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Self-Referral to military mental health teams: A service evaluation

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A service evaluation of self-referral to military mental health teams

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Abstract

Background: The UK military runs a comprehensive mental health service ordinarily accessed via primary care referrals.

Aims: To evaluate the feasibility of self-referral to mental health services within a military environment.

Methods: Three pilot sites were identified; one from each service (Royal Navy, Army, Air Force). Socio-demographic information included age, rank, service and career duration. Clinical data included prior contact with general practitioner (GP), provisional diagnosis and assessment outcome.

Results: Of the 57 self-referrals, 69% (n=39) had not previously accessed primary care for their current difficulties. After their mental health assessment 47 (82%) were found to have a formal mental health problem and 41 (72%) were offered a further mental health clinician appointment. The data compared favourably with a large military mental health department that reported 87% of primary care referrals had a formal mental health condition.

Conclusions: The majority of self-referrals had formal mental health conditions for which they had not previously sought help from primary care; most were offered further clinical input. This supports the view that self-referral may be a useful option to encourage military personnel to seek professional care over and above the usual route of accessing care through their GP.

Key words: Mental Health; Self-referral; Improving Access; Military

Introduction

Serving as a member of the United Kingdom Armed Forces (UKAF) requires personnel to be sufficiently physically and psychologically fit to undertake operational deployment, which can be arduous and challenging [1]. Mental health care within the UKAF is provided by the Defence Mental Health Services (DMHS) which comprise military and civilian mental health professionals including psychiatrists, mental health nurses, psychologists and social workers, who provide mental health assessment, treatment and therapy [2]. In addition, occupational health advice is provided to the general medical community and supportive mental health interventions and guidance are provided to command when requested. The clinical service is delivered on a regional basis to all UK based service personnel from one of 16 Departments of Community Mental Health (DCMH) spread across the UK [3]. A community-based service is also provided to personnel based overseas and in operational areas.

The UKAF has been engaged in combat operations, mainly in Iraq and Afghanistan, since 2001. However the available evidence suggests that, in the main, the mental health of service personnel remains robust despite considerable challenges [1]. Despite the generally low rate of mental disorder among the wider force, an important minority of military personnel experience mental ill-health at some stage during their military career [4]. Whilst the DMHS is relatively easy to access, the available research evidence suggests that UKAF personnel report substantial levels of stigma about seeking help for their mental health difficulties and levels of both stigma and help-seeking are not dissimilar to those found in civilian settings [5, 6]. Evidence also suggests that those suffering with mental health problems, who are arguably in the

greatest need of professional help, experience the highest levels of feared stigmatisation and as a consequence may choose not to seek professional help [7]. Furthermore evidence suggests that personnel often wait until a crisis point before accessing professional support, which arguably is later than would be ideal [8].

Except on military deployments, usual military mental health practice is that access to the DMHS requires referral from a medical officer/general practitioner (GP). Medical officers assess an individual's degree of occupational fitness and assign them a fitness standard, which governs whether they can be deployed, in what capacity and what non-deployed roles they might be suitable for. For this reason, GPs require full visibility of healthcare activity and effectively act as gatekeepers controlling access to specialist mental health care. However DMHS staff are also able to recommend changes to service personnel's fitness standards. Therefore as long as GPs are kept fully informed there is no practical reason why self-referral to the DMHS should lead to personnel being inappropriately deployed or employed. Furthermore a review of National Health Service (NHS) mental health service provision recommended that improved access to mental health services could be facilitated by allowing individuals to self-refer [9]; this has now been successfully implemented within the NHS [10] and could potentially provide the UKAF with a way of improving appropriate uptake of mental health care services.

In a mental health context, self-referral is a relatively new initiative. However within the NHS physiotherapists have accepted self-referrals for some time and the available evidence suggests that access through self-referral generates clinical workloads not dissimilar to those derived from third party referral. Furthermore self-referrers were

likely to have experienced their conditions for longer [11] suggesting that this route may be preferable to accessing care via a GP for those with chronic conditions. Self-referral for mental healthcare was part of the Improving Access to Psychological Therapies (IAPT) pilot in the Newham area of Greater London and Doncaster [10]. In comparison to GP referrals, self-referred IAPT cases were similar in symptom severity, though once again self-referrers had endured their mental ill-health symptoms for longer. It has been estimated that around only 30% of those with psychological problems choose to consult their GPs, often for a variety of reasons [12]. Self-referral may thus, if structured properly, improve access for those with mental health problems who would not otherwise seek help [13].

As stated above, usual UKAF practice is to allow access to mental health care only via GPs; however there are examples of self–referral being utilised within a military context. Since 2003, deployed mental health professionals, operating as a Field Mental Health Team (FMHT), in Iraq and Afghanistan have allowed self-referral. In the UK, the Veterans and Reserves Mental Health Programme (VRMHP) also accepts self-referral, offering demobilised reserves with operationally-related mental health problem access to military mental health care. A published service evaluation suggested that 78% of VRMHP attendees self-referred [14].

Informed by innovations within the NHS and examples of self-referral being implemented in some military environments, a decision was taken to evaluate the impact of self-referrals by offering this referral option at three pilot sites within DMHS. This paper examines the outcome of the service evaluation.

Methods

The population consisted of all Royal Navy (RN), Army, or Royal Air Force (RAF) personnel who opted to access mental health assessment by self-referring to one of three departments of community mental health (DCMH) pilot sites between 2011 and 2013. Personnel were not eligible to self-refer if they were due to deploy or go on military exercise within the forthcoming six weeks, which was a caveat for gaining permission to carry out the evaluation. The self-referral option was advertised using a poster campaign and through other standard mechanisms for dissemination of information within military units in the DCMH catchment area (e.g. unit routine orders). The content of the posters was standardised, but included service-specific contact numbers and media images. Although the gatekeeping for this service was carried out by the mental health professional who received the initial phone call, all participants were made aware that their details and a written report would be communicated with their GP after the initial assessment.

In order to assess whether the pilot could be deemed a success the following standards for the service evaluation were agreed as indicating an outcome suggesting that self-referral could be applied more widely within DMHS:

1. Promote access to care: The majority of personnel self-referring did not otherwise see their GP for a mental health problem in the immediate period prior to self-referral (>50%)

2. Detect mental disorder: The majority of self-referring personnel would be identified as having a mental disorder (>50%)

3.   Provide mental health care: The majority of personnel self-referring would be suitable for acceptance onto a clinician caseload (>50%)

Socio-demographic information was recorded including, age, rank, service (RN, Army and RAF) and length of service. Information about gender was unavailable. Clinical data included details of any previous contact with GP for mental health problems, provisional diagnosis and assessment outcome.

The data was analysed using the Statistical Package for Social Sciences (SPSS) Version 21 statistical software package [15]. Descriptive statistics were used to examine the pilot outcomes against the standards set for the service evaluation. Where there were sufficient numbers, additional analysis of categorical data used the Chi-squared test and comparison of means derived from continuous data was conducted using the Kruskal-Wallis test for non-parametric data [16]. Statistical significance was $p=<0.05$.

It is important to note that this paper reports the findings from a service evaluation which was carried out as a trial of process, not as a research study. The audit was endorsed by the Defence Medical Service's Mental Health Faculty (09/03/2011). The decision was made to publish the findings as a way to ensure that knowledge gained from the evaluation is more widely disseminated.

Results

During the evaluation period 62 personnel self-referred, of whom a complete data set was available for 57. On examining the socio-demographic characteristics neither the

age of participants nor the length of service differed significantly between sites. The majority of personnel, across the sites, were aged over 25. Rank differed significantly between sites. (p = <0.001) in that substantially greater numbers of senior ranks and officers referred themselves to the RN pilot site, while Army self-referrals were predominantly junior ranks with a more representative distribution of ranks at the RAF site (Table 1).

The main results from the service evaluation can be categorised according to each of the audit standards. Standard 1 focussed upon promoting access to care and identified that 68% (n=39/57) of personnel had not accessed their GP for the presenting mental health problem before self-referral and there were no significant differences between the pilot sites in this regard. Standard 2 concerned the detection of mental disorder and indicated that 82% (47) of self-referrals were deemed to have a formal mental health diagnosis. In addition, the majority reported no risk of harm to self or others (81%, 46). A breakdown of the data set by diagnosis is in Table 2. The pilot data set was compared to referrals at a large military DCMH for differences in the number of people assessed as having a formal mental health problem (Table 2). There was no statistically significant difference between routine referrals and the self-referral pilot sites. Standard 3 was concerned with the provision of mental health care. 72% (41) were offered a further appointment with a mental health clinician (Table 4). There were no significant differences in the numbers offered further care between the three pilot sites.

Discussion

This study found that prior to self-referral to military mental health services the majority of armed forces personnel had not sought a mental health referral from their GP. Most self-referrals were deemed to have a formal mental health diagnosis and offered further clinical review. The self-referral pilot was a success according to the outcome standards for the project suggesting it would be suitable for wider use within the UKAF. Interestingly, for reasons that are not clear, most of those who used the self-referral process were aged over 25, which contrasts with the younger age of most armed forces personnel.

The main limitations to this study were the small sample size and that the self-referral sites chosen were not randomised, which reduces the extent to which the results can be generalised and the evidence in favour of a military wide self-referrals scheme [17]. We also did not assess whether, had self-referral not been available, the 57 individuals who used the service would have sought help from their GP. However, personnel from all three services, within the DCMH catchment areas, were able to access the pilot services and there were no restrictions, other than not being imminently due to deploy or go on to an exercise, in who could use the self-referral route. This means that each person who self-referred is likely to have received a similar level of care to any other military mental health patient.

The findings of this service evaluation are consistent with other reports, which have found self-referral to be a viable alternative to standard GP referral. A US military study suggested that self-referral was an effective way of encouraging access for personnel with symptoms suggestive of poorer mental health who had not previously sought care [18]. A US civilian study observed that GPs had increasingly developed a

gatekeeper role, but when those who had sought GP referral were compared with self-referred people, the latter were more likely to receive specialist care sooner. This led to the establishment of a 'drop-in' system at the mental health centre that participated in the study [19].

Offering self-referral may form part of a stigma-reduction or improving access strategy to assist those who otherwise may not request a mental health referral from their GP [13]. The current service evaluation supports this contention, but although the majority of patients had not opted to access their GP we were unable to determine why they chose the self-referral route. However, the diagnostic profile of the pilot sample was different to that seen among routine referrals: 16% of self-referrals were found to have PTSD and 9% depression. This is almost the reverse of what is seen via a traditional referral route across DMHS, where 6% of referrals are for PTSD and 19% for depression [20]. This suggests that self-referral may be a preferable route for people with some conditions although this study was not able to determine why this might be the case.

Whilst this data supports the wider use of self-referral it is notable that Athanasiades *et al.* (21) suggested that personnel who have had a positive experience of self-referral to mental health service providers and communicate their experiences to others may affect the uptake of the service by colleagues. There is however some evidence from civilian settings that suggests that self-referral may not always lead to patients feeling more involved and empowered, which suggests that the perception of the service, if rolled out in the UKAF, should be monitored carefully, particularly during the early

stages, to ensure the service does indeed meet the needs of those who might use it [22].

Finally, before the pilot commenced the UKAF medical services expressed concern that self-referral could lead to a surge in inappropriate referrals that would place an unnecessary burden upon the DMHS. However previous assessments of self-referral within civilian psychological therapy services and self-management workshops suggested that this may not be the case [10, 23]. Indeed the same was true for non-mental health services, for example physiotherapy, where self-referral did not result in a referral surge but it did promote greater engagement and less non-attended appointments [11]. Within this study no differences were identified between inappropriate referrals in the pilot sites compared to the wider UKAF and the majority of those using the pilot service were indeed found to have a diagnosable and treatable mental health condition.

To conclude, this service evaluation supports the concept of self-referral in UKAF mental health services. It is already common practice in non-UK military settings and in some deployed UKAF locations.   It seems unlikely that the widespread introduction of self-referral will result in either a referral surge or substantial numbers of inappropriate referrals. It may however improve access to care and promote a better patient experience. For these reasons policy makers may wish to consider offering self-referral to mental health services to UKAF personnel.

Key Points

- The majority of military personnel who self-referred had not previously accessed their general practitioner.

- The majority of people who self-referred were identified as having a formal mental health problem.

- The majority of people who self-referred were offered a further appointment with a mental health worker.

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Table 1: Socio-Demographic Data

Characteristic	Army site n (%)	RN site n (%)	RAF site n (%)	All sites n (%)
Age <25	11 (50)	3 (18)	5 (28)	19 (33)
Age ≥25	11 (50)	14 (82)	13 (72)	38 (67)
Officers	0 (0)	7 (41)	1 (6)	8 (14)
Senior NCO	2 (9)	6 (35)	5 (27)	13 (23)
Junior ranks	20 (91)	7 (41)	12 (66)	36 (63)
Army	22 (100)	4 (24)	0 (0)	26 (46)
RN	0 (0)	13 (77)	0 (0)	13 (23)
RAF	0 (0)	0 (0)	18 (100)	18 (32)
Mean length of employment (years)	7.5	12.1	11.3	10.1

Table 2: Diagnosis

Diagnosis	Army site n (%)	RN site n (%)	RAF site n (%)	All sites n (%)
Adjustment disorder	7 (32)	8 (47)	6 (33)	21 (37)
No disorder	4 (18)	0 (0)	6 (33)	10 (18)
PTSD	3 (14)	6 (35)	0 (0)	9 (16)
Other	6 (27)	0 (0)	3 (17)	9 (16)
Depression	1 (5)	2 (12)	2 (11)	5 (9)
Substance misuse	0 (0)	1 (6)	1 (6)	2 (4)
Anxiety disorder	1 (5)	0 (0)	0 (0)	1 (2)
Total	**22**	**17**	**18**	**57**

Table 3: Diagnosis compared to routine referrals at a large DCMH

Diagnosis	Pilot n (%)	DCMH n (%)	X^2 = d.f. $p=$
No assigned diagnosis	10 (18)	50 (13)	0.92,1 , *ns*
Diagnosis assigned	47 (83)	338 (87)	

Table 4: Assessment outcome

Outcome	Army site n (%)	Navy site n (%)	RAF site n (%)	All sites n (%)
Further care	16 (73)	12 (71)	13 (72)	41 (72)
Discharged	2 (9)	2 (12)	5 (28)	9 (16)
*Signposted	4 (18)	3 (18)	0 (0)	7 (12)

*Personnel who were directed to seek help from other sources.