IMEG

The Independent Medical Expert Group

Report and recommendations on medical and scientific aspects of the Armed Forces Compensation Scheme

17 May 2013

Topic 1 – Mental Health

Background to this Report

1. The Boyce Review (1) identified mental health disorders as a topic for early attention by the IMEG. The scope is wide and issues are complex. Because of time constraints, the first IMEG report (2011) focussed on issues for inclusion in new legislation from February 2011. In particular it addressed the impact of attributable mental health disorders on capacity for civilian employability, paid as GIP.

2. Consistent equitable compensation awards for mental health disorders present major challenges. These include the subjective nature of these disorders and their multifactorial origins. Despite the availability of effective therapeutic interventions, perceived stigma can delay access and engagement (2) and, in the military context, there is risk of over diagnosis of PTSD. The UK Armed Forces are a selected population with similar mental health disorders to those in the equivalent civilian population, the exception being low rates in the Armed Forces of severe enduring psychotic illness compared to civilians. Military personnel are at higher risk of traumatic psychological problems due to single events or cumulative experience. As in other countries, because of the "healthy worker effect ", rates of suicide amongst members of the UK armed forces are generally lower than in the general population (3) although a recent study which confirmed this general finding found an increased risk in young men aged less than 20 years (4). There has been little research into suicide risk in those who have left UK military service. One cohort study (5) which linked national databases of discharged personnel and suicide, including undetermined deaths, over the period 1996-2005 found that, compared with the general and serving age-specific populations, the risk of suicide, although no greater than in the general population overall was raised in young males (< 24 years) who had served in the army, had short service and low rank. The group with highest risk also had lowest rates of contact with mental health specialists. Mental health problems linked to family relationship problems, debt, and "stress in the workplace" also occur (6). PTSD as a single diagnosis is uncommon. In about 80% of cases it occurs in association with co-morbid conditions of one or more of anxiety, depression, substance misuse. Alcohol is part of military tradition, playing an important part in bonding and group cohesion but, as in wider UK society, alcohol misuse amongst younger personnel (especially women), is an important issue. Research from King's Centre for Military Health Research, London has shown that up to age 35 years, alcohol misuse rates, including binge drinking, in both men and women, are about twice as high in military personnel (13%) compared with the wider general UK population. Alcohol misuse may pre-date or accompany other diagnoses including PTSD (7) and mild traumatic brain injury (8). The relation between mental health symptoms and illness and contact with the criminal justice system, including in the military community, is a subject of frequent media and political comment. Research in UK personnel is limited, but a recent data linkage study of personnel deployed to Iraq and Afghanistan described offending during the life time of participants and assessed the risk factors for violent offending. Violent offending was the most prevalent type and was associated with pre military violence and low military rank. Deployment itself was not independently associated with violent offending but being in a combat role, having increased exposure to traumatic events, post deployment alcohol misuse, having PTSD and high levels of self-reported aggressive behaviour were positively associated (9).

3. The distinction of symptoms from a discrete mental health disorder can be difficult. A mental health disorder is characterised by symptoms which cause functional impairment, interfering

with family and social relationships, impairing performance at work and often associated with alcohol or drug misuse and which meet formal criteria described in one of the classification systems. Holding a combat role is associated with an increased prevalence of PTSD (10). While following the psychological and physical trauma of warfare many people report symptoms such as distressing memories and nightmares. In the majority of cases, these do not require treatment and are not, and do not become, a discrete disorder or cause functional impairment.

4. While serving, stigma, concerns about adverse effects on career progression and standing amongst peers, can make military personnel reluctant to seek help, especially for mental health disorders. Further delay can also occur after service, because military personnel may be wary of civilian professionals, considering them too unfamiliar with military experiences to be of help. This delay in presentation is not unique to military populations and should be distinguished from the less common delayed onset of disorders (11). It is to be hoped that recent anti-discrimination campaigns in civilian and military communities will help to address this. In the military context delayed onset of PTSD is an important phenomenon and may represent about 50% of all cases in military personnel (12).

5. Effective evidence-based therapeutic interventions for most common mental health disorders, including PTSD, are now available and identified in the Guidelines produced by the National Institute for Health and Care Excellence (NICE). These can reduce symptoms and improve or restore function, especially if the disorder has not become long-standing. This should be the case for most AFCS claims at this time, as the Scheme is restricted to injuries and disorders due to service on or after 6 April 2005. Since then, both UK military and civilian health policies have prioritised mental health awareness, resilience building, tackling cultural barriers, and encouraging military personnel to access and use mental health services. AFCS provisions should support this. The AFCS applies to both regular and reservist personnel and criteria for attribution and assessment of severity are the same. There is no evidence of an increase in common mental health problems amongst UK regular forces who have deployed to Iraq or Afghanistan as compared with non-deployed personnel. For regulars there is a significant effect of deployment on alcohol misuse and amongst reservists who served in Iraq or Afghanistan there is an increased rate of PTSD symptoms. The presence of PTSD symptoms amongst deployed reservists was 5% which contrasts with the low rate of 1.8% amongst non-deployed reservists (13). Support for and from the family at home is increasingly recognised as an important factor in ensuring the mental well-being of personnel (14).

AFCS current approach

6. As physical injury and disorders nearly always have a psychological impact, awards for all the descriptors across the tariff tables take account of mental health symptoms, where diagnostic criteria for a specific disorder are not wholly met. AFCS stand-alone awards for mental health disorders do not depend on meeting specific diagnoses such that, for example, PTSD is inherently worth neither more nor less than anxiety disorder. Rather, the legislation considers them both as discrete diagnosable disorders leading to varying levels and durations of functional compromise. The legislation also provides that awards are given for diagnoses made by a “relevant accredited medical specialist” who confirms that the criteria for a mental health disorder, included in the ICD 10 or Diagnostic and Statistical Manual (DSM) IV classifications, are met. Values of award depend on the associated severity. This is expressed in terms of “functional limitation and restriction” as defined in the legislation, (Article 5 of the 2011 Order), taking into account the duration of incapacity, actual or anticipated. As the GIP element of the AFCS award addresses limitations in civilian employability, functional limitation and restriction is in the context of civilian employment.

7. Following the first IMEG report (2011) Table 3 now reads:

Mental disorder, which has caused or is expected to cause, functional limitation and restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.	Level 14
Mental disorder, which has caused, or is expected to cause, functional limitation and restriction at 26 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 2 years.	Level 13
Mental disorder, which has caused, or is expected to cause functional limitation and restriction at 2 years, from which the claimant has made, or is expected to make, a substantial recovery within 5 years.	Level 12
Mental disorder, causing functional limitation and restriction, which has continued, or is expected to continue for 5 years.	Level 10
Permanent mental disorder, causing moderate functional limitation and restriction.	Level 8
Permanent mental disorder causing severe functional limitation and restriction.	Level 6

Definitions

i) "Moderate" means "unable to undertake work appropriate to experience, qualifications and skills at the time of onset of the illness, but able to work regularly in a less demanding job", and

ii) "Severe" means "unable to undertake work appropriate to experience, qualifications and skills at the time of onset of the illness and, over time, able to work only in less demanding jobs".

iii) "Permanent" is defined in the legislation at Article 5 (7) (a) - Functional limitation or restriction is "permanent" where following appropriate clinical management of recommended duration, an injury has reached steady or stable state at maximum medical improvement; and no further improvement is expected.

Issues for consideration

8. The Boyce Review considered mental illness as one of its twelve core issues recommending further work on

a) the differences between mental and physical disorders and whether they were such that a wholly separate approach was appropriate. The Review report also invited consideration of

b) a tailored interim award power for mental health disorders recognising the difficulty in determining prognosis soon after diagnosis.

In addition, the first IMEG report (2011) identified further topics for this review.

c) Causation and attribution of mental health disorders. Their multifactorial aetiology makes it a challenge to identify key causal exposures and make confident attributions on the relationship between mental health disorders and military service.

d) The diagnostic process and basis of diagnosis of mental health disorders in the Scheme. This includes how best to ensure valid and reliable diagnoses and the use of evidence; who should make diagnoses and should self-report be routinely supplemented by additional evidence? An important related aspect is which classification system should be used in the Scheme?

e) How to assess severity of mental health disorders in terms of functional capacity and duration, maintaining equity for mental health disorders of different severity and in relation to awards for all other types of disorders in the Scheme. Assessment should also avoid perverse incentives and take account of the effective interventions available for common mental health problems.

9. In addition to scrutiny of the scientific literature, written and oral evidence was taken from the Royal British Legion, Combat Stress and Veterans' Aid, from the Defence consultant advisers, and from senior civilian experts working in relevant fields. This was followed by discussion of the topics with IMEG members led by Professor Alexander and the Chairman. The Chairman also met with members of the Medical Advisory Committee (MAC) of the British Members Council of the World Veterans' Federation and later the Medical Advisory Committee Mental Health Sub-group submitted a paper and policy statement in which they supported the points raised by the Royal British Legion and Combat Stress and by the Medical Director of Combat Stress. The charities were invited to raise issues, including areas for improvement in the present arrangements and asked to provide general comment on the adequacy of the Scheme. The serving and civilian experts were asked to specifically comment on the issues listed at (a) – (e) above.

a) Differences between mental and physical disorders and separate approaches

10. In their written evidence, the Royal British Legion and Combat Stress considered that the differences between physical and mental health disorders are such that there should be a separate chapter or section of the Scheme with different approaches for mental health claims. The expert witnesses were on the whole less supportive of this approach. The Legion and Combat Stress proposed some change to AFCS nomenclature and tariff table headings to make them less stigmatising, more acceptable to military personnel and veterans, e.g. Table 3 heading "Mental Disorders" should, they felt, be replaced by "Psychological Injury". They also presented a selection of published evidence on the poor employability prospects associated with mental health problems. They proposed that there should be scope for mental health awards to have variable GIPs reflecting individual circumstances and not tied to the basic award tariff level as is the case presently.

Comment

11. The War Pensions Scheme has always made awards for physical and mental disablement on the same basis and uses the same framework of assessment and award for both. This principle has not been controversial and from the outset the AFCS took a similar approach. Both in wider society, and in the armed forces community, efforts to challenge the stigma of mental health problems and encourage people to seek help early, have often stressed the similarities between mental and physical disorders. This includes the fact that, in most cases of mental health problems due to military service, effective treatment should be the norm. In a scheme covering both physical and mental health disorders, where both types of disorder often co-exist, administrative separation

could also risk inequity and undermine consistent decisions and awards. The AFCS descriptor structure acknowledges that all personal injury or illness has an emotional dimension with psychological symptoms recognised in all descriptors. It provides for a separate award if a related discrete diagnosable disorder arises, either at, or around, the time of the physical injury or later. The Scheme focuses on, and pays the highest awards for, those most seriously physically injured and disabled due to service, and current evidence is that this group is especially at risk of associated mental health problems. The Scheme must then be able to provide transparently, combined awards applicable to both physical and mental health disorders. This is most readily achieved by a unified system.

12. In terms of the proposed changes to nomenclature and tariff table headings IMEG recognises the need for the client group to be comfortable with, and have confidence in, the Scheme. However, traumatic psychological events or exposures are not the only or the most common background to attributable mental health symptoms and illness in military personnel; the proposed change in nomenclature might therefore disadvantage some personnel. Such a move would be inconsistent with wider community arrangements and could unintentionally undermine ongoing work on stigma.

13. It was suggested, a point endorsed in the MAC submission, that IMEG consider the decoupling of lump sum awards and GIP, according to individual case facts. As a public no fault, relatively high volume scheme, a key aim in AFCS is to provide equitable decisions and support a model of disability, which avoids perverse incentives and enables individuals to move on with their lives. In our society, that includes, wherever possible, support into paid work. That aim is best met, is most transparent and is easiest to understand, where there is a single rules-based assessment system applicable to all disorders and injuries. This is also administratively most convenient and simple. Most claimants in the Scheme are young, and with evidence confirming expected recovery given appropriate clinical intervention, it would be unhelpful to the great majority of claimants to suggest anything other than an anticipated good outcome with return to normal life. This view was supported by the civilian and military experts consulted. AFCS applies only to service related injury caused on or after 6 April 2005. From the beginning of AFCS, the approach of the military community and wider society has been to prevent disorders becoming chronic and resistant to effective interventions. The hope and increasing reality is that for most service-attributable mental health disorders, function can be improved. To move to decoupling lump sum and GIP could act as a disincentive to engage with treatment and rehabilitation. As set out in the legislation (Article 5 of the 2011 Order), AFCS descriptors and awards aim to reflect the state of maximum medical improvement reached following the provision of best practice treatment. For the less common cases which, over time, fail to improve, the revised tariff (May 2011) is appropriate. IMEG received evidence from the Legion and Combat Stress on the negative impact of mental health problems on employability, and in the current tariff the more disabling disorders are paid a lump sum and GIP, reflecting the impact on civilian employability. The published evidence confirms that employment difficulties are a particular issue with severe enduring psychotic illness which is uncommon in the military population and unlikely, on the balance of probabilities, to be accepted as attributable to service. A fundamental principle of the AFCS is to consider the impact of the attributable injury or disorder on function in the context of paid civilian employment. The first IMEG report (2011) specifically looked at the impact of mental health problems on capacity for work and recommended that for the most severe mental health problems, GIP of 75% was appropriate. It was also suggested in evidence that employers might be given financial incentives to employ people with mental health difficulties. This is not a matter for IMEG, and itself raises potential stigma and discrimination issues. IMEG considers topics and issues from many perspectives but its recommendations to minister must be based on available peer-reviewed evidence.

Recommendation

14. Whilst appreciating the reasons for the proposal, IMEG considers that the Scheme should not develop a separate approach or chapter applicable to claims for mental health disorders or change the current nomenclature and tariff headings. The focus of AFCS is on functional compromise for civilian employment, paid as GIP. This applies equally to physical and mental attributable injury and disorder. There are differences between physical and mental health disorders: diagnosis of physical disorders is more objective, and adjudication guidance should be produced for Scheme administrators and medical advisers, stressing differences relevant to compensation determination. IMEG recommends that the present structure and direct relation between lump sum tariff awards and GIP for all injuries and disorders should be maintained and its application to mental health disorders monitored.

b) Specific interim award provision for mental health disorders

Comment

15. AFCS legislation provides that reference to duration of effects in a mental health descriptor means from the date the claimant first sought medical advice for the disorder. Recognising that it can be difficult to estimate prognosis soon after diagnosis of a mental health problem, the Boyce Review raised the possibility of a specific AFCS mental health interim award. Many AFCS claims for mental health disorders are made before an adequate course of best practice treatment has been delivered. Expert opinion indicates that it is reasonable to assume that maximum medical improvement for the types of common mental health disorder likely to be accepted in the Scheme will be achieved after at most 18 months of evidence-based treatment delivered in sessions of appropriate duration and frequency. Article 52 of the 2011 Order of the Scheme includes a general provision for an interim award for a period of effect, specified in the individual award notification. Interim awards are used where prognosis is difficult to determine. The initial interim award period must be a maximum of two years from the date on which an initial award was made. An award will normally be made final by that date. In exceptional cases, if the prognosis remains uncertain at the end of the initial two year period, the interim award can be further extended for a total of four years from the date of the first interim award. It is expected that use of this further extension will be rare. The time intervals were chosen as consistent with clinical progress for most physical and mental health disorders, subject to best practice treatment, in the general population. In most cases at two years, prognosis can reasonably be predicted even if not actually reached in every case. Interim awards carry no appeal rights, so Article 52 time limits aim also to produce justice and fairness for claimants. In order that the provision should not act as a disincentive for claimants to engage with treatment, believing that, if they were improved at the end of treatment, they might be due a lower award, the legislation provides that where the final decision is to award a higher value tariff than was originally the case, the difference between the amounts paid as interim and final awards, is due. Where the final decision is that a lower value tariff is appropriate, then no additional award is paid, but no money is recoverable from the interim award.

Recommendation

16. There is no need for the Scheme to introduce a tailored interim award provision for mental

health disorders where, at the outset, outcome is uncertain. The use of the Scheme's existing interim award provision should be sufficient. The provision also includes protection for the initial interim award where treatment leads to improved function. For most cases claiming under AFCS where discrete diagnoses, including PTSD, are made, the expectation should be of evidence-based treatment restoring useful function. As for all other injuries and disorders in the Scheme, awards should take into account the phasic nature of some disorders and maximum medical improvement.

c) Attribution

Comment

17. As with most occupational personal injury schemes and civil damages, awards under the AFCS depend on establishing a causal link between the claimed injury/disorder and some aspect of service. The AFCS is an individual jurisdiction with awards paid where attribution to service on or after 6 April 2005 can be established, on the balance of probabilities. To do this requires collection and analysis of evidence on the case facts, service and medical, knowledge of contemporary medical understanding of the causes of the disorder and, finally, a judgement as to whether in the particular case, service factors, events, exposures or circumstances are more likely than not to have caused the disorder to develop or worsen. The MAC mental health submission raises the issue of judgements by lay assessors. Decisions in the AFCS are made by lay staff. That is also true of the War Pensions Scheme. However for War Pensions, the law provides that administrative staff act on certificates on attribution and assessment from the Scheme medical advisers. For AFCS, administrators have the option to seek medical advice in any case. Following the Boyce review, as Departmental policy, there are a number of situations where to ensure robust defensible decisions, advice on the collection and interpretation of evidence is routinely obtained from the Scheme medical advisers. Scheme medical advisers are appointed following a successful career in a clinical or other relevant medical speciality and undertake further training in medico-legal determination, the Scheme legislation and Departmental policy. It is of note that while sharing the underlying need to establish a causal link to service, decisions in US Department of Veterans' Affairs (DVA) disability benefits are not informed by medical advice to the decision-maker, and for direct service connection disability benefits to be paid, the following applies:

> "To establish a scientifically robust causal connection between a physical or mental health disorder and alleged environmental or occupational exposure requires four main types of evidence.
>
> - Evidence of a generally accepted scientific association i.e. the exposure involved is generally accepted as associated with the claimed illness or injury.
>
> - In an armed forces context the relevant exposure/circumstance should be during and due to military service.
>
> - The illness or injury must have had its onset or worsening after the relevant exposure or event.
>
> - To show that the service exposure was at least as likely as not to have been the specific cause there should be evidence that the service related exposure was high or prolonged compared to other possible causes" (15).

18. Attribution, and application of such a template, is probably the most difficult single aspect of the determination of AFCS compensation for mental health disorders. Problems arise because of the very nature of mental health symptoms and illness. Major challenges include the reliance on self-report and lack of objectively verifiable features. In contrast to physical injury and disorders, their disabling effects tend to permeate many aspects of a person's identity, behaviour and attitudes. Emotional symptoms occur in normal people and cover a wide continuum, ranging from normal reactions to pathological states. This means that diagnosable mental health disorders are rarely categorical e.g. compared to many physical disorders where a peptic ulcer or cancer is either present or absent. Making a firm diagnosis must take account of personality traits, the phasic nature of symptoms and the person's normal state. Diagnosable mental health problems should be thought of not as "all or none" but as "more or less" disorders.

19. In addition, mental health disorders are always multifactorial, shaped by a person's constitution, early life, family values and experiences, intelligence, education, as well as the wider societal and cultural factors. The evidence is that for most people who serve, including those from challenging backgrounds, being in the military has a positive effect on their life trajectory. There are risks associated with the recent and current focus on mental health symptoms and illness especially in the military compensation and treatment context. War changes people, just as does any major life experience (16). For most people, combat is distressing, especially in the short term, but adverse reactions, including distress, naturally reduce over time. There is also evidence, including in the context of the recent and current conflicts, that, despite their pain and suffering, many individuals come through traumatic events the stronger (17) with co-existing positive and negative consequences.

20. Not everyone who goes to war becomes ill and there is no evidence that any specific stressful event or situation is sufficient in itself to produce any identifiable post traumatic mental health disorder. Factors classified as pre-disposing, precipitating and maintaining have been identified which contribute to the likelihood of an individual developing or continuing to suffer a mental health disorder post–trauma (18). We note the novel suggestion of the MAC Mental Health Sub-group that, in light of the multifactorial nature of mental health diagnoses, for attribution and award, a formula might be devised. The relative weights of the various factors has not been fully explored in the published peer-reviewed literature and such an approach is likely to be complex and at least initially, controversial. None of these factors has a strong predictive power (18). The Scheme takes the view, as do the civil courts, that while a pre-disposition e.g. dysfunctional childhood or schooling may increase the risk of developing a discrete disorder post-trauma, unless the diagnosis were made in childhood, rejection of a claimed disorder as unrelated to service because it had pre-service origins is rarely appropriate. In general, while accepting that mental health disorders are always multifactorial if, on the balance of probabilities, service is the predominant cause of an injury, the claim is for acceptance. Where a disorder is not attributable to service, but certain criteria are met, worsening by service will be considered.

d) Robust accurate diagnosis

Comment

21. If attribution of disorders is to be decided accurately the disorder must be present and correctly diagnosed. The experts consulted agree that reliability of certain psychiatric diagnoses (especially non-psychotic ones) can be poor. This is partly attributable to such factors as the experience and background of the clinicians, which classification system is used, the phasic nature of

most psychological symptoms and the quality of psychometric measures. There are challenges in diagnosis of mental health problems, with much scope for different diagnoses on the same facts and, in military personnel, over the diagnosis of PTSD. While the AFCS tariff descriptors do not depend on specific diagnoses but duration and severity of functional compromise, diagnostic uncertainty or inaccuracy can lead to inappropriate or ineffectual treatment, and undermine AFCS equity and consistency. To improve diagnostic accuracy, three particular issues were explored:

a) What evidence should be relied upon to make diagnoses? Psychiatric non-organic diagnoses rarely have objectively verifiable correlates and are heavily dependent on self-report of symptoms. For AFCS claims, questions that arise include, is the claimant's recollection or perspective, sufficient, or should confirmatory evidence be obtained routinely? If so, how and from whom?

b) Should there be an AFCS mandatory diagnostic classification? There are two international classification systems, ICD 10 and DSM 1V (19)(20). These list different disorders and, in some cases, have different diagnostic criteria for the same condition. New editions of both ICD and DSM classifications are in preparation with publication of DSM V expected by mid 2013. DSM IV was published in 1994 and preparation of a new edition of the classification, reflecting research and clinical developments, has been a major task over the last five years. While there will be no overall increase in numbers of disorders, DSM V is likely to group disorders differently and may recognise different diagnostic criteria .e.g. for PTSD. Work on ICD 11 is less advanced and no publication date has yet been set. In UK clinical practice, ICD 10 is more usual, while in other countries, especially the USA and for research, DSM is the norm. In UK military practice there is currently no mandatory classification; accredited clinicians use both systems.

c) Who should make the diagnosis? Should they belong to a particular profession and have specified expertise and experience, including knowledge of military life?

22. In terms of evidence to inform claims determination and the role of self-report, the experts confirmed that some patients, both civilian and military, under-report while others may exaggerate or occasionally feign symptoms and effects. There is always opportunity for innocent misinterpretation and misattribution of symptoms to events and circumstances; because symptoms follow an event, they are attributed to it. Client permission to access clinical records and reports from clinicians is obtained as part of the AFCS claims process and decisions in the Scheme are firmly based on the case medical and service facts, contemporary medical understanding of the causes of disorders and the relevant law. The most robust case formulations in AFCS will be multidisciplinary and multidimensional informed by documented information from military and medical records as well as by partners and families. It is vital to have a full clinical, social, occupational and family history, covering personal habits, consumption of alcohol etc. using a through life approach. This will identify pre-service discrete problems as well as predisposing, precipitating and maintaining factors. Corroborative evidence on events, circumstances or changes in behaviour and their time course from partners, family and work colleagues may be useful but in the AFCS context can be administratively complex and raises confidentiality issues. Service medical and personnel records as well as documentation of claimed service theatres, accidents, incidents and exposures should be consulted.

Recommendation

23. Self-report will continue to be the mainstay of clinical history in the Scheme As

recommended best practice, examinations should routinely include family history and adopt a through life approach to clinical and social history, starting with childhood, recognising the possibility of under-reporting and elaboration. Clinicians providing expert opinion should routinely have access to service medical and personnel records and to documented exposures, accidents etc. Advice from significant others can be helpful in certain situations but issues of confidentiality mean that this approach cannot be recommended as mandatory or routine.

Should there be an AFCS mandatory diagnostic classification?

24. Turning to the different classifications and disorder criteria, one option would be for the scheme to mandate diagnoses based on one or other classification system. In UK routine NHS clinical practice, ICD 10 is the required classification, while international research and clinical practice in the USA favours the DSM which requires a more specific symptom profile to be met. For the military no fault compensation schemes, clinical case notes and case formulation, presented by claimants, use both systems and so to require ICD diagnoses for AFCS, certainly in the short term, is likely to require many more expert reports specifically for compensation purposes. This is administratively complex, delays decisions and increases costs as well as causing inconvenience and potential distress for claimants.

Recommendation

25. Because of these uncertainties, adoption of ICD as standard for the Scheme cannot be recommended at this time. Some clinicians already provide ICD based opinions, and we would encourage a continuing move in that direction so that within five years' time that practice will become universal. It is recommended that a short guide for decision makers and Agency medical advisers is produced setting out, the major differences between the two classifications.

Who should make the diagnosis?

26. With the exception of PTSD, (where the aetiology is embedded in the diagnostic criteria), and Adjustment Disorder, accurate attribution for mental health disorders depends first on sound diagnoses. Many AFCS claims are made in service where, as in the NHS, a multi-disciplinary approach to mental health care and support is used. In terms of who should make diagnoses for AFCS, reports should be from a consultant psychiatrist or consultant clinical psychologist. Treating clinicians should provide factual clinical evidence with identification of all causal factors rather than an opinion on attribution. It is the role of SPVA staffs (administrative and medical) to collect and analyse evidence and decide on attribution. It was suggested in evidence by some of the experts that where lower value awards are being considered, other health professionals, including senior nurse practitioners might be appropriate. This proposal was rejected by IMEG as, in the AFCS context, experience and consistency in approaches to diagnosis and assessment are required. Whether or not advice on diagnoses and clinical course should be restricted to clinicians of consultant grade with military or trauma experience was debated. While some veterans reject civilian health professionals, others are equally anxious to cast off all military connection. As resources allow, there perhaps should be a degree of client choice. In earlier generations the links between civilian health professionals and the military were much stronger. Until the end of National Service in 1960, most GPs would have themselves served, or at least, had close contact with the military through family members. During the last few years, efforts to address this have

begun with explicit reference to services for veterans in the NHS Operating Frameworks and in cross-government strategies such as on suicide prevention (21). Health and social care issues are the responsibility of the devolved administrations and suicide strategies have now been established throughout the UK with strong links and a co-ordinated approach nationwide. Although the evidence is that suicide rates are raised in young veterans with short service and discharged from the army, ex- military personnel are not a key high risk group for suicide. They merit a tailored approach to suicide prevention because of the tendency to delay help seeking. The current military and NHS activity in relation to the Murrison recommendations (22) and implementation of the Military Covenant (23) includes an e–learning package on Veterans' health sponsored by the Royal College of General Practitioners, and a continuing professional development package on military and veterans' mental health was recently launched by the Royal College of Psychiatrists. The NHS England Armed Forces Networks and equivalents in the devolved administrations provide routine contact and exchange of views and experiences across the military and civilian communities and regionally based multi-professional Veterans' Mental Health Networks are being set up around the UK. Major aims, in addition to provision of best practice, culturally sensitive and holistic veterans' services include effective partnership working with other public, private and charitable support agencies, avoidance of duplication, awareness raising, and education for civilian primary care health and other support staffs. The recent community based veterans' mental health pilots (24) had variously a lead therapist with military or civilian background. It became clear from the pilots early on that the key issue for clients was less that treating clinicians should have direct military experience, but more that, they should have empathy, interest and willingness to learn and respect military life and its challenges.

27. Looking to the future there was general agreement about possible establishment of a national panel of clinical experts to provide robust diagnosis and assessment of mental health disorders for compensation. While at present, many claimants are still serving and in contact with Defence healthcare services, in the longer term, as more AFCS claims are made post-service, such a group may be particularly useful. This pattern means that, with consent, service clinical records are available to inform compensation decisions. Evidence generated over time in a clinical setting, providing information on clinical pattern and effects on function, rather than one–off examination specifically for compensation is especially helpful in reaching accurate, reliable, full and final decisions.

Recommendation

28. It is recommended that claim determinations should be informed by evidence-based opinion from established specialist clinicians, clinical psychologists or psychiatrists at consultant grade, with experience of trauma-related problems and ideally management of military cases. Civilian experts with appropriate expertise must be aware and respectful of military culture, values, needs and lifestyle. At present most claimants are still serving and under the care of Defence Medical Services. In time, and as the proportion of post-service claims increases, the feasibility of setting up a regionally based national panel of clinical experts, civilian and military, to provide accurate diagnoses and assessment for the Scheme, should be explored. Where a special examination is required, consideration should be given to introducing client choice in terms of consultant background. In addition to a medico-legal function, such a group with national status but based throughout the UK, could play a major role in health professional education.

e) Assessment

29. Compensation decisions in AFCS should provide consistent and equitable awards both

within the tariff award tables and category of injury, and across the range of injuries and illnesses, and should reflect the principle that the more severe the disorder, the higher the award. There is no international consensus on the most effective method of assessment of severity for non-psychotic mental health problems, either in clinical terms or therapeutic outcomes or determination of compensation.

Recommendation

30. To support consistent equitable awards, an assessment protocol for mental health problems should be drawn up. As discussed in the Boyce Review report, in the longer term the protocol might also be applicable in other circumstances, such as for social security benefit determination. The resultant single multipurpose report would be less disruptive to claimants as well as being more consistent, efficient and cost effective. To produce a robust instrument will require considerable investment of time, effort and expertise and input from a range of experts and stakeholders. Assessment of severity of mental health disorders for AFCS should focus on function, as reported by the claimant and ideally confirmed by other evidence. For a full and final award the aim is to take account of the disabling effects of the accepted injury or disorder and the occurrence of any co-morbid or secondary disorder. It also assumes access to appropriate clinical management over a life time. Importantly for attributable disorders, assessment should aim to reflect the phasic nature of the disorder as opposed to a snap-shot at a particular time. In addition to the measures discussed above in relation to more valid and reliable diagnoses, and confirmation of claimant evidence, the following are **recommended**:

i) AFCS case assessment for mental health disorders should routinely include information on clinical management and treatment received. This might involve completion of a simple form by the treating clinician, covering the dates, nature and duration of treatment received and outcome, and the experience and expertise of the clinician.

ii) Consideration should be given to the use of a limited battery of standardized psychometric measures of functional capacity particularly to judge progress over time. There are a large number of available tests but those selected should be standardised, valid and reliable

Other Issues

A. Delayed onset and delayed presentation

31. The AFCS has normal time limits for claiming. Mental health problems in veterans, particularly in earlier years, may be first diagnosed sometime after service termination. While this pattern may still prevail, for the future, awareness raising and campaigns to reduce stigma will hopefully reduce delay in seeking help amongst AFCS clients. There is a special AFCS provision for physical and mental health disorders with delayed onset or, more commonly, delayed presentation. Article 3(b) and (c) of the 2011 Order provides that the definition of “late onset illness” includes:

a) a mental health disorder which is capable of being caused by an incident occurring seven or more years before the onset of the illness; or

b) a mental health disorder capable of being caused by an incident occurring less than seven years before the date of onset of the illness, which disorder is capable of causing the

person suffering from it to be unable to seek medical help for the disorder within seven years of the date of onset of the illness. The legislation also provides that claims for injury benefit for late onset illness should be made within three years of the day the late onset illness was first diagnosed. In such cases, at present, diagnosis of a mental health disorder should be by a relevant accredited medical specialist.

B. Mild traumatic brain injury (mTBI)

32. To make a diagnosis of concussion or mTBI Headquarters Surgeon General uses a definition similar to that recommended by WHO and the US military. All three of the following criteria must be met:

a) a history of related head injury or involvement in a blast

b) a Glasgow Coma Score (GCS) no lower than 13 at 30 minutes post – injury. The totally responsive patient scores 15/15. The GCS is an internationally accepted grading scale to assess the level of consciousness. It records the patient's response to graded stimuli of eye opening, motor response and verbal response: all four limbs are observed for responses to pain (25).

c) One or more of the following:

i) Alteration of consciousness (AOC)/mental state – this may present as a variety of transient physical, cognitive or emotional symptoms. Commonly this will include confusion, disorientation, feeling or looking dazed and difficulty concentrating.

ii) Loss of consciousness (LOC) – for no more than 30 minutes duration post-injury.

iii) Post traumatic amnesia (PTA) - for no more than 24 hours duration post-injury.

iv) Transient neurological abnormalities – such as focal signs or seizures. For a diagnosis of concussion or mTBI, symptoms must be specifically related to a precipitating event which involves physical or blast trauma to the head and not to drugs, alcohol, medications, other illness or injury, psychological trauma or language difficulties.

33. Blast injury, including that to the head, has been common in the recent conflicts. Moderate and severe brain injury are clinically recognisable and absolute numbers are small. However, there are a larger number of personnel who, often, together with injury to other body parts, report closed head injury or meet the definition of concussion or mTBI. While rates of moderate and severe traumatic brain injury are comparable in US and UK troops, rates of concussion or mild brain injury, often first diagnosed at an interval from combat are much higher in US troops (26)(27). ICD 10 post concussive symptoms include headache, impaired memory, balance and concentration, tinnitus, sensitivity to light or sound and irritability, reduced tolerance to stress and alcohol, and insomnia. Soldiers experiencing post concussive symptoms also report poorer general health e.g. fatigue, being unable to work, and increased rates of psychological problems e.g. depression (28).

34. The 2004 WHO meta-analysis on outcomes of mTBI in civilians, where blast injury was not an issue, indicated good outcomes and return to function in the great majority of cases (29). This report together with observations in military populations suggest that concussion/mTBI represents a continuum of damage, with most cases resolving fully within weeks or at most three months post-incident and a smaller sub-set having a poorer prognosis, with symptoms continuing a year or more after the incident. Present evidence would continue to support holistic multidisciplinary treatment and an optimistic encouraging approach to this type of injury. However more recent neuro-imaging techniques notably Diffusion Tensor Imaging has detected in some cases of mild TBI, diffuse axonal injury (30). Even more recently, using this technique, a sub-group of mTBI patients with cognitive impairment was associated with evidence of axonal injury (31). This developing body of evidence from new neuro-imaging techniques offers the potential for early detection, characterisation and ultimately, perhaps, directing treatment of potentially more serious concussive injuries. Given the nature of the recent and current conflicts and the importance of blast incident and injury, this is a topic which in both operational capability and compensation terms may warrant future more detailed consideration by IMEG.

35. The clinical features currently accepted as comprising'Mild Traumatic Brain Injury' (mTBI), cover a wide range of clinical neurological severity. It is therefore not surprising that, within this definition, there is considerable clinical heterogeneity. Thus, there are individuals at the milder end who recover rapidly and fully, while at the other end of the range, there are individuals with persistent symptoms, and evidence of axonal injury demonstrable on brain Magnetic Resonance Imaging (MRI), together with lasting objective neuropsychological sequelae. Further research is likely to add to the findings briefly referred to above. It is possible that in due course, the broad clinical category currently referred to as mTBI will be subdivided using a combination of clinical features (including neuropsychological testing) and MRI appearances.

C. Alcohol and drug related disability

36. Alcohol and drug-related disorders are commonly present, in civilian and military populations, together with other recognised mental health disorders. Research to date on causation and attribution of alcohol use disorders including their relation to trauma and contribution to other disorders is incomplete. Alcohol-related disablement has been claimed under the War Pension Scheme for many years. War Pensions policy, supported by High court case law, has been to consider health problems (physical and mental) arising from alcohol use and misuse as fundamentally arising from a "matter of personal choice" and, as such, not compensable. In 1994 the War Pensions Scheme was amended to enshrine that policy in the law. This now excludes disablement due to injury due to the consumption of alcohol except in the very narrow circumstance where there is an accepted mental health disablement assessed at 50% or more and which has caused the pensioner to start or continue to use alcohol. This provision, now recognised as generous, was intended to cover the rare circumstance where in a conscript service a person at high risk of psychotic illness might be enlisted and become ill while serving. The AFCS has a similar provision excluding benefit for injury or worsening of an injury caused wholly or predominantly by the consumption of alcohol. Given recent and current in service health promotion, healthy life-styles and education on substance misuse as an antidote to emotional symptoms, in the case of AFCS, the exclusion is total.

D. Manual for clinicians: providing evidence in the scheme

37. Finally we **recommend** production of validated manual/guidance for clinicians providing evidence on mental health disorders in the Scheme. This would cover general aspects and challenges of mental health disorders and their attribution – diagnostic pitfalls - PTSD – through life history – at risk vulnerability, predisposing precipitating and maintaining factors - corroborative evidence – how to detect under-reporting or elaboration - how to assess severity - focus on function - best practice treatment – psychometric outcome measures.

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