospital environment and members of the field mental health team tried to ensure that other staff were familiar with the mental health nurses' clinical responsibilities and when it was appropriate to involve them.

Working with other International Security Assistance Force (ISAF) nations — predominantly US clinicians in this instance — while presenting opportunities for collaborative working, also threw up challenges. For this multinational relationship to be successful there must be a mutual appreciation of other cultures and an identification of different methods of clinical practice. For instance, respondents noted that US and Canadian forces deploy psychologists as their primary mental health clinicians and may not recognise the autonomous role of the British military mental health nurse.

However, it was also recognised that US and Canadian mental health clinicians have expertise in certain areas of advanced practice and were willing to share ideas with their British colleagues. An example of this was a US 'combat stress control' programme, which focused on proactive mental health coping mechanisms such as sleep hygiene (controlling behavioural and environmental factors that precede sleep and may interfere with it). This initiative was adopted as a multinational training tool, which included adapting the language for a British audience.

A related issue is that patients often include non-English speaking ISAF troops or local nationals. In these cases, interpreters — many of whom have no medical knowledge — support clinicians by translating. However, addressing perceived mental health issues via an interpreter is particularly challenging, with certain words inevitably becoming 'lost in translation'.

Therefore, the field mental health team tried to tailor their verbal communication appropriately, using clear and concise language. They also introduced techniques to ensure the

correct information was received, as one respondent noted:

'You become aware of how to double check, for instance, asking the same question in three different ways during an assessment. This means that even if the interpreter is mistranslating what has been said, you are still going to get your answer.'

In the hostile and challenging environment of Camp Bastion, the majority of respondents felt that the nursing care they provided was extremely good:

'The care and compassion within our team has been marvellous. Every single member of the team goes "above and beyond" to help people out.'

Providing a compassionate mental health service means understanding the local and military population and respecting their values and beliefs. The field mental health team nurses interviewed for this study treated casualties irrespective of their background, beliefs or affiliations, as one commented:

'At the end of the day, if we have to see patients who are not from the UK, then it makes absolutely no difference.'

Treating non-UK nationals required an appreciation of the local Afghan culture, beliefs and mental health practices, for instance, the locals' identification with 'lucky charms'. Members of the field mental health team ensured that any Afghan patients always had access to these charms, as one respondent noted:

'Every time the mullahs come from the holy facility we get them to bless the patients' lucky charms. And it works.'

Mental wellbeing

Respondents reported gaining considerable personal and collective benefit from operational deployments. There was a feeling that they had chosen to join the armed forces and that operational experience was a large part of why they had enlisted, as one respondent commented:

'It's a rewarding job and there are a lot of people who joined up to do this.'

Having that experience, gaining that extra knowledge, and "toughing it out" through the tour makes people grow.'

For some respondents, being deployed was the only way to gain an empathic understanding of the armed forces population, as one noted:

'There are staff who, once they have been on operations, say it was the final piece of the jigsaw. Because it makes sense then; because the lads are talking about "patrol bases" and "shift patterns". It's only when they experience that themselves that they get a sense of the Afghan experience — understanding what the job of a "recce" platoon" is; what the job of a "mortar platoon" is. That's the bit that makes a lot more sense; understanding the situation and the stresses.'

However, the very nature of deployment involves significant stress. Then there is the post-deployment adjustment process, during which soldiers may recognise alterations in their character, such as general ill-temper (often without a specific accompanying mental health problem).

Respondents felt there was an unrealistic assumption, both in the defence medical services and the wider defence community, that mental health nurses should better understand their own reactions to post-traumatic events; and, therefore, be better able to cope, as one respondent observed:

'Certainly the recurring theme is that people expect medics to look after themselves. "Why are you getting distressed by this? You're a medic. You're used to it. Get over it." You might see a guy with his hand blown off, but it's OK as you're a medic. I think a part of it is an assumption that we self-treat. We've had some people who've been through some nasty incidents on tour and nobody has managed them.'

RECOMMENDATIONS

As the examples above demonstrate, there is a rationale behind initiatives designed to deal with the stress affecting defence medical personnel. These initiatives include trauma risk management (TRiM) — a trauma-

focused peer support system (Jones et al, 2003) — and post-operational stress management (POSM), which includes a period of decompression and personal interviews designed to help soldiers make the adjustment from operational deployment to peacetime.

However, respondents felt that these measures could be inconsistently applied, leading to a perception that no support was available, as one respondent commented:

'You come out here but if you are involved in an incident there is no support and you don't receive TRiM. Nobody is there to help us. We come back, we do our decompression and we are just left.'

Often, during a period of stress families and friends can provide care and assistance, however, this is not available during military operations where other support mechanisms have to be established. Until 2005, the preferred method of group operational support was critical incident stress debriefing (CISD). Controversially, this came to be seen as poor practice as it potentially exacerbated post-traumatic mental health problems (National Institute for Health and Care Excellence [NICE], 2005). However, the withdrawal of CISD has left a lack of structured group support.

In this study, the respondents outlined how they addressed distressing incidents through ad-hoc debriefing such as group discussions and clinical supervision. However, whether this is effective remains a matter of conjecture and requires further research.

CONCLUSION

This paper presents a snapshot of the first British armed forces qualitative research nursing study, which was undertaken during an operational deployment in Afghanistan. It offers an insight into the role of deployed field mental health team nurses and examines some of the challenges they face. The findings demonstrate that managing the mental health of armed forces personnel on an operational deployment requires the ability to develop trusting relationships,

identify factors leading to stress and help staff feel supported.

The paper also offers recommendations for future research into factors that affect the mental health of defence nurses themselves. At present, they use group discussions to deal with traumatic events, however, a better understanding of the factors affecting the delivery of operational nursing care would help to identify any educational and clinical requirements.

If soldiers have access to appropriate interventions in an environment that values leadership and tackles stigma, then battlefield stress and mental health issues can continue to be effectively managed.

The limitations of this study include the small team of deployed mental health nurses; the views refer to a particular time and may not reflect the field mental health team role during a differing operational tempo or environmental and welfare conditions; the first author's role as a DMS senior nursing officer may have introduced bias. **JCN**

REFERENCES

- Fear NT, Jones M, Murphy D, et al (2010) The mental health of UK Afghan and Iraq veterans. *Lancet* 375(9728): 178–97
- Finnegan AP, Finnegan SE, McKee P, Srinivasan M, Simpson R (2010) Predisposing factors leading to depression in the British Army. *Br J Nurs* 19(21): 1355–62
- Finnegan AP, Finnegan SE, Thomas M, Deahl M, Simpson R, Ashford R (2014) The presentation of depression in the British army. *Nurse Educ Today* 34(1): 83–91
- Jones N, Roberts P, Greenberg N (2003) Peer-group risk assessment: a post-traumatic management strategy for hierarchical organizations. *Occupational Med* 53: 469–47
- Monson CM, Taft CT, Fredman SJ (2009) Military-related PTSD and intimate relationships: from description to theory-driven research and intervention development. *Clin Psychol Rev* 29(8): 707–14
- NICE (2005) *Post Traumatic Stress Disorder (PTSD): the management of PTSD in adults and children in primary and secondary care. Clinical guideline CG26*. Available at: <https://www.nice.org.uk/guidance/cg26> (accessed 18 November, 2014)