IMEG

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TOPIC 7 - Mental Health Disorders

Mental health disorders and their associated health care and support among Armed Service personnel and veterans are currently the subject of considerable attention and activity. This includes the recently published review, into NHS services for the armed forces community, written by Dr Andrew Murrison, M.P. for the Prime Minister, and with special focus on mental health.

While UK data on veterans' mental health are incomplete, more information is available on serving personnel. The Armed Forces are a selected younger and healthier population than the equivalent general community. There is emphasis in service on resilience building, stigma reduction, promotion and awareness of good mental health, prevention and early detection of problems and onward referral for specialist help. Levels and types of mental health problems among serving personnel are comparable with the general population. There is a problem with heavy drinking in a significant minority, but otherwise a low frequency of substance abuse and severe, enduring psychotic mental health disorders. Mental health problems are generally multifactorial; many of those who become ill in service may suffer problems related to domestic issues, relationship problems at home or in the workplace. Much current interest and concern focuses on PTSD attributed to the psychological trauma of war, its frequency, outcomes and wider social consequences. PTSD however is only one, and not the most common, mental health disorder associated with combat related traumatic psychological injury.

A recently reported longitudinal study of 10,000 UK Armed Forces personnel serving between 2003 and 2009 found that, among deployed personnel, 4% reported symptoms of probable PTSD, whereas 20% reported symptoms of common mental health disorders (e.g. anxiety, depression) and 13% alcohol misuse. PTSD was more common among those engaged in a combat role and in deployed reservists. Alcohol misuse was more common in deployed regular troops. There is further evidence, from other studies, that PTSD is associated in some 80% of cases, with other psychological problems, most commonly depressive symptoms and alcohol misuse. The relationship of these co-morbid disorders to psychological trauma and to each other has been the subject of many studies, which include studies of twins, but remains unresolved. Expert advice is that while traumatic psychological injury may be followed by increased alcohol consumption, it probably does not itself cause alcohol misuse.

AFCS Current Approach

Currently AFCS considers mental health disorders not in relation to particular diagnoses, but generically. Reflecting the fact that physical disease and injury inevitably cause psychological symptoms and sometimes illness, awards for all the descriptors throughout the tariff tables, take account of mental symptoms where they do not constitute a recognised diagnosis. For an AFCS award to be made currently for a mental health disorder, the symptoms must meet the criteria for a disorder included in the ICD or DSM classification and be made by a relevant accredited medical specialist. Severity and hence award paid is then assessed based on associated "functional limitation and restriction" and actual or anticipated duration of incapacity.

Between 1 November 2005 and 31 March 2010 there were 295 awards for a descriptor from Table 3 descriptors as below:

a) "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

b) "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

c) "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

d) "Mental disorder causing functional limitation and restriction which has continued or is expected to continue for 5 years." Level 10

e) "Permanent mental disorder causing moderate functional limitation and restriction." Level 9

f) "Permanent mental disorder causing severe functional limitation and restriction." Level 8

Argument

A fundamental principle of the AFCS is compensation for the impact of attributable injury illness or disease on capacity for civilian employment, paid as GIP. Capacity for work is an important measure of functional limitation caused by mental health disorders. At present, there are two categories of "permanent" mental disorder each attracting a 50% GIP. Lord Boyce's Review recommended that for the most severe mental health problems, GIP should be at 75%.

Recommendations

I. It is recommended that current Items (e) and (f) above, should be deleted and replaced by:

"Permanent mental disorder causing moderate functional limitation and restriction."
Level 8 i.e. 50% GIP

"Permanent mental disorder causing severe functional limitation and restriction."
Level 6 i.e. 75% GIP

II. with "**moderate**" meaning "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

III. "**Severe**" meaning "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 increasingly less demanding jobs".

Further Work

There are several additional important areas concerning mental health, which need to be addressed. These include:

1. The basis for the diagnosis of mental health disorders. In the absence of objective

measures (such as pathological changes in tissue or characteristic imaging patterns), diagnosis is based on a characteristic cluster of symptoms. At present the criteria for diagnosis are set out in two international classification systems (ICD 10 and DSM IV) which can disagree on their diagnostic criteria and sometimes even on the existence of disorders. This is a very unsatisfactory situation and clear guidance about this needs to be provided to decision makers in AFCS.

2. The diagnosis of mental health disorders and their subsequent effective treatment has important consequences for an individual, independent of a claim under AFCS. It is therefore essential that the diagnosis should be accurate, made by a suitably qualified person with experience of traumatic psychological injury preferably in the military context. If such direct experience is not met, there needs to be clear evidence of understanding, cultural sensitivity and affinity.

3. Psychological illness is necessarily based on self-reported symptoms. Because of the important implications of the diagnosis and associated disability, there is a need to consider whether further confirmatory evidence should be obtained and if so from whom and by what means. This should probably, at the least, include information from the treating clinician(s) of the clinical management and type and duration of treatment received by each claimant.

4. The types of disorders likely to be accepted on balance of probabilities as predominantly due to service include the common mental health disorders. For these, best practice interventions leading to, at least, improved function are now recognised. A compensation issue, to be further explored, is the possible routine use of interim awards, with finalisation of awards on receipt of evidence that an adequate course of a quality assured effective intervention delivered by an accredited mental health professional has been completed.

5. The basis for severity and so compensation paid in the Scheme is functional capacity. There is a need to consider how best this can be measured in a valid and consistent manner.

In its considerations to date of mental health disorders, IMEG has been concerned to ensure that it fully considers and makes recommendations on those issues, which are for inclusion in new legislation in February 2011. Focus on these has meant less time for the other important issues listed above, which have therefore not yet received sufficient attention. In particular, it has not been possible to take wider opinion, including from Combat Stress and other Veterans groups, to inform future recommendations. It is proposed that this further work on mental health disorders will form a major plank of our work during 2011.