The MoD PTSD decision: a psychiatric perspective

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consider a High Court judgment on liability for post-traumatic stress disorder in the military.

In 2003, the High Court of England and Wales handed down judgment in what has come to be known as the Ministry of Defence (MoD) post-traumatic stress disorder (PTSD) case[1]. This was a class action brought by more than 2,000 British military personnel (the claimants) who had served in a number of major operations prior to 1996 (defined as the relevant period) including Northern Ireland, the Falklands, the Gulf War, and Bosnia. The claimants argued that the MoD was negligent in failing to take measures to prevent, detect, or treat the development of psychiatric illness in general and PTSD in particular. Hence the case dealt with a number of issues relevant to psychiatry. These issues ranged from pre-recruitment screening, briefing for, and debriefing after combat, and the treatment of both acute stress reactions and PTSD.

That combat can result in psychiatric injury was not at issue in this case as this was accepted by both sides. Nor was it argued that the MoD did not have a "duty of care" to look after psychiatrically injured personnel. The claimants did not, and could not, argue that the MoD was at fault for sending them to war. Morally, the claimants did not make that argument as they accepted that as an "all volunteer" force they knew the risks of war when they joined the services. Legally, the MoD could claim what is known as "combat immunity", a legal framework which means that during a time of war, personnel cannot sue the military for exposing them to danger.

The judgment outlined the current state of knowledge of PTSD and its prevention, and defined standards of management. The case brought together 16 leading experts in the field, eight instructed by each side, and then subjected their evidence to scrutiny and cross examination. What emerged was arguably the most comprehensive review of the historical PTSD literature to date. Although the case was concerned with issues around the standard of care owed by the MoD to its service personnel for psychiatric injury, the judgment has repercussions for the way in which psychiatric services are provided, not just within the military but also in the wider field of employment, particularly within the emergency services and the public sector.

In this article we will examine the arguments that were presented by the parties, together with the findings of the court in order to extract the issues of significance to psychiatry and mental health care. The article draws on those aspects of the case that define the standard of care expected of the MoD in protecting against and dealing with the psychiatric consequences of combat-related stress.

Standard of care

No one doubts that joining the armed forces exposes a person to risks above and beyond those encountered in normal employment. Ultimately the job of the armed forces is to fight and win wars. In so doing there is always a risk of physical injury and death. That is the nature of the "military contract"[2]. Many jobs involve an element of risk and danger, but there are few in which this is an inherent part of the profession. But if that is the case, does that mean that such an employer must take special care of personnel, over and above the normal "duty of care" that any employer owes to its employees? The judgment in this case establishes that the answer is clearly no. In other words, we cannot expect employers such as the MoD and, by implication, other organisations including the emergency services, to have a higher duty of care than any other employer.

Mr Justice Owen cited the decision of the House of Lords in *McLoughlin v O'Brien*[3] as clearly establishing that there may be liability for psychiatric injury. In defining the standard of medical care owed by the MoD to its service personnel in the provision of psychiatric services he adapted the "*Bolam* test", quoting: "I myself would prefer to put it this way, that he is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a reasonable body of medical men skilled in that particular art … Putting it the other way round, a man is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion who would take a contrary view."[4] He held that the test in this case was whether or not the specialist psychiatric advice given to the MoD fell below the standard accepted by a reasonable and responsible body of military psychiatric opinion[5]. The claimants submitted that where service personnel were concerned, a higher practical standard of care was required than might be the case in other situations. However, Owen J agreed with the defendant that this argument was misconceived.

State of knowledge

Issues

The MoD did not at any stage deny that war can cause psychiatric injury. Nor did it deny that it had a duty of care to look after those who suffered such injury. But there were critical questions about these two issues. Exactly what type of psychiatric disorder could be caused by war? Were these only short-term illnesses, or could they become prolonged? Alternatively, could their onset be delayed? And if the answer to these

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questions was positive, when exactly was such knowledge acquired? Likewise, accepting that the MoD had a duty to provide treatment, what treatments should these have consisted of, and had knowledge of any new treatments become available?

Argued

The claimants submitted that it had long been known that combat causes both acute and chronic psychiatric injuries, that their onset may be delayed, and that there were robust predictors of both. They argued that the MoD had available to it, by the end of the Second World War, the knowledge to prevent or ameliorate the psychological consequences of combat. They criticised the MoD for failing to heed that knowledge and for paying insufficient attention to the data that had emerged from the Vietnam War.

In response, the defendant contended that it had remained informed of the nature and treatment of combat-related psychiatric disorders. In doing so, it submitted that psychiatric thinking for most of the 20th century was of the view that the determinants of prolonged psychiatric disorder are established in early life, either by genetic or developmental processes. War can cause acute breakdown in almost anyone if the stress is severe enough. This is epitomised by the phrase in Lord Moran's *Anatomy of Courage* that "every man has his breaking point"[6]. However, provided that a person was reasonably "normal" before he or she went to war, and provided that psychiatrists observed the principles of so called "Forward Psychiatry", this breakdown would be short-lived. If this was not the case then the cause was not really the war at all, but a person's predisposition and personality (see box 1)[7]. This was the general view of the neurotic disorders, as outlined in all the leading textbooks and classification systems, until it was fundamentally challenged by the recognition of PTSD by the American Psychiatric Association and its inclusion for the first time in the 1980 edition of its *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III).

Held

Owen J reviewed the evolution of the understanding of trauma-related psychiatric injuries by reference to the various wars of the 20th century. In doing so he traced the development of the modern diagnoses of combat stress reaction and PTSD from earlier concepts such as shell shock. In summarising the current state of knowledge he found that there were three types of psychiatric condition that required consideration.

The first of these was the acute reaction to combat. It was known that a linear relationship exists between the acute reaction to combat stress and the duration and intensity of combat. There is also a linear relationship between the number of acute psychiatric casualties and the number of physical casualties. Application of the key doctrines of Forward Psychiatry, which had been identified during the First World War and are sometimes known as the Salmon, or "PIE", principles (see box 1), was believed to increase the rate of recovery from acute reactions to combat stress. These acute reactions have gone under various labels, such as battle fatigue and combat stress reaction, largely to emphasise that they were not seen as medical conditions and were expected to have a good prognosis once the source of the stress, ie combat was removed. Such reactions were also observed, albeit rarely, in civilian life – as in the category of "gross stress reaction" introduced in DSM-I in 1952, which likewise occur in people of normal personality who have a good prognosis.

The second type of condition was a chronic one, now known as PTSD, which was absent from DSM-I and II. Its development as a psychiatric construct emerged from the Vietnam War. A group of honourable psychiatrists, of which the most famous were Robert Jay Lifton and Mardi Horowitz, who were passionately against the Vietnam war, did not accept that chronic psychiatric disorders observed in some veterans, were not related to the war. Politically it was advantageous to demonstrate that even "normal" American "boys" were being psychiatrically damaged in the long term by the war – it was the war that was insane, not the soldiers. They developed the concept of a post-Vietnam syndrome, which stood psychiatric orthodoxy on its head by suggesting that this was nothing to do with personality, genetics or predisposition, and everything to do with the dishonourable circumstances of the war. Within little more than five years, this became incorporated into DSM-III as PTSD[8]. So by 1980 there was a new concept. Like all major changes in thinking, this was greeted with scepticism across the Atlantic, as was established in testimony given at the trial. However, by the late 1980s it had received wider, but not universal, acceptance.

Box 1: The application of Forward Psychiatry principles before recognition of PTSD

Until the late 1970s: "The predominant view was that reactions to traumatic events were transient, and that therefore only people with unstable personalities, pre-existing neurotic conflicts or mental illness would develop chronic symptoms. It was recognition of the long-standing psychological problems of many war veterans, especially Vietnam veterans, and of rape survivors, that changed this view and convinced clinicians and researchers that even people with sound personalities could develop clinically significant psychological symptoms if they were exposed to horrific stressors."[1]

As a result, post-traumatic stress disorder (PTSD) was introduced as a diagnostic category in the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), published in 1980. This was a recognition that traumatic events such as combat, rape and man-made or natural disasters give rise to a characteristic pattern of psychological symptoms.

Prior to 1980, the "PIE" principles of Forward Psychiatry – proximity, immediacy and expectancy – had been applied, ie: "1. Treatment must be administered close to the incident and, insofar as possible, the victim must not be sent out of the war zone for hospitalisation (proximity). 2. Treatment must be administered as close as possible to the time of the onset of the symptoms (immediacy). 3. The victim must understand that he is to return to duty following short intervention (expectancy)."[2]

"[The] principal purpose [of the principles] is the conservation of manpower by returning the soldier to the front line as soon as possible. In essence they involve treatment of those who break down in combat as near as possible to the front line, as soon as possible after breakdown and in the expectation that they will return to duty." Dr Marlowe explained the treatment as consisting of: "… Hot food, rest, encouragement and often an explanation of the 'normal' nature of the symptoms of anxiety and fear embedded in the consistent expectation that the soldier wanted to and was to return to his primary group."[3]

1. See the NICE Guidelines for PTSD (full version) 2005, on pp.14–15.
2. [2003] EWHC 1134 at para 5.17.
3. [2003] EWHC 1134 at para 10.1.

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The next point was the claim that not only could war result in long-term as well as short-term psychiatric causalities, but these might not appear immediately. Owen J ruled that there had been some awareness of this type of condition – delayed PTSD – prior to 1980, but there had been little research to go on and no understanding of its scale or nature. While the Vietnam studies, which started to appear after the introduction of PTSD into DSM-III in 1980, seemed to demonstrate a high incidence of delayed onset of the condition, or at least its reporting, these were widely regarded as attributable to factors unique to the Vietnam War and its aftermath. Owen J ruled that, even to this day, there is a legitimate dispute as to exactly what the Vietnam data meant and that it was perfectly reasonable to be sceptical that it was directly relevant to the different situation of the UK armed forces. Even though delayed-onset PTSD was clearly recognised in DSM-III, and defined as an onset occurring more than six months after the traumatic event, Owen J was persuaded by the data provided by a prospective series of studies from Israel, associated predominantly with the name of Professor Zahava Solomon, who gave evidence in the case, that true delayed onset is uncommon.

The orthodox view since the Second World War, supported by detailed statistical analyses carried out largely in the US, was that a clear relationship existed between acute physical and acute psychiatric casualties. This was known, was not controversial, and was not undermined by Vietnam – at least not at first. Given that the numbers of psychiatric casualties in theatre were small, and nothing like on the scale that had been seen in Korea or the Second World War, it was reasonable not to expect many long-term psychiatric problems either. The emergence of considerable numbers of people with long-term psychiatric problems after Vietnam was therefore a surprise to most. The reasons postulated for why that happened continue to be controversial. Owen J ruled that it was reasonable for the MoD to assume that this was due to factors specific to that war, or indeed not so much the war itself, but America's reaction to it. The claim by the defendant that no conclusions of general application could be drawn from the Vietnam War was held to be justified. The MoD was held to be reasonably well informed both as to the acute reactions to combat stress and to the chronic condition, and so the claimants failed in their contention that the MoD's state of knowledge of the psychiatric consequences of exposure to combat during the relevant period was deficient.

Culture

Issues

Military culture emphasises courage, bravery, stoicism and resilience. It discourages displays of emotion. Its *raison d'etre* is to fight wars and its culture is designed to further this end. None of this was disputed by either side. Neither was it disputed by the MoD that a by-product of this culture was to make it harder for people to admit to psychological disorders, which might be seen as an expression of weakness. The MoD accepted that psychiatric disorders are stigmatised within military culture. What was therefore at issue was whether or not the MoD had a duty to change this culture of stigma towards psychiatric disorder and by so doing, to make it easier for service personnel to seek help for combat stress-related disorders.

Argued

The claimants argued that military culture was antipathetic to psychiatric problems. This militated against their prevention, detection and treatment. Given the hierarchical nature of the organisation, they claimed that the military could have instituted change more effectively than is the case in the wider community.

The MoD argued that bringing about a change in the prevailing attitudes of its organisation was problematic for a number of reasons. It is large, complex, and inherently conservative. While the military has unique values and behaviour, it also reflects the predominant values of wider society. The stigma attached to psychiatric disorder within the armed forces reflects attitudes widely held in society at large. Given the primary purpose of the military, a culture of toughness is necessary[9]. Nevertheless, they argued that a change in culture did occur within the military during the relevant period.

Held

In his judgment, Owen J agreed that stigma did attach to psychiatric disorder within the military. It was seen as a sign of weakness and was perceived, whether rightly or wrongly, to threaten a career. However, there was evidence that a softening of attitude toward psychiatric disorders in the military did take place during the relevant period. He acknowledged that this was a slow process with "pockets of resistance" and little to suggest that the change in attitude "percolated down the ranks". However, he recognised that the ultimate function of the military is to fight and win in battle. This meant that there will always be a necessary culture of toughness. It is a culture of mutual dependence in which the interests of the individual are subordinated to those of the organisation.

Within these parameters the judge held that commanders were genuinely concerned for the psychological welfare of their troops. He also accepted the MoD's argument that, in any event, it was not clear what a responsible employer could do to change the culture. This is demonstrated by the fact that examples of successful de-stigmatisation of psychiatric disorders by civilian employers, and indeed within civilian society, are few and far between. Accordingly, the MoD was not in breach of duty for failing to take adequate steps to change the prevailing attitude towards psychiatric disorder.

Screening

Issue

Screening programmes for various illnesses have been the subject of considerable debate over the years. However, given the nature of psychiatric diagnoses and

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Box 2: Key points arising from the MoD PTSD High Court decision

The MoD PTSD decision clarified the responsibilities of employer and employee in relation to the psychiatric consequences of workplace stress and/or trauma, especially for organisations such as the emergency services.

- The Court recognised that stigma attaches to psychiatric disorders both within the military and wider civil society, but that there is no proven method of reducing this, even if organisations have a duty to try.
- The Court also recognised that military culture is right to promote a culture of "toughness".
- The Court considered the merits of treatment principles known as Forward Psychiatry but found their effectiveness not proven.
- On the other hand, Cognitive Behavioural Therapy was found to be of proven benefit, but this knowledge was not established until the late 1990s.
- Screening for vulnerability to psychiatric disorder before exposure to stressful events is not justified, and at present there is insufficient evidence to support routine screening for disorders after exposure.
- Immediate psychological debriefing after stressful incidents is not supported.
- The Court's decision found there was an obligation on a person experiencing symptoms to inform their employer if they wanted treatment, thus extending the *Hatton v Sutherland* judgment to the military, and by implication to other emergency services.

the fact that the understanding of psychiatric illnesses remains far from complete, screening for a predisposition towards them is perhaps more controversial still. The issue was whether or not a pre-recruitment screening programme that took account of "vulnerability" factors should have been employed by the MoD to identify and exclude from military service individuals who would subsequently go on to develop PTSD.

Argued

The claimants argued that the MoD should have excluded from military service anyone who was not reasonably fit to withstand the psychological stresses of combat or service life in general. It should have identified these potential recruits by screening for low intelligence and for a personal or family history of any psychiatric illness or personality disorder. Those with an IQ of less than 80 should have been automatically excluded from service. Those with other relevant positive findings should have been referred for psychiatric assessment where significant personal or family history should then have led to rejection.

The defendant argued that the claimants' contention was inherently flawed. Screening had been tried in the Second World War and had proved a disaster. The predictors were too weak to be of any practical use. Screening had been found to be insensitive and to lack any predictive power. It argued that screening would result in a system that would exclude far more people who would not breakdown under the stresses of combat than those who would. Any such programme of pre-employment or pre-deployment screening would cause serious disadvantage to the military, by depriving it of manpower at a time when this was at a premium. It would also discriminate against the large numbers of potential recruits inappropriately assessed as being likely to break down[10]. Accordingly, the MoD contended that there is no duty to exercise skill and care in the recruitment of potential employees[11], and no obligation to carry out the screening for which the claimants had argued.

Held

In reaching his decision, Owen J examined the recruitment practices of the MoD during the relevant period as well as the expert evidence before the Court in relation to pre-recruitment screening. Evidence from US experts demonstrated that predictions on the behaviour of soldiers in combat were susceptible to inaccuracies. After excluding more than 2 million people from military service because of psychiatric vulnerability, the US abandoned their screening programme in 1944 because no less important a person than George C Marshall (then US chief-of-staff) decided that it was costing them the war. Many of those previously excluded were then re-enlisted and made satisfactory soldiers. Experience and follow-up studies dating back to the Second World War, have subsequently shown that people who have previously been considered "weak" have gone on to perform admirably in combat, and vice versa. Owen J held that given the current state of knowledge, screening was unreliable, and would lead to the exclusion of large numbers of potential recruits.

This view has recently been endorsed by National Institute for Health and Clinical Excellence (NICE) guidelines. These state that at present there is no accurate way of screening for the later development of PTSD, as all the current predictive screening tools for PTSD "suffer from limited overall efficiency"[12].

In fact, these arguments in relation to screening proved to be academic, since Owen J accepted the legal argument that the MoD was not under a duty of care to recruits in relation to pre-recruitment screening[13].

Briefing

Issues

Intuitively, it seems reasonable to suggest that a fuller awareness of the nature and effects of stress in battle should help soldiers to deal better with stress encountered in actual combat. The corollary of this, presumably, would be a decrease in the incidence and severity of PTSD in combat veterans. The issue here was whether or not the MoD had a duty to brief all personnel routinely prior to combat on the effects of stress and fear. This depended on whether or not pre-combat briefing could actually be shown to have a positive effect in reducing the impact of stress and fear in soldiers and enabling them to cope better with its effects.

Argued

The claimants argued that the MoD was negligent in that it failed to train all service personnel in the nature of the psychiatric consequences of combat stress. They identified two forms of preparation, which they contended would help personnel avoid the damaging consequences of trauma: thorough and realistic training, that would simulate actual combat conditions, and additional briefing about the effects of stress and fear in combat, which would minimise their effects. The

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claimants did not, however, contend that the MoD's general training was inadequate.

The defendant's case was that the best way to prevent psychiatric breakdown was through time-honoured methods such as morale, leadership and, above all, combat training. The MoD argued that specific "fear training" had never been shown to reduce combat breakdown and that, in practice, informal briefings on fear was widespread, although not mandatory. The decision as to whether or not to provide such briefings should be left to the judgment of individual commanders. The defendant submitted that the lack of such briefing could not be shown to have had adverse consequences.

Held

Owen J considered the expert evidence on the issue of whether or not fear training should have been mandatory. During the case the claimants' experts acknowledged that there was no conclusive or empirical evidence that fear training was beneficial. Experts stated that the US army had never had a formal policy of training soldiers to deal with fear associated with combat, nor was fear briefing routinely carried out in Israel. On the contrary, there was a body of opinion that considered fear briefing to have a potentially sensitising effect[14]. In summarising the evidence, Owen J made a number of points: any serving soldier knows that they will encounter fear in combat; there is not a uniform approach to fear within the military hierarchy; it is not possible to be prescriptive about fear training; and many officers undertook fear briefing on an informal basis anyway. He held that the MoD was not negligent if it had failed to brief individual soldiers on fear, and that it was reasonable to leave the decision about fear briefing to individual commanders. While accepting that there is "probably some benefit to be derived from addressing the question of fear and how to cope with it", he stated that this had not been proven.

Forward Psychiatry

Issues

The concept of Forward Psychiatry refers to a set of guiding principles for the delivery of psychiatric care in armed conflict. It emerged during the First World War and was based upon the PIE principles referred to above (see box 1). The issue here was whether or not the MoD had breached its duty of care in failing to provide an early intervention system for combat-related psychiatric injuries that operated on the Forward Psychiatry model. Central to resolving this issue was the question as to whether or not there was any actual therapeutic benefit to be gained from this approach.

Argued

The claimants submitted that the MoD was negligent in failing to employ a system of early intervention based on the principles of Forward Psychiatry for those suffering from acute stress reactions. A key tenet of this argument was that the MoD had failed to deploy forward psychiatric teams in a number of the theatres under consideration.

The MoD argued that acts or omissions in the provision of Forward Psychiatry were subject to combat immunity, as implementation of the PIE principles was dependent on operational considerations. However, even if that was not the case, the defendant claimed that it did not owe a duty to individual soldiers to implement the PIE principles, because despite the general acceptance of the principles of Forward Psychiatry they have never been shown to be of therapeutic benefit to the individual.

Held

Owen J accepted that the nature of modern combat was dramatically different to the static warfare in which the principles of Forward Psychiatry had evolved. He recognised that in some situations it would not be practical to apply PIE in the conventional sense. The PIE principles had evolved in the static conditions of attrition-based warfare that characterised the first half of the 20th century. With the evolution of modern military technology and doctrine, the traditional concept of the "front line" had begun to break down. Modern warfare often employed smaller groups of soldiers in operations acting well forward of their areas of control. In these conditions the PIE principles became increasingly impractical and unworkable. They were better suited to more stable or fixed campaigns such as the Western Front or Korea.

The judge then reviewed the evidence for the effectiveness of Forward Psychiatry. The key paper was a study of the outcome of Forward Psychiatry as practised by the Israeli military during the invasion of Lebanon in 1982[15]. This paper showed that those who had been managed according to the principles of PIE did better in the short and medium term than those who had been evacuated to base hospitals in the rear[16]. However, while accepting the data Owen J found that the paper did not provide sufficient evidential grounds to conclude that the treatment of combat stress reaction casualties by application of the PIE principles resulted in a reduction of subsequent PTSD. Given this relative absence of reliable evidence as to their therapeutic effect there was a further question mark over whether or not it was even ethical to implement the principles of Forward Psychiatry at all[17].

Accordingly, and setting aside the issue of combat immunity, the MoD was under no obligation to provide treatment in accordance with the PIE principles for a number of reasons: the weakness of the evidence as to their therapeutic effect; the primacy of maintaining the fighting force; and the doubt surrounding the ethical basis for such interventions. Even so, Owen J held that the MoD had not lost sight of the principles. This was true despite the fact that in the conditions of modern fast-moving warfare, such as the 1982 invasion of the Falklands and the 1991 Gulf War, it had been almost impossible to employ them. The MoD was not found to be in breach of its duty of care by failing to implement the PIE principles, even though they remained the standard doctrines of military psychiatry.

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11. With the exception of anti-discrimination legislation.
12. NICE guidelines, on p.99.
13. Kapfunde v Abbey National plc and another (1998) 45 BMLR 176, cited by Mr Justice Owen at para 8.10 as providing "clear authority for the proposition that as a general rule an employer is not under a duty to exercise skill and care in the recruitment of *potential employees*".
14. Professor Shalev's second report, cited by Mr Justice Owen at para 9.22.
15. Solomon and Benbenishty (1986). "The role of proximity, immediacy, and expectancy in frontline treatment of combat

In conclusion, Forward Psychiatry is an attractive concept, and few can doubt the negative influence of labelling someone suffering from short-term combat-induced exhaustion with a psychiatric illness. This is illustrated by Spike Milligan's description of his treatment in rear facilities after sustaining a breakdown during the Italian campaign, which is filled with loathing, not just of the military but also of himself[18].

On the other hand, critics who point to the risks of re-traumatisation of already vulnerable personnel by insisting that they return to active duty, and who argue that Forward Psychiatry is really just a way of conserving manpower, may also have a point. Only a randomised trial could ever answer this question, and it is highly unlikely that such a study could ever be conducted.

Debriefing

Issues

It is a common, albeit modern, misconception that the opportunity for emotional ventilation of traumatic experiences after a stressful event is always beneficial. Emotional ventilation is thought, in some way, to facilitate the psychic acceptance of trauma and so to decrease the amount of emotional discomfort that results. Debriefing sessions became common practice after any event that carried the possibility of subsequent distress among those who experienced it. However, recent research has fundamentally questioned the validity of this assumption[19, 20]. In this part of the case, the issue under consideration was whether or not the failure to formally train officers in debriefing skills amounted to a breach of duty, and if so, whether or not this breach resulted in any actual injury.

Argued

The claimants argued that the MoD ought to have trained commanders to carry out operational debriefing[21] after their personnel were exposed to traumatic events. Operational debriefing was defined by the claimants as: "non-medical/specialist intervention, including the opportunity for the reliving of traumatic experiences and the reactions these have provoked, (the 'ventilation' or 'defusing' of what has occurred) carried out on a routine basis within the unit or subunit, usually by immediate commanders, but in an emergency by anyone present who has an understanding of what the individual has been through.

It was submitted that operational debriefing would facilitate the detection of those suffering from an acute stress reaction and those at increased risk of developing post-traumatic disorders. Their original contention that "psychological debriefing" was effective and should have been deployed by the defendant was abandoned. This was because a series of recent reviews had shown that there was no reliable evidence that it was effective and, in fact, that it could even be potentially damaging[22]. A fundamental difference between psychological and operational debriefing is that, in the latter, no attempt is made either to ask people to relive their emotions or to provide any post-traumatic education.

The MoD argued that there was no evidential basis for the claimant's contentions. In any event, while the MoD did not formally train its commanders in debriefing, it was often undertaken on an informal basis by its commanders.

Held

Despite the initial pleading, it became clear during the case that the claimants were no longer arguing for the effectiveness of debriefing in reducing psychiatric injury. Owen J reviewed the evidence for this[23]. He stated that the "assembled experts agreed that there was no empirical evidence supporting the efficacy of interventions by way of psychological debriefings shortly after exposure to trauma". He pointed out that there was even some evidence to the contrary, ie that those who received debriefing were at a significantly increased risk of developing PTSD. He held that the claimants had failed to prove that operational debriefing would have been effective in reducing the risk of post-traumatic disorders, or that it would have assisted in the detection of those at risk for "increased and longer-term reactions".

Detection

Issues

This became a key question in the case. For any psychiatric disorder to be treated it first has to be detected and it was here that there was a considerable divergence of opinion. The issue here was whether or not the MoD had developed and maintained a satisfactory system for the detection of the psychiatric consequences of combat-related trauma.

Argued

The claimants submitted that the MoD was negligent for failing to implement effectively the battleshock component of an important directive in the training of officers[24]. They further proposed a system for the detection of PTSD that involved: the flagging of medical records; a record of exposure to combat; a medical six to 12 months after return from a combat theatre for "high-risk" veterans; the training of medical officers in structured interviewing techniques; and/or the administration of questionnaires for the detection of post-traumatic disorders.

The defendant accepted that commanders had a duty to "know their men". It argued that its commanders were broadly educated as to the possible psychiatric effects of combat and that the nature of the military environment meant that significant changes in personality and behaviour would come to its attention.

This was called "man management", and was central to the detection of any disorder or other difficulties. However, the defendant submitted that not all such changes would or should come to the attention of even an experienced commander, as one of the key features of PTSD is avoidance. In any event, medical and other support staff were also in a position to identify those suffering from mental health problems.

Held

Owen J held that the officer training directive did include a description of battleshock and its management but that there was a systemic failure to provide adequate instruction in its delivery to medical officers. A contributory factor was the prevailing culture that existed in the army towards psychiatric disorder. The question was raised as to whether or not the failure to deliver the battleshock component of the directive had adversely affected the detection of the acute reaction to stress and PTSD.

The judge analysed the evidence on commanders' awareness of psychological reactions to combat stress. He agreed with the MoD that commanders were indeed expected to have a thorough knowledge of their troops, and that the nature of service life meant that they were well placed to observe any changes in their behaviour. Nevertheless, he also acknowledged that difficulties may exist: commanders may not always be in a position to observe their troops closely in the heat of battle; the reaction to stress varies from soldier to soldier; and individuals may suffer a wide range of symptoms. The judge was not persuaded that a more systematic and effective implementation of the training directive's battleshock component would have made a material difference to the detection of the acute reaction.

The detection of PTSD relies on either the self-referral of the individual soldier or on a referral by a commander to the medical officer. Owen J took the view that, in the latter case, it should be for the commander to make a judgment based on his or her knowledge of the individual and on the nature and extent of the problem.

The evidence did not establish a systemic failure in the threshold for referral to medical officers. However, it was apparent that many soldiers were capable of concealing their conditions while continuing to discharge their duties in an acceptable manner. A number of reasons were identified for their failure to seek help, prominent among which was the issue of the stigma attached to psychiatric disorders within the military. This raised the question of whether or not the MoD was under a duty to devise and implement a system for the detection of psychiatric disorders in those who did not seek help. This, of course, was contingent on such a system being possible at all.

Owen J referred to the evidence of a number of the experts which demonstrated the inherent problems in the identification of PTSD[25]. He then considered the system for detection that had been proposed by the claimants. He agreed with the MoD that establishing a system for recording exposure to combat was not mandatory and would have achieved little. He pointed to the evidence of one of the claimants' witnesses who said that flagging the records of every veteran from a conflict simply because they had been there would have been self-defeating[26]. This is demonstrated by the fact that virtually every member of the British army would have undertaken a hazardous tour of duty in Northern Ireland during the period in question, often more than one, and to mark their records would serve little purpose. In technical terms exposure was nearly ubiquitous. Owen J referred to the "obvious difficulties" in recording individuals of "high-risk status" and asked, but could not answer, by what criteria and by whom should this assessment be made?

The claimants failed in their contention that the MoD was under a duty of care to provide a screening programme for the identification of service personnel with an existing psychiatric disorder. They did so because of their inability to provide any evidence that screening for existing psychiatric disorders actually reduces psychiatric morbidity and/or improves outcome.

The key issue remained the question of detection: how accurate can it be? Psychiatric measures are not perfect, even if they are improving, and there will also always be false positives and negatives. The proportion of these is determined by the prevalence of the condition being detected, and it is known that PTSD is not, in fact, a common disorder in the armed forces, despite public perception to the contrary. It is relevent that one does not screen for a disorder in which there is substantial natural improvement. Cervical cancer, for example, does not go away with time unless detected and treated. However, psychological symptoms that have been caused by acute adversity often do indeed go away spontaneously and PTSD is an unusual outcome. Both of these factors (imprecise measurement of a low-prevalence condition and a natural history that tends towards recovery) mean that screening for psychiatric disorders arising after traumatic events, such as combat, has to overcome considerable hurdles before it can be considered to be effective. There is now consensus that the only way in which one can be sure that screening is indeed effective in improving outcome (its only purpose) is via properly conducted randomised controlled trials[27]. The recent Cochrane review concluded that there is at present no evidence to support routine mental health screening[28]. While the recent NICE guidelines acknowledge that there may be a case for screening to detect PTSD in certain high-risk groups in certain situations, they refer to a study of the British army in 2004 which found that a proposed mental health screening programme was unacceptable to service personnel[29].

The MoD had accepted that there had been individual failures in the detection of combat-related stress disorders and in the provision of care to affected service personnel. Some of these individuals subsequently received substantial compensation for their psychiatric injuries. While holding that the MoD had failed to train medical officers adequately in the delivery of the battleshock component of officer training, Owen J concluded that, in all other respects, the claimants had failed to establish that the MoD had breached its duty with regard to providing a system of detection of either the acute or chronic reactions to stress.

Treatment

Issues

A great deal of effort has gone into developing relevant treatment approaches for PTSD since its inception as a

stress reactions among Israelis in the Lebanon war", *American Journal of Psychiatry* 143: 613–617, referred to by Mr Justice Owen at paras. 10.16–10.23.

16. See also Solomon Z, Rami S, and Mikulincer M (2005), "Frontline treatment of combat stress reaction: a 20-year longitudinal evaluation study", *American Journal of Psychiatry* 162: 2,309–2,314. However this still does not overcome the fundamental problem of selection bias.

17. Jones E and Wessely S (2003). "Forward psychiatry in the military: its origins and effectiveness", *Journal of Traumatic Stress* 16: 411–419.

18. Shephard B (2000). *War of Nerves, Soldiers and Psychiatrists 1914–1994*, London, Jonathan Cape.

19. Wessely S, J Bisson, Rose S. (2000). "A systematic review of brief psychological interventions ('debriefing') for the treatment of immediate trauma-related symptoms and the prevention of post traumatic stress disorder". In: Oakley-Browne M, Churchill R, Gill D, Trivedi M, Wessely S (eds), *Depression, Anxiety and Neurosis Module of the Cochrane Database of Systematic Reviews*; issue 3 ed. Oxford: Update Software.

20. Emmerik, A, J Kamphuls, J, Hulsbosch A, Emmelkamp P (2002). "Single session debriefing after psychological trauma: a meta analysis", *Lancet* 360: 736–741.

21. Operational debriefing, as defined by the claimants, is derived from the SLA Marshall model of historical group debriefing. (Marshall SLA (1947). *Men against fire. the problem of battle cCommand in future war*, New York, William Morrow & Co); Professor Shalev is quoted by Mr Justice Owen at para 11.3: "… [historical group debriefing] was meant to enable groups of soldiers, at the immediate aftermath of combat, to review and reconstruct a comprehensive picture of the event – combining the views of all the participants … to restore a group narrative of the event – yet in a way that would not discard any individual experience. Psychological healing was expected to result from this powerful group process."

22. See [2003] EWHC 1134 at para 11.7; Solomon Z and Neria Y (1999). *Post Traumatic Stress Disorder*; para 11.8; Foa, Friedman, Keane (eds) (2000). *Effective Treatments for PTSD*; para 11.9, Foa et al (2001). *Guidelines for Mental Health Professionals: Response to the Recent Tragic Events in the*

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US; para 11.1, Rose, Bisson and Wessely (2002). *Psychological Debriefing for Preventing Post Traumatic Stress Disorder* (PTSD).

23. Mr Justice Owen, at paras 11.15–11.21, held that there was a close similarity between psychological and operational debriefing in that the evidence as to the effectiveness of the former applied to the latter. Both shared the critical elements of group participation, a review of the traumatic event, ventilation of emotions and cognitive processing.

24. Army Training Directive 5; in 1985 the army's annual training directive for health was revised to include training in battle-shock for all officers and NCOs down to the rank of corporal. In 1990 it was extended to all ranks (see [2003] EWHC 1134 at paras 12.1, 12.14 and 12.18).

25. For example, at para 12.68 he quoted Professor Solomon: "the connection between many (if not most) PTSD symptoms and the trauma that gave them birth is indirect and remote … even where the wartime origin of the symptoms is apparent, some symptoms, such as recurrent nightmares, are suffered by nearly all soldiers to one degree or another…"; see also paras 12.69 and 12.70.

26. Dr Deahl, quoted at p. 371.

27. Conducted under the guidance of the National Screening Committee.

28. Gilbody S, House A, et al (2001). "Routinely administered questionnaires for depression and anxiety: systematic review", *British Medical Journal* 322: 406–409.

29. NICE guidelines at pp.101–103.

30. With exception of Professor Foa who claimed that the failure to use CBT during the 1980s amounted to substandard care; see para. 13.19.

31. See references to *ISTSS, Effective Treatments for PTSD* (2000), edited by Foa, Keane and Friedman, at para. 13.38.

32. See quote of KB Wells at para 13.37.

33. Studies referred to at para 13.51: ISTSS Guidelines; van Etten ML, Taylor S (1998). "Comparative efficacy of treatments for post-traumatic stress disorder: a meta-analysis", *Clinical Psychology and Psychotherapy* 5, 126–144; Sherman JJ (1998). "Effects of psychotherapeutic treatments for PTSD: a meta-analysis of controlled clinical trials." *Journal of Traumatic Stress* 11, 413–435.

34. See reference to Foa and Meadows, 1997, at para 13.57 and paras 13.56 and 13.58.

formal psychiatric diagnosis in 1980. This has involved both the adaptation of existing therapies used in other psychiatric illnesses and the development of entirely new therapeutic techniques designed specifically for use in PTSD. This knowledge base had expanded rapidly. Given that the MoD had accepted a duty of care to provide appropriate treatment for psychiatric illness, it had a duty to remain reasonably well informed of developments in treatment. The issues were, first, whether or not the treatments that the claimants had called for were available to, and used by, military psychiatrists and, second, whether or not any of these treatments were mandatory during the relevant period.

Argued

The claimants argued that the MoD was negligent in failing to employ a system of early treatment for combat-related psychiatric disorders. During the first part of the relevant period (which was, approximately, from the end of the Korean War to the beginning of the Falklands War) the mainstay of treatment involved individual non-specific or psychoanalytic psychotherapy, various forms of abreaction, group therapy and the use of various medications.

Not surprisingly, the MoD argued that it had been up to date with regards to treatment options and had not shown any undue delay in introducing new treatments. But while the MoD's medical services had used all of these (some of which, such as group therapy, had originally been pioneered by British military psychiatrists), none of these developments had any particular effectiveness on the conditions that would later be labelled as PTSD.

It was agreed by both sides that the arrival of Cognitive Behavioural Therapy (CBT) had changed the picture and that it was now not disputed that CBT represented the treatment of choice for PTSD. This was agreed even before the publication of the NICE guidelines that came to the same conclusion. However, what was not agreed was the question of when this knowledge became widely known, such that it could be considered a requisite standard of care.

Held

With the exception of CBT, Owen J agreed that the MoD had used the treatments specified by the claimants. He took the view that there was broad consensus in the expert evidence on a number of issues: that failure by the MoD to treat diagnosed psychiatric illness would amount to a breach of its duty of care; that good practice involved a clinical judgment on which treatments to offer based on the individual circumstances of the case; and that failure to use any single treatment or combination of treatments did not amount to a breach of duty[30]. In other words, until the acceptance of CBT by the wider mental health community, Owen J held that there had been no clear single standard of care required of the MoD.

As for the efficacy of CBT itself, Owen J accepted that knowledge was not available until the middle or end of the 1990s, that CBT was the treatment of choice and that it represented an improvement on previous treatments. This did not mean that CBT had not been used successfully before then, merely that there was insufficient evidence for its effectiveness to be able to say that the MoD had a duty to use it in the treatment of PTSD in service personnel. Accordingly, the claimants failed in their contention that there was a systematic failure with regard to the use of the available treatments.

Another question was whether or not it was reasonable to extrapolate from civilian studies of PTSD to the military, or was the military environment so unique that this would be unwise? There was evidence that combat-related PTSD was more difficult to treat and had a worse prognosis than its civilian counterpart[31]. What was not at issue was that, during the relevant period, no studies had been reported that demonstrated the effectiveness of any preventative or therapeutic intervention for combat-related PTSD[32]. In fact, Owen J concluded that this was not the case. Given the degree of comorbidity, such as with substance abuse and the difficulties inherent in the "macho" culture that is part of the armed forces, some might be surprised by this conclusion, but, as it was, it had no impact on the case.

Owen J then considered the treatments. He found common ground between most of the assembled experts that treatment gains were, in fact, at best modest regardless of the type of treatment applied. He referred to a number of studies[33] in reaching his conclusion that CBT was likely to have been an effective treatment for combat related PTSD and that those forms of psychotherapy that contain an element of exposure were also likely to have been an effective treatment[34]. As to the evidence for pharmacotherapy, the judge found that there was strong evidence that certain drug treatments for combat-related PTSD (SSRIs) were likely to have been effective. Other drug treatment (MAOIs and TCAs) were also likely to have been effective, although to a lesser degree, and the effects of benzodiazepines were unlikely to have been of sufficient benefit to outweigh their side effects.

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Conflict of interest

Simon Wessely gave evidence in the PTSD class action on behalf of the MoD. He is an unpaid civilian consultant adviser in psychiatry for the army. Jamie Hacker Hughes is a consultant clinical psychologist for the Defence Medical Services.

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