Veterans Community Mental Health Care: Lessons from our Canadian Allies

Report Completed by:

Andrew A Smith
RN(MH).

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For the Veterans under my care, for those engaged with Combat Stress and for those who have yet to seek help; this Fellowship is dedicated to the men and women whose mental health suffers as a result of their service in the Armed Forces.
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I must firstly express my gratitude to the Winston Churchill Memorial Trust for affording me the opportunity to complete a travelling Fellowship. The experience has been indisputably life changing and they have my unending thanks for all of their support and guidance during the last year. My colleagues at Combat Stress have been, and continue to be a great source of support and I must acknowledge all of the interest and enthusiasm they’ve shared and for which I am very grateful. Thanks and appreciation must also go to Burdett Trust for funding the project. The support of my Regional Community and Outreach Team in Northern Ireland was invaluable during my Fellowship and special thanks must go to Mark Bradshaw and Marcella Canavan, who helped to provide clinical cover in absence.

There were countless individuals in Canada who contributed to the success of my studies; in particular I must thank Marney Wright for her immense support in facilitating my short tenure with the Operational Stress Injury Clinic in Calgary, where I was made to feel part of the team from day one of my visit. Dr Stephen Boucher, Psychiatrist and Medical Director within the OSI clinic, was an inspiration and I cannot thank him enough for his time and sagacious contribution. Thanks must also go to Dr May Wong, Stacey Ferland, Gabrielle Curley, Pia Barnes, Susan James and Colleen Clark for their extraordinary help.

Greg Prodaniuk, Regional Coordinator Western Canada, was decisive in organising my experiences with the Operational Stress Injury Social Support service. My conversations with him and Major Carl Walsh were invaluable in learning how their service was developed and the therapeutic benefits it provides to Veterans across Canada. Support from Zack Donovan and Michelle Turner was gratefully appreciated from within the OSISS team in Calgary and I remain particularly indebted to Jeffrey Docksey for sharing his experiences and methods coordinating peer support services.

I not only have to acknowledge and thank the Veterans who consented to sharing their experiences in Canada, but also those in Northern Ireland whose insights helped to shape much of what I would eventually learn.

And finally, with thoughts closer to home, I would like to thank my wife Donna for believing in what I was doing, taking care of our two sons while I was away and for never faltering in her support.
Introduction

My career in mental health began shortly after enlisting into the Armed Forces, where I completed training at the Royal Centre for Defence Medicine before my first posting as a Community Psychiatric Nurse (CPN) within one of the Army’s community psychiatric departments. From there I completed tours in Iraq and Northern Ireland before deciding to leave the Army following 9 years service. I experienced a gradual transition away from the military after continuing to work as a civilian CPN within the Ministry of Defence (MOD) before taking up my current role with a national Veterans mental health organisation called Combat Stress, where I’ve now worked in the field of providing healthcare to Veterans for over 3 years.

At the time of commencing my employment with Combat Stress, the organisation was in the process of developing their community and outreach services, which meant I was able to take an active role in establishing the clinical outreach service in Northern Ireland. This involved working closely with Regional Welfare Officers already established within the community where I learnt much about the many challenges our UK Veterans faced when suffering from a variety of mental health problems after leaving the Armed Forces. I feel I’ve a vested interest in the development and continued improvement to community mental health services available for Veterans as a mental health care professional working within the United Kingdom. With my own ambitions and also the continued efforts of Combat Stress to improve the provision of mental health care and support in the community, I was drawn to exploring how Britain’s military allies provided these same services. Evidently, this lead me to apply for my Fellowship under the Patient Care category with a proposed research project to go and study the well established Canadian community mental health care model in the province of Alberta.

I wanted the research to be as comparable as possible, choosing my own region in Northern Ireland as the basis for that comparison. The Operational Stress Injury Clinic (OSIC) in Calgary, Alberta, serviced a region in approximate size to Northern Ireland and also shared an almost exact geographic population. I had also been advised that Calgary’s OSIC was one of the best examples of Veterans mental health care in Canada, which dually encouraged me to decide that Calgary was the perfect location to base my Fellowship. But, I also wanted to explore how welfare and social support is provided to Veterans in Canada. This came in the form of their nationally provided Operational Stress Injury Social Support (OSISS) service, which worked closely with the OSIC, Veterans Affairs Canada and a number of other agencies involved in supporting Veterans. The regional OSISS team administrated from Edmonton, just a few hours north of Calgary, was recommended as a potential area for study. And thus, I based my project around studying both of these services.
The primary aim of my Fellowship was to travel and work with the Canadian Community Veterans Mental Health Services, bringing knowledge, examples of good practice and improvement back to Veterans in the United Kingdom.
Background

There are many assumptions made about Veterans mental health and it is often postulated that Post Traumatic Stress Disorder (PTSD) is the most common problem effecting Veterans or sometimes even the only problem they suffer from after leaving the Armed Forces, but this isn’t true. It’s been found that depression, anxiety disorders and problems with alcohol are the most frequent issues experienced by ex-service personnel. All of these can still be caused by the stresses of operational deployments and the demands of service life; they can also be as a result of the stresses someone experiences as a result of leaving the armed Forces and transitioning into civilian life. But the fact remains that we know relatively little about the mental health needs of our UK Veterans, a population that has been estimated to be in the region of 3.8 million people. The National Health Service (NHS) are responsible for the healthcare of all ex-serving personnel and until recently there were very few, if any, means of tracking those ex-service individuals accessing NHS services with mental health problems connected to their careers in the Armed Forces. As we begin to learn more and improve the efficiency of how we track the health of our Veterans, it was discovered that only half of Veterans suffering from mental health problems had accessed services from the NHS and those who did were rarely referred to any specialist treatment services. This highlights the importance of the services provided by Combat Stress and other third sector organisations which are often the preferential choice for Veterans due to their specialist understanding and affiliation with the Military. Whether specialised services for Veterans are more appropriate than statutory services is the subject of much debate, and the answer may lie somewhere within improved integrated partnerships, but it would be difficult to deny the current “expectations” within society that Veterans deserve the very highest levels of care after leaving the Armed Forces.

PTSD, while not the most common problem experienced by Veterans, is still one of the most complex and difficult to treat, meaning it has become the subject of increased research and discussion. A recent study involving 10,000 regular and reservist personnel following operational deployments found that there were lower than expected levels of PTSD, with approximately 4% exhibiting probable symptoms, but the true level of PTSD among Veterans is still unknown. A rational hypothesis, based on the estimated number of Veterans residing in the UK, could therefore predict that 4% were suffering from, or had suffered from, probable symptoms of PTSD. As an estimate, that’s an approximate number of 150’000 individuals suffering from PTSD related symptoms in the UK, and the number of those suffering from the more commonly experienced problems such as depression, other anxiety disorders or alcohol misuse is arguably significantly higher still. As it is widely acknowledged, serving and ex-serving personnel are cautious in seeking help for mental health issues so we know many of the suspected Veterans suffering from these
problems either do not seek help or in some cases wait up to an average of 13 years to access services\textsuperscript{14,15}. Efforts to increase our understanding of why Veterans are so reticent in seeking help and implement strategies to reduce barriers to treatment were described as critical in 2011\textsuperscript{16} and reflected a growing exertion by many organisations to engage more Veterans in care.

Community services play an integral role in identifying, assessing, supporting, treating and helping Veterans recover. Further development is therefore crucial, and can potentially be found by examining the successes of our Allies whose specialist community mental health services have been longer established than ours in the UK.
Details of Itinerary

Departure: Belfast, Northern Ireland

Operational Stress Injury Clinic

Orientation: Operational Stress Injury Clinic (OSIC) Calgary

My first visit to the OSIC was a welcome one, where I met the Operational Manager, Marney Wright, for a comprehensive orientation. Meeting every staff member and gaining an understanding of their role was a valuable experience on the first day, and Marney was keen to highlight the diversity of mental health professions within the clinic.

The clinic itself is established within spacious and comfortable offices located within the office buildings of a Mall. It is easily accessible and well sign posted, also feeling appropriate in location on the second floor adjacent to private medical and dental facilities. There is a professional setup, with dedicated staffed reception and waiting area before entering the clinical rooms where each clinical team member had their office. I was kindly provided with my own office from which to base my study, a comfortable room along the same corridor as their Medical director, Dr Stephen Boucher. From the outset, I was given every opportunity to integrate myself with the team and learn as much as possible within an open and engaging environment.

Early observations during the orientation allowed for a number of areas to be examined, including accessibility and location of the community service. The Mall’s Office Centre, located centrally within the structure, appeared superlative. The offices themselves were luxurious which added to a sense of quality of service. Veterans I spoke with regarded the OSIC location as
“ideal” and quoted it’s free and ample parking as one of many anecdotal benefits. Others responded positively to the ease at which the Mall could be accessed via car or public transport. Staff at the clinic were also complimentary as to the clinics location, feeling there were therapeutic benefits such as normalisation and positive exposure.

![Image of the Mall](image1.jpg)

*(Entrance to the Mall, where Veterans would then proceed to the Office Centre and OSIC)*

**Triage: Observing Initial Assessment Process**

A scheduled morning with Gabrielle “Gabby” Curley, Nurse Clinician, allowed for my first observed assessment to take place. The Veteran kindly consented and after an induction into the assessment template used by the triage nurses, I was able to observe the detailed initial mental health assessment completed during a 2 hour process. This occurs following the receipt of a referral from Veterans Affairs Canada, which is discussed at an allocation meeting before being referred for triage assessment. This constitutes the first phase of the anticipated care pathway in use within the OSIC, “Stage 1” which is “Assessment.” I would have an opportunity to observe the next phase of this initial stage in the following weeks. The triage assessment examined the main reporting problems, the significance of any operational experiences as contributing factors, psychosocial circumstances, mental state examination and risk. The thorough examination is then presented during a team meeting at which point the individual continues along the assessment stage of the pathway, which may also include signposting/referring to another service if appropriate.

Of particular note during the triage nurse assessment was the level of information provided about the OSIC, the pathway and the stage they were in. They were also provided with clear information on the next stage following completion of the report. Appropriate psycho-education is also provided at this stage, and on this occasion that focused on substance misuse sleep hygiene. After completing the assessment, the Veteran attended another appointment that afternoon to complete their introduction to CROMIS. A comprehensive diary booking system allowed for immediate
allocation of next appointment, irrespective of which staff member that were with; which furnished the Veteran with their next confirmed appointment upon leaving the clinic. This was an early example of how well integrated the OSIC was.

**Psychomets: Induction with Coordinator**

A review of all psychometric tools, their implementation and use for monitoring outcomes. Specifically, a review of the client-reported outcomes monitoring information system (CROMIS).

**Medical Director, Dr Stephen Boucher**

Dr Boucher, originally from the United Kingdom before emmigrating to Canada, gave up much of his valuable time to discuss the functions, structure and origins of the OSIC. When discussing the developments the clinic had achieved it was obvious that much of its success could be attributed to his commitment to continued development; an inspirational Psychiatrist whom I benefitted greatly from.

After leading me through two presentations detailing the services the OSIC provide and the clinical/treatment outcomes, I was able to establish a firmer understanding of the range of treatments and support available for Canadian Veterans residing in Alberta. Dr Boucher’s familiarity with UK health services meant many comparisons could be made and he helped to highlight the diversity between healthcare provision in Canada and the UK, which was pertinent to my study. Barriers to treatment were discussed at length, and he provided numerous articles and research for further consideration. An area which arose from that discussion was examining the strong evidence linking childhood trauma and adult mental health illness following exposure to traumatic incidents during operational deployments. I was also introduced to the psychopharmacological algorithm used for managing PTSD within the clinic and discussed benefits in using its approach.

**National OSIC Managers Meeting**

Canada’s vast size creates some logistical challenges, which were overcome on this occasion by conducting the national meeting via a telephone conference. The meeting demonstrated strategic elements of how the service is managed, coordinated and supervised across large geographic regions. Governance, policy reviews and amendments to VAC assessment procedures were all examined. The meeting was chaired by the national service manager.
VRT: Examining Virtual Reality Therapy, Dr May Wong

The clinic has the facility to provide virtual reality exposure therapy, an innovative intervention used to help treat patients suffering from PTSD, normally in conjunction with prolonged exposure therapy. Dr May, one of the team’s Clinical Psychologists, gave an expert introduction and demonstration of how the therapy is used within the clinic environment. This involved a detailed rationale behind its application and some experiential learning which more than amply demonstrated the sense of “reality” which can be simulated.

(A demonstration by Dr May Wong, Clinical Psychologist)

The equipment uses a range of applications to help simulate realistic and familiar operational environments and is programmed by the clinician via some user friendly software. The use of true-to-life auditory effects and a visually simulated environment through optics positioned over the eyes allow the patient to guide themselves through the exposure based exercise. Olfaction is also used to help create the virtual exposure.

(A simulated IED attack in Iraq, with Dr May’s intern simulating the patient)
Triage Meeting and Team Meeting (AM/PM)

I was able to observe the team’s triage meeting, where initial triage assessments are discussed and treatment plans formulated by the team. Based on the outcomes of assessments by triage nursing staff, psychiatrists and any other clinical evaluations, the individual is allocated an appropriate clinician within the team or referred to an outside service if required. This meeting would occur to facilitate the individuals’ transitions from the “Intake and Assessment” stage of the trauma treatment pathway and into the “Stabilisation” stage. This is based on acquiring a diagnosis of operational stress injury (OSI) which will have been confirmed during their Consultant Psychiatric assessment. An example of the pathway can be seen below.

![Pathway Diagram](image)

The triage meeting was facilitated by the entire team in an integrated approach, where each member was able to contribute their opinion and provide advice on the outcome of the individuals’ treatment. Each decision I observed being made was based on the agreement of the entire team and it was perhaps the best example of multidisciplinary practice I had seen during my career. I learnt much from the proficiency of the meeting and how outcomes were recorded using intelligent yet user friendly reports completed during the meeting, a process all team members took part in.

Team “Success” Meeting

The second meeting that day took place in the afternoon and could be described as a form of group supervision, with some interesting exercises to help promote improved working relationships and practises. It’s obvious the team, and manager, take team integration seriously and see great value in continually ensuring it has opportunity to strengthen and grow. There were moments in that meeting which were quite humbling, especially the personal courage displayed by one of the triage nurses, Pia Barnes, when approaching the subject of stigma. I enjoyed both team meetings that day, learning a
great deal about how the clinic functioned as a team and supported the integrated practice model. The compassion they displayed for the individuals under their care was magnanimous and reflected the reverence shown by many in Canada towards all serving members and retired members of their Armed Forces.

**Observing Stabilisation Session with Trauma/Triage Counsellor**

Another scheduled morning with one of the OSIC clinicians, this time Stacey Ferland, who is employed as a trauma counsellor within the team. The Veteran declined his consent for me to observe the session, but voluntarily suggested he meet me an hour before his appointment to share his experiences. This was a valuable experience and the Veteran commented on the immediacy in which he received help once diagnosed, the ease of access and also the wide range of treatment options available; reporting that he felt very much involved in his own care and well informed of any decisions.

Stacey familiarised me with the model of stabilisation they use, its purposes and how she helps to prepare Veterans for trauma therapy. Much of the stabilisation involves psycho-education and the development of coping skills; including a well evidenced arsenal of grounding techniques. Engagement is also developed at this stage and the Veteran was certainly motivated regards engaging in treatment and appeared encouraged by the consistent message that he could recovery from the effects of operational stress. Like Dr Boucher, Stacey was originally from the United Kingdom and shared invaluable insights from her experiences working within community mental health care in both countries.

**Further Observation of the Initial Assessment Process**

With this element of my study being of such importance, I made a conscious effort to learn as much as possible about how Veterans are assessed after accessing services. Gabby was once again very accommodating in allowing me to observe the initial triage assessment.

**Bio-Feedback:**

**Stabilisation:** Another morning with Stacey Ferland. First half of our meeting was focused on bio-feedback and the approaches used within the clinic. An intervention known as “HeartMath” was examined and after being familiarised with the system I engaged in further experiential learning, being expertly lead through what a session would look like. Stacey was a keen advocate of bio-feedback and demonstrated its benefits and also where it can be used in the various stages of treatment. It is not something commonly used in the UK, and my
first encounter with such a comprehensive technology model of treatment was striking. During that morning I was also able to observe, with the consent of the patient, a stabilisation appointment. Another valuable experience and evidence of how much emphasis is placed on ensuring Veterans are well prepared prior to commencing any trauma therapy.

Further Observation of Initial Assessment Process
The OSIC has two Nurse Clinicians who facilitate and complete the initial triage assessments, and Pia Barnes had scheduled me in to observe one of her assessments on that Friday afternoon. Timings would allow for me to follow the Veteran through the entire assessment process and also observe their initial Consultant Psychiatric assessment during my final few weeks.

Referral Sources and Pathways into Treatment
Veterans Affairs Canada (VAC) provided evidence of referral criteria and referral processes. The VAC, a branch of the Department of Defence, act as a central referral source for Veterans and employ a robust healthcare tracking system which enables the government to monitor the needs of the Veteran community and be responsive to these. There is a proactive approach to providing mental health care and support, with all of the Veterans I spoke to having a clear understanding of the actions they needed to take in order to receive help. Each Veteran receiving treatment has an allocated case manager.

This was developed to meet the “increasingly complex health and social needs” of Canadian Veterans, with the term “new” referring to those who had served in more recent conflicts such as Afghanistan; the Charter replacing their Pension Act which was similar to the UK Ministry of Defence’s war disablement pension scheme. There was a general feeling that the New Veterans Charter was positive, with the only disadvantage being less financial reward when compared to the previous Act.

Operational Stress Injury Social Support (OSISS)
This was my first meeting with a member of the OSISS team that covered Calgary, Zack Donovan, who was the regions Peer Support Coordinator. I also met Michelle Turner who coordinated the OSISS family support service within
the region. The coordinator role involves individual key working and also the management of volunteers who help provide a range of psycho-social support services through a peer support model. A small team of coordinators work closely with the OSIC, and Michelle was integrated into the team and allocated an office within the clinic. The coordinators do not have any active role in the clinical care an individual receives, but acts as a source of support during their care. Zack and Michelle both worked hard to ensure I developed a good understanding of the peer support services they provided.

**Veteran Peer Support Group - Calgary**

Accompanied by Zack Donovan, I took part in one of his regional peer support groups which was held within of Calgary’s British Legion branches. I am happy to report that the Veterans who attended the group shared the same sense of humour as our own Veterans in the UK and it was rewarding to experience how the OSISS model used the skills and experiences of their Veterans to such good effect. The peer coordinator qualifies for the position by having recovered from a service related mental health illness themselves and, obviously given the area of specialism, they are also retired service men and women. I learnt much from the group members and coordinator that evening.

**Operational Stress Injury Clinic**

**Clinical Meeting / Triage Meeting / Team Meeting**

A further opportunity to observe how the team assesses new referrals, plans initial triage assessments, monitors outcomes, manages care and also support/ supervise each other. An emphasis for the team is to evaluate and assess the “causality.” Only those individuals whose mental health problems can be attributed to service are then entitled to treatment – which meets the overall purpose of the OSIC which exists to treat “operational” injuries. There were clearly defined referral pathways for all individuals, irrespective of the outcome of their assessment.

**Exploring Military Archives, Calgary Military Museum**

It was important to understand the types of operations Canadian Veterans had experienced and what similarities they shared with those of the UK Armed Forces. The archives gave valuable insights into operational deployments undertaken by local regiments, and also the wider Canadian Armed Forces.
The memorial (as pictured above) honours those from a local infantry regiment, and the archives were rich in military operations from WWI through to the modern day conflict in Afghanistan. Since 1947 the Canadian Armed Forces have completed 72 “international” operations and have an estimated 3’600 soldiers, airmen and sailors deployed at any one time. From NATO peacekeeping missions during the Balkans conflict to their most recent operations in Afghanistan, their Veterans have largely the same operational experiences as that of our own UK Armed Forces personnel. 158 Canadian Armed Forces Personnel were killed during the conflict in Afghanistan, with a further 1859 non-fatal casualties during the same period.

**Examining treatment pathway with OSIC manager, Marney Wright.**

Marney provided information regarding the initial intake process, assessment process, treatment stages within the pathway and also discharge planning within the of “case completion.” I was able to examine policies and procedures that clearly define the service and help structure the treatment and management of Veterans under OSIC care.

(Example of treatment process map, attached appendix 1)

Each process is mapped for the various stages of engagement along the treatment pathway, defining at which stages communication with the VAC is
required, recommended or mandatory. The process map also includes details of the data collected at that stage.

The national guidance for operational stress injury clinics, published in 2011, helps to coordinate a nationwide service and governs the OSIC network which exists across Canada. It is an extensive resource which defines the role, functions and purpose of the mental health care provided to Veterans, and also that of serving members of the Armed Forces.

Accelerated Resolution Therapy (ART), with Colleen Clark
There was quite a positive mood amongst the team about this new therapy introduced to the OSIC by Colleen Clark, an experienced trauma therapist. She had recently began using ART with encouraging outcomes, and the entire team were due to attend formalised training within the weeks following my return to UK. Although unable to observe the therapy in use with a Veteran, I learnt much about it and had the opportunity to study the available research which supported its use as an effective intervention for individuals suffering from an OSI.

A Review of Family/Carer Support
The OSIC provides spousal and family support, which can take the form of individualised therapy or couples therapy. This is provided by the Social Workers employed within the team, and primarily used as an adjunct to the treatment of the Veterans OSI. The framework used for providing this support was remarkable and provided a great insight into the approaches used to help support not only the individual involved in treatment but also their family relationships. Susan James, who facilitates the couples therapy, also provided information on how family support is factored into the stabilisation stage of the pathway where required. With the consent of both individuals, I was able to observe the couples therapy session and examine
how this might fit within a model of community mental health care in the UK. Significant consideration is given to family support within the OSIC service.

**OSISS:**  
**Family Support / Spousal Support**  
The OSISS service also makes a significant contribution to supporting the families of veterans. I was able to observe, and partake, in the OSISS spousal support group which was held within the OSIC. It is similar to the OSISS veteran group and functions as a peer support service. Michelle Turner, who facilitates the group, shared her experiences in running this element of the OSISS where, at the time of my visit, she helped to support some 36 families within her large region.

**Psychomet:**  
**Measuring Outcomes**  
A full review of the strategies used to capture and measure clinical outcomes using psychometric assessment tools. Also reviewing how psychometric testing used within the OSIC to enhance assessment outcomes and plan treatment.

**Military Orientation:**  
**Reference Folder for Clinicians**  
Within the departments reference library they have a folder containing information on military operations and deployments, offering a comprehensive insight into the types of environments and conflicts which their Veterans would have experienced. Reviewing the information contained within the folder and how it can assist clinicians was insightful.

**TeleHealth:**  
An opportunity to review how the OSIC uses telehealth to enhance their service. Also visited a health centre in Calgary for further information on how telehealth is used throughout the region by a growing number of healthcare providers. It would have many practical uses within the community, especially for individuals residing in areas with difficulties accessing services.

**Operational Stress Injury Social Support (OSISS)**

**OSISS:**  
**One Week with the OSISS Team – Edmonton**  
I travelled to Edmonton to attend the OSISS regional meeting, technical meeting and training days. I met with Regional Coordinator, Greg Prodaniuck; National Coordinator, Jim Woodley; Department of Defence OSISS Manager, Major Carl Walsh; VAC National Manager, Serge Arsenault &
the entire regional team comprising of peer coordinators for both the veterans and family service.

I was also invited to attend the Edmonton support group facilitated by Jeffry Docksey on 02\textsuperscript{nd} October and meet some of the Veterans who avail of their support.

**OSIC: Final Week with OSIC**

My last week was spent within the OSIC. I was able to observe an initial assessment with Dr Boucher, following the patient on from their initial triage, and examine how treatment plans are formulated through the integrated assessment process. I also attended their training day and team event on 08\textsuperscript{th} October which proved very beneficial.

**Final Day:** In keeping with Churchill Fellowship tradition, I was pleased to be able to show my gratitude and thanks by presenting the OSI clinic with a framed Churchill Crown. Some individual presentations were made to those who had played an integral part in my Fellowship. I left Canada with new insights, new ambition and further drive to improve mental health care services for
Veterans in the UK. I also left having formed new relationships and friendships for which I will be eternally grateful.
Operational Stress Injury - Diagnosis
For veterans to be eligible for mental health treatment in Canada they will usually be diagnosed as suffering from an operational stress injury (OSI). This is a broad diagnosis and defined by Veterans Affairs Canada (VAC) as “any persistent psychological difficulty resulting from operational duties performed while serving in the Canadian Armed Forces or as a member of the Royal Canadian Mounted Police. It is used to describe a broad range of problems which include diagnosed psychiatric conditions such as anxiety disorders, depression, and post-traumatic stress disorder (PTSD) as well as other conditions that may be less severe, but still interfere with daily functioning.”

There were clear benefits observed when using this diagnosis with Veterans and the most significant was perhaps the degree to which it helped lessen the impact of stigma associated with depression or anxiety. It helped those engaged in treatment to identify with their illness and recognise that it is attributed to their service, that they became unwell as a result of operational stress being clearly defined; an important aspect when examining barriers to help-seeking. It is well known that an individual’s diagnosis, and the meaning they attach to it, can have a significant impact on their engagement and recovery. The OSI diagnosis acknowledges a wide variety of conditions associated with operational service and is used as standard practice throughout Canada, and also the United States.

Integrated Care
The OSIC is an exceptional model of integration between key mental healthcare professionals and promotes all of the principles relating to an integrated care pathway (ICP) approach in a community setting. Implementing ICPs within UK community health services has had mixed success, but the benefits they provide far outweigh the challenges in their implementation; with evidence suggesting that integrated care can be achieved successfully with joint strategic input and practitioner development. These two approaches, with clear operational management and practitioner input, were visible within the OSIC. But, the “grassroots” of this success appeared to lie in the level at which practitioners were involved in planning patient care and the use of case management during the initial phases of the assessment process, which further enhanced the ICP. Case management, predominantly the OSIC psychiatric nursing staff within the assessment phase, allowed for a closed loop of services by working closely with the Veteran during assessment, planning, treating and evaluating care and underpinned the integrated care approach. The proficient use of “content tools” such as national guidelines, practice support, protocols, clinical outcome progression, indicators from evidence-based practice, pharmacological algorithms and clear inclusion/exclusion criteria all helped to augment the ICP approach within the clinic. All of these variables, from the level of integrated care to the
tools they use to help structure their service, amplify the quality of care Veterans received and placed them at the centre of their recovery.

Treatment
The OSI clinic offer a wide variety of treatments, ranging from the familiar and well established to the more modern and innovative. The use of virtual reality exposure therapy for the treatment of operational stress injuries is a relatively new concept and has been proven as an effective intervention for a range of mental health disorders. One recent study found that 70% of service personnel suffering from PTSD who were treated using virtual reality therapy showed a 30% improvement in symptoms following 10 interventions. There is converging evidence which supports its use and the OSI clinic have proven its effectiveness with Veterans accessing treatment within the community. It is seldom found in the UK and not readily available throughout the NHS, with the primary treatment function in statutory mental health services being CBT. Academic studies in the UK have proven its potential effectiveness and University College London is one of a number of institutes completing research into its clinical applications, with one study highlighting its ability to increase self-confidence among many additional therapeutic benefits. From my observations, virtual reality therapy worked tremendously well and is perhaps the most effective form of exposure therapy I have witnessed. It’s application in helping to treat individuals suffering from PTSD is without question completely valid and should be considered as a treatment option.

An even newer therapy than the virtual reality is “accelerated resolution therapy” (ART), which was just in the process of being implemented during my period with the OSI clinic. The evidence supporting its use has found it to be a safe and effective treatment, but perhaps more compelling is the evidence that indicates ART can be delivered in significantly less time than those therapies currently endorsed to treat operational stress injuries such as PTSD. The OSI clinic were the first healthcare organisation to import the therapy from the US into Canada and it has so far been successfully implemented, with all clinical staff due to complete training as a result of this.

Other adjunctive treatments such as HeartMath and Yoga therapy provided interventions which promoted biofeedback and self-regulatory treatment; and again the Veterans I met responded well to these interventions. HeartMath, like virtual reality therapy, utilises technology to provide an interface between patient and computer. Described as a scientifically validated system using technology to improve stress and promote resilience, it works well with Veterans already familiar with using technology within their lives; such as computers, laptops and “smart” devices such as phones and electronic tablets. The feedback it provides gives a unique visual demonstration of an individual’s emotional state.
The use of psycho-social family support and formalised family/relationship therapy also added significantly to the OSI clinic’s repertoire of interventions and ability to achieve recovery. This treatment option helped to acknowledge the adverse affect PTSD can have on couples and families\textsuperscript{31}, while further demonstrating the clinic’s commitment to holistic care. The family therapy was provided contemporaneously with the Veterans individual treatment.

Psycho-education factored heavily into every aspect of treatment, commencing during their initial assessment and continuing throughout their recovery. It was structured and consistent, which meant every veteran I met was cognisant not only in terms of their mental health but also the treatment pathway. The level of insight, retention and understanding demonstrated by all service users was remarkable and ultimately quite empowering. Educating their service users was demonstrated as a key component in the effective treatment of operational stress injuries and reflected the large evidence base that supports its use when treating PTSD especially\textsuperscript{32,33}. It fits well with the community model and was delivered effortlessly during individual clinical appointments and also groups.

**Monitoring**

The clinic uses an impressive array of psychometric assessment and monitoring tools, which are used conjointly to measure outcomes and also inform practice. The use of CROMIS (Client-reported Outcome Monitoring Information System) was quite intriguing. It is described as a national “web-based software suite” that supports ongoing, session-by-session patient reported mental health outcomes and tracking. The approach is to monitor important mental indicators to prevent deterioration and/or premature drop-out, by “accurately” identifying those at risk and providing actionable, “just-in-time” evidence-informed recommendations to the patient and clinician managing their care. The software has been demonstrated in randomized controlled trials not only to facilitate clinical performance monitoring in mental health care systems, but also to measurably improve clinical outcomes\textsuperscript{34}. The system appeared to be user friendly and seamlessly collected and collated the information at source, making it almost immediately available for review by the clinician either before or after the Veteran’s review. Its functions as a monitoring system were remarkably efficient when compared to current approaches in the UK and although I wasn’t able to witness an occasion where it helped to improve a clinical outcome, evidence demonstrates that it has this capability. For reasons of efficiency and practical uses it seemed an invaluable and innovative way to monitor patient outcomes.

**Peer Support**

As someone who served in the Armed Forces I could not help but be encouraged by the OSISS and principles it abides by; utilising the trust and camaraderie that exists between individuals who have served within the Armed Forces to provide a coordinated level of peer and social support. A nationwide military initiative, it employs veterans as peer coordinators across large geographic regions in Canada, providing welfare and social
support via a network of volunteer peer support workers. During my visit they discussed the outcome of their most recent satisfaction survey, where 99% of those who responded agreed that they would recommend the OSISS to someone else. The survey also found that 97% of the service users felt the support they received was appropriate. These outcomes were based on 1000 returned surveys and painted a positive view of the service they provided, with 54% providing messages of thanks within the additional comments sections; a rewarding outcome for the staff. The survey did not measure wellness, but it did measure value, and all of the veterans I spoke with who were engaged with OSISS had a shared view of just how valuable they found the support.

Part of that value was derived from the knowledge that the OSISS was a military initiative, a branch of their Government in partnership with Veterans Affairs Canada. I encountered a number of Veterans who expressed comfort in their opinion that the Military “still cared” for them, both medically and socially. The social support granted by the peer coordinators and volunteer peer support workers aims to provide positive psychosocial interactions with Veterans throughout various stages of their treatment, but is not isolated to this or restricted by treatment criteria. It is a standalone model which enhances the individuals clinical care, compliments certain aspects of treatment or acts entirely on its own merit where required. Peer support in Canada is common and used quite frequently in helping to treat individuals suffering from anxiety and depression. Analyses in 2011 of seven randomised trials found that peer support interventions used to treat depression improved symptoms more than “usual care” alone and were comparable to cognitive behavioural group therapy outcomes. Peer support is also recognised as a key concept in the recovery approach within mental health care. The OSISS model is unique in that the peer is similar in a more fundamental way than more traditional uses; normally the similarity is based on the type of mental health experience, gender or age for example. But, the OSISS peer coordinator and volunteer support worker are both similar to each other based on their military background and “status” as a Veteran as well as their mental health experiences. This means the supportive relationship is one of equality, shared experience and trust to a degree which is arguably more fortified in comparison to other peer support programs within community models. Larger social support networks, enhanced self-esteem and social functioning have been proven as key benefits when evaluating peer support outcomes, which makes its coalition with recovery focused care quite favourable. There are challenges in supervising and supporting volunteers in peer support roles, but a review of existing literature found that carefully recruited, appropriately trained and supervised peer support workers can deliver mental health interventions effectively, with particular value in community settings.

Studies have found that peer support can be formalised into three broad categories when treating Veterans; which are referred to as peer outreach for those exposed to traumatic events, paraprofessional peer support for a trauma-focused intervention and peer support for recovery from PTSD.

Peer support outreach for those exposed to traumatic events seeks to identify and engage with Veterans suffering from mental health problems following a traumatic event, with an aim to assist them in accessing mental health services. Paraprofessional peers are trained in appropriate supportive interventions, such as mental health first aid, and aim to enhance or
supplement the service provision from mental healthcare professionals\textsuperscript{42}. Peer support for recovery from PTSD provides services to Veterans who have not made, or are in the process of making, significant steps in recovery. This particular approach is much more holistic and aims to promote general improvement in mental health symptoms and has been proven as a successful intervention in the treatment of a range of serious mental health conditions; including PTSD and other mental health problems associated with operational stress\textsuperscript{43, 44}. 
Recommendations

- The operational stress injury diagnosis is examined for use throughout mental health care services in the UK, with a view to it becoming standardised practice when diagnosing mental health problems caused by operational service in the Armed Forces.

- Integrated recovery pathways be used within community mental health services treating Veterans, with provision of services concentrated on developing established clinics that offer timely, evidence based and recovery focused care in the community. With Combat Stress treatment centres commissioned to provide intensive PTSD treatment programs, community clinics could specialise in treating other mental health problems attributable to service; with focus on identified diagnosis such as depression, alcohol and substance use disorders as well as more generalised anxiety problems.

- A national peer support service be developed, mirroring the OSISS model. Combat Stress Regional Welfare Officers could facilitate the peer coordinator role throughout pre-existing regions across the UK. A trial could be completed in one region, with progression to a national service within Combat Stress. A three phase model could work within this structure:
  
  o Peer support within outreach for those exposed to traumatic events – working to compliment early engagement and social support within established community and outreach teams across Combat Stress.
  o Paraprofessional peer support for trauma-focused intervention – working within treatment centres and community clinics, commensurate with the treatment phases of the recovery focused model.
  o And, peer support for recovery following treatment – again, based within pre-established community and outreach teams supporting recovery

- Accelerated Resolution Therapy (ART) is examined as a potential community based intervention for treatment of operational stress injuries. A trial could be commenced in parallel with further research, and it is recommended this be considered within a UK region.

- Virtual Reality Therapy be trialled within one of Combat Stress’s treatment centres and considered as a community treatment option within established clinics.
• A system that matches CROMIS capabilities and functions be developed for use with Veterans engaged in mental health treatment in the UK. This would be with the distinct aim of improving outcomes and providing a modern user friendly electronic monitoring system.

I learnt a great deal during my Fellowship and encountered mental health services which epitomised the “gold” standard in community care. The potential for recommendations were seemingly endless, but varied significantly in terms of be realised. So, the recommendations as an outcome of my Fellowship study are intended to be measurably achievable when assessed against current resources within the UK. It is hoped that each of these recommendations can be achieved in helping to enhance community mental health services for Veterans.

There are some considerations for further study. The first is how much responsibility the UK Government should have in providing specialised mental health care services for Veterans; whereby in comparison with Canada our Government departments, such as Veterans Affairs and the MOD, do not provide direct healthcare services to Veterans, there is an argument that more funding should be allocated for this. The second consideration is the development of closer partnerships with our forces allies across the globe; an international consortium which shares best practice, knowledge and experience in the interests ensuring that individuals leaving the Armed Forces who do develop mental health problems have the best possible chance of recovering.
Summary

The views and opinions in this report are based on the outcomes of my Fellowship project and do not necessarily reflect those of the Winston Churchill Memorial Trust or my employer. Both have been incredibly supportive of my project and I am pleased to be part of the review process looking at improving the community mental health services provided by Combat Stress; my Fellowship experiences have had an unquestionable impact on my ability to contribute to improving community services where I work and also my own practice.

I have been able to disseminate the research within our national outreach service and contributed to making changes and improvements to our community services. In addition to this, I will be presenting the outcomes of my Fellowship to the trauma advisory panel in Northern Ireland.

The greatest beneficiary will however be the Veterans for whom we support, who deserve the absolute highest standards in care and every practical opportunity to engage with services that promote sustainable recovery and a healthy, prosperous lifestyle after leaving the Armed Forces.
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