Ministry of Defence

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FOI2023/05664

[redacted]

25 May 2023

Dear [redacted],

Release of Information

Thank you for your correspondence of 4 May 2023 in which you requested the following information:

> 'Please may I request the answers to the following questions.
> (1) How many people currently serving within the Royal Navy have a formal diagnosis of ADHD (Attention Deficit Hyperactivity Disorder).
> (2) If an individual serving in the Royal Navy presents with symptoms of ADHD what is the process from there?
> (3) In the past 12 months has the Royal Navy funded or undertaken themselves (perhaps within DCMH) any assessments for ADHD.
> (4) If the answer to (3) is yes. Please can you tell me how many were undertaken in the past year.
> (5) Further to (4) If Available, the information too for the prior 3 years.
> (6) Does the Royal Navy accept applicants with a diagnosis of ADHD?
> (7) Further to (6) Does the Royal Navy accept applicants with a diagnosis of ADHD and taking medication?
> (8) Further to (6) and (7) if yes to either answer. Are there any restrictions for those applicants.
> (9) If a service person is diagnosed with ADHD are they able to continue to serve?
> (10) Further to question (4) Of those people [assessed in the last year] how many were medically discharged within 12 months of receiving an ADHD diagnosis."
> In addition to my previous questions sent earlier today, could you please address one more additional question:
> 11) Does having an ADHD diagnosis prevent you from applying for some roles within the Royal Navy, and if yes, which roles?'

Your enquiry has been considered to be a request for information in accordance with the Freedom of Information Act 2000.

A search has now been completed within the Ministry of Defence and I can confirm that information in scope of your request is held.

In response to part one of your request, as at March 2023, there were **265** serving Royal Navy (RN) personnel who had a formal diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) in their medical record.

In response to part two of your request, RN personnel would undergo a medical assessment and subsequent occupational grading would follow.

In response to part three of your request, in the past 12 months ADHD assessments would have been carried out at Departments of Community Mental Health (DCMH)

In response to part four of your request, between 1 April 2022 and 31 March 2023, **16** RN personnel had a first appointment at DCMH for ADHD.

In response to part five of your request, between 1 April 2020 and 31 March 2023, **27** RN personnel had a first appointment at DCMH for ADHD.

In response to part ten of your request, of the **27** RN personnel who had a first appointment at a DCMH for ADHD between April 2020 and March 2023, fewer than 5 were subsequently medically discharged within a year of their first appointment.

Medical discharge figures presented are for UK Regular RN personnel. Please note, ADHD may not have been listed as a principal or contributory cause of the subsequent medical discharge and it may have been for an unrelated condition.

In response to part eleven of your request, each case of diagnosed ADHD is assessed and dependant on the level of the candidate's condition, this will determine suitable roles within the RN.

Finally, in response to parts six, seven, eight and nine of your request, information can be found in the Joint Service Policy (JSP) 950 6-7-7- Joint Service Manual of Medical Fitness, in particular sections four and five. A copy of which is enclosed with this letter.

If you have any queries regarding the content of this letter, please contact this office in the first instance.

If you wish to complain about the handling of your request, or the content of this response, you can request an independent internal review by contacting the Information Rights Compliance team, Ground Floor, MOD Main Building, Whitehall, SW1A 2HB (e-mail CIO-FOI-IR@mod.uk). Please note that any request for an internal review should be made within 40 working days of the date of this response.

If you remain dissatisfied following an internal review, you may raise your complaint directly to the Information Commissioner under the provisions of Section 50 of the Freedom of Information Act. Please note that the Information Commissioner will not normally investigate your case until the MOD internal review process has been completed. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF. Further details of the role and powers of the

Information Commissioner can be found on the Commissioner's website at https://ico.org.uk/.

Yours sincerely

Navy Command Secretariat - FOI Section

ANNEX L

PSYCHIATRY PRE-ENTRY

Special Conditions Affecting the M Grading

1. The M grading is a clinical quality distinguishing those whose mental capacity makes them suitable for normal training and posting, from those of limited intellectual capacity who necessitate rejection.The recruit selection test procedures will usually provide an objective assessment of mental ability to facilitate grading.

2. The M grading is dependent not only on the candidate's innate ability, but also on their capacity to use that ability. No formal clinical assessment is practicable or required during the examination. A history of head injury, indications of learning difficulties and a practical application of knowledge gained should be sought by exploring the candidate's school career, literacy, nature of employment since leaving school, hobbies and interests, etc before grading M2.

Special Condition Affecting Fitness for Service

General

3. Examining medical officers should have a good knowledge of mental health matters and in all cases, a critical examination of the candidate's psychiatric history is imperative to determine suitability for military Service. For candidates with a previous mental health diagnosis, identifying vulnerabilities which may contribute to the presentation of a further disorder during Service will be helped by ensuring that:

a. the diagnosis of a mental health disorder was correct and made by a suitably qualified professional;

b. the aetiology or perceived stressor preceding the onset of the disorder was identified;

c. timely evidence-based therapy was provided.

4. It is important to differentiate between conditions representing understandable emotional and behavioural responses to significant life events (e.g. parental divorce, bereavement) and those disorders with a hereditary or complex aetiology (e.g. depression). Whilst the former may settle within acceptable time frames and with no psychiatric input, the latter are more likely to have a significant effect on function and greater risk of relapse. Candidates with a diagnosis made during adolescence require particular scrutiny. This is to ensure that individuals who have presented at a time of normal and understandable emotional turmoil are not unnecessarily declared UNFIT if they are symptom free and have developed coping strategies adequate for Service life.

5. If there is insufficient evidence presented at the pre-employment medical examination (or prior questionnaire screening) to enable a decision, additional clarifying evidence (e.g. contemporaneous medical records) should be requested from the candidate or the candidate's GP. When specified within this policy or where uncertainty remains, the case should be referred to the single Service occupational physician responsible for Service entry.

6. Candidates with current psychiatric disease or dysfunctional behaviour are always UNFIT. In certain circumstances they may become FIT after a prescribed period of time once the condition has resolved.

7. The guidance given in this section is based on evidence for prognosis and recurrence rates for most of the mental health conditions listed in the ICD-10 classification of mental and behavioural

disorders[1]. Advice is provided for all relevant diagnostic groups and the ICD Code is given for ease of reference.

Dementias (F00-F03)

8. These are rare in the recruit age group although in theory variant Creutzfeldt – Jakob disease could occur. Candidates are UNFIT.

Organic Amnesic Syndrome (F04)

9. Recovery from this condition is extremely rare. Candidates are UNFIT.

Delirium (F05)

10. The causes of delirium are numerous though, in the recruit age group, delirium is most likely to have been due to high temperature associated with severe infection. In such cases there should be no bar to recruitment provided the infection was acute and single and has completely remitted. If this was not the case, then the cause should be determined and the case discussed with the sS occupational physician responsible for Service entry.

Other Mental Disorders due to Physiological Conditions (F06-F09)

11. This group of conditions are caused by a variety of aetiological factors. Most of the conditions have a serious underlying cause and candidates are normally UNFIT. In cases of doubt, the examining physician should seek the opinion of the single Service occupational physician responsible for service entry.

12. Candidates with a history of post-concussion syndrome (F07.2) may be determined FIT provided that the candidate has been symptom-free, including from vestibular disturbances and mental health co-morbidities, for 1 year prior to application. (See 6-7-7 Section 4 Annex G 4G.08 for the neurological assessment of head injuries.)

Mental and Behavioural Disorder due to Psychoactive Substances (F10-F19)[2]

13. **Illicit Drugs**. Discovery of the use of any illicit drugs is not a clinical matter per se. It becomes a clinical matter when illness, most particularly drug dependence, has occurred. **Examining medical officers are not obliged to inform recruiting staff if a history of substance abuse not resulting in clinical illness is volunteered during the course of an examination.**

14. **Drugs**. Candidates with current drug related health problems are UNFIT. Before accepting anyone with a previous history of drug-related health problems, referral to the single Service occupational physician responsible for Service entry is recommended as the risk of relapse must be carefully considered.

a. Candidates in whom there is evidence of drug dependence in the 3 years prior to application are normally UNFIT. If there is unequivocal evidence from an addiction clinic that the candidate has been clean[3] for more than 3 years prior to application then recruitment may be permitted.

b. Candidates that have been diagnosed with harmful use of drugs not amounting to drug dependence in the 2 years prior to application are normally UNFIT. If there is good evidence in the candidate's medical history that the individual has been clean[3] and symptom free for more

[1] Some categories are not included either because they are only used by mental health researchers or because they are irrelevant for military candidates.
[2] F10 relates to alcohol. F11 to F19 relates to opioids, cocaine, cannabis and other drugs.
[3] Defined as absolutely no drug use.

than 2 years prior to application with no ongoing treatment, then recruitment may be permitted.

c. A history of infrequent recreational use without evidence of damage to health is not a medical bar to entry.

15. **Alcohol misuse**. If there is good evidence that prior to application the candidate has been symptom-free and has not been undergoing any treatment, then recruitment may be permitted. It is advised that corroborative evidence is sought and in cases of doubt, the examining physician should seek the opinion of the single Service occupational physician for service entry.

a. Candidates with a history of alcohol dependence (F10.2) with or without associated problems (F10.3-F10.7) are UNFIT[4]. Those who have been alcohol dependent have a 70% chance of relapse, with only 30% remaining abstinent or being able to drink in a controlled way.

b. Candidates who have been diagnosed with harmful use of alcohol (F10.1) in the 2 years prior to application are normally UNFIT. The prognosis of those who have been diagnosed with harmful use of alcohol not amounting to dependence (F10.1) is variable and the risk remains.

Schizophrenic and Delusional Disorders (F20-F29)

16. With the exception of acute and transient psychotic disorders (F23), all candidates with diagnoses in this category are UNFIT. These disorders represent a variety of ill-understood conditions whose relationship to schizophrenia and other psychotic disorders is uncertain. Even though such conditions often have many of the qualities of "good prognosis" schizophrenia there is still a significant relapse rate of up to 30%. If there is very clear evidence that the illness was short-lived, i.e. fully abated (with or without treatment) within 1 month of diagnosis, and due to an obvious cause, the candidate should be discussed with the single Service occupational physician responsible for Service entry. Where an organic cause (such as a toxic reaction to a drug or an acute severe infection[5]) is evident, candidates may be determined FIT but where the cause is found to be functional, i.e. resulting from a mental health condition, candidates will be UNFIT.

Mood (Affective) Disorders (F30-F39)

17. Disorders of mood, especially depression, are not confined to this category as diagnoses may also be classified in the anxiety and stress-related categories (F41 and F43). Disorders in this group range from the profoundly disabling psychotic affective disorders (e.g. mania) to less distressing, mild and transient lowering of mood secondary to a minor life stressor. In some individuals the genetic predisposition is so strong that the condition may become overt with no triggering stressor. However, in most cases of affective disorder, an episode of illness is precipitated by a stressful life event.

18. Candidates with a diagnosis of a single episode of mild or moderate depression (F32.0, 32.1) with a clear precipitating stressor may be determined FIT provided that all treatment, including medication, has been completed and the individual must be free from symptoms and off medication for 1 year.

19. A diagnosis of a single episode of severe depression without psychosis (F32.2) suggests a greater impact on functioning, a requirement for more extensive therapy and higher risk of relapse. To be determined FIT, all treatment (including medication) must be completed and the candidate must be free from symptoms and off medication for 2 years. The episode of depression itself and the treatment pathway should not be more than 24 months in total[6].

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[4] Alcohol is a legal drug and lifetime risk of relapse is high.
[5] i.e. similar to delirium.
[6] DCA Advice - the natural recovery of depression is about 2 years and with treatment around 6-9 months with some needing maintenance medication for 6-12 months.

20. A candidate with a history of two of more episodes of depression or a recurring or persistent depressive disorder (F33), severe depression with psychosis, manic disorder (F30) or bipolar affective disorder (F31) will be UNFIT. If there is a doubt about the diagnosis the case should be referred to single service occupational physician responsible for Service entry.

Phobic Anxiety Disorder (F40)

21. In these disorders, severe physiological arousal occurs which is markedly disproportionate to the seriousness or danger of the triggering stimulus. Phobias may be classified into 3 major groupings of specific phobia, social phobia and agoraphobia. Specific phobias developing in childhood have a poorer prognosis than those starting in adult life and if untreated, can persist for many years. However, phobias are very amenable to treatment and a candidate may normally be determined FIT provided that all treatment, including medication, has been completed and the individual has been free from symptoms and off medication for 1 year. Candidates presenting with a history of 2 or more episodes will be UNFIT.

Other Anxiety Disorders (F41)

22. As discussed in paragraph 3, it is important to differentiate short term anxiety presenting as part of a normal reaction to a clear trigger, such as exams, from a more significant presentation meeting the diagnostic criteria for a condition such as panic disorder or generalised anxiety disorder. Even with a clear diagnosis of an anxiety disorder candidates may present with a history ranging from a single brief stress-related episode to a longstanding condition, seemingly more related to a vulnerable personality than to external stressors. In those cases where it is clear that the condition was brief and triggered by significant life stress then the candidate may be determined FIT as long as they have been symptom and treatment-free for at least 1 year. Candidates with two or more episodes of anxiety or with a longstanding history of panic or generalised anxiety disorder are UNFIT.

Adjustment Disorders (F43.2)

23. Adjustment disorders are characterised by excessive emotional and behavioural symptoms in response to a perceived stressor, however the presence of symptoms of depression or anxiety often make diagnostic distinction uncertain. The emotional response, any maladaptive coping strategies and reduced functioning would be expected to develop within 3 months of the stressor and settle within 6 months; if the latter is not the case the diagnosis should reflect the enduring symptoms of anxiety and depression. Understanding the aetiology of the disorder is imperative in deciding whether the emotional response was commensurate with the stressor and thus the individual's capacity to withstand further stress.

24. Candidates with a diagnosis of adjustment disorder may normally be determined FIT provided that all treatment, including medication, has been completed and the individual has been free from symptoms and off medication for 1 year. Candidates with two or more episodes are UNFIT.

Obsessive Compulsive Disorder (OCD) (F42)

25. Candidates with a history of OCD are UNFIT.

Post-Traumatic Stress Disorder (PTSD) (F43.1)

26. A previous history of PTSD, diagnosed by a consultant psychiatrist or clinical psychologist, is a significant risk factor for the development of further PTSD. Because of the likelihood of Service personnel being involved in stressful operational environments, the candidate should normally be determined UNFIT, even if previously treated. In cases where the diagnosis is uncertain or not made by a consultant psychiatrist or clinical psychologist, the examining physician should seek the opinion of the single service occupational physician responsible for Service entry.

Dissociative Disorders (F44)

27. These disorders include dissociative fugue where the sufferer goes into a trance-like state, and conversion disorders, where there is loss of sensation or loss of function of limbs or loss of vision or similar incapacity. All candidates with this diagnosis, whether from an organic or psychological[7] cause, should normally be determined UNFIT.

Somatoform Disorders (F45)

28. Candidates with a somatisation disorder diagnosed by a consultant psychiatrist or clinical psychologist, including somatisation and hypochondriacal disorder, are normally UNFIT.

Eating Disorders (F50)

29. Candidates with a confirmed diagnosis of anorexia nervosa (F50.0) or the atypical form of this condition (F50.1) are UNFIT. For anorexia nervosa it is not currently possible to reliably distinguish between the 20% of sufferers who make a full recovery and do not relapse in the future, from the remainder who relapse and remit or who remain severely ill.

30. Candidates with a diagnosis of bulimia nervosa (F50.2) without co-morbidity such as anorexia, atypical eating disorder patterns or personality disorder, may be determined FIT one year after recovery provided they are fully functioning and symptom-free. Candidates meeting this criteria and candidates for whom the diagnosis is uncertain should be discussed with the single Service occupational physician responsible for Service entry. Candidates with two or more discrete episodes are UNFIT.

31. Candidates with Other Specified Feeding and Eating Disorders (F50.9) are UNFIT.

Mental Disorder Associated with the Puerperium (F53)

32. Candidates with a history of puerperal psychosis (F53.1) from which they have fully recovered, should be discussed with a single Service occupational physician responsible for Service entry.

33. Candidates with a history of puerperal depression have an increased risk of developing a depressive episode outside of the puerperium. The guidelines to be followed are the same as those for mood (affective) disorders (F30-F39) (Paras 17 - 20).

Disorders of Personality (F60-F69)

34. ICD-10 lists a number of categories under this heading. All of these conditions indicate deeply ingrained and enduring patterns of behaviour, and candidates with a diagnosis in this group must be determined UNFIT. In cases of doubt, the examining physician should seek the opinion of the single Service occupational physician responsible for Service entry.

35. Disorders of sexual preference (F65) e.g. fetishism, exhibitionism, voyeurism, paedophilia and sadomasochism are listed with the personality disorders. Such cases should be discussed with the single Service occupational physician responsible for Service entry.

Gender Identity Disorders (F64)

36. Candidates with Gender Identity Disorders may present untreated, during treatment or having completed all hormonal and surgical treatment. In each case the candidate is required to meet the same physical and mental entry standards as any other candidate. JSP 889 'Policy for the

[7] Even in cases in which there is clear causative stressor.

Recruitment and Management of Transgender personnel in the Armed Forces'[8] gives the overarching MOD policy with the medical aspects of recruiting covered in Annex A.

37. Candidates who have completed transition (and, where appropriate, have been stabilised on hormone medication and fully recovered from surgery) may be determined FIT, subject to fulfilling the normal medical standards according to the individual's legal gender, including any time periods required in this Annex to allow for the resolution of psychological problems encountered before or during the transition process. Any ongoing hormone therapy must be compatible with world-wide Service and have been stable for at least 6 months. Refer to JSP 889 Annex D for further guidance.

38. **Candidates in transition**. Transition is an extremely stressful period and may involve regular treatment (surgical or hormonal) and follow-up. It is likely that the requirements for treatment and review, as well as the psychological stresses of this period, will normally be UNFIT.

a. Candidates who are undergoing surgical procedures should normally be considered UNFIT until those procedures are complete and the normal recovery times for surgery laid out in the appropriate Annexes[9] of this JSP have been achieved and then assessed in line with para 37 above.

b. Candidates undergoing hormone treatment must be stable for at least 6 months on a medication regimen and the medication and review requirements must not preclude world-wide service before they can be determined FIT. If the hormone therapy is a prelude to surgical procedures then the candidate should normally be UNFIT until that surgery and appropriate recovery is complete.

c. Whilst gender identity disorders themselves are not a reason for referral for psychiatric assessment, candidates in transition should be carefully assessed for previous and ongoing psychiatric conditions or distress which should be graded in accordance with the relevant paragraph of this Annex.

d. Where any doubt exists about the suitability of a candidate for military service the examining physician should seek the opinion of the single Service occupational physician responsible for Service entry.

e. For assessment of the risks of musculoskeletal injury in military training see Section 4 Annex K.

39. Candidates currently experiencing gender dysphoria are normally considered UNFIT in line with para 6 of this Annex.

Disorders of Psychological Development (F80-F89)

40. Candidates diagnosed with autism (F84) or similar disorders by a specialist autism service are normally UNFIT. Candidates diagnosed with Asperger's syndrome (F84.5) by a specialist autism service may appear unremarkable on examination but should normally be UNFIT. If there is doubt about the diagnosis or the condition is mild and does not cause disability, candidates should be referred to the single Service occupational physician responsible for Service entry. In cases of mild, entirely non-disabling Asperger's Syndrome, the single Service occupational physician may advise single Service recruiting staff psychiatric assessment is not required. This because pre-entry tests of suitability for military life (e.g. selection interviews and tests) are as good a form of assessment as a psychiatric assessment.

[8] JSP 889 'Policy for the Recruitment and Management of Transgender Personnel in the Armed Forces' (V1.1 Aug 19).
[9] Annexes E, F and J.

The Hyperkinetic Disorders (F90)

41. Attention Deficit Hyperactivity Disorder (ADHD) is the most common diagnosis to present in this category. There is a large spectrum of behaviour in children and adolescents that attracts this diagnosis. Symptoms suggestive of this disorder may also be part of normal adolescent behaviour or be presenting features of anxiety or depressive disorders. For an unambiguous diagnosis there must be an early onset (prior to the age of 7 years[10]) with impaired attention and overactivity, both of which occur in all kinds of locations (e.g. home, school, sports centre, doctor's surgery). This is because the impaired attention and hyperactivity is excessive when compared with other children of the same age and IQ.

42. ADHD can be associated with co-morbid common mental disorders (CMD) and substance misuse. In cases where a CMD or substance misuse is present, the prognosis is poor and candidates should be determined UNFIT.

43. Candidates with ADHD but without co-morbidities may be determined FIT if the candidate has been stable without evidence of dysfunctional behaviour for one year prior to application[11] without medication. Corroborative evidence should be sought to confirm that the individual has been functioning normally (e.g. maintenance of regular employment, attendance at school or college) and where there is doubt the case should be referred to the single Service occupational physician.

44. Candidates with a diagnosis of hyperkinetic conduct disorder with evidence of violent and/or delinquent behaviour should be determined UNFIT as current evidence indicates that these forms of the condition are unlikely to improve with time.

Intentional Self-Harm (X60-X84)

45. The spectrum of intent in respect of intentional self-harm ranges from stress relief by cutting, through manipulative behaviour or emotional blackmail of others to serious suicidal intent. It is often difficult to tell from a candidate's recorded history where past episodes lie on this spectrum. Candidates with a history of self-harm may have taken a medication overdose. Superficial cutting, typically of the arms, thighs or abdomen, is also common.Evidence suggests that cutting is often a maladaptive way of relieving stress and is more appropriately termed self-mutilation.It may be linked to acute stressors but might also be indicative of long term personality problems or a history of past childhood abuse.

46. Candidates with a single episode of self-harm or self-mutilation occurring more than 2 years before application in response to a stressful event may be determined FIT provided the 2 year interim has been free from all symptoms. If there was no precipitating stressful event then the candidate should normally be considered UNFIT, as this indicates an enduring endogenous risk of further self-harm.

47. Candidates with a history of 2 or more episodes, even with clear stressors, should normally be considered UNFIT, as repetition indicates a substantial risk of further repetition and a significant increase in risk of later death by suicide. If multiple episodes occur over a short period of time (weeks rather than months), and can clearly be ascribed to the same single stressful event, then for the purposes of selection these may be regarded as a single episode. Additionally, if 2 or more episodes are attributable to independent stressors but there is robust evidence that the candidate has subsequently developed coping strategies adequate for Service life, the case may be referred to the single Service occupational physician with responsibility for Service entry in line with para 5.

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[10] Developmental course of ADHD symptomatology during the transition from childhood to adolescence: a review with recommendations. Willoughby MT. Journal of Child Psychology and Psychiatry 44.1 (2003), pp 88-106.
[11] This is developed from an overview of all available prognostic evidence.

ANNEX L

PSYCHIATRY IN-SERVICE

Special conditions affecting mental capacity

1. Mental capacity is dependent not only on the innate mental ability of a Service Person, but also on their capacity to use that ability. During most medical examinations, no formal clinical assessment of mental capacity is practicable or required. Where this area is being reviewed following completion of basic training, such as after physical illness or injury, full psychometric testing by a clinical psychologist should be undertaken. Any changes in JMES should only be conducted following the above and on advice from a consultant neurologist, consultant psychiatrist, clinical psychologist or other recognised subject matter expert in the field.

Special conditions affecting psychological stability

2. **Requirements to be considered for Medically Fully Deployable (MFD) status**[1]. Service life places great psychological demands on individuals. Individuals with underlying psychiatric conditions may be at increased risk of exacerbating their condition during military service. Therefore, it is important to consider the following factors when grading individuals as MFD:

a. Must be fit to deploy at short notice to any location world-wide, and serve as directed by Command.

b. There must be a high degree of certainty that they will be able to cope with heightened levels of stress, and maintain sufficient psychological stability to remain functional and effective.

c. They must be able to deploy away from their support network for prolonged periods, in a largely self-reliant capacity, without becoming an administrative burden or operational risk due to psychological instability.

d. They must be able to safely operate weapon systems on operations and in training.

e. They must be able to deploy without additional special support requirements (i.e. JMES E1 or E2).

f. Relapse of symptoms must not pose a risk of high risk behaviours that may present significant problems in theatre, e.g. serious self-harm, violence or unpredictable behaviour that may endanger others.

3. **General considerations for awarding a JMES**. In deciding on the JMES for a psychological condition the clinician should consider the following factors:

a. The level of hardship individuals are likely to encounter (temperature, noise, nutrition, hydration, arduous physical activities, sleep disturbance, loss of social support etc).

b. The level of medical support required (immediacy, availability, skill mix, resources).

c. The duties to be performed (likelihood of exposure to traumatic events, burden of working hours, likelihood of new/novel tasking requiring adaptation, leadership role etc) and the person's previous experience of, or training for, these duties.

[1] Further details on definition and award in JSP 950 Leaflet 6-7-7 Section 2 Annex A and sS policy.

d. The current welfare of individuals and their personal support networks (current relationship difficulties, financial difficulties and legal problems etc) and the ability to communicate with that network.

e. The degree to which the current and anticipated symptoms affect function; particularly how symptoms affect concentration, sleep, judgement, impulsivity, attitude, morale and motivation.

f. The risk and speed of relapse, potential for incapacitation by a relapse and the responsiveness of the condition to treatment.

g. The Service Person's degree of insight about their condition and its effect on the team around them and the operational tasks.

h. Clear consideration should be given to the need for performing safety critical tasks, e.g. in aviation-related roles, that may confer a lower tolerance of risk and require higher assurances of stability.

4. **Care pathways**. In mental health, care pathways can be very lengthy and in deciding a permanent JMES the length of the care pathway is a secondary consideration, and it may be appropriate to set a permanent JMES before completion of treatment. Grading decisions will take into account whether the patient has received an appropriate evidence-based level of care, requires further treatment, prognosis and the likelihood of recovery to an employable status. Treatment provided should be at least equivalent to the prevailing standard in the National Health Service. Single Service authorities dictate assessment points in this regard and final grading is the remit of Single Service Medical Boards.

5. In specialist groups such as aircrew, divers, submariners and Special Forces, this policy does not take precedence over the specific occupational policies that govern these specialist areas.

Common mental disorders (including adjustment disorders, mood and anxiety disorders, phobias, post-traumatic stress disorder (PTSD), and eating disorders)

6. Common Mental Disorders (CMD) form the bulk of the clinical activity within the Defence Mental Health Services.

7. **Stepped care**. Patients requiring psychological therapy are stepped through levels of care according to need.

a. **Initial interventions**. Self-help material and resources with no formal psychotherapeutic intervention by the clinician, other than to provide the material and signpost the patient to the appropriate resources, including formal referral to mental health services. This is commonly the step conducted in non-specialist mental health settings like Primary Care.

b. **Low intensity therapy**. Guided self-help where a patient is assisted by a clinician, usually on a weekly basis, to complete a psychotherapy programme. Low intensity therapy is often standardised, of shorter duration, less intensive and aimed at mild to moderate presentations.

c. **High intensity therapy**. Individualised therapy, usually by a qualified therapist in the modality, using an individual approach and more intensive treatment. High intensity therapy is generally aimed at moderate to severe presentations or where no standardised low intensity therapy exists for the condition (e.g. PTSD).

d. **Complex case management and specialist psychotherapy**. Severe and complex conditions that require long-term care from multiple professionals. Patients requiring this level of care are likely to be significantly functionally limited and should normally be considered unfit for military service.

8. In setting this policy *"NICE guidance CG123: Common mental health problems: identification and pathways to care" May 2011 (reviewed August 2018)"* introduces the stepped care model for CMD. This is mirrored in the guidelines for individual disorders, and these are delivered within the tenets of providing lower level, least intrusive interventions first, then escalating as required through the steps. The specific guidelines also specify a number of sessions of intervention at each level of care, which differs slightly between conditions but are broadly comparable:

a. **Initial interventions**. Session limit does not apply.

b. **Low intensity therapy**. 6-10 sessions.

c. **High intensity therapy**. 12-30 sessions.

d. **Complex case management and specialist psychotherapy**. On-going, long-term care.

9. **Temporary grading for CMD**. Patients undergoing stepped care for CMD should normally be graded MND to allow them to access treatment with appropriate occupational restrictions to manage access to treatment, address risks (to self and others), accommodate psychotropic medication and enable the care pathway as required. However, patients undergoing initial intervention in Primary Care may not need to be graded MND and pragmatism and an individual occupational assessment should guide clinicians, including consideration of any psychotropic medication the patient may be taking. For patient undergoing low intensity interventions and above, there may also be rare, individual cases where MND grading may not be appropriate, but in such cases a grading discussion with an occupational health physician or Service[2] consultant psychiatrist represents best practice. On successful completion of treatment and a period of stability of not less than one month, Service Persons may be upgraded (please see stability requirements for other specific conditions below).

10. **Permanent grading for CMD**. Permanent grading is the sole remit of Single Service Medical Boards, taking account of recommendations by specialist clinicians as required. As a general rule, patients should be awarded a permanent grading if:

a. Required by sS policy.

b. The stepped care pathway has been completed. See Para 3 for considerations to be reviewed in defining a permanent grade.

c. Patients requiring long-term treatment with psychotropic medications should be graded no higher than MLD with appropriate restrictions.

d. Service Personnel should be graded permanently MND if, after treatment, one or more of the following criteria are met:

(1) They have had the maximum of 12-30 high intensity sessions (if appropriate) of an acceptable quality and continuity (which may or may not have been preceded by 6-10 sessions of low intensity therapy) and the condition remains unresolved.

[2] This term encompasses all consultant psychiatrists working for the MOD, uniformed or civilian.

(2) They have had adequate trials of 2 psychotropic medications appropriate to their condition (providing the patient opted for this treatment), and has not demonstrated an adequate therapeutic response. This is a significant marker of treatment-resistance.

(3) Their condition and social environment is so unstable that it prohibits meaningful progress or engagement with psychotherapy after 6 months of attempts at stabilisation, regardless of the stage they have reached in the stepped care process.

(4) If, in the opinion of a service consultant psychiatrist, the risk of relapse on exposure to the operational environment is unacceptably elevated.

Conditions normally incompatible with military service

11. **Psychosis**. Service Persons with psychotic illness, whether recurrent or not, are normally graded permanently MND. The only clear exception is a single, brief psychotic episode of less than 7 days' duration where there is a clear, definable organic aetiology (e.g. delirium, drug side effect etc). In these exceptional cases the patient should remain symptom free for 6 months off all psychotropic medications before being considered for a deployable medical category.

12. **Bipolar affective disorder**. Service Persons with bipolar affective disorder (Types I and II) are normally are normally graded permanently MND.

13. **Personality disorders**. Service Persons with these disorders are normally graded permanently MND.

14. **Recurrent CMD**. Patients who re-present with a CMD within 3 years of completing a stepped care pathway would are normally graded permanently MND if they fail to respond to maintenance medication and/or 6 booster sessions of high intensity therapy. Exceptions in these circumstances are individuals that can be offered sufficient occupational protection to minimise recurrence risks, whilst still being able to fulfil an employable and/or deployable function for their Service.

15. **Lithium therapy**. Service Persons on lithium therapy should normally be graded MND due to the risks associated with this medication and the conditions it is used for. However, at the discretion of the Single Service Medical Board, retention may be considered in a MLD category.

16. **Recurrent and/or persistent self-harm**. A single episode of self-harm[3] in response to a stressful event does not in itself render an individual unfit for military service. However, Service persons with a history of 2 or more episodes, even with clear stressors, should normally be considered unfit for military service, as repetition indicates a substantial risk of further repetition and, of more concern, a significant increase in risk of later death by suicide. However, there are exceptional cases where Service persons with a second episode of self-harm may be fit for further military Service, for example an individual with a long period of stability in between episodes. In such cases, retention can be considered but this should normally be supported by a comprehensive risk assessment from a MOD Consultant Psychiatrist, including an assessment for any underlying pre-disposing conditions. If multiple attempts occur over a short period of time (weeks rather than months), and can clearly be ascribed to the same single stressful event or occur whilst the patient is still undergoing treatment or waiting for therapeutic intervention to commence, then for the purposes of this policy, these may be regarded as a single episode.

17. **Repeated or prolonged inpatient care**. Due to the likelihood of relapse and long-term illness, Service Persons requiring repeated (3 or more) or a single prolonged (longer than 56 days) inpatient admission to a mental health ward are normally graded permanently MND.

[3] Self-harm refers to an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act and is an expression of emotional distress.

18 **Substance misuse disorders requiring detoxification**. Service Persons requiring more than 2 episodes of inpatient detoxification or more than 4 detoxifications overall (inpatient and community) for dependent use of any substance are normally graded permanently MND. The Executive management of substance misuse is covered under the relevant single Service policies.

Substance misuse disorders[4]

19. Most Service Persons considered as part of this policy will misuse alcohol, but it can be applied to all psycho-active substance misuse[5]. Service Persons who present with substance misuse disorders should be graded MND and offered 6-10 sessions of low intensity therapy and/or a maximum of 12-30 sessions of high intensity therapy (if appropriate) of an evidenced-based therapeutic modality depending on severity and need. Treatment is independent of any required disciplinary processes which may run concurrently.

20. If treatment is completed and the Service Person continues to misuse the substance but is not dependent on the substance, then it is a Chain of Command responsibility to manage them through the normal administrative routes. Grading is dependent upon functional ability to perform all duties[6].

21. If the Service Person has a recognised dependence syndrome, they should normally be graded MND.

22. Clinicians may need to disclose illicit substance misuse to Command if the public interest test or the requirement to protect others is met, and this is incumbent on clinicians to do in cases of risk that needs to be mitigated by command. This same approach holds true for these risks that are encountered in any condition in this policy. If the clinician considers this necessary the clinician should seek consent to disclose, take account of GMC guidance on confidentiality and seek senior guidance as required. Disclosure without consent may be necessary.

Adult Attention Deficit Hyperactivity Disorder (ADHD)

23. ADHD has a high association with co-morbid CMD and substance misuse, and in cases where a CMD or substance misuse is present, the occupational management should follow that of the CMD or substance misuse disorder as detailed above.

24. Service Persons with ADHD, in the absence of a CMD or substance misuse disorder, are fit for deployable service. Service Persons with ADHD tend not to be adversely affected by a rapidly changing, high-tempo and challenging working pattern or environment, such as operations. They usually remain on stimulant medication long-term as normally it improves functioning (from a lower but functional threshold); long-acting preparations are preferable in the deployed setting. However, a disruption in stimulant medication is unlikely to have an operational impact in individuals with a functional pre-medication threshold, and there is no withdrawal syndrome. If a decision is made to continue the medication during a deployment, which is reasonable to do, it is best practice to test functioning without stimulant medication on an appropriate UK-based exercise to simulate the disruption of stimulant supply on operations to confirm functionality. Service Persons who have been stable on stimulant medication for 6 months can be graded MLD.

Transgender personnel[7]

25. The grading of all transgender Service Persons requires consideration of their mental health, surgical/medical treatment and follow-up requirements.

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[4] Substance misuse is an over-arching term that includes both harmful use of a substance(s) and dependence on it.
[5] https://www.gov.uk/government/collections/defence-mental-health-statistics-index
[6] Reference should be made to single Service substance misuse policies.
[7] Further information can be found in JSP 889 'Policy for the Recruitment and Management of Transgender Personnel in the Armed Forces'.

26. **Medical grading of Service Persons who do not wish to undergo hormonal or surgical gender confirmation**. Service Persons may remain MFD unless, as a result of physical or mental health issues that affect deployability, a Service psychiatrist, psychologist or occupational physician advises otherwise.

27. **Medical grading of serving personnel wishing to undergo hormonal or surgical gender confirmation**. Initially, Service Persons are to be graded MND. MLD and MFD may be considered once their condition is stable, taking into account their on-going medical support needs and compatibility with military environments.

Psychiatric Reports for Medical Boards

28. There is no absolute requirement for a grading recommendation or report from a Service consultant psychiatrist when awarding a permanent JMES. owever, it is best practice for such reports to be prepared in order for the determining clinician to have the best possible information to inform the JMES. Psychiatric reports submitted for Medical Boards must follow the format detailed at Appendix 1. A psychiatric report must be provided to a Medical Board if requested.