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Quarterly UK Armed Forces Mental Health: Presenting complaints at MOD Departments of Community Mental Health January 2013/14 – March 2014/15

INTRODUCTION

1. This quarterly report provides statistical information on mental health in the UK Armed Forces for the period January 2013/14 – March 2014/15. Data used in this report summarises all **new episodes of care** of UK Armed Forces personnel referred for assessment to specialist mental services at the MOD Departments of Community Mental Health (DCMH) for outpatient care, and **all admissions** to the MOD mental health in-patient care contractors. Following assessment by mental health specialists based on presenting symptoms, an initial diagnosis categorised by World Health Organisation's International Statistical Classification of Diseases and Health-Related Disorders 10th edition (ICD-10) is recorded. Some personnel may be assessed as having no psychiatric disorder.

2. This report includes previously unpublished data for 1 January 2015 - 31 March 2015.

3. The report provides new episodes of care at DCMH using the MOD electronic primary care patient record (DMICP^a) and in-patient admissions using in-patient provider contractor records.

KEY POINTS

Initial Assessments at MOD DCMH

4. During the three-month period January - March 2014/15, 1,306 new episodes of care for mental disorder were identified among UK Armed Forces personnel at a rate of 8.0 per 1,000 personnel at risk. The rate has increased from the previous quarter, however the change is not statistically significant and is similar to the rate for the same quarter in the previous financial year.

5. The populations at risk this quarter remain broadly consistent with the findings in previous reports. For the 1,306 personnel assessed for a new episode of care with a mental disorder during the period January - March 2014/15 there were some statistically significant findings:

- Royal Marines had significantly lower rates of mental disorder than the Army and the RAF.
- Females had significantly higher rates of mental disorder than males.
- Other ranks had significantly higher rates of mental disorder than Officers.

6. The rate of mental disorder among personnel previously deployed to Iraq and/or Afghanistan was significantly higher than personnel who had not been identified as having previously deployed prior to their episode of care in the latest quarter (8.5 and 7.1 per 1,000 personnel at risk per quarter respectively).

7. Neurotic disorders were the most prevalent disorder in the period January - March 2014/15; this was consistent with the findings in the previous four quarters. Adjustment disorders accounted for the majority (50%) of all Neurotic disorders. Rates of PTSD remained low at 0.4 per 1,000 personnel at risk (n = 65), and there was no significant change in the rate of PTSD compared to previous quarters.

Admissions to the MOD In-patient Contractor

8. During the three-month period January - March 2014/15, there were 94 admissions to the MOD in-patient care contractor representing a rate of 0.6 per 1,000 personnel at risk; 81 of these patients had been seen at a DCMH at some point prior to their admission. The overall rate of admission to the MOD in-patient care contractor remains consistent over the five quarter period.

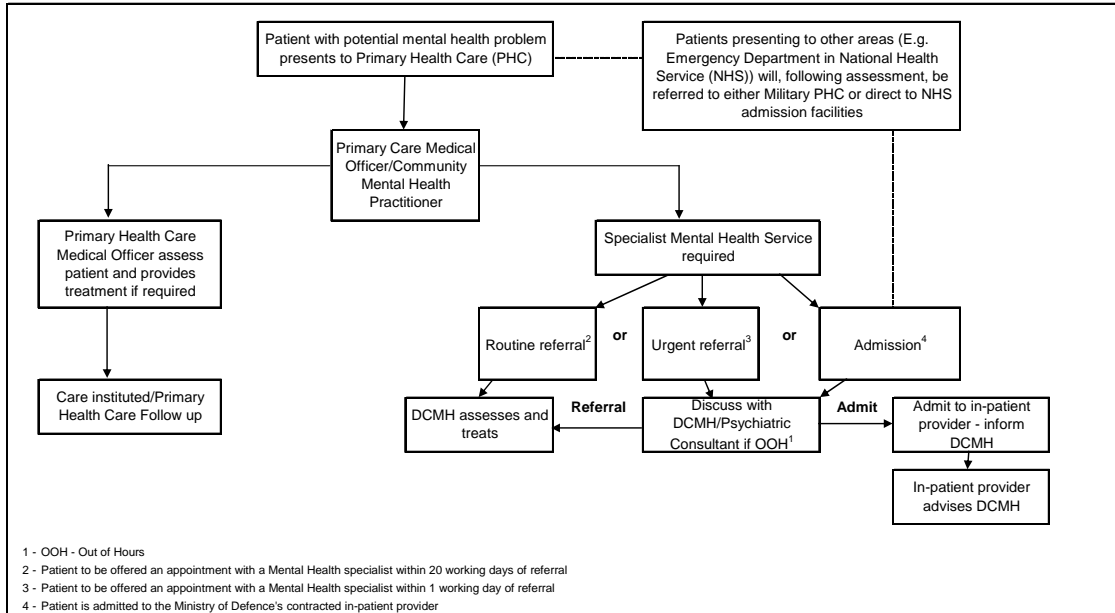
^a Defence Medical Information Capability Programme

Introduction

9. 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).

10. 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 :



11. This report summarises all attendances for a new episode of care of Service personnel to the **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.

12. DCMH are specialised psychiatric services based on community mental health teams closely located with primary care services at sites in the UK and abroad. This does not include information on patients seen only by their GP or medical officer. 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.

DATA, DEFINITIONS AND METHODS

Data Sources

13. 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.

14. 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.

15. The patient data from each data source 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 Forces personnel and is used to gather information on a person's service, Regular/Reservist status, gender, age and deployment.

16. Deployment data prior to April 2007 was derived from the single services Operation Location tracking (OPLOC) systems^b and data since April 2007 is obtained from the JPA system. The data covers deployments to Operation TELIC (Iraq, 2003-2011), Operation VERITAS (Afghanistan 2001-2008) and Operation HERRICK (Afghanistan, 2006-present).

17. 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.

18. 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.

Data Coverage

19. The data in this report include regular UK Armed Forces personnel, Ghurkhas, 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.

20. 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). 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.**

^b 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 Defence Statistics' deployment database, reported a cohort error rate of less than 0.5 per cent.

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.

21. 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

22. 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.

23. Changes made to the methodology in July 2009 and July 2013 can be read in more detail in the UK Armed Forces Annual Mental Health Report, published at www.gov.uk/government/publications/mod-national-and-official-statistics-by-topic.

24. It is possible that new episodes of care for personnel who withhold consent may be counted twice in this report. The number of personnel who withheld consent for their demographic data to be recorded in the DS Database returns can be found in the Background Quality Report (BQR) published at www.gov.uk/government/publications/mod-national-and-official-statistics-by-topic.

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 quarter and multiplied by 1,000 to calculate the rate.

26. In order to understand if a difference in rates is statistically significant, 95% confidence intervals are used. Statistical significance indicates that a finding is not due to chance. 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.

27. The recent changes to the Armed Forces population through redundancy programmes, changes in recruitment patterns, the move to the new employment model and the new structures

required to meet Future Force 2020^c, is likely to impact on the trends in rates presented as the Armed Forces population shrinks and the Service profile of the serving population changes

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.

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.

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.

Revisions

32. Previously published information for the periods July-September 2014/15 and October – December 2014/15 have been revised. This is due to an error in the DMICP data source where **37** new episodes of care at a MOD DCMH were not identified as being for Service personnel. These records were therefore excluded from the publications of this report at that time. Defence Statistics were made aware of the correction of this error within DMICP in June 2015 and subsequently have revised the information presented in this release :

- An additional 9 initial assessments for new episodes of care for July-September 2014/15.
- An additional 28 initial assessments for new episodes of care for October-December 2014/15.

^c https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/62487/Factsheet5-Future-Force-2020.pdf

Glossary of terms

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.

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.

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.)

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.

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.

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, Gurkhas, Military Provost Guard Staff, mobilised reservists, Full Time Reserve Service personnel and Non-regular Permanent Staff.

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, but excluding FTRS personnel, Gurkhas, Naval activated Reservists, mobilised Reservists, Military Provost Guarding Service (MPGS) and Non Regular Permanent Service (NRPS). Unless otherwise stated, includes trained and untrained personnel.

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

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- 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*.
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Results

New Episodes of Care at MOD DCMHs, 1 January - March 2015 summary

33. During the three-month period January - March 2015, a total of 1,624 UK Service personnel were recorded as having been assessed for a new episode of care at MOD DCMH, representing a rate for the period of 9.9 per 1,000 personnel at risk^d.

34. **Table 1** provides details of the key socio-demographic characteristics for the 1,624 new episodes of care at MOD DCMH during January - March 2015.

Table 1: UK Armed Forces¹ new episodes of care at MOD DCMH by demographic characteristics, 1 January 2015 – 31 March 2015, numbers, percentages and rates per 1,000 personnel at risk per quarter

Characteristic	All episodes seen	Episodes of care assessed with a mental disorder			Episodes of care assessed without a mental disorder ²		
		Number	Rate	95% CI	% of all episodes seen	Number	% of all episodes seen
All	1,624	1,306	8.0	(7.5 - 8.4)	80%	318	20%
Service							
Royal Navy	206	166	6.5	(5.5 - 7.5)	81%	40	19%
Royal Marines	47	40	5.1	(3.5 - 6.7)	85%	7	15%
Army	1,020	801	8.4	(7.8 - 8.9)	79%	219	21%
RAF	351	299	8.5	(7.6 - 9.5)	85%	52	15%
Gender							
Males	1,327	1,050	7.1	(6.7 - 7.5)	79%	277	21%
Females	297	256	16.0	(14.0 - 18.0)	86%	41	14%
Rank							
Officers	156	127	4.4	(3.6 - 5.1)	81%	29	19%
Other ranks	1,468	1,179	8.7	(8.2 - 9.2)	80%	289	20%
Deployment - Theatres of operation³							
Iraq and/or Afghanistan ⁴	1,005	850	8.5	(7.9 - 9.1)	85%	155	15%
of which, Iraq	493	427	8.0	(7.2 - 8.8)	87%	66	13%
Afghanistan ⁴	878	743	8.8	(8.2 - 9.4)	85%	135	15%
Neither Iraq nor Afghanistan ⁴	619	456	7.1	(6.4 - 7.7)	74%	163	26%

Data Source : DMICP

1. Eligible UK Armed Forces personnel (see paragraph 19).

2. Patients assessed without a mental disorder (see paragraph 21).

3. Deployment to the wider theatre of operation (see paragraph 17)

4. Data for Afghanistan between 1 January 2003 and 14 October 2005 were not available for person level deployment (see paragraph 18).

35. Of the 1,624 new episodes of care, 1,306 (80%) were assessed with a mental disorder, representing an overall rate for new episodes of care for mental disorder of 8.0 per 1,000 personnel at risk. There were 318 episodes (20%) where patients were assessed as not having a specific or identifiable mental disorder at the initial assessment. **Table 1** shows some statistically significant findings:

36. Royal Marine personnel had a significantly lower rate of mental health disorder (5.1 per 1,000 personnel at risk) compared to the Army and RAF (8.4 and 8.5 per 1,000 personnel at risk per quarter respectively).

37. The rate of mental disorder was significantly higher in females than males (16.0 and 7.1 per 1,000 personnel at risk per quarter respectively).

38. Rates of those assessed with a mental health disorder among Other Ranks were significantly higher than Officers (8.7 and 4.4 per 1,000 personnel at risk per quarter respectively).

39. The rate of mental disorders for personnel identified as having previously deployed to Iraq and/or Afghanistan was significantly higher in the latest quarter compared to those identified as not having previously deployed to either Operation (8.5 and 7.1 per 1,000 personnel deployed at risk per quarter respectively)

^d Using a four-month average of the number of regular and mobilised reserves on strength from 1 January 2015 to 1 April 2015 (see paragraph 25).

New Episodes of Care at MOD DCMH for the five quarter period January-March 2013/14 to January-March 2014/15

Trends overall and by demographic variable

40. **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 (January 2014 to March 2015).

Table 2: UK Armed Forces¹ new episodes of care at MOD DCMH, 1 January 2014 - 31 March 2015 by quarter, numbers and rates per 1,000 personnel at risk per quarter

	All episodes seen	Episodes of care assessed with a mental disorder			Episodes of care assessed without a mental disorder
		Number	Rate	95% CI	
January - March 2013/14	1,699	1,345	7.9	(7.5 - 8.3)	354
April - June 2014/15	1,230	1,230	7.3	(6.9 - 7.7)	307
July - September 2014/15	1,451 ^r	1,132 ^r	6.8 ^r	(6.4 - 7.2)	319 ^r
October - December 2014/15	1,598 ^r	1,258 ^r	7.6 ^r	(7.2 - 8.0)	340 ^r
January - March 2014/15	1,624	1,306	8.0	(7.5 - 8.4)	318

Data Source : DS Database and DMICP

1. Eligible UK Armed Forces personnel (see paragraph 19).

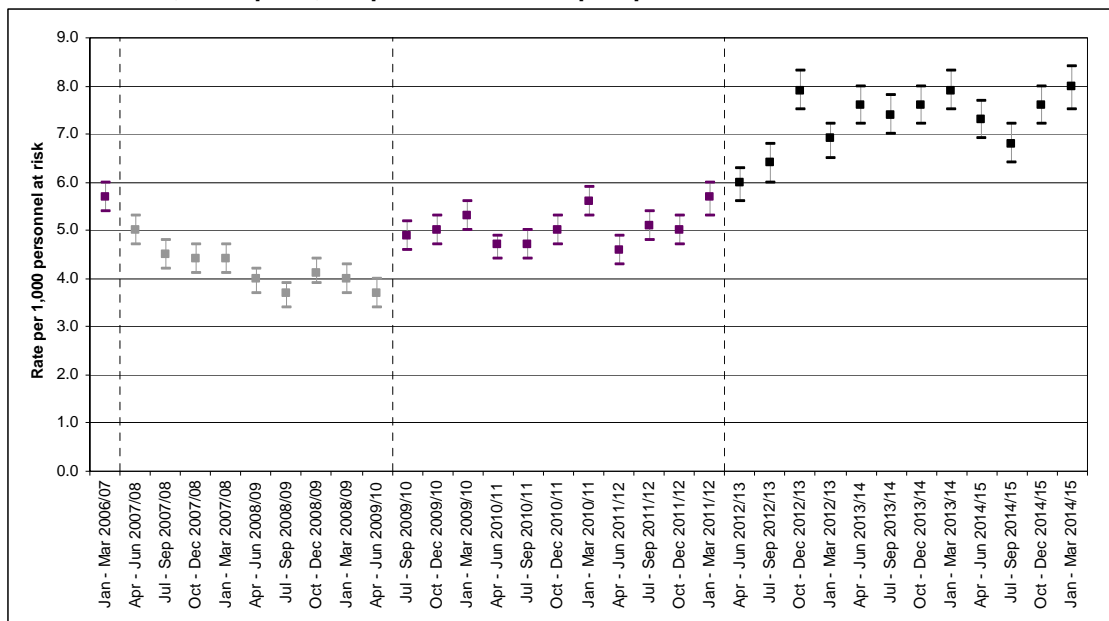
2. Data up to 30 June 2014 sourced from DS database and DMICP. Data from 01 July 2014 onwards, DMICP only data (see paragraph 13)

3. Revisions to previously published figures are annotated with "r" (see Paragraph 32)

41. **Table 2** shows there was no significant change in the overall rate for mental disorder quarter on quarter throughout the latest five quarter period. The decline in rates in July-September 2014/15 (from 7.3 to 6.8 per 1,000 personnel at risk) was likely due to quarter on quarter variation.

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

Figure 1: UK Armed Forces¹ new episodes of care for a mental disorder, January 2007 to March 2015^{2,3,4}, rates per 1,000 personnel at risk per quarter and 95% confidence intervals



Data Source : DS Database and DMICP

1. Eligible UK Armed Forces personnel (see paragraph 19).
2. January 2007 - June 2009 new attendances, July 2009 onwards new episodes of care (see paragraph 22).
3. 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.
4. April 12 - revised methodology (see paragraph 22).
5. Data up to 30 June 2014 sourced from DS database and DMICP. Data from 01 July 2014 onwards, DMICP only data (see paragraph 13).

43. **Figure 1** shows between July 2009^e and March 2012, the rate was stable at around 5.0 per 1,000 personnel at risk, 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.** Between April 2012/13 and March 2013/14 rates of UK Armed Forces personnel assessed with a mental health disorder increased, however there was no significant increase quarter on quarter with the exception of the rate in October-December 2012/13, when the rate rose from 6.4 in July-September 2012/13 to 7.9 per 1,000, before falling to 6.9 per 1,000 personnel at risk in January-March 2012/13. Since March 2013/14 rates of UK Armed Forces personnel assessed with a mental disorder were stable at around 7.5 per 1,000 personnel at risk, with a decrease to 6.8 per 1,000 personnel at risk in July-September 2014/15 likely due to quarter on quarter variation.

44. It is not clear if the overall rise in rates between April-June 2012/13 and January-March 2013/14 was due to DMICP template usage 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**.

45. **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.

^e Methodology change from July 2009 onwards and April 2012 (see paragraph 22)

Table 3: UK Armed Forces¹ new episodes of care at MOD DCMH by Service, 1 January 2014 – 31 March 2015 by quarter, numbers and rates per 1,000 personnel at risk per quarter

	Service											
	Royal Navy			Royal Marines			Army			RAF		
	Episodes of care assessed with a mental disorder											
	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI
January - March 2013/14	164	6.3	(5.4 - 7.3)	34	4.3	(2.9 - 5.8)	859	8.5	(8.0 - 9.1)	288	8.0	(7.0 - 8.9)
April - June 2014/15	176	6.8	(5.8 - 7.8)	31	3.9	(2.6 - 5.3)	782	7.9	(7.3 - 8.4)	241	6.7	(5.8 - 7.5)
July - September 2014/15	143	5.6	(4.6 - 6.5)	32	4.1	(2.7 - 5.5)	715 ^r	7.3	(6.8 - 7.8)	242	6.8	(5.9 - 7.6)
October - December 2014/15	174	6.8	(5.8 - 7.8)	39	5.0	(3.4 - 6.5)	786 ^r	8.1 ^r	(7.5 - 8.7)	259 ^r	7.3 ^r	(6.4 - 8.2)
January - March 2014/15	166	6.5	(5.5 - 7.5)	40	5.1	(3.5 - 6.7)	801	8.4	(7.8 - 8.9)	299	8.5	(7.6 - 9.5)

Data Source : DS Database and DMICP

1. Eligible UK Armed Forces personnel (see paragraph 19).

2. Data up to 30 June 2014 sourced from DS database and DMICP. Data from 01 July 2014 onwards, DMICP only data (see paragraph 13)

3. Revisions to previously published figures are annotated with "r" (see Paragraph 32)

46. **Table 3** shows some significant differences in the rates of mental health disorders between the Services. The Royal Marines had significantly lower rates of mental disorders compared to the Army and RAF in each of the last five quarters, with the exception of October - December 2014/15 where the rate for Royal Marines was not significantly different to the RAF.

47. The lower rates of mental disorders among Royal Marines compared to the other Services 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 (Personal communication-Def Prof Mental Health).

Table 4: UK Armed Forces¹ new episodes of care at MOD DCMH by gender and rank, 1 January 2014 – 31 March 2015 by quarter, numbers and rates per 1,000 personnel at risk per quarter

	Gender						Rank					
	Males			Females			Officers			Other Ranks		
	Episodes of care assessed with a mental disorder											
	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI
January - March 2013/14	1,079	7.0	(6.6 - 7.4)	266	16.3	(14.3 - 18.2)	138	4.7	(3.9 - 5.4)	1,207	8.6	(8.1 - 9.0)
April - June 2014/15	1,001	6.5	(6.1 - 7.0)	229	14.1	(12.2 - 15.9)	141	4.8	(4.0 - 5.6)	1,089	7.8	(7.3 - 8.3)
July - September 2014/15	893 ^r	5.9	(5.5 - 6.3)	239	14.1	(12.3 - 15.8)	95	2.7	(2.1 - 3.2)	1,037 ^r	7.8	(7.3 - 8.3)
October - December 2014/15	996 ^r	6.6	(6.2 - 7.1)	262 ^r	16.3 ^r	(14.3 - 18.2)	109	3.7	(3.0 - 4.4)	1,149 ^r	8.4 ^r	(7.9 - 8.9)
January - March 2014/15	1,050	7.1	(6.7 - 7.5)	256	16.0	(14.0 - 18.0)	127	4.4	(3.6 - 5.1)	1,179	8.7	(8.2 - 9.2)

Data Source : DS Database and DMICP

1. Eligible UK Armed Forces personnel (see paragraph 19).

2. Data up to 30 June 2014 sourced from DS database and DMICP. Data from 01 July 2014 onwards, DMICP only data (see paragraph 13)

3. Revisions to previously published figures are annotated with "r" (see Paragraph 32)

48. The rate of mental disorder was significantly higher in females than males throughout the latest 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.

49. 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 Other 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).

50. **Table 4** shows no significant difference in the quarterly rates of mental disorder among Officers with the exception of July-September 2014/15 when there was a significant fall in the rate to 2.7 per 1,000. The rate rose to 4.4 per 1,000 in the latest quarter suggesting the fall in the previous quarter was due to quarter on quarter variation.

Table 5: UK Armed Forces¹ new episodes of care at MOD DCMH by deployment^{2,3}, 1 January 2014 – 31 March 2015 by quarter, numbers and rates per 1,000 personnel at risk per quarter

Date	Deployment - Theatres of operation ²											
	Iraq and/or Afghanistan ³			of which						Neither		
				Iraq		Afghanistan ³						
	Episodes of care assessed with a mental disorder											
Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	
January - March 2013/14	885	8.2	(7.6 - 8.7)	475	8.0	(7.3 - 8.7)	729	8.1	(7.5 - 8.7)	460	7.4	(6.7 - 8.1)
April - June 2014/15	829	7.7	(7.2 - 8.3)	424	7.3	(6.6 - 8.0)	692	7.7	(7.1 - 8.3)	401	6.5	(5.8 - 7.1)
July - September 2014/15	738	7.0	(6.5 - 7.5)	379	6.7	(6.1 - 7.4)	637	7.2	(6.6 - 7.7)	394	6.3	(5.7 - 7.0)
October - December 2014/15	807	7.9	(7.3 - 8.4)	403	7.3	(6.6 - 8.1)	697	8.0	(7.4 - 8.6)	451	7.1	(6.5 - 7.8)
January - March 2014/15	850	8.5	(7.9 - 9.1)	427	8.0	(7.2 - 8.8)	743	8.8	(8.2 - 9.4)	456	7.1	(6.4 - 7.7)

Data Source : DS Database and DMICP

1. Eligible UK Armed Forces personnel (see paragraph 19).
2. Deployment to the wider theatre of operation (see paragraph 17).
3. Data for Afghanistan between 1 January 2003 and 14 October 2005 were not available for person level deployment (see paragraph 18).
4. Data up to 30 June 2014 sourced from DS database and DMICP. Data from 01 July 2014 onwards, DMICP only data (see paragraph 13).
5. Revisions to previously published figures are annotated with "r" (see Paragraph 32)

51. **Table 5** shows there was no significant difference in the rate of mental disorder among personnel identified as having previously deployed to Iraq and/or Afghanistan compared to those identified as not having previously deployed prior to their episode of care, for three of the last five quarters. The latest quarter shows the rate of mental disorders among personnel identified as having previously deployed was significantly higher than that of personnel identified as not having previously deployed (8.5 and 7.1 per 1,000 personnel at risk per quarter).

Trends by mental disorder

52. **Table 6** (see page 14) provides details of the types of presenting complaints, by ICD-10 grouping, for the 1,306 new episodes of care assessed with a mental disorder during January - March 2014/15 and for the previous four quarters.

53. Neurotic disorders were the most common disorder throughout the five quarter period presented in **Table 6**. Adjustment disorders accounted for 50% of all neurotic disorders in the latest quarter, in line with previous quarters.

54. Mood disorders were the second most common disorder throughout the five quarter period and in January - March 2014/15. Depressive episodes accounted for 77% of all mood disorders, in line with previous quarters.

Table 6: UK Armed Forces¹ Initial mental disorder assessments for all new episodes of care seen at MOD DCMH by ICD-10 grouping, 1 January 2014 – 31 March 2015 by quarter, numbers and rates² per 1,000 personnel at risk per quarter

Date	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		
	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
January - March 2013/14	63	0.4	(0.3 - 0.5)	62	0.4	(0.3 - 0.5)	410	2.4	(2.2 - 2.6)	331	1.9	(1.7 - 2.1)	823	4.8	(4.5 - 5.2)	105	0.6	(0.5 - 0.7)	408	2.4	(2.2 - 2.6)	49	0.3	(0.2 - 0.4)
April - June 2014/15	62	0.4	(0.3 - 0.5)	60	0.4	(0.3 - 0.4)	321	1.9	(1.7 - 2.1)	271	1.6	(1.4 - 1.8)	814	4.8	(4.5 - 5.1)	83	0.5	(0.4 - 0.6)	419	2.5	(2.2 - 2.7)	33	0.2	(0.1 - 0.3)
July - September 2014/15	69	0.4	(0.3 - 0.5)	66	0.4	(0.3 - 0.5)	317 ^r	1.9	(1.7 - 2.1)	255 ^r	1.5	(1.3 - 1.7)	715 ^r	4.3	(4.0 - 4.6)	65	0.4	(0.3 - 0.5)	389 ^r	2.3	(2.1 - 2.6)	31	0.2	(0.1 - 0.3)
October - December 2014/15	67	0.4	(0.3 - 0.5)	66	0.4	(0.3 - 0.5)	362 ^r	2.2	(2.0 - 2.4)	294 ^r	1.8	(1.6 - 2.0)	805 ^r	4.8	(4.5 - 5.2)	68	0.4	(0.3 - 0.5)	416 ^r	2.5	(2.3 - 2.7)	24 ^r	0.1	(0.1 - 0.2)
January - March 2014/15	54	0.3	(0.2 - 0.4)	54	0.3	(0.2 - 0.4)	402	2.4	(2.2 - 2.7)	311	1.9	(1.7 - 2.1)	817	5.0	(4.6 - 5.3)	65	0.4	(0.3 - 0.5)	409	2.5	(2.2 - 2.7)	33	0.2	(0.1 - 0.3)

Data Source : DS Database and DMICP

1. Eligible UK Armed Forces personnel (see paragraph 19).
2. The rates and confidence intervals have been rounded to 1 decimal place (see paragraph 26).
3. Revisions to previously published figures are annotated with "r" (see Paragraph 32)

Admissions to the MOD's In-patient Contractors

55. **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.

56. During the three-month period January - March 2014/15 there were 94 admissions to a MOD in-patient contractor^f, a rate of 0.6 per 1,000 personnel at risk per quarter.

57. Of the 94 admissions, 81 had been seen at a DCMH between January 2007 and the date of their admission. The remaining patients were admitted to one of the in-patient contractors without either Defence Statistics records or DMICP showing that they had been seen at a DCMH prior to their admission. Possible explanations of this are emergency admissions or personnel overseas being admitted following an aeromedical evacuation back to the UK.

Table 7: UK Armed Forces¹ admissions to the MOD in-patient contractors by Service, 1 January 2014 – 31 March 2015 by quarter, numbers and rates² per 1,000 personnel at risk per quarter

Date	All admissions			Service								
				Naval Service ³			Army			RAF		
	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI
January - March 2013/14	70	0.4	(0.3 - 0.5)	8	0.2	(0.1 - 0.5)	50	0.5	(0.4 - 0.6)	12	0.3	(0.2 - 0.6)
April - June 2014/15	86	0.5	(0.4 - 0.6)	17	0.5	(0.3 - 0.8)	58	0.6	(0.4 - 0.7)	11	0.3	(0.2 - 0.5)
July - September 2014/15	94	0.6	(0.4 - 0.7)	18	0.5	(0.3 - 0.8)	61	0.6	(0.5 - 0.8)	15	0.4	(0.2 - 0.7)
October - December 2014/15	90	0.5	(0.4 - 0.7)	14	0.4	(0.2 - 0.7)	56	0.6	(0.4 - 0.7)	20	0.6	(0.3 - 0.9)
January - March 2014/15	94	0.6	(0.5 - 0.7)	15	0.4	(0.3 - 0.7)	67	0.7	(0.5 - 0.9)	12	0.3	(0.2 - 0.6)

Data Source : British Forces Germany and SSFT in-patient data..

1. Eligible UK Armed Forces personnel (see paragraph 19).
2. The rates and confidence intervals have been rounded to 1 decimal place (paragraph 26).
3. Royal Navy and Royal Marines combined to protect patient confidentiality.

58. **Table 7** shows throughout the five quarter period there were no significant changes in rates of admission. Furthermore, there were no significant differences in the rates of in-patient admissions between each of the Services. This finding is consistent with previous quarters.

Table 8: UK Armed Forces¹ admissions to the MOD in-patient contractors by gender and rank, 1 January 2014 – 31 March 2015 by quarter, numbers and rates² per 1,000 personnel at risk per quarter

Date	Gender						Rank					
	Males			Females			Officers			Other Ranks		
	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI
January - March 2013/14	59	0.4	(0.3 - 0.5)	11	0.7	(0.3 - 1.2)	8	0.3	(0.1 - 0.5)	62	0.4	(0.3 - 0.5)
April - June 2014/15	76	0.5	(0.4 - 0.6)	10	0.6	(0.3 - 1.1)	~	0.1	(0.0 - 0.2)	~	0.6	(0.5 - 0.7)
July - September 2014/15	79	0.5	(0.4 - 0.6)	15	0.9	(0.5 - 1.5)	5	0.1	(0.0 - 0.3)	89	0.7	(0.5 - 0.8)
October - December 2014/15	82	0.5	(0.4 - 0.7)	8	0.5	(0.2 - 1.0)	8	0.3	(0.1 - 0.5)	82	0.6	(0.5 - 0.7)
January - March 2014/15	76	0.5	(0.4 - 0.6)	18	1.1	(0.7 - 1.8)	~	0.1	(0.0 - 0.3)	~	0.7	(0.5 - 0.8)

Data Source : British Forces Germany and SSFT in-patient data..

1. Eligible UK Armed Forces personnel (see paragraph 19).
2. The rates and confidence intervals have been rounded to 1 decimal place (paragraph 26).
3. Data presented as "~" has been suppressed in accordance with Defence Statistics rounding policy (see paragraph 28).

59. **Table 8** shows females had a significantly higher rate of admission compared to males in the latest quarter (1.1 and 0.5 per 1,000 personnel at risk). All other quarters show no significant difference between males and females.

60. Rates of admissions among Other Ranks were significantly higher compared to the rates of admissions among Officers for all quarters except in January-March 2013/14 and October-December 2014/15 where there was no significant difference between admission rates among Officers and Other Ranks.

^f See paragraph 12 for further information on the data providers for in-patient care.

61. 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.

Table 9: UK Armed Forces¹ admissions to the MOD in-patient contractors by deployment^{2,3}, 1 January 2014 – 31 March 2015 by quarter, numbers and rates⁴ per 1,000 personnel at risk per quarter

Date	Deployment - Theatres of operation ²											
	Iraq and/or Afghanistan ³			of which						Neither		
				Iraq		Afghanistan ³						
	Admissions assessed with a mental disorder											
Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	Number	Rate	95% CI	
January - March 2013/14	45	0.4	(0.3 - 0.5)	25	0.4	(0.3 - 0.6)	41	0.5	(0.3 - 0.6)	25	0.4	(0.3 - 0.6)
April - June 2014/15	51	0.5	(0.3 - 0.6)	26	0.4	(0.3 - 0.7)	40	0.4	(0.3 - 0.6)	35	0.6	(0.4 - 0.7)
July - September 2014/15	78	0.7	(0.6 - 0.9)	38	0.7	(0.5 - 0.9)	66	0.7	(0.6 - 0.9)	16	0.3	(0.1 - 0.4)
October - December 2014/15	56	0.5	(0.4 - 0.7)	19	0.3	(0.2 - 0.5)	53	0.6	(0.4 - 0.8)	34	0.5	(0.4 - 0.7)
January - March 2014/15	62	0.6	(0.5 - 0.8)	27	0.5	(0.3 - 0.7)	57	0.7	(0.5 - 0.8)	32	0.5	(0.3 - 0.7)

Data Source : British Forces Germany and SSFT in-patient data.

1. Eligible UK Armed Forces personnel (see paragraph 19).

2. Deployment to the wider theatre of operation (see paragraph 17).

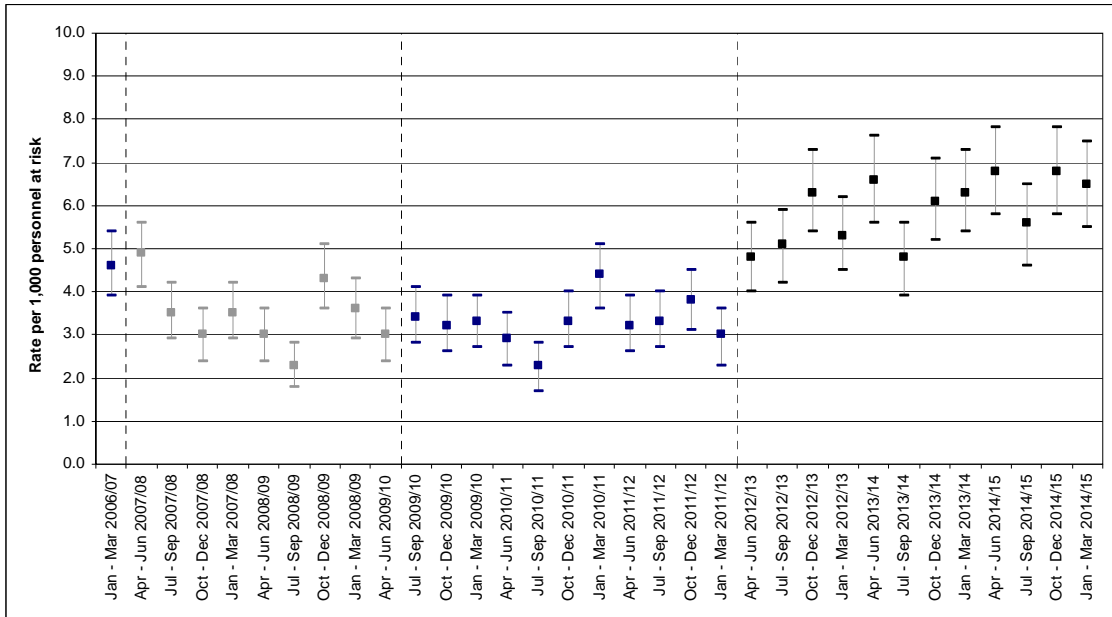
3. Data for Afghanistan between 1 January 2003 and 14 October 2005 were not available for person level deployment (see paragraph 18).

4. The rates and confidence intervals have been rounded to 1 decimal place (paragraph 26).

62. **Table 9** shows during the five quarter period presented there were no significant difference in the rate of admissions among personnel identified as having previously deployed to Iraq and/or Afghanistan compared to those identified as not having previously deployed prior to their admission. However, there was one exception in July-September 2014/15 where personnel identified as having previously deployed to Iraq and/or Afghanistan had a significantly higher rate of admission compared to those who had not been identified as having previously deployed (0.7 and 0.3 per 1,000 personnel at risk per quarter respectively).

Annex A - Rate of UK Armed Forces personnel assessed with a mental disorder quarterly by Service, Time Series, January 2007 to March 2015.

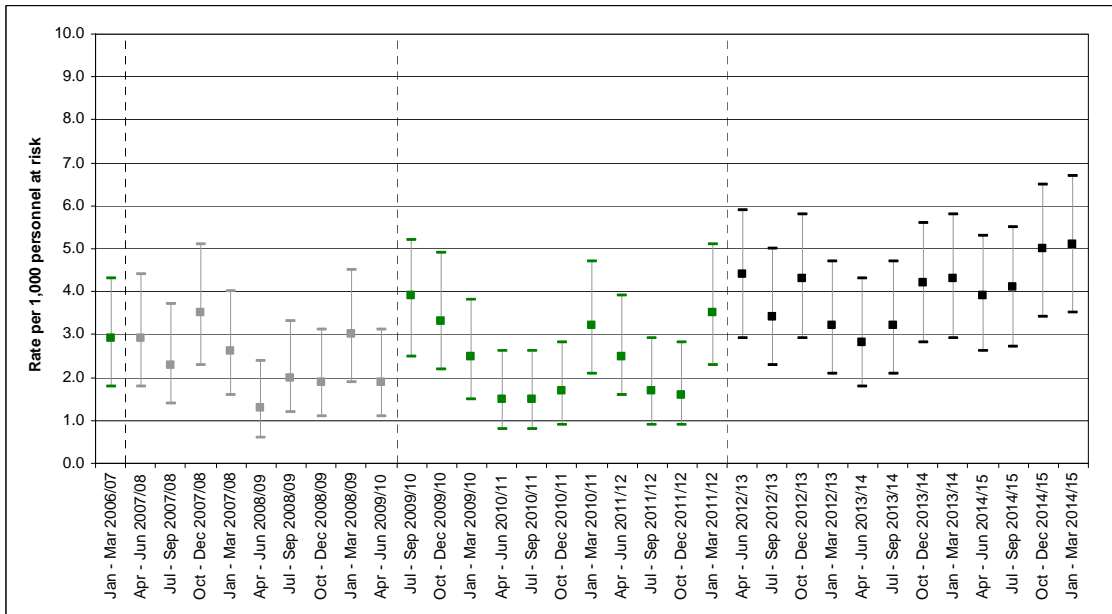
Figure A1: Royal Navy¹ personnel assessed with a mental disorder, 1 January 2007 to 31 March 2015^{2,3,4}, rates per 1,000 personnel at risk per quarter and 95% confidence intervals



Data Source : DS Database and DMICP

1. Eligible UK Armed Forces personnel (see paragraph 19).
2. January 2007 - June 2009 new attendances, July 2009 onwards new episodes of care (see paragraph 22).
3. 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.
4. April 12 - June 2013 new methodology (see paragraph 22).
5. Data up to 30 June 2014 sourced from DS database and DMICP. Data from 01 July 2014 onwards, DMICP only data (see paragraph 13).

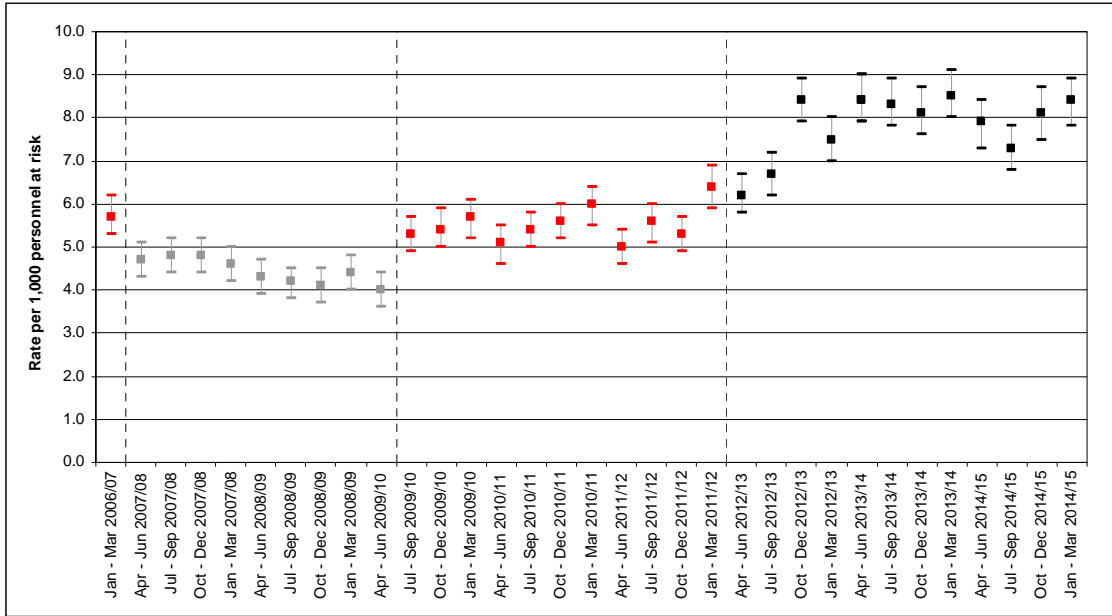
Figure A2: Royal Marine¹ personnel assessed with a mental disorder, 1 January 2007 to 31 March 2015^{2,3,4}, rates per 1,000 personnel at risk per quarter and 95% confidence intervals



Data Source : DS Database and DMICP

1. Eligible UK Armed Forces personnel (see paragraph 19).
2. January 2007 - June 2009 new attendances, July 2009 onwards new episodes of care (see paragraph 22).
3. 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.
4. April 12 - June 2013 new methodology (see paragraph 22).
5. Data up to 30 June 2014 sourced from DS database and DMICP. Data from 01 July 2014 onwards, DMICP only data (see paragraph 13).

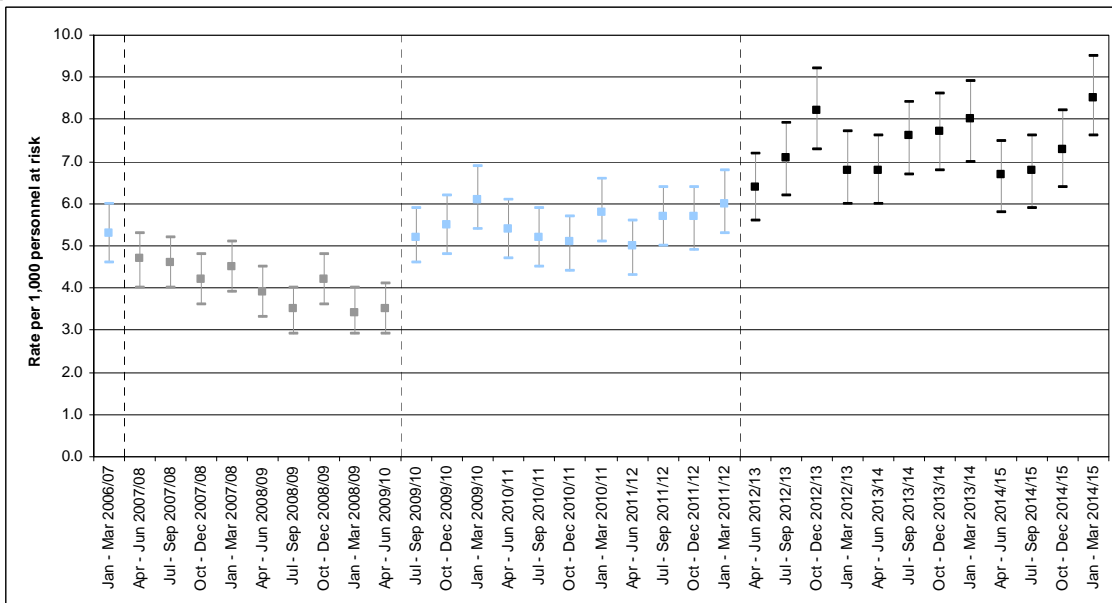
Figure A3: Army¹ personnel assessed with a mental disorder, 1 January 2007 to 31 March 2015^{2,3,4}, rates per 1,000 personnel at risk per quarter and 95% confidence intervals



Data Source : DS Database and DMICP

1. Eligible UK Armed Forces personnel (see paragraph 19).
2. January 2007 - June 2009 new attendances, July 2009 onwards new episodes of care (see paragraph 22).
3. 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.
4. April 12 - June 2013 new methodology (see paragraph 22).
5. Data up to 30 June 2014 sourced from DS database and DMICP. Data from 01 July 2014 onwards, DMICP only data (see paragraph 13).

Figure A4: RAF¹ personnel assessed with a mental disorder, 1 January 2007 to 31 March 2015^{2,3,4}, rates per 1,000 personnel at risk and 95% confidence intervals



Data Source : DS Database and DMICP

1. Eligible UK Armed Forces personnel (see paragraph 19).
2. January 2007 - June 2009 new attendances, July 2009 onwards new episodes of care (see paragraph 22).
3. 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.
4. April 12 - June 2013 new methodology (see paragraph 22).
5. Data up to 30 June 2014 sourced from DS database and DMICP. Data from 01 July 2014 onwards, DMICP only data (see paragraph 13).