

Veterans' mental

Dr Walter Busuttill describes the role of third sector charity Combat Stress, its community outreach services and bespoke residential treatment programmes

Combat Stress is the leading veterans' third sector charity that provides services for ex-servicemen and women suffering from mental health problems. It offers phasic residential group and individual interventions as well as community welfare support.

In the last year Combat Stress has started to transform and expand its community services and is building a network of multidisciplinary community outreach services. This development will also help to expand the scope of its phasic residential treatment programmes, allowing a mix of residential and community treatment options.

In order to fund these clinical developments, HRH Prince Charles, patron of Combat Stress, will launch its 90th year appeal, 'The enemy within', at St James' Palace. The appeal aims to raise £30 million over the next three years.

Military psychiatry: combat

War theatre mental breakdown has been described as a combat stress reaction (CSR) by military psychiatrists¹. It incorporates many features of acute stress disorder (ASD) and is characterised by three phases of functional decompensation and symptom development. The premonitory phase starts before explicit exposure to psychological trauma occurs (pre-combat). It includes symptoms of: high arousal with a restricted field of interest; severe psychological and physical symptoms of anxiety, emotional dysfunction, diminished social interaction and withdrawal, sustained criticism and mistrust. This is followed by an acute phase usually precipitated by exposure to a severe psychologically traumatic event (combat). This phase is characterised by gross psychiatric symptoms including cognitive impairment with dissociation, confusion and disorientation. The final phase is the stabilisation phase, which develops over several days or weeks and is characterised by affective symptoms (depression, guilt and shame), intrusive thoughts and vivid images of traumatic event/s; sleep disturbance, fatigue and irritability.

CSR can resolve spontaneously, or it may resolve following early intervention comprising rest and

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basic cognitive therapy-based psychological interventions, or it may progress into long-term psychiatric illness including anxiety disorders, depression and alcohol misuse as well as post-traumatic stress disorder (PTSD) characterised by re-experiencing symptoms including nightmares, flashbacks and intrusive memories; hyperarousal symptoms including hypervigilance, physical and psychological symptoms of anxiety including panic attacks and emotional numbing; and avoidance symptoms including social withdrawal. The main factor determining the development of CSR, ASD and PTSD is a dose response effect: the more severe and prolonged the exposure to psychologically traumatic stressors, the more likely it is that mental breakdown and illness will develop².

‘Many veterans said they coped with mental health symptoms by drinking alcohol to excess. Heavy alcohol use can mask anxiety and other symptoms of PTSD’

Recent British research studies demonstrate no significant differences between the rates of mental disorder between personnel deployed or not deployed in Iraq or Afghanistan with the exception of PTSD, where increased rates of between one and eight per cent are evident³. These figures are low compared to other military organisations fighting in the same war zones, with the US and Australian military reporting higher rates of PTSD⁴. The main reason given for these comparatively lower rates concerns differences in the methodology of studies as well as a lower dose response effect following the implementation of ‘harmony guidelines’ that in comparison limit the duration and frequency of tours of duty for the British soldier. Individuals present with more problems if these guidelines are breached, and there are particular difficulties in those whose tours are unexpectedly extended⁵.

Military physical and psychiatric health is the responsibility of the Defence Medical Services (DMS), part of the Ministry of Defence. In-service psychiatric care is organised into 15 multidisciplinary Departments of Community Mental Health (DCMH) situated all over the UK with additional DCMHs in Germany, Cyprus and Gibraltar. There is rapid access to a high standard of mental health care. A hospital-based service contracted out to an NHS consortium is also available in combat zones.

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Psychiatric field teams are staffed by uniformed community psychiatric nurses (CPNs) supported by military psychiatrists. Currently there are approximately 180,000 personnel serving in the UK military. The DCMHs deal with around 5,000 referrals each year which equates to 4.5 referrals per 1,000⁶. Clinical audits indicate that common presentations include alcohol misuse, depression, anxiety and adjustment disorders, with low rates of PTSD. Alcohol misuse in servicemen exposed to combat is at higher levels than comparative civilian populations, especially in the younger servicemen⁷. In-service suicide rates are unremarkable, although one recent study demonstrated that suicide rates for ex-serviceman under 24 years were two or three times higher than their civilian counterparts. Reasons for this are not clear with suggestions of a) pre-service vulnerability, b) trouble readjusting to civilian life and c) exposure to more adverse experiences⁸.

Despite the good mental health services offered to servicemen, many veterans report that they were unable to present for help with mental health problems during their military service. Reasons cited include fears of losing their career, maintaining a macho image and keeping a stiff upper lip⁹. Many report that they coped with mental health symptoms by drinking alcohol to excess¹⁰. Heavy alcohol use can mask anxiety and other symptoms of PTSD, at least initially. Studies demonstrate that delayed onset PTSD is common in British veterans and that it is more likely to develop during the first year after the serviceman has left the military¹¹, suggesting that the loss of support structures within a military environment, and adjustment to civilian life, increase vulnerability¹².

Veterans present with loss of social and occupational function, self-imposed isolation, poor relationships, and marital, family and economic difficulties

The work of Combat Stress

In Britain, a veteran is defined as someone who has served in the armed forces for at least one day, and who has now left the military. There are approximately 5.5 million veterans and 7.5 million family dependents in Britain. Since 1948 the NHS

has been responsible for looking after the health of veterans. Until recently there was only one specialist NHS service for veterans (this was in Hull). Within the last 18 months the MOD and NHS, aided by the national third sector charity for veterans' mental health, Combat Stress, have set up six pilot sites across the country aimed at signposting veterans into mainstream mental health care and to specialist trauma services if these exist locally. It is also hoped that the NHS initiative, Improving Access to Psychological Therapies (IAPT), will allow better access to mental health therapies; although there are concerns that the level of expertise of the average IAPT mental health worker may be challenged by the veterans' common complex presentation, and that referral to mainstream psychological services will remain necessary.

The MOD also offers a mental health assessment service to veterans at St Thomas' Hospital in London, and for reservists, at Chilwell in Nottingham. More recently a partnership contract between the MOD, NHS and Combat Stress has been negotiated and signed with an emphasis on joint working and cooperation.

Over the past 90 years Combat Stress has helped more than 90,000 veterans and their families. Currently there are 4,190 veterans actively receiving care either in the community or attending residential treatment services or both. There are a further 5,617 passive cases. These are individuals who are either in the process of accessing care, or who would already have accessed care and their intervention has been completed. They, however, have not yet been discharged from our services. Some individuals procrastinate and cannot decide whether they are prepared to engage in mental health care. There has been a steady increase in veterans who have served in the Iraq and Afghanistan wars over the past few years, with new cases currently presenting at a combined rate of approximately 160 per year, with an ever-increasing trend projected. Since 2003, 665 Iraq veterans and 154 Afghanistan veterans have asked for advice and help.

In the last five years referral rates have increased by 66 per cent, with 1,257 new referrals received in the year to 1 April 2009. This is compared to rates of 300-400 new referrals a year before this time. Approximately five years ago the average age of the veteran was 60, with many veterans having served in the Second World War. Currently the average age is 43, and falling. Eighty-one and a half per cent of our veterans are ex-Army, the remainder coming equally from the Royal Navy and RAF, with a very small number of ex-Merchant Navy seamen. Female veterans account for around three per cent of the total.

Combat Stress offers help within an environment that is sensitive to the military culture and offers a supportive therapeutic milieu that encourages peer support. Many staff are ex-military; in particular, the regional welfare officers (RWOs), who are the first point of contact, are all ex-military officers. They share a common background and culture with the veteran. Combat Stress offers telephone help and advice, community mental health treatment, and welfare that is currently expanding to regional multidisciplinary outreach teams, as well as specialist evidence-based residential group and individual multidisciplinary treatments, carers groups and rehabilitation. Treatment also aims to lead the veteran back into their local NHS services. Joint working with other ex-service charities and work re-training schemes is the norm.

Combat Stress is partly funded by the NHS in Scotland. In other parts of Britain it is funded partly through the War Pensions Agency with 60 per cent of its overall funds coming from charity.

Size of the problem

No British veteran population studies investigating mental health and welfare needs exist. Large Combat Stress patient clinical audits (n=602), supported by comprehensive psychometric data, demonstrate that some 92 per cent of new clinical cases will have been exposed to multiple psychologically traumatic events while serving in the military, with 75 per cent qualifying for a primary diagnosis of PTSD. Co-morbid presentations are common, comprising mainly depression and alcohol misuse. The remaining 25 per cent of veterans present with primary diagnoses of anxiety, and depressive and alcohol-related illnesses¹³. The clinical picture is further complicated as 52 per cent of the veterans have other underlying issues, including exposure to childhood sexual, physical and emotional trauma, neglect and poor care giving^{13,14}.

Typically, veterans delay their presentation to Combat Stress by an average of 14 years following discharge from the military, thus chronic complex clinical presentations are the norm. Attendant loss of social and occupational function is common. Veterans also present with self-imposed isolation, poor relationships, and marital, family and economic difficulties^{13,14}.

Treating mental health problems in veterans can be complicated because of pre-service difficulties including exposure to psychological trauma, neglect during childhood, or a poor family background. These are often the reasons behind joining the military in the first place. Military life itself can also contribute through exposure to bullying, the alcohol culture, exposure to psychological trauma, and

family problems caused by cyclical separations¹⁵. Veterans are more likely to experience earlier onset of physical disorders as a result of occupational factors such as orthopaedic problems including chronic pain and ENT (ear, nose, throat) problems. Those who suffer from chronic PTSD commonly suffer a higher than expected incidence of other physical disorders including cardiac problems and diabetes, with large US veteran studies demonstrating that physical illnesses develop 10 years earlier than in veterans without PTSD¹⁶⁻¹⁸. Leaving the service and adjusting to civilian life is another key risk factor, as is seeking help for issues such as shame, stigma or guilt^{9,12}.

These issues, and maintaining a macho image, are factors that prevent the veteran seeking help and admitting he has a problem. Indeed most referrals (50 per cent) to Combat Stress come from family members – usually the partner or wife of the veteran, commonly precipitated by a family, relationship or marital crisis. In many of these cases, the veteran has been given an ultimatum to get better by his spouse or girlfriend. The majority will have tried to access care through the NHS before coming to the attention of Combat Stress, but for a variety of cultural reasons, care through mainstream NHS services has not resulted in the resolution of clinical symptoms. Other referrals include 11 per cent from the NHS, social services and Military Service Discharge Boards. Service charities, welfare organisations, veterans' associations and the Service Personnel and Veterans Agency combined, account for 31 per cent¹⁴.

Combat Stress services

Community outreach services are divided into 16 regions across Britain and Ireland, each having an RWO. Each RWO is managed by a Welfare Support Desk Officer (WSDO) who coordinates the work of the RWO, and who liaises and supports the veteran by telephone. The geography of the outreach clinical services is defined by the regions that RWOs have historically covered alone. Multidisciplinary clinical teams are currently being set up. These will comprise the RWO, WSDO, CPN, a generic mental health worker, who ideally will be a psychotherapist with family therapy experience, or a social worker, and local access to psychiatric and psychology sessional clinics.

The RWO is a retired military officer who, although not formally trained in mental health, has received in-house training about mental health problems. The RWO remains the main entry point into care for the veteran. This is because issues of stigma, shame and other civilian barriers can be broken down by the RWO, who comes from the same culture and

speaks the same language as the veteran.

Once referred, the veteran will receive an initial RWO home visit. The RWO also provides welfare advice, for example helping the veteran apply for benefits and accessing other ex-service charities as required.

Currently, if a mental health problem exists, then, with the GP's written consent, veterans are offered a multidisciplinary residential five-day mental health assessment. This is conducted at one of three treatment centres. Some assessments can also be conducted on an outpatient basis.

Eighty per cent of new veterans accessing our services will have tried to get help from the NHS but for some reason NHS intervention has either failed to be delivered, or failed to work, or it may simply be that this help has not been sufficient to control symptoms and improve function. Many have had problems with stigma and have been too ashamed to declare their military service, or have lost faith in the NHS. Some have been told not to talk about their military service in a civilian group setting for fear that their traumatic experiences are too upsetting for other civilian patients accessing the same NHS services^{9,14}. Mainstream NHS services

do not deliver bespoke veterans' services.

Specialised psychological trauma services in the NHS are uncommon, and NICE (National Institute for Health and Clinical Excellence) guidelines do not address the needs of chronic severe or chronic complex presentations of PTSD^{19,20}.

Combat Stress has three residential treatment centres, each with approximately 30 beds including some double rooms for carers to attend with the veteran. The centres are in Ayrshire, Shropshire and Surrey. Each is run by an MDT comprising occupational therapists, psychotherapists, registered mental health nurses, nursing assistants, psychiatrists and psychologists. These centres have a therapeutic milieu that is highly supportive and sensitive to a military culture. Some, but not all, staff are ex-military. Peer support is encouraged but this is directed by staff.

Because of the chronic nature of many of the veterans' mental health illness, the main therapeutic aims are to improve function, maintain wellness and treat psychiatric symptoms. A phasic rehabilitation model of care has been adopted in keeping with the recovery model and in keeping with presentations of complex PTSD¹⁹⁻²².

The first phase is a **preparatory** phase. This includes: RWO assessment, multidisciplinary team referral meeting, information gathering from GP and NHS team and active preparation for initial assessment admission including NHS detoxification from alcohol and drugs.

The second phase comprises **stabilisation and safety**. This includes: a five-day MDT residential assessment, prescription of appropriate medications, establishing trust and safety within a therapeutic milieu, subsequent further admissions (current practice), care planning, liaison with GPs and other treating agencies, treatment of co-morbid disorders such as chronic pain, depression, alcohol dependence before trauma work is undertaken, psychoeducation groups for PTSD, alcohol and illicit drugs, coping, anxiety and anger management.

The third phase comprises **disclosure and working through** of the traumatic material. This utilises individual trauma-focused therapies including trauma-focused cognitive behaviour therapy (CBT) and eye movement desensitisation and reprocessing (EMDR). Psychodynamic therapies are also used for attachment problems.

The final phase is **rehabilitation and reintegration**. This utilises occupational therapy (OT) interventions including normalising activities of daily living, and a healthy living and OT run exercise programme, welfare support, and reintegration within society and work re-training.

Current staffing and configuration influences the

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ability to deliver treatment to so many patients. Currently, veterans are offered three two-week residential admissions or six one-week admissions over a one-year period before their care plans are reviewed. Many are offered outpatient support and treatment by Combat Stress and the NHS between residential admissions. It is hoped that the introduction of community MDTs will allow more local group and individual interventions.

Treatment approach: outcome audit and research evidence

Patients accessing Combat Stress services are more likely to engage with and remain in treatment, and become plugged in to their local NHS services¹⁴. Joint management between Combat Stress and the NHS is the norm.

An independent clinical audit one-year outcome study demonstrated that veterans accessing Combat Stress services showed improvement in function and symptoms, increased medication compliance and engagement in therapy²³. An internal two-year follow-up clinical audit (n=57) conducted in veterans suffering from severe complex clinical presentations²⁴ demonstrated psychiatric symptom reduction with 58 per cent definitely better, 15.7 per cent improved a little, and 1.8 per cent discharged as needing no further treatment; improvement in function (58 per cent definitely better and 17.5 per cent improved a little); and improved employment rates from 26 per cent to 47 per cent. Other findings included reduction in isolation, improved compliance with medication and uptake of psychotherapy, as well as better engagement with NHS services, a reduction in or abstinence from alcohol and illicit drugs, and a better adjustment to civilian life overall, although this was not measured directly.

One previous study conducted in veterans accessing Combat Stress services, which comprised two-week residential treatment phases three times a year, demonstrated deterioration in improvement between residential treatment admissions²⁵. Because of this it was recognised that it is important that patients are maintained in the community. It is hoped that community outreach services will prevent relapse and augment residential treatment gains with local treatment and support progress, as well as promote joint working with local NHS services to maintain improvements.

Large exit satisfaction surveys (n=1681) indicate very high levels of satisfaction with the residential services provided. An audit (n=49) conducted using a standardised wellbeing tool, the Warwick-Edinburgh Mental Well Being Scale (WEMWBS)²⁶, measured over an average of 18 months at three treatment points, demonstrated that high levels

of mental wellbeing are maintained over time. Pre-treatment control group mean wellbeing scores were statistically significantly lower compared to post-treatment at all three follow-up points. Patients report easier engagement with Combat Stress and are treated in a sympathetic and empathic environment²⁷.

Combat Stress offers evidence-based interventions in accordance with published research²² and best practice²¹.

Phasic treatment models that include trauma-focused therapies for treatment of severe chronic PTSD in combat veterans and in adult survivors of sexual trauma are the gold standard^{19,21,22,28}. It must not be forgotten that clinical audits of Combat Stress veterans report that 52 per cent have been exposed to childhood trauma including sexual abuse¹⁴. Phasic treatments for chronic PTSD in veterans are used as mainstream in Australian²⁹ and in American veteran rehabilitation models³⁰. A recent independent published study has demonstrated that insidious and delayed clinical presentations are common in the veterans seen by Combat Stress¹¹.

The role of a fully developed national outreach service

Currently, Combat Stress is developing its community outreach services. It is hoped that this will enable the delivery of community clinical assessments and treatments and, for those who need it, bespoke residential treatment programmes in line with those run by the Australian Veterans rehabilitation services and the Veterans Association of the USA.

In future, it is essential that Combat Stress is able to deliver diverse bespoke interventions comprising a mixture of residential and community-based services. Wherever possible, treatment will be offered locally to the veteran and residential interventions will be avoided. This philosophy is based on sound research findings from Australia, demonstrating that intensive interventions are only required for those patients who suffer from the most severe clinical presentations and that less intense interventions including community-based treatments are appropriate for those who are not severely unwell³¹.

The research literature has demonstrated that most residential programmes work best if they are part of a bespoke community outreach service^{29,32}. Thus the programmes will comprise a mixture of residential and community-based treatment phases and will be targeted more specifically to individual need. It is anticipated that these will comprise:

- an intensive five- to six-week residential programme for relatively recent onset severe PTSD that is then

augmented with community-based treatment interventions

- a PTSD substance misuse psychoeducation programme, which plugs into the first programme above and follows that pathway
- a PTSD-treatment resistant programme that will commence in a residential setting but then transfer to the community
- an old-age programme
- an upgraded rolling programme (two-week admissions three times a year, with outreach maintainance)
- a respite care programme that will include summer camps allowing the individual to have a holiday as well as offering respite to carers
- carers' groups similar to those established in the Australian Veterans mental health services are already offered in Combat Stress treatment centres as well as in the community. These will be expanded to be more widely run. The groups help, educate and support the family members of the veteran accessing the care of Combat Stress.

The role of a fully developed community outreach service

There are many compelling reasons why a fully developed community outreach service would be beneficial to veterans accessing treatment from Combat Stress. Such a service would:

- help to engage patients quickly and more easily
- allow speedier clinical assessment, and speedier clinical management, especially when joint working with local NHS services
- help to liaise with, and plug veterans into, NHS services including general practitioners, community mental health teams, psychologists and psychotherapists
- enable joint working, education and good PR between Combat Stress and NHS services including GPs and community mental health teams, raising awareness of the needs of veterans
- allow better and easier access to the treatment programmes delivered by Combat Stress, by allowing community assessment to take place, therefore freeing beds in residential treatment centres
- enhance the overall treatment outcomes delivered by Combat Stress, in that it would augment and complement the residential treatment programmes, allowing their expansion, diversification and development into a mix of residential and community-based treatments in keeping with best practice and the research evidence from Australia in particular
- prevent residential treatment where it is not needed, in keeping with research evidence from

Australia, demonstrating that intensive treatments can be detrimental to those who do not actually need them, particularly if their psychiatric presentations are not severe

- reduce stigmatisation and allow veterans to ask for help more easily, especially if treatment is available locally
- reduce the timescale between servicemen leaving the military and their request for help, from an average of 14 years to far less time. This would make it much easier to treat a far less complicated clinical presentation than otherwise would result
- allow more family work and more carers' groups to be conducted, directed appropriately by a mental health professional
- allow local veterans' group and individual therapy to be conducted, again by a mental health professional. It should be noted that group meetings of veterans that are not directed by a mental health professional can in theory be detrimental to mental health in the long term. This research evidence was borne out after the Vietnam War³³
- in the longer term, once psychiatric and psychological clinics are established, outreach would allow the assessment, treatment and management all in an outpatient environment.
- enable better working with residential treatment centres, allowing joint residential, community outreach programmes to be set up, following established practice in Australia and America
- residential programmes that work in tandem with community outreach will decrease the need for residential treatment. This in turn will allow more intensive residential treatment to be delivered to those who need it most
- one of the main aims of Combat Stress' current intervention is to help the veteran re-access NHS mental health services wherever possible. In most cases, joint clinical management between the NHS and Combat Stress is undertaken depending on the clinical presentation and the veteran's own wishes. Less commonly, clinical management may be entirely taken over by the NHS. It is hoped that community outreach services will work with, liaise with, champion and educate the local NHS services. Outreach services will still include welfare. This will ensure, for example, that help is delivered in accessing work retraining.

Conclusion

Combat Stress has been at the forefront of the management of veterans' mental health care during the past 90 years. It recognises the need for cutting-edge bespoke treatment interventions. It is currently implementing these interventions, including a £30 million appeal in support of its further service

developments incorporating community outreach services, which will allow enhancement of its residential treatment programmes. ■

Visit www.combatstress.org.uk for further details.

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