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Issued By:
Defence Statistics (Health)
Ministry of Defence
Oak 0 West #6028
Abbey Wood (North)
Bristol
BS34 8JH

Enquiries
Press Office:
Tel: 020 721 83253

Statistical Enquiries:
Head of Health
Tel: 030 67984423
Fax: 0117 9319632
Email:DefStrat-Stat-Health-PQ-FOI@mod.uk

Internet:
http://www.dasa.mod.uk

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If you have any comments or questions about this publication or about Defence Statistics in general, you can contact us as follows:

E-mail:
Defence-Statistics-Enquiries@mod.uk

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DefStrat-Stat-Health-PQ-FOI@mod.uk

Quarterly UK Armed Forces Mental Health:
Presenting complaints at MOD Departments of Community Mental Health
April 2012/13 - June 2013/14

INTRODUCTION

1. This quarterly report provides statistical information on mental health in the UK Armed Forces for the period April 2012/13 - June 2013/14. Data used in this report summarises all **new episodes of care** of UK Armed Forces personnel at the MOD Departments of Community Mental Health (DCMH) for outpatient care, i.e. new patients, or patients who have been seen at a DCMH but were discharged from care and have been referred again, and **all admissions** to the MOD in-patient care contractors.

2. This data updates previous reports and includes previously unpublished data for 1 April 2013 - 30 June 2013.

CHANGES SINCE LAST PUBLICATION

3. This is the first report in this quarterly series providing new episodes of care at DCMH in 2012/13 using the MOD electronic primary care patient record (DMICP[a]) in addition to those submitted to the existing Defence Statistics (DS) reporting database. The inclusion of new episodes of care from the MOD patient electronic record (DMICP) in 2012/13 has resulted in an increase of 21% compared to the number previously published for 2012/13 in the quarterly series of the UK Armed Forces mental health report using data submitted by DCMH in the existing DS database.

KEY POINTS

Initial Assessments at MOD DCMH

4. During the three-month period April - June 2013, 1,367 new episodes of care for mental disorder were identified within UK Armed Forces personnel, a rate of 7.6 per 1,000 strength.

5. The differences between populations this quarter remain broadly consistent with the findings in previous reports. For the 1,367 personnel assessed for a new episode of care with a mental disorder during the period April - June 2013 there were some statistically significant findings:

- Rates for Army personnel were significantly higher than the other three Services.
- Rates for females were significantly higher than for males.
- Rates for Other ranks were significantly higher than for Officers.

6. Comparing those previously deployed on Op TELIC and/or Op HERRICK and those not deployed to either operation:

- There was no significant difference between the rate of mental disorder for personnel previously deployed to Op TELIC and/or Op HERRICK and personnel who had not been identified as having previously deployed prior to their episode of care in the latest quarter (7.5 per 1,000 compared with 7.7 per 1,000 strength respectively). These findings are consistent across all the periods presented in this report.

7. Neurotic disorders were the most prevalent disorder in the period April - June 2013, this was consistent with the findings in the previous four quarters. Adjustment disorders accounted for the majority of all Neurotic disorders. Rates of PTSD remained low at 0.6 per 1,000 strength (n = 106), there was no significant increase in the rate of PTSD compared to previous quarters.

Admissions to the MOD In-patient Contractor

8. During the three-month period April - June 2013, there were 73 admissions to the MOD in-patient care contractor representing a rate of 0.4 per 1,000 strength; 68 of these patients had been seen at a DCMH at some point prior to their admission. The rate of admission to the MOD in-patient care contractor showed no change compared to previous quarters.

[a] Defence Medical Information Capability Programme

BACKGROUND NOTE

9. DCMH are specialised psychiatric services based on community mental health teams closely located with primary care services at sites in the UK and abroad. Information on patients seen only by their GP or medical officer will be investigated for the next annual report. All UK based and aero-medically evacuated Service personnel based overseas requiring in-patient admission are treated by one of eight NHS trusts in the UK which are part of a consortium headed by the South Staffordshire and Shropshire NHS Foundation trust; UK based Service personnel from British Forces Germany were treated at Guys and St Thomas Hospital in the UK up until April 2013 and from this date, at Gilead IV hospital, Bielefield under a contract with SSAFA through the Limited Liability Partnership

10. Following an external consultation exercise in July 2012, all releases of this report now present the latest quarter and the previous four quarters of mental health data only. Time trend graphs presenting rates since the start of data collection in January 2007 have also been included in this report. Annual data are presented in the annual report along with the rate ratios for those with a mental disorder comparing those previously deployed with those not previously deployed.

11. This is the first report in this quarterly series providing new episodes of care at DCMH in 2012/13 using the MOD electronic primary care patient record (DMICP[b]) in addition to those submitted to the existing Defence Statistics (DS) reporting database. This improves the robustness and integrity of the data which has only been possible since the introduction of system developments enabling DCMH to begin recording new episodes of care in mental health templates within DMICP. The inclusion of new episodes of care from the MOD patient electronic record (DMICP) in 2012/13 has resulted in an increase of 20% compared to the number previously published for 2012/13 in the quarterly series of the UK Armed Forces mental health report using data submitted by DCMH in the existing DS system. The quarterly reports affected by this methodology change in 2012/13 have been revised and are available on the Defence Statistics website. Detail of the methodology change and a summary of it's impact can be found in the section on **'Data, definitions and methods'**

12. Due to the methodology changes implemented in July 2009 and in July 2013, when looking at trends over time for new episodes of care, it is advisable to note :

- Prior to 2009/10, only an individual's first attendance at a DCMH or an in-patient provider were included in the data collected.
- Since 2009/10, the report captures all new episodes of care provided by DCMH to Defence Statistics in monthly returns.
- Since 2012/13, the report captures all new episodes of care recorded in the MOD patient electronic record in addition to monthly returns provided by DCMH.

Therefore, data between 2009/10 and 2011/12 use the same methodology of capturing new episodes of care and data in years 2007/08, 2008/09 and 2012/13 cannot be directly compared to this period. The data presented in the tables in this quarterly report are reflective of the new methodology only.

13. A rigid pseudo-anonymisation process, and other measures preserving patient confidentiality, has enabled full verification and validation of the DCMH and in-patient records, importantly allowing identification of repeat attendances. It also ensures linkage with deployment databases was possible, so that potential effects of deployment could be measured.

POINTS TO NOTE

14. Interpretation of the findings in this report continues to require caution. The data contained within this report covers the activity of the formal professional mental health services in the Armed Forces and as such, does not represent the totality of mental health problems in the UK Armed Forces. DS (formerly DASA) data starts from January 2007 and if personnel were receiving treatment prior this date they would not be captured in the following data. These figures report only attendances for new episodes of care after January 2007, not all those who were receiving treatment at the start of data collection.

15. Mental health problems are present in both civilian and military populations and result from multi-factorial issues. The Headquarters Surgeon General (HQ SG) and Joint Medical Command (JMC) are striving to minimise the stigma associated with mental illness and foster the appropriate understanding, recognition and presentation for management of these issues in UK Armed Forces personnel. Stigma concerning mental health issues is, however, deeply embedded in both military and civilian populations and it will take time to produce attitudinal cultural change.

[b] Defence Medical Information Capability Programme

16. Some mental health problems will be resolved through peer support and individual resources; patients presenting to the UK Armed Forces' mental health services will have undergone a process that begins with the individual's identification of a problem and initial presentation to primary care or other agencies such as the padres or Service social workers. A proportion of mental health issues will have been resolved at these levels without the need for further referral. The diagnostic breakdown in this report is based upon initial assessments at DCMH, which may be subject to later amendment. For epidemiological information on mental health problems in the UK Armed Forces, reference should be made to the independent academic research conducted by the King's Centre for Military Health Research (KCMHR). This research, conducted on a large and representative sample of the UK Armed Forces population, provides a reliable overview of mental health in the UK Armed Forces[c].

DATA SOURCES

17. DCMH are specialised psychiatric services based on community mental health teams closely located with primary care services at sites in the UK and abroad. Information on patients seen only by their GP or medical officer will be investigated for the next report

18. All UK based and aero-medically evacuated Service personnel based overseas requiring in-patient admission are treated by one of eight NHS trusts in the UK which are part of a consortium headed by the South Staffordshire and Shropshire NHS Foundation trust; UK based Service personnel from British Forces Germany were treated at Guys and St Thomas Hospital. When presenting in-patient data in this report, the data include returns from both medical providers.

19. Defence Statistics receive data from DCMH and in-patient providers for <u>all</u> UK regular Armed Forces personnel from the following sources :

- Since January 2007, DCMH have submitted relevant information required to produce this report to Defence Statistics on a monthly basis (captured on the DS database).
- Since April 2012, system developments enabled DCMH to begin recording on the MOD's electronic patient record system (DMICP) in a consistent way for reporting.
- Since January 2007, SSSFT and Guys and St Thomas' hospital have submitted relevant information required to produce this report to Defence Statistics.

20. DMICP data is compiled from the DMICP data warehouse. DMICP comprises an integrated primary Health Record (iHR) used by clinicians to enter and review patient information and a pseudo-anonymised central data warehouse. Free text entered by clinicians in the patient record does not transfer to the data warehouse. Prior to this data warehouse, medical records were kept locally, at each individual medical centre.

21. The DMICP programme commenced during 2007 and by 2010 was in place for the UK and the majority of Germany. Rollout to other overseas locations took place between November 2011 and May 2013.

22. A DMICP template is a specifically designed electronic form which is accessed by clinicians entering data in the patient record. Templates are used to ensure key pieces of information relating to a specific patient consultation are recorded in a consistent way for analysis. Items in templates are coded in order that they transfer into the data warehouse. The circumstances under which clinicians must enter data into the patient record through a template are mandated through policy and protocols.

23. In April 2012, a new set of templates enabled DCMH to begin recording information on mental health episodes of care in the integrated health record; capturing the information in the format required to produce this report. These templates were designed to capture information in the same way as the existing Defence Statistics database, with the ultimate aim of reducing duplicate data entry by clinicians.

24. There has been no audit of the clinical accuracy of the DMICP mental health data entered in the patient record and no validation of the patient record with data held in the data warehouse.

[c] Their findings are published in the peer-reviewed medical literature and are freely available in the public domain at URL:http://www.kcl.ac.uk/kcmhr/information/publications/publications.html.

25. The patient data from each data sources were cross referenced with the Joint Personnel Administration (JPA) system for UK Armed Forces personnel. JPA is the most accurate source for demographic information on UK Armed Forced personnel and is used to gather information on a person's service, Regular/Reservist status, gender, age and deployment.

DATA COVERAGE

26. The data in this report include regular UK Armed Forces personnel (including Ghurkhas and Military Provost Guard Staff), mobilised reservists, Full Time Reserve Service personnel and Non-regular Permanent Staff as all of these individuals are eligible for assessment at a DCMH.

27. DCMH staff record the initial mental health assessment during a patient's first appointment, based on presenting complaints. The information is provisional and final diagnoses may differ as some patients do not present the full range of symptoms, signs or clinical history during their first appointment. The mental health assessment of condition data were categorised into three standard groupings of common mental disorders used by the World Health Organisation's International Statistical Classification of Diseases and Health-Related Disorders 10th edition (ICD-10).

28. A number of patients present to DCMH with symptoms that require the treatment skills of DCMH staff, whilst not necessarily having a specific and identifiable mental disorder. In the **Findings** section, these cases are referred to as "assessed without a mental disorder".

29. From July 2009 onwards, Defence Statistics (formerly DASA) have also included data from four mental health posts located in medical centres, attached to a DCMH, staffed by mental health nurses and operating in the same way as a DCMH; seeing and treating personnel referred for specialist care with suspected mental health disorders. Throughout this report the term DCMH included these four mental health posts.

30. Up to 2009 if Service personnel withheld consent, their data was supplied in fully anonymised format. DS received 148 records for personnel assessed with a mental disorder for the period April 2007 – June 2009, but with no demographic information provided. In 2009/10 DCMH staff agreed to collect basic demographic information (Service, gender, rank, age and deployment) for Service personnel who withheld consent thus enabling DS to include these cases within the tables.

METHODOLOGY

Change to methodology in July 2009

31. To ensure these statistics pick up all new episodes of care, DS have made some changes to data collection and validation from July 2009 onwards. Prior to July 2009, we identified individuals who had previously attended a DCMH and removed them from the analysis. Following discussions with mental health professionals, DS reviewed the methodology and expanded our data collection in order to more effectively capture the overall burden of mental health in the UK Armed Forces, including the effect of deployment on those who might have previously been seen for an unrelated mental health condition. We now include all new episodes of care, including both first referrals and patients who were seen at a DCMH previously, were discharged from care and have been referred again for a new episode of care.

32. As a result of the change in methodology, recorded numbers for 2009/10 have increased from previous years. This increase should be treated with caution, however, as is clear by comparison to the figures produced using the previous methods, that this increase was due to the change in the methodology used and not an increase in the absolute number of Armed Forces personnel in attendance at a DCMH (see UK Armed Forces mental health reports July – September 2009 and October – December 2009 for methodology comparisons). Importantly, the patterns and main trends remained the same and high profile findings such as rates of PTSD and substance abuse did not significantly change.

Change to methodology implemented in July 2013

33. In April 2012, system developments enabled the DCMH to begin recording episodes of care in mental health templates on the MOD's electronic patient record system, DMICP[a], providing Defence Statistics with the same pseudo-anonymised information sourced from the legal patient record. These data gathered in the templates covered all the data needed to produce this report. As submitting information using the existing Defence Statistics (DS) database

incurs a resource burden within DCMH, it is now appropriate to take the first step towards reducing this resource burden and using a more robust and appropriate data source to underpin the reporting of incidence of mental health in the Armed Forces.

34. For the period 2012/13 there were :
    - 5,728 new episodes of care recorded in the DMICP data warehouse;
    - 5,531 new episodes of care recorded in the DS database

35. Initial investigations by Defence Statistics comparing new episodes of care recorded on both systems revealed differences :
    - 2,565 records had an exact match;
    - 2,031 records had a match but with a different attendance date and/or mental disorder assessment;
    - 827 DMICP records had no match in the DS database[d].
    - 723 DS database records had no match in the DMICP data warehouse[e].

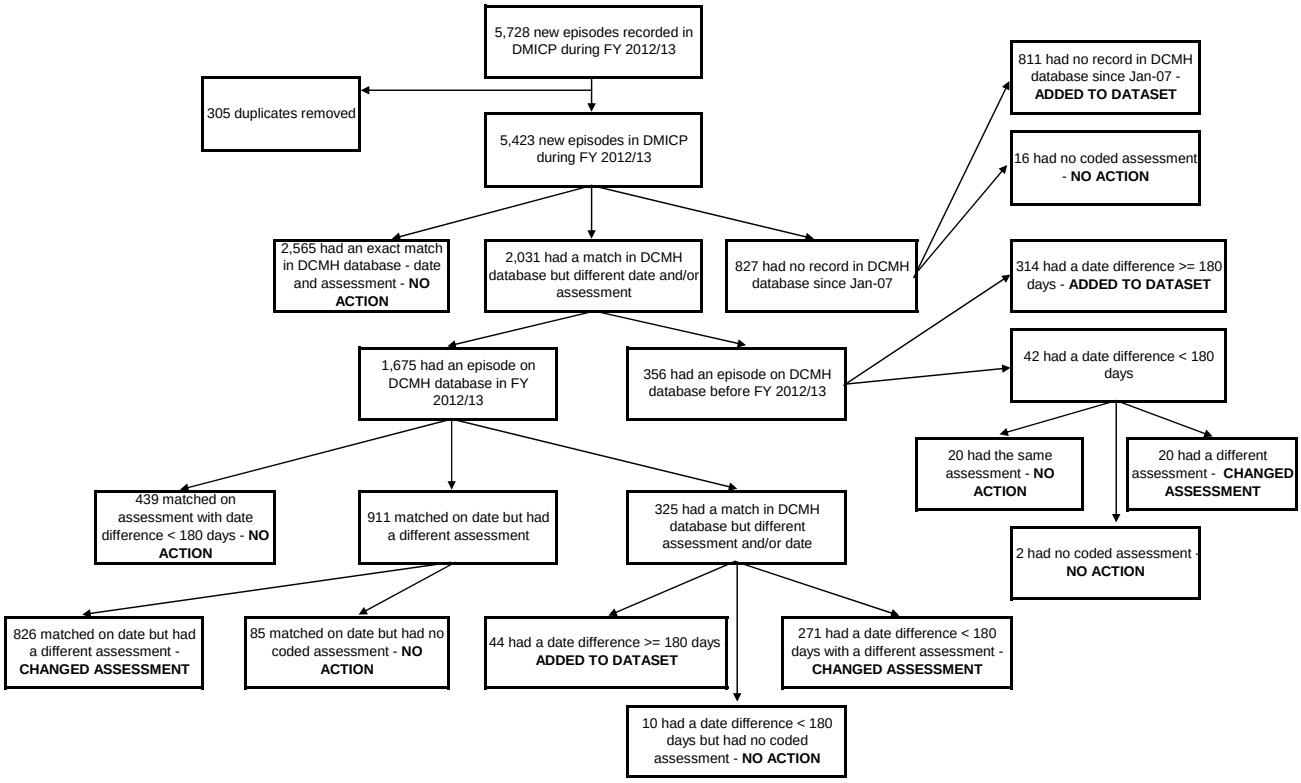
36. This initial step towards using DMICP as the single source of new episodes of care data therefore required records from both the DS database and DMICP to be included in this report.

37. Where a new episode of care was held in both data sources, data was processed according to validation rules created in consultation with Defence Consultant Advisor (Psychiatry) to ensure data accuracy and integrity :
    - Where there was a difference in the initial assessment for mental disorder, the assessment recorded on DMICP was reported as this is the legal patient record. Difficulties in recording where a patient has multiple mental health disorders in the DS database may explain these differences; it may also be the result of a reporting error by clinician's to the DCMH administrator for inputting in the DS database.
    - Where there was a difference in first appointment date in both data sources, if the date difference was less than 180 days and no record of patient discharge was held, the two records were assumed to be for the same episode of care and the existing DS database record was retained. If the date difference was greater than 180 days, the records were assumed to be for two separate episodes of care and both the DS database and DMICP records were reported.

38. The following flow diagram illustrates the methodology used in creating the number of new episodes of care for this report. The diagram shows the process of comparing DMICP data (n=5,728) to the DS reporting system (n=5,531) for the period 2012/13 :

[d] A possible explanation for this could be clinician's not informing DCMH administrators of all records for submission to the DS reporting system each month

[e] This may be due to the introduction of the new system for recording mental health consultations where the transition from paper to electronic records may lead to less than 100% compliance on the electronic system and issues with accuracy in the initial stages, as well as the inclusion of 140 records submitted by DCMH Cyprus and Gibraltar who are not currently using DMICP.



Key :
NO ACTION : The DMICP new episode of care was already accounted for in the existing DS reporting system and no further action was required.
CHANGED ASSESSMENT : The DMICP new episode of care was already accounted for in the existing DS reporting system with the same appointment date but with a different mental health disorder coded at initial assessment. The DMICP assessment was used in this report.
ADDED TO DATASET : The DMICP new episode of care was not accounted for in the existing DS reporting system and was added to the dataset.
DUPLICATES REMOVED : Where multiple templates were completed for the same episode of care

39. In summary, for the period 2012/13 :
    - 5,531 new episodes of care were previously reported in the DS database.
    - 1,169 new episodes of care on DMICP with no matching record in the DS database

40. The impact of this change in methodology was an increase on the number of new episodes of care for 2012/13 compared to that previously reported on the DS database of 21%. This same increase was also seen in the number assessed with a mental disorder and associated demographic breakdowns, however, increases for each Service varied between approximately 15% to 35%, indicating larger differences within the Services in the coverage and accuracy of new episodes of care reported on DMICP.

41. Of the 1,117 previously reported mental disorder assessments amended to reflect the assessment made in the DMICP record, around 85% of disorder types remained within the same ICD-10 grouping. For example, 84% of Neurotic Disorders originally reported in the DS system remained as a Neurotic Disorder after the inclusion of DMICP data.

42. Comparisons between 2012/13 and previous years should be treated with caution as it is likely this increase is a result of the change in methodology.

43. Defence Statistics are working closely with DCMH to improve coverage and accuracy of coding and use of templates within the electronic patient record to enable DMICP to become the single source of new episode of care data for this report and to enable the removal of the existing DS database, reducing the data capture burden with the DCMH.

44. It should be noted Defence Statistics cannot verify demographic information submitted in the DS database (Service, gender, rank, age and deployment) for Service personnel who withheld consent (see paragraph 30). Without the anonymised unique patient identifier,

records for these personnel submitted in the DS database could not be identified in the DMICP record. It is therefore possible that new episodes of care for personnel who withhold consent may be counted twice in this report. In Q1 2013/14, 12 Service personnel withheld consent in records submitted in the DS database.

45. In order to calculate the rates in this report, an estimate of person time at risk is required for the denominator value. The estimate was calculated using a four-month average of strengths figures (e.g. the strength at the first of every month between April 2013 and July 2013 divided by four for Q1 2013/2014). Strengths figures include regulars (including Ghurkhas and Military Provost Guard Staff), mobilised reservists, Full Time Reserve Service personnel and Non-regular Permanent Staff as all of these individuals are eligible for assessment at a DCMH.

46. With the recent changes to the Armed Forces population through redundancy programmes, changes in recruitment patterns and the move to the new employment model and the new structures required to meet Future Force 2020[f], there will be an impact on the trends in rates presented as the Armed Forces population shrinks and the age and gender profile of the serving population changes, as seen in 2012/13 for rates of new episodes of care, caused by the reduction in recruitment of personnel under 20 years of age.

47. The 95% confidence interval for a rate provides the range of values within which we expect to find the real value of the indicator under study, with a probability of 95%. If a 95% confidence interval around a rate excludes the comparison value, then a statistical test for the difference between the two values would be significant at the 0.05 level. If two confidence intervals do not overlap, a comparable statistical test would always indicate a statistically significant difference. The rates and confidence intervals presented have been rounded to 1 decimal place and therefore when small numbers are presented the rate may lie towards one end of the confidence interval instead of more centrally between the lower and upper confidence interval.

48. Defence Statistics maintains a database of individual deployment records from November 2001. Data prior to April 2007 was derived from the single services Operation Location tracking (OPLOC) systems[g] and data since April 2007 is obtained from the Joint Personnel Administration (JPA) system. The data covers deployments on Operation TELIC (Iraq) (2003-2011) and Operation HERRICK (Afghanistan) (2001-present).

49. The deployment data presented in this report represent deployments to the theatre of operation and not deployment to a specific country i.e. deployment to Op TELIC includes deployment to Iraq and other countries in the Gulf region such as Kuwait and Oman. Therefore, this data cannot be compared to data on personnel deployed to a specific country such as Iraq.

50. Deployment markers were assigned using the criteria that an individual was recorded as being deployed to the Iraq and/or Afghanistan theatres of operation if they had deployed to these theatres prior to their appointment date. Person level deployment data for Afghanistan was not available between 1 January 2003 and 14 October 2005. Therefore, it is possible that some UK Armed Forces personnel who were deployed to Afghanistan during this period and subsequently attended a DCMH have not been identified as having deployed to Afghanistan in this report but have been captured in the overall figures for episodes of care at a DCMH. **Please note: this report compares those who had been deployed before their episode of care with those who have not been identified as having deployed before their episode of care.**

51. Operation TELIC is the name for UK operations in Iraq which started in March 2003 and finished on 21 May 2011. UK Forces were deployed to Iraq to support the Government's objective to remove the threat that Saddam posed to his neighbours and his people and, based on the evidence available at the time, disarm him of his weapons of mass destruction. The Government also undertook to support the Iraqi people in their desire for peace, prosperity, freedom and good government.

[f] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/62487/Factsheet5-Future-Force-2020.pdf

[g] Around 4% of data obtained prior to April 2007 could not be fully validated for a number of reasons including data entry errors, personnel not recording on the system in the theatre of operation, records of contractors or personnel from other Government Departments. However research carried out by the King's Centre for Military Health Research on a large Tri-Service sample of personnel deployed during the first phase of Op TELIC in 2003, who were identified from DASA's deployment database, reported a cohort error rate of less than 0.5 per cent.

52. Operation HERRICK is the name for UK operations in Afghanistan which started in April 2006. UK Forces are deployed to Afghanistan in support of the UN authorised, NATO led International Security Assistance Force (ISAF) mission and as part of the US-led Operation Enduring Freedom (OEF).

53. This report includes additional breakdown by age. The age presented is the patients age at the date of their episode of care, or for the in-patient data, the date of their admission.

54. In line with Defence Statistics' rounding policy for health statistics (May 2009), and in keeping with the Office for National Statistics Guidelines, all numbers less than five have been suppressed and presented as '~'. Where there is only one cell in a row or column that is less than five, the next smallest number (or numbers where there are tied values) has also been suppressed so that numbers cannot simply be derived from totals.

STRENGTHS AND WEAKNESSES OF THE DATA PRESENTED IN THIS REPORT

55. A key strength of this report is the presentation of the number of Service personnel who have been seen for a new episode of care at a DCMH or in-patient facility, as reported by clinician's. The inclusion in this report of new episodes of care direct from the legal electronic patient record improves the robustness and integrity of the underlying data. As the data is held in a pseudo-anonymised format in the DMICP data warehouse, patient consent is not an issue. A further strength is the use of the pseudo-anonymised patient identifier to enable DS to validate data therefore improving accuracy and enabling linkage to deployment records to identify any effect of deployment on mental health in the Armed Forces and in addition, the tables in this report have been scrutinised to ensure individual identities have not been revealed inadvertently.

56. Users should be aware that this report does not currently include information on patients seen only by their GP or Medical Officer. Mental disorder types reported here are the clinician's initial assessment during a patient's first appointment at a DCMH, based on presenting complaints, therefore final diagnosis may differ as some patients do not show full range of symptoms, signs or clinical history during their first appointment. It should also be noted that the clinician's primary diagnosis is reported here, however patients can present with more than one disorder. A further weakness of data in this report is that with any new data collection system, there is a training burden; user inexperience with the new mental health templates in DMICP may have affected coverage and accuracy.

REFERENCES

i. Singleton N, Lewis G (2003). Better or Worse: A longitudinal study of the mental health of adults living in private households in Great Britain, *Her Majesty's Stationery Office (HMSO): London*.

ii. Meltzer H, Singleton N, Lee A et al (2002). The social and economic circumstances of adults with mental disorders, *Her Majesty's Stationery Office (HMSO): London*.

New Episodes of Care at MOD DCMHs, April - June 2013 summary

57. During the three-month period April - June 2013, a total of 1,733 UK Service personnel were recorded as having been assessed for a new episode of care at MOD DCMH, representing a rate for personnel seen for the period of 9.6 per 1,000 strength[h].

58. **Table 1** provides details of the key socio-demographic characteristics for the 1,733 new episodes of care at MOD DCMH during April - June 2013.

Table 1: New episodes of care at MOD DCMH by demographic characteristics, 1 April 2013 - 30 June 2013, numbers and rates per 1,000 strength per quarter

Characteristic	All patients seen	Patients assessed with a mental disorder			Patients assessed without a mental disorder[1]
		Number	Rate	95% CI	
All	**1,733**	**1,367**	**7.6**	**(7.2 - 8.0)**	**366**
Service					
Royal Navy	229	175	6.6	(5.6 - 7.6)	54
Royal Marines	35	22	2.8	(1.8 - 4.3)	13
Army	1,127	916	8.4	(7.9 - 9.0)	211
RAF	342	254	6.8	(6.0 - 7.6)	88
Gender					
Males	1,402	1,089	6.7	(6.3 - 7.1)	313
Females	331	278	16.4	(14.5 - 18.3)	53
Rank					
Officers	158	127	4.2	(3.4 - 4.9)	31
Other ranks	1,575	1,240	8.3	(7.8 - 8.7)	335
Deployment - Theatres of operation[2]					
Op TELIC and/or Op HERRICK[3]	1,080	872	7.5	(7.0 - 8.0)	208
of which, Op TELIC	582	466	7.0	(6.4 - 7.7)	116
Op HERRICK[3]	886	712	7.6	(7.0 - 8.1)	174
Neither Op TELIC nor Op HERRICK[3]	653	495	7.7	(7.0 - 8.4)	158

Data Source : DS Database and DMICP

1. Patients assessed without a mental disorder (see paragraph 28).
2. Deployment to the wider theatre of operation (see paragraph 49).
3. Data for Afghanistan between 1 January 2003 and 14 October 2005 were not available for person level deployment (see paragraph 50).

59. Of the 1,733 new episodes of care, 1,367 (79%) were assessed with a mental disorder, representing an overall rate for new episodes of care for mental disorder of 7.6 per 1,000 strength. There were 366 patients who were recorded as having no mental disorder at their initial assessment. **Table 1** shows some statistically significant findings;

60. Army had a significantly higher rate of mental disorder (8.4 per 1,000 strength) compared to the other services. Royal Marines has a significantly lower rate compared to the other three Services (2.8 per 1,000 strength).

61. The rate of mental disorder was higher in females than males (16.4 per 1,000 strength and 6.7 per 1,000 strength respectively).

62. Rates of those assessed with a mental health disorder in Other Ranks were higher than Officers. Ranks had a significantly higher rate of mental disorder at 8.3 per 1,000 strength compared to Officers at 4.2 per 1,000 strength.

New Episodes of Care at MOD DCMH for the five quarter period April - June 2013

Trends overall and by demographic variable

[h] Using a four-month average of regular and mobilised reserves strength from 1 April 2013 to 1 July 2013 (see paragraph 45).

63. **Table 2** presents numbers and rates of Service personnel who attended a DCMH for a new episode of care and were assessed with a mental disorder in the last five quarters (April 2012 to June 2013). Data for the period April 2012 to March 2013 have been revised due to the inclusion of records from DMICP (see paragraphs 33-42) and will therefore supersede any previously published reports covering April 2012 - March 2013 data.

Table 2: Episodes of care at MOD DCMH, 1 April 2012 - 30 June 2013 by quarter, numbers and rates per 1,000 strength per quarter

		Patients assessed with a mental disorder			
	All patients seen	Number	Rate	95% CI	Patients assessed without a mental disorder
April - June 2012/13	1,556 r	1,140 r	6.0 r	(5.6 - 6.3)	416 r
July - September 2012/13	1,610 r	1,208 r	6.4 r	(6.0 - 6.8)	402 r
October - December 2012/13	1,886 r	1,462 r	7.9 r	(7.5 - 8.3)	424 r
January - March 2013/14	1,648 r	1,248 r	6.9 r	(6.5 - 7.2)	400 r
April - June 2013/14	1,733	1,367	7.6	(7.2 - 8.0)	366

Data Source : DS Database and DMICP
1. "r" denotes revised data due to changes in methodology (see paragraphs 33-42).

64. **Table 2** shows that the rate for the latest quarter, April – June 2013/14 was significantly higher than the rate for the same time period a year ago (7.6 per 1,000 strength and 6.0 per 1,000 strength respectively). In April 2012, DCMH began recording episodes of care using the electronic patient record (DMICP) as well as the Defence Statistics database; it is not clear if the rise in numbers is due to the implementation of DMICP in the DCMH or a true rise in the number of Service personnel assessed with a mental disorder.

65. **Table 2a** presents the number and percentage increase of Service personnel who attended a DCMH for a new episode of care and were assessed with a mental disorder in the last five quarters (April 2012 to June 2013). The figures compare those before and after the new methodology was introduced with percentage increase.

Table 2a: Episodes of care at MOD DCMH before and after methodology change, 1 April 2012 - 30 June 2013 by quarter, numbers and percentage increase per quarter.

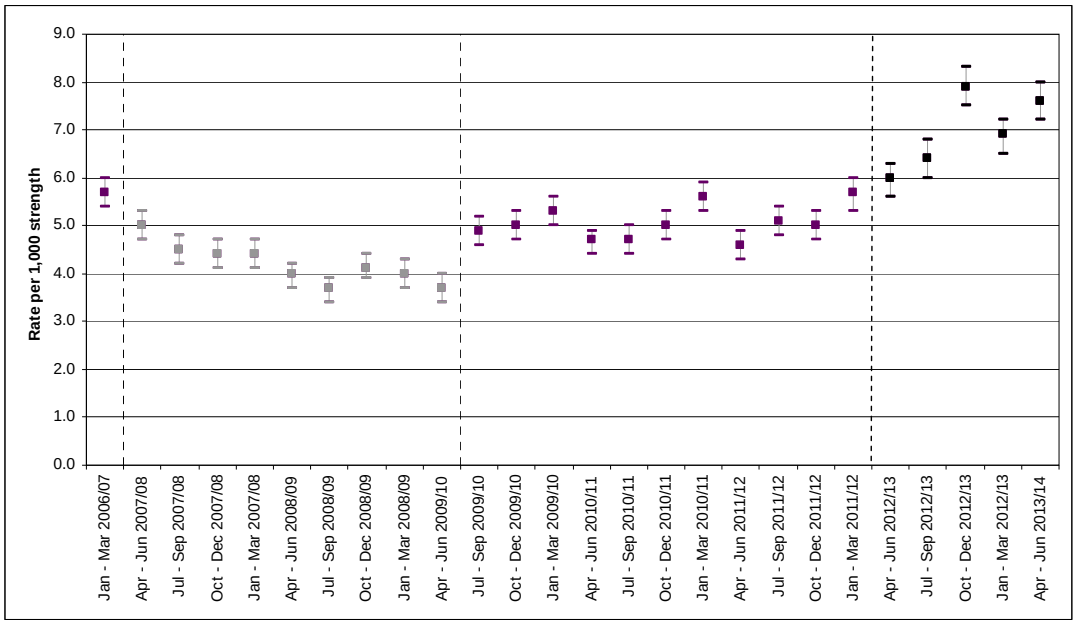
	All patients seen published	All patients seen revised	Percentage increase	Patients assessed with a mental disorder published	Patients assessed with a mental disorder revised	Percentage increase
	n	n	%	n	n	%
April - June 2012/13	1,269	1,556	23	954	1,140	19
July - September 2012/13	1,366	1,610	18	1,043	1,208	16
October - December 2012/13	1,577	1,886	20	1,268	1,462	15
January - March 2013/14	1,319	1,648	25	1,030	1,248	21
April - June 2013/14	1,434	1,733	21	1,145	1,367	19

1. DS database only
2. DS Database and DMICP

66. Table 2a shows the introduction of the new data source (DMICP) has lead to percentage increase in the number of patients seen in each quarter (between 18% and 25%) and to a lesser extent the number of patients assessed with a mental disorder in each quarter (between 15% and 21%).

67. **Figure 1** presents the rate of Armed Forces personnel assessed with a mental disorder each quarter since the start of data collection in January 2007.

Figure 1: UK Armed Forces personnel assessed with a mental disorder, January 2007 to June 2013[1,2,3], rates per 1,000 strength per quarter and 95% confidence intervals



Data Source : DS Database and DMICP
1. January 2007 - June 2009 new attendances, July 2009 onwards new episodes of care (see paragraphs 31-32).
2. January 2007 represents a genuine baseline as at this point all cases were 'new episodes of care' as this was the start of data capture by Defence Statistics.
3. April 12 - June 13 revised methodology to include electronic record source (see paragraphs 33-42).

68. **Figure 1** shows since July 2009[i] the rate has been stable at around 5.0 per 1,000, with a rise in January – March each year, **Please note that quarterly data after April 2012 using the new methodology is not comparable across the quarters presented before April 2012.** Since the 1 April 2012 there has been a rise in the rate of personnel assessed with a mental disorder, it is not clear if the rise in rates is due to the implementation of DMICP in the DCMH or a true rise in the number of Service personnel assessed with a mental disorder. Figure 1 has been repeated for each of the Services and is available in **Annex A**.

69. **Tables 3, 4** and **5** present the demographic details for Service personnel who attended a DCMH for a new episode of care and were assessed with a mental disorder in the last five quarters.

Table 3: Episodes of care at MOD DCMH by Service, April 2012 – June 2013 by quarter, numbers and rates per 1,000 strength per quarter

	Service											
	Royal Navy			Royal Marines			Army			RAF		
	Patients assessed with a mental disorder											
Date	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI
April - June 2012/13	134 r	4.8 r	(4.0 - 5.6)	35 r	4.4 r	(2.9 - 5.9)	712 r	6.2 r	(5.8 - 6.7)	259 r	6.4 r	(5.6 - 7.2)
July - September 2012/13	140 r	5.1 r	(4.2 - 5.9)	27 r	3.4 r	(2.3 - 5.0)	761 r	6.7 r	(6.2 - 7.2)	280 r	7.1 r	(6.2 - 7.9)
October - December 2012/13	172 r	6.3 r	(5.4 - 7.3)	34 r	4.3 r	(2.9 - 5.8)	937 r	8.4 r	(7.9 - 8.9)	319 r	8.2 r	(7.3 - 9.2)
January - March 2012/13	143 r	5.3 r	(4.5 - 6.2)	25 r	3.2 r	(2.1 - 4.7)	821 r	7.5 r	(7.0 - 8.0)	259 r	6.8 r	(6.0 - 7.7)
April - June 2013/14	175	6.6	(5.6 - 7.6)	22	2.8	(1.8 - 4.3)	916	8.4	(7.9 - 9.0)	254	6.8	(6.0 - 7.6)

Data Source : DS Database and DMICP
1. . "r" denotes revised data due to changes in methodology (see paragraphs 33-42).

70. The Royal Navy and Army have seen an increase in the number of episodes of care in April - June 2013/14 compared to the same time period a year ago (6.6 per 1,000 strength and 8.4 per 1,000 strength respectively). The RAF have remained fairly stable across the five quarters presented. The annual report released on 3 October 2013 showed a rise in PTSD rates among Royal Marines, this compared rates derived from here using different methodologies and may have been a reflection of this change. Trends presented in **Table 3** compare quarterly data derived rates using the same methodology and may therefore explain the decrease in the rate for Royal Marines in the latest quarter.

[i] Methodology change from July 2009 onwards (see paragraphs 31-32) and April 2012 onwards (See paragraphs 33-42)

71. The Royal Marines had the lowest rate of mental disorders compared to the other Services, this may be due to the rigorous training they undergo which ensures only the 'elite' go forward as Royal Marines (thus the selection process removes those that may be more susceptible to mental health problems) and/or it may be due the tight unit cohesion that exists amongst the elite forces, thus the support received from the Unit further supports the 'healthy worker' effect (Pers comm. Def Prof Mental Health).

Table 4: Episodes of care at MOD DCMH by gender and rank, April 2012 – June 2013 by quarter, numbers and rates per 1,000 strength per quarter

	Gender						Rank					
	Males			Females			Officers			Other Ranks		
	Patients assessed with a mental disorder											
	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI
April - June 2012/13	891 r	5.2 r	(4.8 - 5.5)	249 r	14.0 r	(12.3 - 15.7)	112 r	3.5 r	(2.8 - 4.1)	1,028 r	6.5 r	(6.1 - 6.9)
July - September 2012/13	973 r	5.7 r	(5.3 - 6.1)	235 r	13.3 r	(11.6 - 15.0)	126 r	4.0 r	(3.3 - 4.6)	1,082 r	6.9 r	(6.5 - 7.3)
October - December 2012/13	1,147 r	6.8 r	(6.4 - 7.2)	315 r	18.2 r	(16.1 - 20.2)	126 r	4.0 r	(3.3 - 4.7)	1,336 r	8.7 r	(8.2 - 9.1)
January - March 2012/13	991 r	6.0 r	(5.6 - 6.4)	257 r	15.0 r	(13.2 - 16.9)	120 r	3.9 r	(3.2 - 4.6)	1,128 r	7.5 r	(7.0 - 7.9)
April - June 2013/14	1,089	6.7	(6.3 - 7.1)	278	16.4	(14.5 - 18.3)	127	4.2	(3.4 - 4.9)	1,240	8.3	(7.8 - 8.7)

Data Source : DS Database and DMICP
1. "r" denotes revised data due to changes in methodology (see paragraph 33-42).

72. The rate of mental disorder was higher in females than males throughout the five quarters (**Table 4**). This finding was replicated in the civilian population where females were more likely to report mental health problems than males. A study following up the mental health of adults suggested that this is because females are likely to have more interactions with health professionals (Singleton N, Lewis G 2003). Defence Statistics have not investigated whether females in the UK Armed Forces have more interactions with health professionals than their male colleagues.

73. Rates of those assessed with a mental health disorder in Other Ranks were significantly higher than Officers in each of the quarters presented. The differences between ranks and Officers may be due to educational and/or socio-economic background, where both higher educational attainment and higher socio-economic background are associated with lower levels of mental health disorder (Meltzer *et al* 2002). The majority of Officers (with the exception of those promoted from the Ranks) are recruited as graduates of the higher education system, whilst the majority of Other Ranks are recruited straight from school and often from the inner cities (particularly for the Army).

Table 5: Episodes of care at MOD DCMH by deployment[1,2], April 2012 – June 2013 by quarter, numbers and rates per 1,000 strength per quarter

	Deployment - Theatres of operation[1]											
	Op TELIC and/or Op HERRICK[2]			*of which* *Op TELIC*			*Op HERRICK*[2]			Neither		
	Patients assessed with a mental disorder											
Date	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI
April - June 2012/13	702 r	5.8 r	(5.3 - 6.2)	*414 r*	*5.5 r*	*(4.9 - .06)*	*536 r*	*5.8 r*	*(5.3 - 6.3)*	438 r	6.4 r	(5.8 - 7.0)
July - September 2012/13	775 r	6.4 r	(6.0 - 6.9)	*461 r*	*6.2 r*	*(5.7 - 6.8)*	*602 r*	*6.5 r*	*(6.0 - 7.0)*	433 r	6.4 r	(5.8 - 7.0)
October - December 2012/13	935 r	7.8 r	(7.3 - 8.3)	*528 r*	*7.4 r*	*(6.8 - 8.1)*	*734 r*	*7.8 r*	*(7.3 - 8.4)*	527 r	8.0 r	(7.3 - 8.7)
January - March 2012/13	814 r	7.0 r	(6.5 - 7.5)	*459 r*	*6.7 r*	*(6.1 - 7.3)*	*663 r*	*7.1 r*	*(6.6 - 7.7)*	434 r	6.6 r	(6.0 - 7.3)
April - June 2013/14	872	7.5	(7.0 - 8.0)	*466*	*7.0*	*(6.4 - 7.7)*	*712*	*7.6*	*(7.0 - 8.1)*	495	7.7	(7.0 - 8.4)

Data Source : DS Database and DMICP
1. Deployment to the wider theatre of operation (see paragraph 49).
2. Data for Afghanistan between 1 January 2003 and 14 October 2005 were not available for person level deployment (see paragraph 50).
3. "r" denotes revised data due to changes in methodology (see paragraphs 33-42).

74. There was no significant difference in the rate of mental disorder for personnel identified as having previously deployed to Op TELIC and/or Op HERRICK compared to personnel who had not been identified as having previously deployed prior to their episode of care throughout the five quarter period presented (**Table 5**).

Trends by mental disorder

75. **Table 6** (see page 10) provides details of the types of presenting complaints, by ICD-10 grouping, for the 1,367 new episodes of care assessed with a mental disorder during April - June 2013 and for the previous four quarters.

76. Neurotic disorders were the most common disorder throughout the five quarter period presented in **Table 6**. Adjustment disorders accounted for 56% of all neurotic disorders in the latest quarter, in line with previous quarters. All other disorders have remained fairly constant across the five quarters.

Table 6: Initial mental disorder assessments for all new episodes of care seen at MOD DCMH by ICD-10 grouping, April 2012 to June 2013 by quarter, numbers and rates[1] per 1,000 strength per quarter

	ICD-10 description																							
	Psychoactive substance use			*of which disorders due to alcohol*			Mood disorders			*of which depressive episode*			Neurotic disorders			*of which PTSD*			*of which adjustment disorders*			Other mental disorders		
	Patients assessed with a mental disorder																							
Date	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI
April - June 2012/13	81 r	0.4 r	(0.3 - 0.5)	*76 r*	*0.4 r*	*(0.3 - 0.5)*	333 r	1.7 r	(1.6 - 1.9)	*282 r*	*1.5 r*	*(1.3 - 1.7)*	679 r	3.6 r	(3.3 - 3.8)	*71 r*	*0.4 r*	*(0.3 - 0.5)*	*393 r*	*2.1 r*	*(1.9 - 2.3)*	47 r	0.2 r	(0.2 - 0.3)
July - September 2012/13	67 r	0.4 r	(0.3 - 0.4)	*76 r*	*0.4 r*	*(0.3 - 0.5)*	338 r	1.8 r	(1.6 - 2.0)	*268 r*	*1.4 r*	*(1.3 - 1.6)*	759 r	4.0 r	(3.7 - 4.3)	*93 r*	*0.5 r*	*(0.4 - 0.6)*	*430 r*	*2.3 r*	*(2.1 - 2.5)*	44 r	0.2 r	(0.2 - 0.3)
October - December 2012/13	70 r	0.4 r	(0.3 - 0.5)	*64 r*	*0.3 r*	*(0.3 - 0.4)*	328 r	1.8 r	(1.6 - 2.0)	*291 r*	*1.6 r*	*(1.4 - 1.8)*	801 r	4.3 r	(4.0 - 4.6)	*79 r*	*0.4 r*	*(0.3 - 0.5)*	*454 r*	*2.5 r*	*(2.2 - 2.7)*	69 r	0.4 r	(0.3 - 0.5)
January - March 2012/13	69 r	0.4 r	(0.3 - 0.5)	*67 r*	*0.4 r*	*(0.3 - 0.5)*	325 r	1.8 r	(1.6 - 2.0)	*257 r*	*1.4 r*	*(1.2 - 1.6)*	820 r	4.5 r	(4.2 - 4.8)	*89 r*	*0.5 r*	*(0.4 - 0.6)*	*470 r*	*2.6 r*	*(2.3 - 2.8)*	34 r	0.2 r	(0.1 - 0.2)
April - June 2013/14	68	0.4	(0.3 - 0.5)	*66*	*0.4*	*(0.3 - 0.5)*	338	1.9	(1.7 - 2.1)	*307*	*1.7*	*(1.5 - 1.9)*	902	5.0	(4.7 - 5.3)	*106*	*0.6*	*(0.5 - 0.7)*	*506*	*2.8*	*(2.6 - 3.0)*	67	0.4	(0.3 - 0.5)

Data Source : DS Database and DMICP

1. The rates and confidence intervals have been rounded to 1 decimal place (paragraph 47).
2. "r" denotes revised data due to changes in methodology (see paragraphs 33-42).

Admissions to the MOD's In-patient Contractors

77. **Tables 7 to 9** provide details by demographic breakdowns for the latest five quarters for admissions to in-patient contractors. It is important to note that an individual may be seen for an episode of care at a DCMH and then be admitted to an in-patient facility, therefore individuals may appear in both datasets and the numbers provided in this report. As a result it is not appropriate to add together the DCMH episodes of care and in-patient admissions.

78. During the three-month period April - June 2013, 73 Service personnel were admitted to a MOD in-patient contractor[j], a rate of 0.4 per 1,000 strength.

79. Of the 73 admissions, 68 had been seen at a DCMH between January 2007 and the date of their admission. The remaining five patients were admitted to one of the in-patient contractors without Defence Statistics records and DMICP records showing that they had been seen at a DCMH prior to their admission.

Table 7: Admissions to the MOD in-patient contractors by Service, April 2012 – June 2013 by quarter, numbers and rates[1] per 1,000 strength per quarter

	All admissions			Service								
				Naval Service[2]			Army			RAF		
	Patients assessed with a mental disorder											
Date	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI
April - June 2012/13	70	0.4	(0.3 - 0.5)	9	0.3	(0.1 - 0.5)	48	0.4	(0.3 - 0.5)	13	0.3	(0.2 - 0.6)
July - September 2012/13	87	0.5	(0.4 - 0.6)	14	0.4	(0.2 - 0.7)	65	0.6	(0.4 - 0.7)	8	0.2	(0.1 - 0.4)
October - December 2012/13	74	0.4	(0.3 - 0.5)	~	0.3	(0.1 - 0.5)	61	0.5	(0.4 - 0.7)	~	0.1	(0.0 - 0.3)
January - March 2013/14	71	0.4	(0.3 - 0.5)	11	0.3	(0.2 - 0.6)	53	0.5	(0.4 - 0.6)	7	0.2	(0.1 - 0.4)
April - June 2013/14	73	0.4	(0.3 - 0.5)	9	0.3	(0.1 - 0.5)	52	0.5	(0.3 - 0.6)	12	0.3	(0.2 - 0.6)

Data Source : British Forces Germany and SSFT in-patient data.(see paragraph 18-19).
1. The rates and confidence intervals have been rounded to 1 decimal place (paragraph 47).
2. Royal Navy and Royal Marines combined to protect patient confidentiality.
3. Data presented as "~" has been suppressed in accordance with Defence Statistics rounding policy (see paragraph 54).

80. **Table 7** shows the overall admission rate and for each Service remains stable throughout the period presented with no significant difference in rates between each Service.

Table 8: Admissions to the MOD in-patient contractors by gender and rank, April 2012 – June 2013 by quarter, numbers and rates[1] per 1,000 strength per quarter

	Gender						Rank					
	Males			Females			Officers			Other Ranks		
	Patients assessed with a mental disorder											
Date	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI
April - June 2012/13	61	0.4	(0.3 - 0.4)	9	0.5	(0.2 - 1.0)	6	0.2	(0.1 - 0.4)	64	0.4	(0.3 - 0.5)
July - September 2012/13	73	0.4	(0.3 - 0.5)	14	0.8	(0.4 - 1.3)	~	0.1	(0.0 - 0.3)	~	0.5	(0.4 - 0.7)
October - December 2012/13	~	0.4	(0.3 - 0.5)	~	0.2	(0.0 - 0.5)	~	0.1	(0.0 - 0.3)	~	0.5	(0.4 - 0.6)
January - March 2013/14	63	0.4	(0.3 - 0.5)	8	0.5	(0.2 - 0.9)	5	0.2	(0.1 - 0.4)	66	0.4	(0.3 - 0.5)
April - June 2013/14	64	0.4	(0.3 - 0.5)	9	0.5	(0.2 - 1.0)	~	0.1	(0.0 - 0.3)	~	0.5	(0.4 - 0.6)

Data Source : British Forces Germany and SSFT in-patient data.(see paragraph 18-19).
1. The rates and confidence intervals have been rounded to 1 decimal place (paragraph 47).
2. Data presented as "~" has been suppressed in accordance with Defence Statistics' rounding policy (see paragraph 54).

81. **Table 8** shows no significant difference in the admission rate between males and females throughout the last five quarters. This was in contrast to the higher rates seen among females attending a MOD DCMH for a new episode of care during the same period.

82. During April - June 2013 there was a significant difference in the rate of admission for Other Ranks compared to Officers (0.5 per 1,000 compared to 0.1 per 1,000 respectively).

83. The admissions data are based on very small numbers and therefore we would expect to see these data fluctuate on a quarter by quarter basis.

[j] See paragraph 16 for further information on the data providers for in- patient care.

Table 9: Admissions to the MOD in-patient contractors by deployment[1,2], April 2012 – June 2013 by quarter, numbers and rates[3] per 1,000 strength per quarter

	Deployment - Theatres of operation[1]											
	Op TELIC and/or Op HERRICK[2]			*of which*						Neither		
				Op TELIC			*Op HERRICK*[2]					
	Patients assessed with a mental disorder											
Date	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI
April - June 2012/13	45	0.3	(0.2 - 0.5)	27	0.3	(0.2 - 0.5)	30	0.3	(0.2 - 0.5)	28	0.4	(0.3 - 0.6)
July - September 2012/13	45	0.4	(0.3 - 0.5)	27	0.4	(0.2 - 0.5)	33	0.4	(0.2 - 0.5)	25	0.4	(0.2 - 0.5)
October - December 2012/13	56	0.5	(0.3 - 0.6)	23	0.3	(0.2 - 0.5)	51	0.6	(0.4 - 0.7)	31	0.5	(0.3 - 0.6)
January - March 2013/14	45	0.4	(0.3 - 0.5)	18	0.3	(0.1 - 0.4)	36	0.4	(0.3 - 0.5)	29	0.4	(0.3 - 0.6)
April - June 2013/14	34	0.3	(0.2 - 0.4)	18	0.3	(0.2 - 0.4)	33	0.4	(0.2 - 0.5)	39	0.6	(0.4 - 0.8)

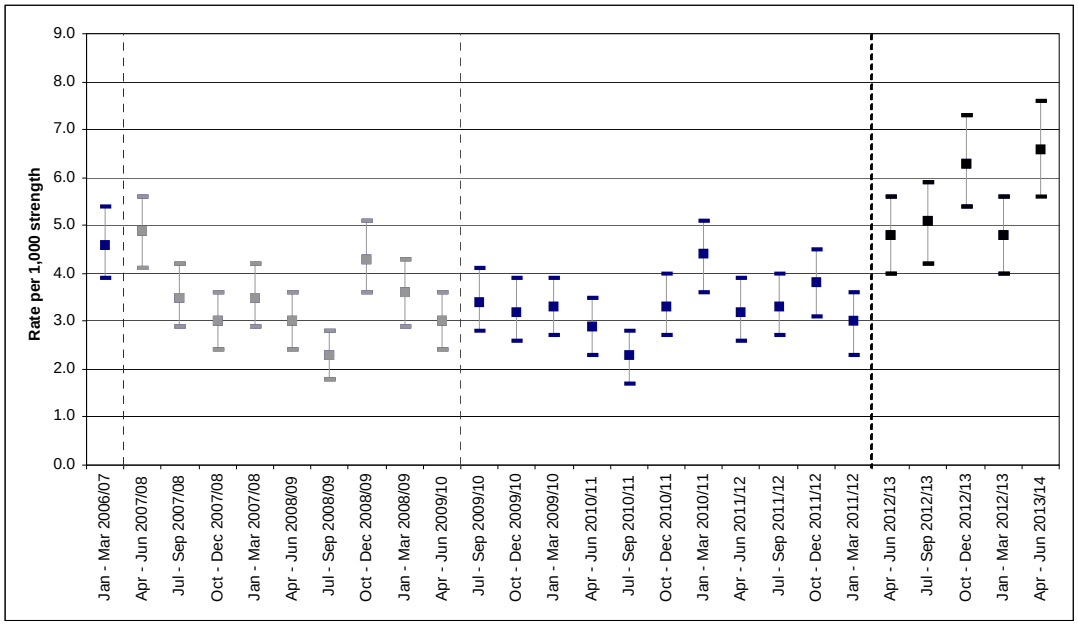
Data Source : British Forces Germany and SSFT in-patient data.(see paragraph 18-19).

1. Deployment to the wider theatre of operation (see paragraph 49).
2. Data for Afghanistan between 1 January 2003 and 14 October 2005 were not available for person level deployment (see paragraph 50).
3. The rates and confidence intervals have been rounded to 1 decimal place (paragraph 54).

84. **Table 9** shows there was no significant difference in the admission rates between those previously deployed on Op TELIC and/or Op HERRICK and those who had not been previously deployed over each of the five quarters presented. This is also the case for those seen for an episode of care at a DCMH (see paragraph 74).

Rate of Armed Forces personnel assessed with a mental disorder quarterly by Service, Time Series, January 2007 to June 2013.

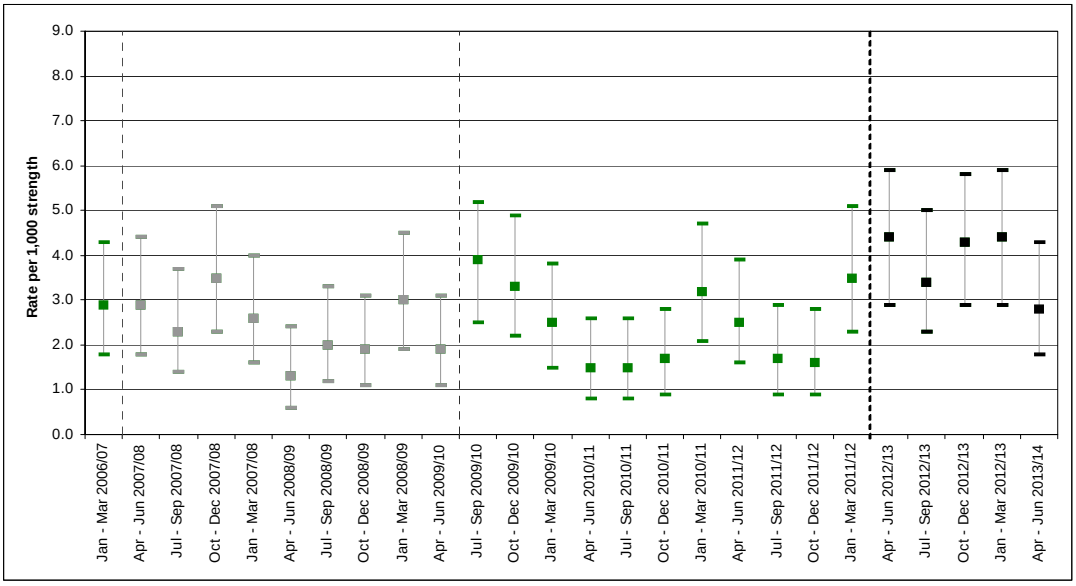
Figure A1: Royal Navy personnel assessed with a mental disorder, January 2007 to June 2013[1,2,3], rates per 1,000 strength per quarter and 95% confidence intervals



Data Source : DS Database and DMICP

1. January 2007 - June 2009 new attendances, July 2009 onwards new episodes of care (see paragraphs 31-32).
2. January 2007 represents a genuine baseline as at this point all cases were 'new episodes of care' as this was the start of data capture by Defence Statistics.
3. April 12 - June 2013 new methodology (see paragraph 33-42).

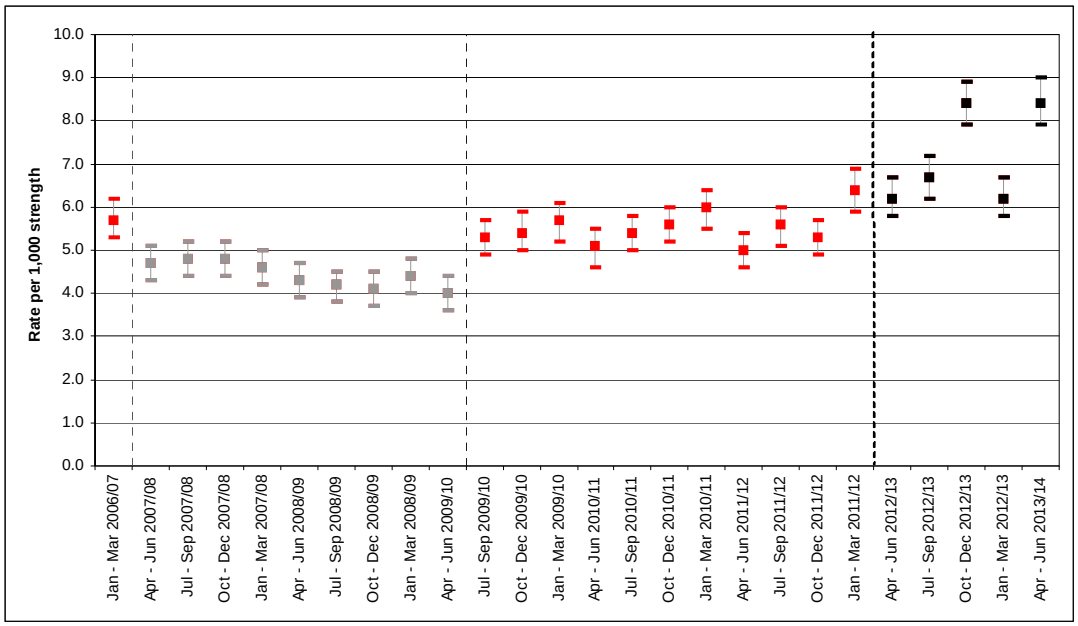
Figure A2: Royal Marine personnel assessed with a mental disorder, January 2007 to June 2013[1,2,3], rates per 1,000 strength per quarter and 95% confidence intervals



Data Source : DS Database and DMICP

1. January 2007 - June 2009 new attendances, July 2009 onwards new episodes of care (see paragraphs 31-32).
2. January 2007 represents a genuine baseline as at this point all cases were 'new episodes of care' as this was the start of data capture by Defence Statistics.
3. April 12 - June 2013 new methodology (see paragraphs 33-42).

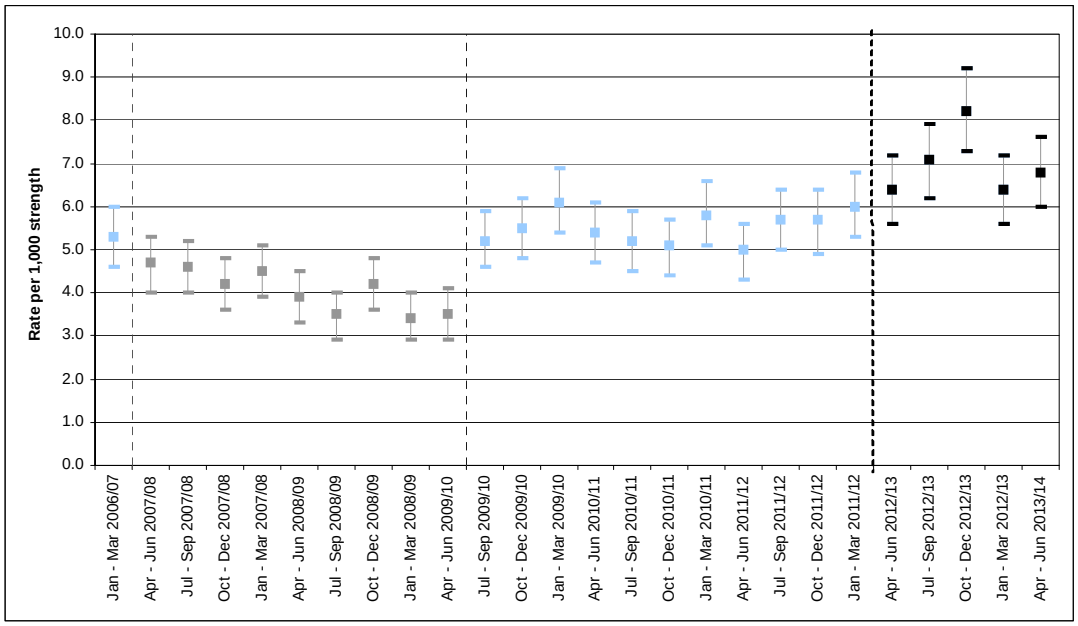
Figure A3: Army personnel assessed with a mental disorder, January 2007 to June 2013[1,2,3], rates per 1,000 strength per quarter and 95% confidence intervals



Data Source : DS Database and DMICP

1. January 2007 - June 2009 new attendances, July 2009 onwards new episodes of care (see paragraphs 31-32).
2. January 2007 represents a genuine baseline as at this point all cases were 'new episodes of care' as this was the start of data capture by Defence Statistics.
3. April 12 - June 2013 new methodology (see paragraphs 33-42).

Figure A4: RAF personnel assessed with a mental disorder, January 2007 to June 2013[1,2,3], rates per 1,000 strength per quarter and 95% confidence intervals



Data Source : DS Database and DMICP

1. January 2007 - June 2009 new attendances, July 2009 onwards new episodes of care (see paragraphs 31-32).
2. January 2007 represents a genuine baseline as at this point all cases were 'new episodes of care' as this was the start of data capture by Defence Statistics.
3. April 12 - June 2013 new methodology (see paragraphs 33-42).