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UK Armed Forces mental health:

Presenting complaints at MOD Departments of Community Mental Health
April - June 2012

2 October 2012

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INTRODUCTION

1. This report provides statistical information on mental health in the UK Armed Forces for the period April 2011 - June 2012. From 1 July 2009 onwards, data used in this report summarises all **new episodes of care** of UK Armed Forces personnel at the MOD's Departments of Community Mental Health (DCMHs) 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's in-patient care contractors.

2. This data updates previous reports and includes previously unpublished data for 1 April to 30 June 2012. The report now also presents in-patient data for overseas patients from 1 April 2011 onwards.

3. Following an external consultation exercise, all future releases of this report will present the latest quarter and the previous four quarters of mental health data only. It will also no longer present the initial mental disorder assessments for all new episodes of care seen at a DCMH by deployment and ICD 10 grouping using rate ratios, due to the fluctuations in the quarterly analysis. Annual data including trends, will only be 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. The annual report will be published in July of each year.

4. DCMHs are specialised mental health services based on community mental health teams closely located with primary care services at sites in the UK and abroad. **Information on patients only seen in the primary care system is not currently available.** To ensure these statistics pick up all **new episodes of care**, DASA have made some changes to data collection and validation from 1 July 2009 onwards. From this date, DASA have also included data from four mental health posts located in medical centres, attached to a DCMH, staffed by psychiatrists and mental health nurses and operating in the same way as a DCMH; seeing and treating personnel referred with suspected mental health disorders. Throughout this report the term DCMH includes these four mental health posts. Details of these changes can be found in the section on **'Data, definitions and methods'**.

5. A rigid pseudo-anonymisation process, and other measures preserving patient confidentiality, has enabled full verification and validation of the DCMH returns. It has also ensured linkage with deployment databases was possible, so that potential effects of deployment could be measured. The first report[a] in this series provides important background information on data governance. A summary of this, along with detail of some minor methodology changes, can be found later in the section on **'Data, definitions and methods'**.

KEY POINTS

Initial Assessments at MOD DCMHs

6. During the three-month period April - June 2012, 954 new episodes of care for mental disorder were identified within UK Armed Forces personnel, representing a rate of 5.0 per 1,000 strength.

7. For the 954 personnel assessed for a new episode of care with a mental disorder, there were some statistically significant findings:

- Rates for Army and RAF personnel were significantly higher than Royal Navy and Royal Marines personnel.
- Rates for females were significantly higher than for males.
- Rates for Other ranks were significantly higher than for Officers.

These findings are consistent with previous reports.

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

- The overall rate of mental disorders for those who had previously deployed compared to those who have not previously deployed was not significantly different.

9. Neurotic disorders were the most prevalent disorder in the period April - June 2012, this is consistent with the findings in the previous four quarters. In the latest quarter, adjustment disorders accounted for the majority of all Neurotic disorders whilst rates of PTSD remained low at 0.3 per 1,000 strength (n = 66).

[a] UK Armed Forces psychiatric morbidity: Assessment of presenting complaints at MOD DCMHs and association with deployment on operations in the Iraq or Afghanistan theatres of operation January – March 2007.

Admissions to the MOD's In-patient Contractor

10. During the three-month period April - June 2012, there were 69 admissions to the MOD's in-patient care contractor representing a rate of 0.4 per 1,000 strength; 48 of these patients had been seen at a DCMH at some point prior to their admission.

POINTS TO NOTE

11. 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. These figures report only attendances for new episodes of care, not all those who were receiving treatment in the time period.

12. 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 produce attitudinal cultural change.

13. 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 DCMHs, 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[b].

DATA, DEFINITIONS AND METHODS

14. To ensure these statistics pick up all new episodes of care, DASA 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, DASA 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.

15. From July 2009 onwards, 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.

16. 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).

17. A number of patients present to DCMHs 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".

18. If Service personnel withhold consent, DCMH staff collect basic demographic information only (Service, gender, rank, age and deployment) thus enabling DASA to include these cases within the tables. For the latest quarter, six cases were included in the analysis where personnel withheld consent but basic demographic information was supplied by the DCMH. As a result these could not be verified or linked to personnel data.

[b] 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.

19. All UK based and aeromedically evacuated Service personnel based overseas (excluding Germany based Service personnel) requiring in-patient admission, are treated by the South Staffordshire and Shropshire NHS Foundation trust. From April 2011 all quarterly reports now include UK Service personnel from British Forces Germany (BFG) who are treated at Guys and St Thomas' Hospital in the UK. Historically BFG in-patients were only reported annually, however due to changes in the reporting process we are now able to include these patients quarterly.

20. 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 January 2012 and April 2012 divided by four for Q4 2011/2012). This estimate is in line with the method used for the annual reports. Strengths figures include regulars (including Gurkhas 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.

21. 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. The rates presented for financial years, 2007/08, 2008/09 and 2009/10 were calculated using updated strength figures[c] between 1 April 2007 and 1 April 2009 inclusive. Strength figures after 1 April 2009 are provisional and subject to change due to ongoing validation of the Joint Personnel Administrative system (JPA).

22. DASA 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[d] and data since April 2007 is obtained from the Joint Personnel Administration (JPA) system. The data covers deployments on Operation TELIC (Iraq) (2003-2009) and Operation HERRICK (Afghanistan) (2001-present).

23. 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.

24. 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.**

25. Operation TELIC is the name for UK operations in Iraq which started in March 2003 and finished in July 2009. 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.

26. 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).

[c] UK Defence Statistics 2011, the annual statistical compendium published by the Ministry of Defence, 28th September 2011.
[d] 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.

27. In line with DASA's rounding policy (May 2009) all numbers fewer than five have been suppressed. Where there is only one cell in a row or column that is fewer than five, the next smallest number has also been suppressed so that numbers cannot be derived from totals. Where there are equal values, both numbers have been suppressed.

28. Data revisions have been made following late submissions from two DCMHs being supplied to DASA after the release of the January - March 2012 quarterly report. As a result the overall figures, Service, Gender, Rank, Deployment and mental disorder group totals has changed as a result thus tables 2, 3, 4, 5 and 6 have been amended with the correct information.

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RESULTS

New Episodes of Care at MOD DCMHs, April - June 2012 summary

29. During the three-month period April - June 2012, a total of 1,269 UK Service personnel were recorded as having been assessed for a new episode of care at the MOD's DCMHs, representing a rate for the period of 6.7 per 1,000 strength[e].

30. **Table 1** provides details of the key socio-demographic characteristics of the 1,269 new episodes of care at the MOD's DCMHs during April - June 2012.

Table 1: New episodes of care at the MOD's DCMHs by demographic characteristics, 1 April 2012 – 30 June 2012, numbers and rates per 1,000 strength.

Characteristic	All patients seen	Patients assessed with a mental disorder			Patients assessed without a mental disorder[1]
		Number	Rate	95% CI	
All	**1,269**	**954**	**5.0**	**(4.7 - 5.3)**	**315**
Service					
Royal Navy	126	90	3.2	(2.6 - 3.9)	36
Royal Marines	31	24	3.0	(1.9 - 4.5)	7
Army	805	611	5.3	(4.9 - 5.8)	194
RAF	307	229	5.7	(5.0 - 6.4)	78
Gender					
Males	1,017	747	4.3	(4.0 - 4.6)	270
Females	252	207	11.6	(10.0 - 13.2)	45
Rank					
Officers	115	92	2.9	(2.3 - 3.4)	23
Other ranks	1,154	862	5.5	(5.1 - 5.8)	292
Deployment - Theatres of operation[2]					
Op TELIC and/or Op HERRICK[3]	798	623	5.1	(4.7 - 5.5)	175
of which, Op TELIC	455	361	4.8	(4.3 - 5.3)	94
Op HERRICK[3]	613	477	5.2	(4.7 - 5.6)	136
Neither Op TELIC nor Op HERRICK[3]	471	331	4.8	(4.3 - 5.3)	140

1. Patients assessed without a mental disorder (see paragraph 17).
2. Deployment to the wider theatre of operation (see paragraph 23).
3. Figures for Afghanistan theatre of Operation for period October 2005 – present (see paragraph 24).

31. Of the 1,269 new episodes of care, 954 (75%) were assessed with a mental disorder, representing an overall rate for new episodes of care for mental disorder of 5.0 per 1,000 strength. There were 315 patients who were recorded as having no mental disorder at their initial assessment. Table 1 shows some statistically significant findings :

32. Army and RAF personnel had significantly higher rates of mental disorder (5.3 per 1,000 strength and 5.7 per 1,000 strength respectively) compared to Royal Navy personnel and Royal Marine personnel (3.2 per 1,000 strength and 3.0 per 1,000 strength respectively).

33. The rate of mental disorder was higher in females than males (11.6 per 1,000 strength and 4.3 per 1,000 strength respectively).

34. 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 5.5 per 1,000 strength compared to Officers at 2.9 per 1,000 strength. 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 all., 2003). 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).

35. There was no significant difference in the rate of mental disorder among those previously deployed to Op TELIC and/or Op HERRICK compared to those who had not been identified as having previously deployed prior to their episode of care (5.1 and 4.8 per 1,000 strength respectively), thus there was no adverse effect of deployment on absolute rates of mental health in Q1 of 2012/13.

New Episodes of Care at MOD DCMHs for the five quarter period April-June 2011 to April -June 2012

[e] Using a four-month average of regular and mobilised reserves strength from 1 April 2012 to 1 July 2012 (see paragraph 20).

Trends by demographic variable

36. **Tables 2, 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 (April 2011 to June 2012).

Table 2: Episodes of care at the MOD's DCMH, April 2011 – June 2012 by quarter, numbers and rates per 1,000 strength.

		Patients assessed with a mental disorder			Patients assessed without a mental disorder
	All patients seen	Number	Rate	95% CI	
April - June 2011	1,219	916	4.6	(4.3 - 4.9)	303
July - September 2011	1,345	993	5.1	(4.8 - 5.4)	352
October - December 2011	1,350	968	5.0	(4.7 - 5.3)	382
January - March 2012	r1,490	r1,093	5.7	(5.3 - 6.0)	r397
April - June 2012	1,269	954	5.0	(4.7 - 5.3)	315

1. Changes to previously published totals are annotated with 'r' (see paragraph 28)

37. The overall rate of Service personnel assessed with a mental disorder has remained stable through out the last five quarters, with no significant changes quarter on quarter. The rise in the rate for the period January - March 2012 was seen in the same period last year and may be a reflection of personnel returning from the previous summer deployment to Afghanistan.

Table 3: Episodes of care at the MOD's DCMH by Service, April 2011 – June 2012 by quarter, numbers and rates per 1,000 strength.

	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 2011	96	3.2	(2.6 - 3.9)	21	2.5	(1.6 - 3.9)	587	5.0	(4.6 - 5.4)	212	5.0	(4.3 - 5.6)
July - September 2011	98	3.3	(2.7 - 4.0)	14	1.7	(0.9 - 2.9)	640	5.6	(5.1 - 6.0)	241	5.7	(5.0 - 6.4)
October - December 2011	109	3.8	(3.1 - 4.5)	13	1.6	(0.9 - 2.8)	610	5.3	(4.9 - 5.7)	236	5.7	(4.9 - 6.4)
January - March 2012	85	3.0	(2.3 - 3.6)	28	3.5	(2.3 - 5.1)	r733	6.4	(5.9 - 6.9)	247	6.0	(5.3 - 6.8)
April - June 2012	90	3.2	(2.6 - 3.9)	24	3.0	(1.9 - 4.5)	611	5.3	(4.9 - 5.8)	229	5.7	(5.0 - 6.4)

1. Changes to previously published totals are annotated with 'r' (see paragraph 28).

38. **Table 3** shows some significant differences in the rate of mental disorder between the Services. In each of the last five quarters, the Army and RAF had significantly higher rates compared to the Royal Navy and Royal Marines.

39. Each Service has its own recruitment policies and standards; a possible explanation for the higher rates in the RAF is that they recruit older personnel compared to the other Services and these personnel often have higher educational attainment on joining the Armed Forces. In the civilian population it has been shown that higher educational attainment can lead to greater help seeking behaviour (Meltzer et all., 2003). Thus it may be that the RAF do not have absolute higher levels of mental health problems, rather they are more likely to seek help to resolve them.

40. 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).

41. Within each of the Services there have been no significant increase over the five quarters presented in Table 3, with the exception of the Army in the period January-March 2012 which saw a rise from 5.3 to 6.4 per 1,000 strength and then a significant decrease in the following period back to a rate of 5.3 per 1,000 strength. The reason for this remains unclear at present but may reflect personnel returning from the previous summer deployment to Afghanistan.

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Table 4: Episodes of care the MOD's DCMH by gender and rank, April 2011 – June 2012 by quarter, numbers and rates per 1,000 strength.

	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 2011	737	4.1	(3.8 - 4.4)	179	9.8	(8.4 - 11.2)	87	2.6	(2.1 - 3.1)	829	5.1	(4.7 - 5.4)
July - September 2011	801	4.5	(4.2 - 4.8)	192	10.6	(9.1 - 12.1)	104	3.1	(2.5 - 3.7)	889	5.5	(5.1 - 5.9)
October - December 2011	772	4.4	(4.1 - 4.7)	196	10.8	(9.3 - 12.3)	103	3.1	(2.5 - 3.7)	865	5.4	(5.0 - 5.7)
January - March 2012	r874	5.0	(4.7 - 5.3)	219	12.2	(10.6 - 13.8)	r106	3.3	(2.6 - 3.9)	r987	6.2	(5.8 - 6.6)
April - June 2012	747	4.3	(4.0 - 4.6)	207	11.6	(10.0 - 13.2)	92	2.9	(2.3 - 3.4)	862	5.5	(5.1 - 5.8)

1. Changes to previously published totals are annotated with 'r' (see paragraph 28).

42. The rate of mental disorder was higher in females than males throughout the five quarters presented in **Table 4**. This finding is replicated in the civilian population where females are 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 (Better or Worse; a follow up study of the mental health of adults in Great Britain London, National Statistics, 2003). DASA have not investigated whether females in the UK Armed Forces have more interactions with health professionals than their male colleagues.

43. 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 all., 2003). 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 the MOD's DCMHs by deployment[1,2], April 2011 – June 2012 by quarter, numbers and rates per 1,000 strength.

	Deployment - Theatres of operation[1]											
				of which								
	Op TELIC and/or Op HERRICK[2]			*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 2011	560	4.5	(4.1 - 4.9)	*374*	*4.4*	*(4.0 - 4.9)*	*401*	*4.7*	*(4.3 - 5.2)*	356	4.9	(4.4 - 5.4)
July - September 2011	656	5.3	(4.9 - 5.7)	*407*	*5.0*	*(4.5 - 5.4)*	*456*	*5.3*	*(4.8 - 5.8)*	337	4.7	(4.2 - 5.2)
October - December 2011	628	5.1	(4.7 - 5.5)	*399*	*5.0*	*(4.5 - 5.5)*	*442*	*4.9*	*(4.5 - 5.4)*	340	4.8	(4.3 - 5.3)
January - March 2012	r708	5.8	(5.4 - 6.2)	r *411*	*5.3*	*(4.8 - 5.8)*	r *537*	*6.0*	*(5.4 - 6.5)*	r385	5.5	(4.9 - 6.0)
April - June 2012	623	5.1	(4.7 - 5.5)	*361*	*4.8*	*(4.3 - 5.3)*	*477*	*5.2*	*(4.7 - 5.6)*	331	4.8	(4.3 - 5.3)

1. Deployment to the wider theatre of operation (see paragraph 23).
2. Figures for Afghanistan theatre of Operation for period October 2005 – present (see paragraph 24).
3. Changes to previously published totals are annotated with 'r' (see paragraph 28).

44. **Table 5** shows there was no effect of deployment on overall rates of mental health in the UK Armed Forces. The quarterly trends presented show no significant difference in the rates of mental health among those who had previously deployed to Op TELIC and/or Op HERRICK compared to those who had not been identified as having previously deployed prior to their episode of care (for example in April – June 2012, rate of 5.1 per 1,000 compared to 4.8 per 1,000 respectively).

Trends by mental disorder

45. **Table 6** (see page 9) provides details of the types of presenting complaints, by ICD-10 grouping, for the 954 patients seen for a new episode of care during April - June 2012 and assessed with a mental disorder and for the previous four quarters.

46. Neurotic disorders were the most common disorder throughout the five quarter period presented in **Table 6**. Adjustment disorders accounted for 60% of all neurotic disorders in the latest quarter, in line with previous quarters.

47. Rates of PTSD remained low at 0.3 per 1,000 strength for the latest quarter. This finding has remained consistent for the last five quarters, thus the rate of PTSD being assessed at the DCMH has not changed over time.

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48. Rates for each mental disorder type have remained stable throughout the last five quarters, however rates of neurotic disorder (and adjustment disorder) significantly increased for the period January-March 2012 to 3.7 per 1,000 strength and then significantly decreased in the latest quarter to 3.1 per 1,000 strength. The reason for this remains unclear at present but may reflect personnel returning from the previous summer deployment to Afghanistan.

49. Mood disorders had the second highest rate of mental disorder in each of the five quarters presented, with depressive episodes accounting for 91% of all mood disorders assessed at a DCMH.

50. Rates of psychoactive substance use remain low throughout five quarters presented; in the latest quarter Service personnel were assessed at a rate of 0.4 per 1,000 strength.

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Table 6: Initial mental disorder assessments for all new episodes of care seen at a DCMH by ICD-10 grouping, April 2011 to June 2012 by quarter, numbers and rates[1] per 1,000 strength.

	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 2011	56	0.3	(0.2 - 0.4)	*54*	*0.3*	*(0.2 - 0.3)*	217	1.1	(1.0 - 1.2)	*209*	*1.1*	*(0.9 - 1.2)*	566	2.9	(2.6 - 3.1)	*59*	*0.3*	*(0.2 - 0.4)*	*394*	*2.0*	*(1.8 - 2.2)*	77	0.4	(0.3 - 0.5)
July - September 2011	74	0.4	(0.3 - 0.5)	*72*	*0.4*	*(0.3 - 0.5)*	252	1.3	(1.1 - 1.5)	*233*	*1.2*	*(1.0 - 1.3)*	592	3.0	(2.8 - 3.3)	*69*	*0.4*	*(0.3 - 0.4)*	*371*	*1.9*	*(1.7 - 2.1)*	75	0.4	(0.3 - 0.5)
October - December 2011	71	0.4	(0.3 - 0.5)	*67*	*0.3*	*(0.3 - 0.4)*	256	1.3	(1.2 - 1.5)	*218*	*1.1*	*(1.0 - 1.3)*	575	3.0	(2.7 - 3.2)	*68*	*0.3*	*(0.3 - 0.4)*	*362*	*1.9*	*(1.7 - 2.1)*	66	0.3	(0.3 - 0.4)
January - March 2012	r86	0.4	(0.4 - 0.5)	r*85*	*0.4*	*(0.3 - 0.5)*	r237	1.2	(1.1 - 1.4)	r*210*	*1.1*	*(0.9 - 1.2)*	r709	3.7	(3.4 - 4.0)	r*77*	*0.4*	*(0.3 - 0.5)*	r*434*	*2.3*	*(2.0 - 2.5)*	61	0.3	(0.2 - 0.4)
April - June 2012	65	0.3	(0.3 - 0.4)	*61*	*0.3*	*(0.2 - 0.4)*	241	1.3	(1.1 - 1.4)	*230*	*1.2*	*(1.1 - 1.4)*	589	3.1	(2.8 - 3.3)	*66*	*0.3*	*(0.3 - 0.4)*	*353*	*1.9*	*(1.7 - 2.0)*	59	0.3	(0.2 - 0.4)

1. The rates and confidence intervals have been rounded to 1 decimal place (paragraph 21).
2. Changes to previously published totals are annotated with 'r' (see paragraph 28).

Admissions to the MOD's In-patient Contractors

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

52. During the three-month period April - June 2012, there were 69 admissions of Service personnel to the MOD's in-patient contractors[f] which correspond to a rate of 0.4 per 1,000 strength.

53. Of the 69 admissions, 48 had been seen at a DCMH between January 2007 and the date of their admission. The remaining 21 patients were admitted to one of the in-patient contractors without DASA's records showing that they had been seen at a DCMH prior their in-patient admission.

Table 7: Admissions to the MOD's in-patient contractors by Service, April 2011 – June 2012 by quarter, numbers[1] and rates[2] per 1,000 strength.

	All admissions			Service								
				Naval Service[3]			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 2011	85	0.4	(0.3 - 0.5)	8	0.2	(0.1 - 0.4)	72	0.6	(0.5 - 0.8)	5	0.1	(0.0 - 0.3)
July - September 2011	72	0.4	(0.3 - 0.5)	7	0.2	(0.1 - 0.4)	60	0.5	(0.4 - 0.6)	5	0.1	(0.0 - 0.3)
October - December 2011	74	0.4	(0.3 - 0.5)	~	0.1	(0.0 - 0.3)	61	0.5	(0.4 - 0.7)	~	0.2	(0.1 - 0.4)
January - March 2012	73	0.4	(0.3 - 0.5)	7	0.2	(0.1 - 0.4)	56	0.5	(0.4 - 0.6)	10	0.2	(0.1 - 0.4)
April - June 2012	69	0.4	(0.3 - 0.4)	9	0.3	(0.1 - 0.5)	47	0.4	(0.3 - 0.5)	13	0.3	(0.2 - 0.6)

1. British Forces Germany in-patients are now included in the 2011/12 totals (paragraph 19).
2. The rates and confidence intervals have been rounded to 1 decimal place (paragraph 21).
3. Royal Navy and Royal Marines combined to protect patient confidentiality.
4. Data presented as "~" has been suppressed in accordance with DASA's rounding policy (see paragraph 27).

54. **Table 7** shows the overall rate of admissions to the MOD's in-patient contractors has remained at 0.4 per 1,000 strength in each of the last five quarters.

55. For each Service the rate of admission to the MOD in-patient contractor has remained stable over time.

Table 8: Admissions to the MOD's in-patient contractors by gender and rank, April 2011 – June 2012 by quarter, numbers[1] and rates[2] per 1,000 strength.

	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 2011	77	0.4	(0.3 - 0.5)	8	0.4	(0.2 - 0.9)	9	0.3	(0.1 - 0.5)	76	0.5	(0.4 - 0.6)
July - September 2011	63	0.4	(0.3 - 0.4)	9	0.5	(0.2 - 0.9)	~	0.1	(0.0 - 0.3)	~	0.4	(0.3 - 0.5)
October - December 2011	66	0.4	(0.3 - 0.5)	8	0.4	(0.2 - 0.9)	~	0.1	(0.0 - 0.3)	~	0.4	(0.3 - 0.5)
January - March 2012	65	0.4	(0.3 - 0.5)	8	0.4	(0.2 - 0.9)	~	0.1	(0.0 - 0.3)	~	0.4	(0.3 - 0.5)
April - June 2012	60	0.3	(0.3 - 0.4)	9	0.5	(0.2 - 1.0)	6	0.2	(0.1 - 0.4)	63	0.4	(0.3 - 0.5)

1. British Forces Germany in-patients are now included in the 2011/12 totals (paragraph 19).
2. The rates and confidence intervals have been rounded to 1 decimal place (paragraph 21).
3. Data presented as "~" has been suppressed in accordance with DASA's rounding policy (see paragraph 27).

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

57. There were no significant differences over the last five quarters in the rate of admissions between officers and other ranks. This is in contrast to the higher rates seen among other ranks attending a MOD DCME for a new episode of care.

[f] UK in-patient data provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust and British Forces Germany in-patient data provided by Guys and St Thomas' Hospital.

THIS REPORT IS NO LONGER VALID.
PLEASE SEE Q1 2013/14 RELEASED 3 OCTOBER 2013 FOR THE UPDATED QUARTERLY DATA

Table 9: Admissions to the MOD's in-patient contractors by deployment[1,2], April 2011 – June 2012 by quarter, numbers[3] and rates[4] per 1,000 strength.

	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 2011	46	0.4	(0.3 - 0.5)	*33*	*0.4*	*(0.3 - 0.5)*	*33*	*0.4*	*(0.3 - 0.5)*	39	0.5	(0.4 - 0.7)
July - September 2011	45	0.4	(0.3 - 0.5)	*24*	*0.3*	*(0.2 - 0.4)*	*33*	*0.4*	*(0.3 - 0.5)*	27	0.4	(0.2 - 0.5)
October - December 2011	49	0.4	(0.3 - 0.5)	*26*	*0.3*	*(0.2 - 0.5)*	*39*	*0.4*	*(0.3 - 0.6)*	25	0.4	(0.2 - 0.5)
January - March 2012	43	0.3	(0.2 - 0.5)	*27*	*0.3*	*(0.2 - 0.5)*	*28*	*0.3*	*(0.2 - 0.4)*	31	0.4	(0.3 - 0.6)
April - June 2012	41	0.3	(0.2 - 0.4)	*25*	*0.3*	*(0.2 - 0.5)*	*30*	*0.3*	*(0.2 - 0.4)*	28	0.4	(0.3 - 0.6)

1. Deployment to the wider theatre of operation (see paragraph 23).
2. Figures for Afghanistan theatre of operation for period October 2005 – present (see paragraph 24).
3. British Forces Germany in-patients are now included in the 2011/12 totals (paragraph 19).
4. The rates and confidence intervals have been rounded to 1 decimal place (paragraph 21).

58. **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 there (for example, in April-June 2012 rate of 0.3 per 1,000 compared to 0.4 per 1,000 respectively).