Community psychiatry in the RAF: an evaluative review

Julian C. Hughes

This paper offers a descriptive survey of RAF community psychiatry. It shows that most of the morbidity encountered in the community now served by RAF psychiatrists is at the 'minor' end of the psychiatric spectrum. It mostly requires supportive psychotherapy and the key worker is often the community psychiatric nurse. The study allows discussion of four related issues: the essential nature of military psychiatry; the future provision of community psychiatry to the RAF; psychiatric training and continuing professional development in the RAF; and the possibility of research.

In recent years there has been a reduction in the medical establishments of the Armed Forces. This has affected those providing psychiatric care. What is the present need for psychiatric services within the Royal Air Force (RAF) community? While published papers indicate areas in which military psychiatrists have expertise (e.g. Fletcher *et al*, 1991; Psychiatric Division of the RAF Medical Service, 1993; Busuttil *et al*, 1995), their day-to-day clinical activities may be obscure to many civilian colleagues. This paper attempts to give some insight into community psychiatric practice in the RAF in recent times.

Anthony & Fowlie (1982) recorded referral rates to the RAF community psychiatric services of about 7 per 1000 in 1980; 29% had stress and adjustment reactions. Using the General Health Questionnaire (GHQ) in a systematic random sample from one RAF flying station, Barrow (1985) found a rate of caseness of 11.6%, a figure similar to that found in the general population. However, both of these studies included dependents (i.e. the families of servicemen or women) who have been increasingly excluded from RAF psychiatric care. So it is difficult to know what figures would emerge for the population now served by RAF psychiatrists.

This paper offers a descriptive study of community psychiatry in the RAF. It attempts to answer a general question, namely what is the nature of the psychiatric morbidity being dealt with by RAF community psychiatrists? In answering this question some indication of treatment will be given. The question allows consideration of four related issues. Firstly, it raises a question concerning the essential nature of military psychiatry. Secondly, it raises questions concerning the future provision of psychiatric care to the RAF. Thirdly, it has implications for training and continuing professional development (CPD) in the RAF. Fourthly, it suggests a research role for RAF psychiatrists.

The study

The study was a survey of my work as a Senior Registrar in the Department of Community Psychiatry at Princess Alexandra Hospital, RAF Wroughton. We used a 'shifted out-patient' model allowing close liaison with general practitioners (GPs), with consultant supervision and the support of a multidisciplinary team. During the course of the study, three out of the team of nine were lost because of cuts. Patients from my 'catchment area' were not usually seen by other psychiatrists. The total patient population served was about 9000.

Data were collected on all community patients seen during six months in early 1995. Diagnoses were made in accordance with ICD–10 (World Health Organization, 1992). Standardised instruments were used occasionally and cases were discussed with the consultant. Known episodes of deliberate self-harm and previous abuse or trauma, together with family or social circumstances, were recorded and the management of the patient was noted.

Findings

In six months 70 patients were seen, with a mean age of 31 years (range: 20–52) and a sex ratio of 1.7 males to 1 female. Most patients were married (53%), while 27% were single and 20% divorced or separated. Only 13% were dependants (which should be compared with around 50% in Anthony & Fowlie, 1982). Almost half (46%) were new referrals and 50% were discharged from follow-up. The average number of appointments per patient was 2.6 (range: 1–13), the mode was 1, and there was a non-attendance rate of 12%.

Table 1 records the 94 diagnoses. Multiple diagnoses mainly occurred in the context of

https://doi.org/10.1192/pb.21.7.418 Published online by Cambridge University Press

Table 1. Diagnoses made in 70 RAF community patients seen over six months according to ICD-10 criteria

ICD code	Diagnosis	*n*
F10.1	Harmful use of alcohol	4
F10.20	Alcohol dependence, currently abstinent	8
F10.24	Active alcohol dependence	2
F10.26	Alcohol dependence, episodic use	1
F20.05	Paranoid schizophrenia, complete remission	1
F23.3	Acute predominantly delusional psychotic disorder	2
F25.2	Schizoaffective disorder, mixed type	1
F32.0	Mild depressive episode	10
F32.1	Moderate depressive episode	3
F33.0	Recurrent depressive disorder, currently mild	1
F33.1	Recurrent depressive disorder, currently moderate	1
F40.01	Agoraphobia with panic disorder	1
F40.2	Specific (isolated) phobias	2
F41.0	Panic disorder	1
F43.1	Post-traumatic stress disorder	7
F43.20	Brief depressive adjustment reaction	5
F43.21	Prolonged depressive adjustment reaction	24
F43.22	Mixed anxiety and depressive adjustment reaction	2
F43.23	Adjustment disorder with predominant disturbance of other emotions	5
F50.3	Atypical bulimia nervosa	1
F51.0	Non-organic insomnia	1
F51.3	Sleepwalking	1
F60.2	Dissocial personality disorder	1
F60.31	Borderline personality disorder	5
F60.7	Dependent personality disorder	1
No psychiatric diagnosis		3
Total		94

personality disorder, post-traumatic stress disorder (PTSD) and alcohol problems, and typical concomitants were depressive or adjustment disorders. The instances of psychoactive substance misuse all related to alcohol. The four patients with schizophrenic or delusional disorders (F20–F29) were in remission. Of the seven patients with PTSD, three had sustained their trauma in the context of their military activities, although none had been engaged in hostilities.

Intentional self-harm had occurred in nine patients. Assault, either sexual or physical, was a factor in five cases. There were three cases of childhood sexual abuse and three further recordings of emotional or physical abuse or neglect. In six cases family disharmony was an important factor. Forensic matters were significant for three patients. One patient had a psychiatric examination purely for administrative reasons.

In terms of management, most patients received some form of psychotherapy, usually at the supportive level, and almost half of the patients had a community psychiatric nurse (CPN), often as the key worker. Other forms of psychotherapy included cognitive–behavioural therapy, problem-solving, 'debriefing', behaviour therapy, marital therapy and group therapy (for alcohol problems, assault and PTSD).

In the six months of the study there were four hospital admissions, one being for administrative reasons. Concerning drug medication, 20 patients were on antidepressants, two on antipsychotics, one on a benzodiazepine and one was prescribed disulfiram.

Occupational or social interventions included two recommendations for patients to be posted to different locations to reduce environmental stress. Several patients, including service personnel, were referred to the National Health Service (NHS). No service personnel were discharged from the RAF on psychiatric grounds, although it was suggested that some patients should be allowed to leave of their own volition.

Discussion

The main question to be answered by this study concerns the clinical need being met by

https://doi.org/10.1192/pb.21.7.418 Published online by Cambridge University Press

community RAF psychiatrists. The study shows that most of the psychiatric morbidity was 'minor', largely requiring supportive psychotherapy, often from CPNs.

The morbidity described here is similar to that reported by Anthony & Fowlie (1982), except that I recorded more 'stress and adjustment reactions' (46% v. 29%). Compared with most previous studies of the RAF community (e.g. Barrow, 1985), an important difference is that fewer dependants are now seen by the RAF psychiatric services.

The evidence for whether psychiatric clinics in GP settings lead to more referrals at the less severe end of the spectrum of psychiatric illnesses has been contradictory. The present study clearly shows a predominance of 'minor' psychiatric disorders being referred. However, it would seem that the RAF community studied was even further skewed towards the 'minor' end than appears in most community studies in a civilian setting. Thus, while 5.7% (4/70) of the patients in this study received diagnoses of schizophrenic-type or delusional disorder, in Strathdee *et al* (1990) for primary care clinics the corresponding percentages were 15% for males and 9% for females. In the civilian study only 4% had adjustment disorders.

In Jackson *et al* (1993), the rate of referral, the pattern of diagnoses, the percentage of females referred (over 60%) and the employment status clearly differed from the present study. For example, the prevalence rate of schizophrenia and mania in the year of their study was 7.0 per 1000 in the index group; whereas the corresponding rate in the present study would have been between 0.4 and 0.9 per 1000. Similarly, their rate of inception to care for depression was over four times that of this study. Interestingly, however, the inceptions of adjustment disorder were almost exactly the same in both studies.

The four issues relating to this study can now be considered. Firstly, what is the essential nature of military psychiatry? Clearly this study is limited to the RAF and says nothing about other services offered by military psychiatrists. Other research (see above) indicates areas of expertise for military psychiatrists. In the RAF community, however, in comparison with civilian settings, what is noticeable is the 'minor' nature of psychiatric disorder.

RAF community psychiatrists would wish to emphasise their occupational role. It has long been their tenet that treatment might be made more effective by close liaison between the psychiatrist and GP at the place of work. Environmental stresses peculiar to the military setting, with a lack of tolerance of emotional disorder, can often play a role in someone requiring psychiatric referral. The RAF psychiatrist is cognizant of such factors and is in a position to manipulate the person's occupational environment.

It is not, however, clear that this occupational role must be played by the psychiatrist. It is the GP who holds the key occupational position. And there is another side to the occupational hat: psychiatrists may come to be associated too strongly with the RAF rather than with the patient. The GP is less likely to be thus perceived since the patient will have received ordinary medical care from the GP, sometimes over a long period.

Secondly, what of the future provision of psychiatric care to the RAF? Earlier studies (e.g. Anthony & Fowlie, 1982) argued with some cogency in favour of a community (rather than a traditional hospital) approach to RAF psychiatry. It could now be argued that, to a large extent, the type of psychiatric morbidity in the present RAF community does not require the expertise of a psychiatrist. Moreover, where a psychiatrist is required, it is not obvious that he or she should be military.

Such suggestions will seem anathema to some, but consider the significant autonomy of CPNs in managing many psychiatric disorders; the ability of various types of adequately trained therapists to deliver certain forms of psychotherapy; the many RAF stations which have had no RAF community psychiatric team serving them for years; and the RAF stations which already have close links with civilian psychiatrists and CPNs.

Against such radical suggestions the spectre of war is always raised. For this reason it would seem important to maintain some sort of military psychiatric establishment. This connects to the third issue, which concerns training and CPD. The present study suggests that clinical experience, at least within RAF community psychiatry, is limited. This would argue in favour of wider experience being gained elsewhere. Only by making the training attractive and by ensuring continuing stimulation is it likely that psychiatrists will be retained within the armed services. Even then, sizeable hostilities might well require civilian psychiatrists to volunteer. So more 'cross-fertilisation' between military and civilian psychiatrists would seem desirable.

The final issue concerns research. Perhaps the new generation of military psychiatrists should, apart from spending time in civilian settings, mainly devote themselves to the provision of specialist services for the military in a research environment. Research into psychological aspects of trauma and into the interaction of personality with present stressors would seem to be areas in which military psychiatrists could make a contribution. The role of military psychiatrists could become more educational and advisory. The challenge would be to maintain authority, credibility and funding.

https://doi.org/10.1192/pb.21.7.418 Published online by Cambridge University Press

The problems of maintaining a viable military psychiatric service under present conditions have probably not yet been resolved, but should concern us all. The lessons of past conflicts should not be forgotten; military psychiatry should provide a repository for such knowledge (O'Brien, 1994).

Acknowledgements

I am grateful to former colleagues for their helpful comments on an earlier draft of this paper. In addition I must record a debt of thanks to Dr Keron Fletcher and Dr David Stevens for significant help over several years. The opinions and remaining errors are entirely my own.

References

ANTHONY, E. & FOWLIE, D. G. (1982) Community psychiatry in the Royal Air Force. *British Journal of Clinical and Social Psychiatry*, **1**, 23–29.

BARROW, S. (1985) Psychiatric illness in a Royal Air Force community. *Psychiatry in Practice*, **4**, 8–15.

BUSUTTIL, W., TURNBULL, G. J., NEAL, L. A., *et al* (1995) Incorporating psychological debriefing techniques within a brief group psychotherapy programme for the treatment of post-traumatic stress disorder. *British Journal of Psychiatry*, **167**, 495–502.

FLETCHER, K. D., PRICE, D. & COOK, C. C. H. (1991) Problem drinking and family history. *British Journal of Addiction*, **86**, 1335–1341.

JACKSON, G., GATER, R., GOLDBERG, D., *et al* (1993) A new community mental health team based in primary care. A description of the service and its effect on service use in the first year. *British Journal of Psychiatry*, **162**, 375–384.

O'BRIEN, L. S. (1994) What will be the psychiatric consequences of the war in Bosnia? *British Journal of Psychiatry*, **164**, 443–447.

PSYCHIATRIC DIVISION OF THE ROYAL AIR FORCE MEDICAL SERVICE (1993) The management of hostages after release. *Psychiatric Bulletin*, **17**, 35–37.

STRATHDEE, G., BROWN, R. M. A. & DOIG, R. J. (1990) Psychiatric clinics in primary care: the effect on general practitioner referral patterns. *Social Psychiatry and Psychiatric Epidemiology*, **25**, 95–100.

WORLD HEALTH ORGANIZATION (1992) *The ICD–10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. Geneva: WHO.

Julian C. Hughes, *Senior Registrar, Rivendell Assessment Centre, Radcliffe Infirmary, Oxford OX2 6HE*

https://doi.org/10.1192/pb.21.7.418 Published online by Cambridge University Press