Ministry of Defence

UK Armed Forces Mental Health: Quarterly report Apr-Jun 2007/08 – Jul-Sep 2015/16

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This quarterly report provides statistical information on mental health in the UK Armed Forces for the period 1 April 2007 to 30 September 2015. It summarises all initial assessments for a new episode of care among Service personnel at MOD Specialist Mental Health Services (Departments of Community Mental Health (DCMH) for outpatient care, and all admissions to the MOD's in-patient care contractor) by quarter.

This quarter series provides figures for the number of UK Armed Forces personnel assessed at a MOD DCMH and/or to be admitted to one of the MOD's in-patient care providers in addition to the number of new episodes of care. This report presents quarterly data trend information on presentations for mental health assessment. This report is the first in the series presenting information on presentations to MOD Specialist Mental Health Care by Regular and Reservist personnel.

All tables provided in previous releases of this report have been updated with data for July-September 2015/16 and are available in the separate Excel file at https://www.gov.uk/government/collections/defence-mental-health-statistics-index.

Key Points and Trends

Personnel assessed with mental disorders at MOD Specialist Mental Health Services have risen steadily from 0.6% of UK Armed Forces personnel at risk in April-June 2007/08, to **0.8%** in July-September 2015/16. It is unclear what proportion of this rise is due to the success of anti-stigma campaigns and what is a true rise in mental health disorders.

In the latest quarter, **1,350** UK Armed Forces personnel had **1,398** new episodes of care for a mental disorder at MOD Specialist Mental Health Services.

Higher presentations in certain demographic groups remained broadly similar to that seen in previous quarters :

- **Army** and **RAF** personnel - the lower rates of mental disorder seen among Royal Marines may be the due to the recruitment selection process, support received as a result of tight unit cohesion and high levels of preparedness for combat;
- **Females** - this is replicated in the UK civilian population and may be a result of females being more likely to report mental health problems than males;
- **Other Ranks** - higher educational attainment and socio-economic background are associated with lower levels of mental health disorder and this may explain differences in the rates between officers and other ranks;

In line with previous findings, Adjustment Disorders were the most prevalent disorder during the period July-September 2015/16, accounting for 32% of all new episodes of care seen at a MOD DCMH. PTSD rates remained low with less than 0.1% of all UK Armed Forces personnel assessed with this disorder between July-September 2015/16.

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Background Quality Report: www.gov.uk/government/statistics/mental-health-in-the-uk-armed-forces-background-quality-report

Contents

Supplementary tables containing :

- all data presented in this publication
- updated tables from previous quarterly reports presenting numbers, rates and 95% confidence intervals on new episodes of care and numbers of UK Armed Forces personnel

And the UK Armed Forces Mental Health Annual summary providing annual trends over time and comparisons between the UK Armed Forces to the general UK population

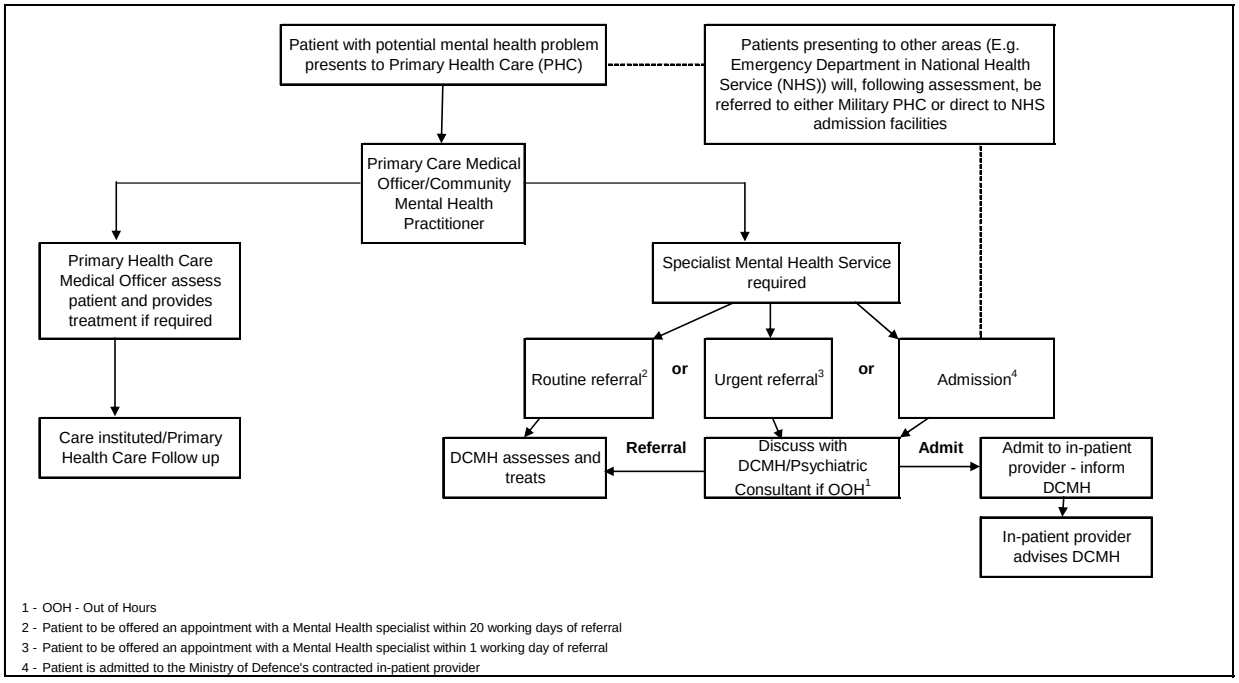
can be found at: https://www.gov.uk/government/collections/defence-mental-health-statistics-index

Introduction

1. Assessment and care-management within the Armed Forces for personnel experiencing mental health problems is available at three levels :

- In Primary Health Care (PHC), by the patient's own Medical Officer (MO).
- In the community through specialists in military Departments of Community Mental Health (DCMH).
- In hospitals, either the NHS or the contracted In-Patient Service Provider (ISP).

2. The level of care a patient may require is determined by a number of factors, including the severity of symptoms and the degree of risk posed by the patient's current condition. The following diagram shows the pathways into mental health services in the Armed Forces :



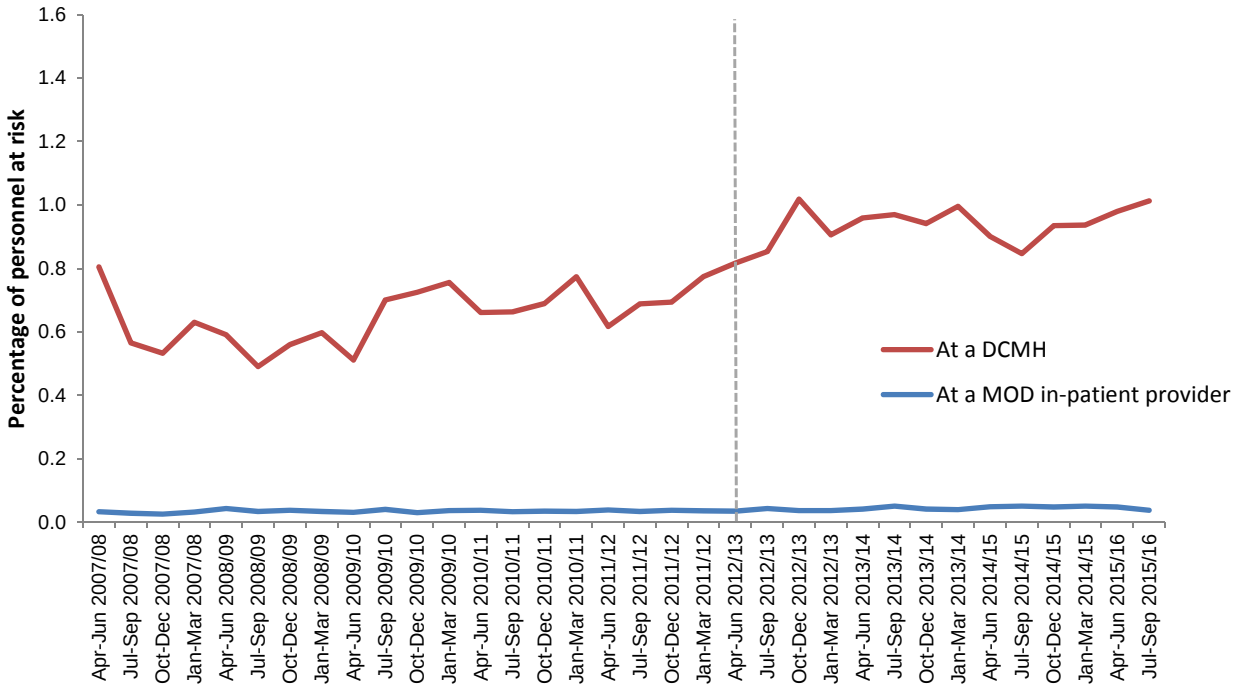
3. This report summarises all attendances for a new episode of care of Armed Forces personnel at MOD Specialist Mental Health Services (**MOD's DCMH for outpatient care, and all admissions to the MOD's in-patient care contractor) only**. It therefore captures patients referred to the Specialist Mental Health Service and does not represent the totality of mental health problems in the Armed Forces as some patients can be treated wholly within the primary care setting by their GP or medical officer.

4. DCMH are specialised psychiatric services based on community mental health teams closely located with primary care services at sites in the UK and abroad. 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 SSSFT NHS Foundation trust; UK based Service personnel from British Forces Germany are treated at Gilead IV hospital, Bielefeld under a contract with SSAFA through the Limited Liability Partnership. When presenting in-patient data in this report, the data include returns from both contract providers.

Results : Trends in UK Armed Forces mental health initial assessments Apr-Jun 2007/08 – Jul-Sep 2015/16

5. UK Armed Forces personnel may access specialist mental health care as an outpatient at a MOD Department of Community Mental Health (DCMH) and/or as an in-patient at a MOD in-patient care provider. Clinician's record the patient's initial mental health assessment based on the presenting signs and symptoms. A number of patients are assessed by clinician's as having no specific and identifiable mental disorder.

Figure 1 : UK Armed Forces personnel presenting at MOD Specialist Mental Health Services by Service type, Apr-Jun 2007/08 – Jul-Sep 2015/16, percentage of personnel at risk.

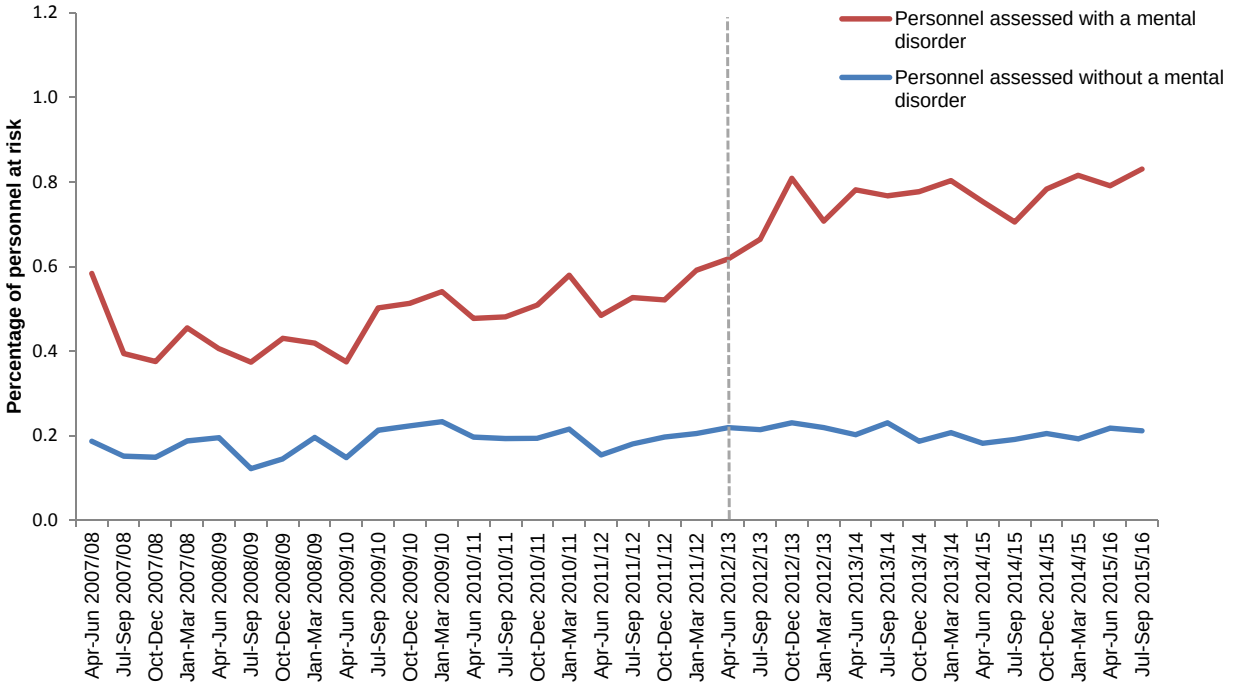


Source : DS Database, DMICP, SSSFT and BFG

1. Dotted lines represent 2012/13 revised methodology to include electronic patient record data source (paragraph 23)
2. Percentages are based on the calculation of the absolute number and are presented to 1dp (See paragraph 27)
3. Please note, an individual may have had contact at both DCMH and In-patient provider.

6. There has been a rising trend in the percentage of UK Armed Forces personnel seen at both MOD DCMH and in-patient provider. Possible explanations for the rise maybe the successful effect of campaigns run by the MOD to reduce stigma, resulting in more UK Armed Forces personnel presenting for assessment or a true rise in mental disorders among military personnel. It is not possible to determine proportionately how much of the overall changes seen in initial assessments were due to each of these factors.

Figure 2 : UK Armed Forces personnel presenting at MOD Specialist Mental Health Services by initial assessment[3], Apr-Jun 2007/08 – Jul-Sep 2015/16, percentage of personnel at risk.



Source : DS Database, DMICP, SSSFT and BFG

1. Dotted lines represent 2012/13 revised methodology to include electronic patient record data source (paragraph 23)
2. Percentages are based on the calculation of the absolute number and are presented to 1dp (See paragraph 27)
3. Clinician's initial assessment based on presenting symptoms (paragraphs 21 and 22)

7. Over time, an increasing proportion of personnel seen at MOD Specialist Mental Health Services were assessed with having a mental disorder, thus requiring the treatment skills and services of MOD mental health clinicians. In the latest quarter, 80% of those presenting to MOD Specialist Mental Health Services were assessed with having a mental disorder compared to 66% in the first quarter of 2008/09. The reasons for this are unclear.

Results : Number of UK Armed Forces personnel initial assessments Jul-Sep 2014/15 – Jul-Sep 2015/16

Table 1 : UK Armed Forces personnel presenting at MOD Specialist Mental Health Services by Service provider, initial assessment, Jul-Sep 2014/15 – Jul-Sep 2015/16, numbers and percentage of personnel at risk.

	Jul-Sep 2014/15	Oct-Dec 2014/15	Jan-Mar 2014/15	Apr-Jun 2015/16	Jul-Sep 2015/16
Number of personnel	n	n	n	n	n
Personnel with an initial assessment with MOD Mental Health Services[1]	**1,502**	**1,650**	**1,658**	**1,647**	**1,690**
At a DCMH	*1,445*	*1,595*	*1,598*	*1,603*	*1,645*
At a MOD in-patient provider	*86*	*82*	*87*	*78*	*61*
Personnel assessed with a mental disorder[2]	*1,180*	*1,301*	*1,340*	*1,294*	*1,350*
Personnel assessed without a mental disorder[2]	*320*	*341*	*317*	*357*	*344*
Missing mental disorder information[3]	*10*	*16*	*3*	*1*	*5*
Percentage of personnel at risk	%	%	%	%	%
Personnel with an initial assessment with MOD Mental Health Services[1]	***0.9***	***1.0***	***1.0***	***1.0***	***1.0***
At a DCMH	*0.8*	*0.9*	*0.9*	*1.0*	*1.0*
At a MOD in-patient provider	*0.1*	*0.0*	*0.1*	*0.0*	*0.0*
Personnel assessed with a mental disorder[2]	*0.7*	*0.8*	*0.8*	*0.8*	*0.8*
Personnel assessed without a mental disorder[2]	*0.2*	*0.2*	*0.2*	*0.2*	*0.2*
Missing mental disorder information[3]	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*

Source : DS Database, DMICP, SSSFT and BFG

1. Please note, an individual may have had contact at both DCMH and In-patient provider.
2. Clinician's initial assessment based on presenting symptoms. Please note an individual may have had more than one contact with mental health services and be assessed with a mental and without a disorder on separate occasions (paragraphs 21 and 22)
3. Initial diagnosis not available (See BQR)
4. Percentages are based on the calculation of the absolute number and are presented to 1dp (paragraph 27)

8. In the latest quarter, **1.0% (n=1,690) of UK Armed Forces personnel presented to MOD Specialist Mental Health Services.** Of these, 1,645 personnel were assessed at a DCMH and 61 were assessed at a MOD In-Patient provider (please note personnel may be in contact with both service types). The percentage of personnel presenting to DCMHs has increased since Jul-Sep 2014/15, although there was no significant difference quarter on quarter during this period.

9. In Jul-Sep 2015/16, **61** UK Armed Forces personnel were seen at one of the MODs in-patient providers, of which **44** (72%) also had an assessment at a DCMH either prior to or on the same day as their in-patient admission.

10. Higher presentations to MOD Specialist Mental Health Services in certain demographic groups remained broadly similar to that seen in previous quarters :

- Army and RAF personnel
- Females
- Other Ranks

11. Since Jan – Mar 2014/15, higher rates of mental disorder were seen among personnel previously deployed to Iraq and/or Afghanistan. Defence Statistics will continue to monitor this to determine if this trend continues.

Table 1a : UK Armed Forces personnel presenting at MOD Specialist Mental Health Services by Service provider, initial assessment, Jul-Sep 2014/15 – Jul-Sep 2015/16, numbers.

	Jul-Sep 2014/15			Oct-Dec 2014/15			Jan-Mar 2014/15			Apr-Jun 2015/16			Jul-Sep 2015/16		
	Regular	Reserves	Other[4]	Regular	Reserves	Other[4]	Regular	Reserves	Other[4]	Regular	Reserves	Other[4]	Regular	Reserves	Other[4]
Number of personnel	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n
Personnel with an initial assessment with MOD Mental Health Services[1]	**1,449**	**17**	**36**	**1,605**	**21**	**24**	**1,635**	**~**	**~**	**1,602**	**20**	**25**	**1,634**	**19**	**37**
At a DCMH	*1,396*	*~*	*~*	*1,550*	*21*	*24*	*1,578*	*20*	*0*	*1,558*	*20*	*25*	*1,589*	*19*	*37*
At a MOD in-patient provider	*81*	*~*	*~*	*82*	*0*	*0*	*84*	*~*	*~*	*78*	*0*	*0*	*61*	*0*	*0*
Personnel assessed with a mental disorder[2]	*1,134*	*17*	*29*	*1,268*	*15*	*18*	*1,322*	*~*	*~*	*1,260*	*~*	*~*	*1,304*	*~*	*~*
Personnel assessed without a mental disorder[2]	*313*	*0*	*7*	*329*	*6*	*6*	*312*	*5*	*0*	*346*	*~*	*~*	*334*	*~*	*~*
Missing mental disorder information[3]	*10*	*0*	*0*	*16*	*0*	*0*	*3*	*0*	*0*	*1*	*0*	*0*	*5*	*0*	*0*

Source: DMICP, SSSFT, BFG and JPA

1. Please note, an individual may have had contact at both DCMH and In-patient provider (See BQR).
2. Clinician's initial assessment based on presenting symptoms. Please note an individual may have had more than one contact with mental health services and be assessed with a mental and without a disorder on separate occasions (paragraphs 21 and 22)
3. Initial diagnosis not available (See BQR)
4. Includes MPGS and where Derived Assign Type is not completed on JPA at time of data extraction
5. Entitlement to mental health care is different for Regulars and Reserves and therefore the statistics between these groups are not comparable (See BQR)
6. Data presented as "~" has been suppressed in accordance with Defence Statistic's rounding policy (paragraph 28)

12. Regular and Reservist personnel have different entitlements to mental health care and therefore comparisons on presentation to MOD Specialist Mental Health Services should not be made between these two groups. In addition to differences in entitlement to care, Reservists may also present to their NHS GP for treatment and therefore will not be included in the statistics presented in Table 1a.

Results : Number of new episodes of care among UK Armed Forces personnel Jul-Sep 2014/15 – Jul-Sep 2015/16

Number of new episodes of care at MOD Specialist Services in Jul-Sep 2014/15 – Jul-Sep 2015/16

13. Personnel may have more than one episode of care in a three-month period. To understand clinical activity and prevalence of mental health disorders assessed at MOD Specialist Mental Health Services, it is important to present the total number of new episodes of care. This is of particular use to MOD's policy areas and other internal users of this report.

Table 2 : UK Armed Forces new episodes of care at MOD Specialist Mental Health Services by Service provider, initial assessment[2], Jul-Sep 2014/15 – Jul-Sep 2015/16, numbers and percentage of personnel at risk.

	Jul-Sep 2014/15	Oct-Dec 2014/15	Jan-Mar 2014/15	Apr-Jun 2015/16	Jul-Sep 2015/16
Number of new episodes of care	n	n	n	n	n
New episodes of care at MOD Mental Health Services[1]	**1,545**	**1,688**	**1,718**	**1,717**	**1,748**
At a DCMH	*1,451*	*1,598*	*1,624*	*1,631*	*1,682*
At a MOD in-patient provider	*94*	*90*	*94*	*86*	*66*
Episodes assessed with a mental disorder[2]	*1,214*	*1,328*	*1,394*	*1,357*	*1,398*
Episodes assessed without a mental disorder[2]	*321*	*342*	*320*	*359*	*345*
Missing mental disorder information[3]	*10*	*18*	*4*	*1*	*5*
Percentage of personnel at risk	%	%	%	%	%
New episodes of care at MOD Mental Health Services[1]	***0.9***	***1.0***	***1.0***	***1.1***	***1.1***
At a DCMH	*0.9*	*1.0*	*1.0*	*1.0*	*1.0*
At a MOD in-patient provider	*0.1*	*0.1*	*0.1*	*0.1*	*0.0*
Episodes assessed with a mental disorder[2]	*0.7*	*0.8*	*0.8*	*0.8*	*0.9*
Episodes assessed without a mental disorder[2]	*0.2*	*0.2*	*0.2*	*0.2*	*0.2*
Missing mental disorder information[3]	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*

Source : DS Database, DMICP, SSSFT, BFG

1. Percentages are based on the calculation of the absolute number and are presented to 1dp (paragraph 27)
2. Clinician's initial assessment based on presenting symptoms (paragraphs 21 and 22)
3. Initial diagnosis not available (See BQR)

14. As seen in Table 1, the proportion of new episodes of care for a mental health disorder over the latest five-quarter period remained stable at around 0.8% of the UK Armed Forces population.

15. Table 1 and Table 2 shows between July and September 2015/16, **1,350** UK Armed Forces personnel had **1,398** new episodes of care for a mental disorder at MOD Specialist Mental Health Services.

Table 2a : UK Armed Forces new episodes of care at MOD Specialist Mental Health Services by Service provider, initial assessment[2], Jul-Sep 2014/15 – Jul-Sep 2015/16, numbers.

	Jul-Sep 2014/15			Oct-Dec 2014/15			Jan-Mar 2014/15			Apr-Jun 2015/16			Jul-Sep 2015/16		
	Regular	Reserves	Other[4]	Regular	Reserves	Other[4]	Regular	Reserves	Other[4]	Regular	Reserves	Other[4]	Regular	Reserves	Other[4]
Number of new episodes of care	n	n	n	n	n	n	n	n	n	n	n	n	n	n	n
New episodes of care at MOD Mental Health Services[1]	**1,491**	**17**	**37**	**1,643**	**21**	**24**	**1,694**	**~**	**~**	**1,670**	**22**	**25**	**1,692**	**19**	**37**
At a DCMH	*1,402*	*~*	*~*	*1,553*	*21*	*24*	*1,603*	*21*	*0*	*1,584*	*22*	*25*	*1,626*	*19*	*37*
At a MOD in-patient provider	*89*	*~*	*~*	*90*	*0*	*0*	*91*	*~*	*~*	*86*	*0*	*0*	*66*	*0*	*0*
Episodes assessed with a mental disorder[2]	*1,167*	*17*	*30*	*1,295*	*15*	*18*	*1,375*	*~*	*~*	*1,322*	*~*	*~*	*1,352*	*~*	*~*
Episodes assessed without a mental disorder[2]	*314*	*0*	*7*	*330*	*6*	*6*	*315*	*5*	*0*	*347*	*~*	*~*	*335*	*~*	*~*
Missing mental disorder information[3]	*10*	*0*	*0*	*18*	*0*	*0*	*4*	*0*	*0*	*1*	*0*	*0*	*5*	*0*	*0*

Source: DMICP, SSSFT, BFG and JPA

1. Please note, an individual may have had contact at both DCMH and In-patient provider (See BQR).
2. Clinician's initial assessment based on presenting symptoms (paragraphs 21 and 22)
3. Initial diagnosis not available (See BQR)
4. Includes MPGS and where Derived Assign Type is not completed on JPA at time of data extract
5. Entitlement to mental health care is different for Regulars and Reserves and therefore the statistics between these groups are not comparable (See BQR)
6. Data presented as "~" has been suppressed in accordance with Defence Statistic's rounding policy (paragraph 28)

Number of new episodes of care by mental disorders at MOD DCMH in Jul-Sep 2014/15 – Jul-Sep 2015/16

16. Adjustment Disorders were the most prevalent disorder during the period July-September 2015/16, accounting for 32% of all new episodes of care seen at a MOD DCMH, in line with previous findings. Mood disorders accounted for 31% of all new episodes of care and 7% of all new episodes seen during the latest quarter were for PTSD.

17. Due to quarter on quarter variation in the data presented in this report it can be difficult to identify recent trends in presentations to MOD Specialist Mental Health Services. The UK Armed Forces Mental Health Annual Summary (see link on page 2) provides more detailed information on annual trends since 2007/08 and presents possible explanations for trends and comparisons to the UK general population.

18. More detailed tables presenting quarterly numbers of personnel and episodes of care data, rates per 1,000 personnel at risk and 95% Confidence Intervals by demographic breakdowns and mental disorders are available in Excel tables at https://www.gov.uk/government/collections/defence-mental-health-statistics-index.

Glossary

Admissions In-patient admissions to the MOD mental health in-patient care providers.

Army The British Army consists of the General Staff and the deployable Field Army and the Regional Forces that support them, as well as Joint elements that work with the Royal Navy and Royal Air Force. Its primary task is to help defend the interests of the UK.

Assessed without a mental disorder 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 as defined under ICD-10.

Defence Medical Information Capability Programme (DMICP) is the MOD electronic primary health care patient record.

Department for Community Mental Health (DCMH) DCMH are specialised psychiatric services based on community mental health teams closely located with primary care service at sites in the UK and abroad.

FTRS (**Full-Time Reserve Service**) are personnel who fill Service posts for a set period on a full-time basis while being a member of one of the Reserve Services, either as an ex-regular or as a volunteer. An FTRS reservist on:
Full Commitment (FC) fulfils the same range of duties and deployment liability as a regular Service person;
Limited Commitment (LC) serves at one location but can be detached for up to 35 days a year;
Home Commitment (HC) is employed at one location and cannot be detached elsewhere.

Each Service uses FTRS personnel differently:

- The Naval Service predominantly uses FTRS to backfill gapped regular posts. However, they do have a small number of FTRS personnel that are not deployable for operations overseas. There is no distinction made in terms of fulfilling baseline liability posts between FTRS Full Commitment (FC), Limited Commitment (LC) and Home Commitment (HC).
- The Army employ FTRS(FC) and FTRS(LC) to fill Regular Army Liability (RAL) posts as a substitute for regular personnel for set periods of time. FTRS(HC) personnel cannot be deployed to operations and are not counted against RAL.
- The RAF consider that FTRS(FC) can fill Regular RAF Liability posts but have identified separate liabilities for FTRS(LC) and FTRS(HC).

Gurkhas are recruited and employed in the British and Indian Armies under the terms of the 1947 Tri-Partite Agreement (TPA) on a broadly comparable basis. They remain Nepalese citizens but in all other respects are full members of HM Forces. Since 2008, Gurkhas are entitled to join the UK Regular Forces after 5 years of service and apply for British citizenship.

Joint Personnel Administration (JPA) is the system used by the Armed Forces to deal with matters of pay, leave and other personnel administrative tasks. JPA replaced a number of single-Service IT systems and was implemented in April 2006 for RAF, November 2006 for Naval Service and April 2007 for Army.

International Statistical Classification of Diseases and Health-Related Disorders 10th edition (ICD-10) is the standard diagnostic tool for epidemiology, health management and clinical purposes. The following ICD 10 Chapters have been included in this report :

- **F10 - F19 Mental and behavioural disorders due to psychoactive substance misuse, including alcohol**. A wide variety of disorders that differ in severity (from uncomplicated intoxication and harmful use to obvious psychotic disorders and dementia), but that are all attributable to the use of one or more psychoactive substances (which may or may not have been medically prescribed).

- **F30 - F39 Mood affective disorders, including depressive episodes.** Disorders in which the fundamental disturbance is a change in affect or mood to depression (with or without associated anxiety) or to elation. The mood change is usually accompanied by a change in the overall level of activity; most of the other symptoms are either secondary to, or easily understood in the context of, the change in mood and activity. Most of these disorders tend to be recurrent and the onset of individual episodes can often be related to stressful events or situations.

- **F40 - F49 Neurotic Stress related and somatoform disorders, including PTSD and Adjustment disorders.** This includes mental disorders characterized by anxiety and avoidance behaviour, with symptoms distressing to the patient, intact reality testing, no violations of gross social norms, and no apparent organic aetiology.

- **F00 - F09**, **F20 - F29 and F50 - F99 are presented as 'Other mental health disorders'.** This includes, disorders grouped together on the basis of their having in common a demonstrable etiology in cerebral disease, brain injury, or other insult leading to cerebral dysfunction; schizophrenia and eating disorders.

In-patient services are provided through eight NHS trusts in the UK which are part of a consortium headed by the South Staffordshire and Shropshire NHS Foundation Trust (SSSFT) and at Gilhead IV Hospital, Bielefield, Germany under a contract with Guys and St Thomas Hospital in the UK up until April 2013 and from this date the Soldiers, Sailors, Airmen and Families Association (SSAFA) through the Limited Liability Partnership. In patient care is provided for all Regular Armed Forces personnel including Mobilised Reservists.

Mental disorder Patients assessed by clinicians at a MOD DCMH or in-patient provider with a mental and behavioural disorder categorised under Chapter V in ICD-10.

Military Provost Guard Service (MPGS) provides trained professional soldiers to meet defence armed security requirements in units of all three Services based in Great Britain. MPGS provide armed guard protection of units, responsible for control of entry, foot and mobile patrols and armed response to attacks on their unit.

Ministry of Defence The Ministry of Defence (MOD) is the United Kingdom government department responsible for the development and implementation of government defence policy and is the headquarters of the British Armed Forces. The principal objective of the MOD is to defend the United Kingdom and its interests. The MOD also manages day to day running of the armed forces, contingency planning and defence procurement.

Mobilised Reservists are Volunteer or Regular Reserves who have been called into permanent service with the Regular Forces on military operations under the powers outlined in the Reserve Forces Act 1996. Call-out orders will be for a specific amount of time and subject to limits (e.g. under a call-out for warlike operations (Section 54), call-out periods should not exceed 12 months, unless extended.)

MOD Specialist Mental Health Services encompass the delivery of care through MOD's DCMH for outpatient care, and all admissions to the MOD's in-patient care contractor. It does not cover mental health care for patients treated wholly in the primary care setting by GPs.

New episodes of care New patients; or patients who have been seen at a DCMH but were discharged from care and have been referred again. This represents the level of clinical activity/prevalence and does not represent the number of personnel assessed as an individual may have more than one episode of care.

Non Regular Permanent Staff (NRPS) are members of the Army Volunteer Reserve Force employed on a full time basis. The NRPS comprises Commissioned Officers, Warrant Officers, Non Commissioned Officers and soldiers posted to units to assist with the training, administrative and special duties within the Army Reserve. Typical jobs are Permanent Staff Administration Officer and Regimental Administration Officer. Since 2010, these contracts are being discontinued in favour of FTRS (Home Commitment) contracts. NRPS are not included in the Future Reserves 2020 Volunteer Reserve population as they have no liability for call out.

Number of Personnel represents the number of individuals with an initial assessment at MOD Specialist Services. An individual may have more than one episode of care but the individual will only be counted once in the number of personnel.

Officer An officer is a member of the Armed Forces holding the Queen's Commission to lead and command elements of the forces. Officers form the middle and senior management of the Armed Forces. This includes ranks from Sub-Lt/2nd Lt/Pilot Officer up to Admiral of the Fleet/Field Marshal/Marshal of the Royal Air Force, but excludes Non-Commissioned Officers.

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 (IASF) mission and as part of the US-led Operation Enduring Freedom (OEF).

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 support the Government's objective to remove the threat that Saddam Hussein posed to his neighbours and his people and, based on 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 and freedom.

OPLOC was the single Service Operation Location Tracking system used to identify personnel deployed to Iraq and Afghanistan prior to April 2007.

Other Ranks Other ranks are members of the Royal Marines, Army and Royal Air Force who are not officers but Other Ranks include Non-Commissioned Officers.

Personnel at Risk is defined as the number of serving UK Armed Forces personnel eligible for mental healthcare. This includes regular UK Armed Forces personnel, Ghurkhas, Military Provost Guard Staff, mobilised reservists, Full Time Reserve Service personnel and Non-regular Permanent Staff.

Rate Ratio (RR) provides a comparison of cases seen between personnel identified as having deployed to a theatre and those who have not been identified as having deployed to either theatre.

Routine Referrals from a GP or Medical Officer (MO) are seen at a DCMH within 20 working days of referral.

Royal Air Force (RAF). The Royal Air Force (RAF) is the aerial defence force of the UK.

Royal Marines (RM) Royal Marines are sea-going soldiers who are part of the Naval Service. RM officer ranks were aligned with those of the Army on 1 July 1999.

Royal Navy (RN) The sea-going defence forces of the UK but excludes the Royal Marines and the Royal Fleet Auxiliary Service (RFA).

SSAFA is the Soldiers, Sailors, Airmen and Families Association providing in-patient care through the Limited Liability Partnership to personnel from British Forces Germany.

SSSFT is the South Staffordshire and Shropshire NHS Foundation Trust which heads up the consortium providing in-patient care through eight NHS trusts in the UK.

Strength is defined as the number of serving UK Armed Forces personnel.

UK Regulars are full time Service personnel, including Nursing Services and Gurkhas, but excluding FTRS personnel, Naval activated Reservists, mobilised Reservists, Military Provost Guarding Service (MPGS) and Non Regular Permanent Service (NRPS). Unless otherwise stated, includes trained and untrained personnel.

UK Reserves include FTRS personnel, Volunteer Reserves and Non Regular Permanent Service (NRPS) but exclude Military Provost Guarding Service (MPGS).

Urgent Referrals from a GP or Medical Officer (MO) are seen at a DCMH within one working day of referral.

Data, Definitions and Methods

Data Sources

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

DCMH

- Between 01 January 2007 and 30 June 2014, the report captures data provided by DCMHs to Defence Statistics in monthly returns.
- For the period 01 April 2012 to 30 June 2014, new episodes of care data was also sourced from the electronic patient record held in Defence Medical Information Capability Program (DMICP) in addition to those provided by DCMH in monthly returns.
- Since 01 July 2014, DMICP was the single source of DCMH new episodes of care data.

In-patient

- Since January 2007, SSSFT and Gilead IV hospital Bilefield have submitted relevant in patient records.

Data Coverage

20. The data in this report include regular UK Armed Forces personnel, Ghurkhas, Military Provost Guard Staff and all currently serving Reserve personnel who have previously deployed since 1 January 2003 as all of these individuals are eligible for assessment at a DCMH.

21. 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).

22. 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 Results section, these cases are referred to as "assessed without a mental disorder".

Methodology

23. Due to the methodology changes implemented in July 2009 and in July 2013, when looking at trends over time for new episodes of care across the series of published reports, 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 submitted by DCMHs to Defence Statistics.
- 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 submissions provided by DCMH to Defence Statistics.

24. Changes made to the methodology in July 2009 and July 2013 can be read in more detail in the Background Quality Report (BQR) published at www.gov.uk/government/publications/mod-national-and-official-statistics-by-topic.

Rates

25. Rates enable comparisons between groups and over time, taking account of the number of personnel in a group (personnel at risk) at a particular point in time**. The number of events (ie. mental disorders) is then divided by the number of personnel at risk per annum and multiplied by 1,000 to calculate the rate per 1,000 personnel at risk.**

26. Rates for Reservist mental health have not been calculated as there are currently data quality issues with accurately identifying the number of personnel at risk.

Percentage

27. Previous publications of this report have provided rates alongside numbers to provide context and comparison between groups. This information is still available in the Excel file accompanying the release of this report, however, due to user feedback, this publication now provides a focus on the percentage of the population at risk. This is calculated in the same way as the rate per 1,000 but multiplying by 100 instead of 1000, ie **The number of events (ie. mental disorders) is then divided by the number of personnel at risk per annum and multiplied by 100 to calculate the percentage of personnel affected.**

28. The information presented in this publication has been structured to release information into the public domain in a way that contributes to the MOD accountability to the British public but which doesn't risk breaching individual's rights to medical confidentiality. 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 '~' to prevent the inadvertent disclosure of individual identities. 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. Tables 1 and 2 of the quarterly mental health report bulletins published after 1 October 2015 include numbers fewer than five for records missing a mental disorder; this is because it presents numbers in a non-medical category and there is no risk to individuals' identities being disclosed.

Strengths and weaknesses of the data presented in this report

29. 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. In addition, the tables in this report have been scrutinised to ensure individual identities have not been revealed inadvertently.

30. Users should be aware that this report does not 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. Changes in methodology in 2009/10 and 2012/13 also make it difficult to compare new episodes of care data over time. 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. In addition, DMICP is a live

system and extracts for this report are taken six weeks after the end of the reporting period. Therefore any amendments to records or late data entries may be excluded from this report.

31. More detailed information on the data, definitions and methods used to create this report can be found in the Background Quality Report (BQR) published at www.gov.uk/government/publications/mod-national-and-official-statistics-by-topic.

References

a) http://www.mind.org.uk/mental_health_a-z/8105_mental_health_facts_and_statistics. [Accessed 03/10/2013]

b) Sundin J., Jones N., Greenberg N., Rona R., Hotopf M., Wessely S., and Fear N. (2010) Mental Health among commando, airborne and other UK Infantry personnel Occupational Medicine, 60, 552-559.

c) 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*.

d) 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*.

Further Information

Symbols

~ Numbers fewer than 5 have been suppressed in accordance with the Defence Statistics rounding policy (2008) where publication of the number could lead to the disclosure of individual identities.

Revisions

There are no planned revisions of this bulletin. Amendments to figures for earlier reports may be identified during the quarterly and/or annual compilation of this bulletin. This will be addressed in one of two ways:

i. Where number of figures updated in a table is small, figures will be updated and those which have been revised will be identified with the symbol “r”. An explanation for the revision will be given in the footnotes to the table.

ii. Where the number of figures updated in a table is substantial, the revisions to the table, toghether with the reason for the revisions will be identified in the commentary at the beginning of the revelevant chapter / section, and in the commentary above the affected tables. Revisions will bot be identified by the symbol “r” since where there are a large number of revisions in a table this could make them more difficult to read.

Occasionally updated figures will be provided to the editor during the course of the year. Since this Bulletin is published electronically, it is possible to revise figures during the course of the year. However to ensure continuity and consistency, figures will only be adjusted during the year where it is likely to substantially affect interpretation and use of the figures.

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