Capita

# Literature Review

**Implementation of Troubles Permanent Disablement Payment Scheme: Rapid Review April 2021**

## Troubles Permanent Disablement Payment Scheme (TPDPS)

## Acknowledgements

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# 1. Introduction

In 1998 The Good Friday/Belfast Agreement recognised the enduring physical and psychological impact of the Troubles on victims and survivors and undertook never to forget the needs of those who died or were injured and their families: *"The tragedies of the past have left a deep and profoundly regrettable legacy of suffering. We must never forget those who have died or been injured, and their families. But we can best honour them through a fresh start, in which we firmly dedicate ourselves to the achievement of reconciliation, tolerance, and mutual trust, and to the protection and vindication of the human rights of all".*

The 2014 Stormont House Agreement made a commitment to *'seek an acceptable way forward on the proposal for a pension for severely physically injured victims in Northern Ireland'.* Subsequently the Stormont House Implementation Group was established by the Northern Ireland Executive to oversee the outworking of the Agreement including progressing the pension proposal. A draft consultation paper was developed which encompassed recommendations from a comprehensive advice paper drawn up by the Commission for Victims and Survivors (CVS) in 2014. At an early-stage consideration was given to addressing the pension needs not just of those who were physically injured but also the psychologically injured.

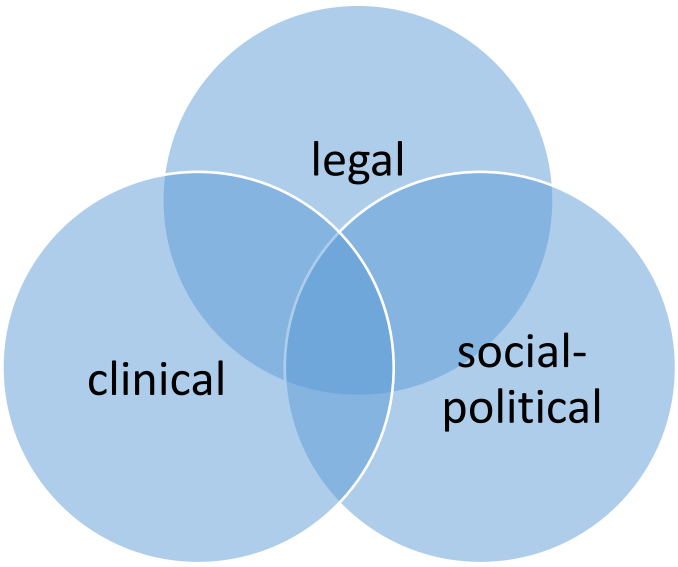
In January 2020 *The Victims' Payments Regulations* were published. On 24th August 2020 the Northern Ireland Executive Office (TEO) designated the Department of Justice (DoJ) to administer the scheme. Later this year the Troubles Permanent Disablement Payment Scheme (TPDPS) will open for applications from individuals who have been injured, either physically or psychologically, or both, as a consequence of the violence of the Troubles between 1966 and 2010 inclusive.

The Scheme is an important and much-awaited process for Northern Ireland and further afield. It has the potential to directly improve the lives of a large number of victims and survivors through the provision of Payments. Its implementation also has the potential to deliver indirect benefits to victims and survivors as it provides an opportunity to reach people with complex needs (social, functional and psychological) who have previously experienced barriers to accessing treatment and support from statutory health and social care services or from the many services and supports available from the community and voluntary sector. Reaching and supporting those who have been previously marginalised and who have not engaged with services, or who have chosen not to come forward for a variety of reasons, provides an opportunity for improving outcomes and the quality of life for these

individuals. A wider positive impact on societal well-being may result as we begin to address aspects of the legacy of the past.

The implementation of the TPDPS presents particular challenges however, in large part as it lies at the sometimes-difficult intersection of clinical, legal and political (policy) worlds- as represented in Figure One.

Figure One: Perspectives & contextual factors




Each perspective must be considered in determining the means by which the Scheme will be implemented as no one perspective taken alone will solve the challenges which lie ahead. A successful Scheme must be victim-centred, acceptable to the public, efficient and legally defensible. Such an outcome is possible if detailed attention is paid to all perspectives.

Capita has been tasked by the DoJ with initiating a preparatory process in order to design an assessment process.

Under the Scheme applicants will be required to collate and present medical evidence in support of their application, but it is likely that many will face difficulties in providing sufficient evidence. Those applicants who have been physically injured will

for the most part collate evidence without undue difficulty. It can be reasonably assumed however that many of those who apply for a psychological injury may have had no previous contact with mental health services, or only minimal and fleeting contact with inadequate recording of diagnosis, causation, symptoms and outcomes. Some will have had contact with primary care services but with no or inadequate recording of diagnosis, causation, symptoms and outcomes. In addition, it is known that some historic records will have been destroyed or will be inaccessible. A systemic approach to the retrieval and collation of existing medical records for the purposes of the Scheme will be necessary and this will have major resource implications.

Understanding that many of those who were impacted by the Troubles/ Conflict have never come forward or been involved with mental health services it may be necessary to develop a process which allows for a full psychiatric assessment, including the establishment of a formal diagnosis if this is thought to be necessary.

The need for medical assessments is likely to be substantial. Based on available data it is estimated that several thousand individuals may meet the suggested criteria for a Victims Payment, that is, a diagnosis of PTSD, or another stress-related condition, which is related to a Troubles/Conflict-related event, has a severe impact on levels of personal and occupational function, and is permanent.

It is important to note that the process of application to the Scheme will result in an increased need for treatment and support in some cases.,. This will result from when there is a referral for appropriate treatment which results from the application and consequent diagnostic medical assessment, and which may be necessary to establish permanence. Beyond this eventuality the upset caused by the process will also result in some individuals being referred for support and treatment.

Whilst several thousand individuals will potentially be successful in their applications, there will be many others who are unsuccessful but will still require resources to build evidence to support their claim even though they ultimately not meet the full criteria for the Payment. Many of these individuals may require services secondary to this process.

Key issues to be addressed in this paper include defining psychological trauma and defining psychological injury, including commenting on relevant mental health

conditions (mental health diagnoses which result from psychological injury); possible approaches to diagnostic assessments; considerations as to how permanence will be defined for the purposes of the Scheme; and considerations of the means by which the assessment of impact on function, and the question of the degree of disablement will be considered.

## 2. Background and Context

The Troubles/conflict in NI has been a significant and distinctive stressor in the life of the community in Northern Ireland (NI) since political violence erupted in 1968. The population has experienced continuous civil disorder and political violence though this has diminished in intensity in recent years. The impact of the Troubles should not be underestimated. By December 1997, 3,585 people had been killed , 35,000-50,000 injured (Fay et al, 1999), 16,000 had been charged with terrorist offences, and 34,000 shootings and 14,000 bombings had occurred (Muldoon et al, 2005).

The toll of the dead and injured represents almost 3 percent of the population. If we extrapolate these figures to Britain, some 111,000 people would have died, with 1.4 million people injured. This represents just under half of British deaths (265,000) during the Second World War. Further extrapolating the deaths to the United States, some 526,000 would have died, more than died during the Second World War (405,000) and nine times the American war dead in Vietnam. The large number of incidents underlines the intensity of the conflict: once again, extrapolating these figures to Britain or the US show the intensity of the violence; shooting incidents alone would have numbered over 1 million in Britain, and over 5 million in the United States.

The duration, intensity and extent of the Troubles has ensured that a large proportion of the population have direct, personal experience of political violence. While many have experienced injury, much larger numbers have witnessed acts of violence, ranging from bomb explosions to shootings, to vehicle hijacking and rioting. By 1998, about one in seven of the adult population reported having been the victim of a violent incident. Threats and intimidation have been a common theme throughout the conflict; in the early years of the disturbances, large population movements occurred as a result of intimidation, with families moving out of religiously mixed areas into areas dominated by their co-religionists where they felt more secure. Threats have also been employed to ensure that communities do not inform on paramilitaries, and threats and violence have been meted out to those deemed to be engaged in “anti-

social" behaviour. One in five of the population reports being intimidated at some stage during the Troubles.

Many have also experienced the indirect impact of violence, through having a family member or close relative killed or injured or knowing someone who has been killed or injured. The nature of Northern Ireland society, with large, extended families and closely knit communities, means that a death or an injury as a result of the violence has wide repercussions. By 1998, approximately one in five reported having had a family member or close relative injured or killed, and more than half personally knew someone who had been injured or killed. An additional form of indirect experience of violence is collective exposure to violence, through being caught up in a violent act, for example an explosion or a riot. Exactly a quarter of those interviewed in 1998 had been caught up in an explosion, while almost the same number had been caught up in a riot. However, in the early 1970s, when riots were widespread, the levels of exposure were higher, and more than one in three had experienced a riot. This is, then, a conflict whose effects extent far beyond those who participate in the violence or who live in the most affected areas; the effects extend to the society as a whole.

Despite "the Troubles" being mainly low intensity in form, the enduring nature of the conflict in a relatively small population of 1.5 million people has ensured that most members of the population have been affected emotionally and psychologically. Prior to the ceasefires Cairns and colleagues (1995) suggested that the entire population "is at some degree of uncontrollable risk" (p.133). Fay and colleagues (1999) distinguish between low and high intensity violence. These researchers found that low intensity violence such as bomb scares, security force searches and feeling unsafe in a particular area was associated with increased stress levels, but victims of high intensity violence, such as seeing people killed or injured, being injured in an explosion or having a close relative killed or injured were more vulnerable to developing more serious stress reactions such as PTSD.

In addition to the bereaved, many thousands have been the victims of violent attacks or witnesses to horrific incidents. Others have been rescuers (either as civilians or emergency personnel) and exposed to the carnage of destructive acts such as car bombs and mass shootings. A proportion of this group exposed to traumatic events will develop mental health problems, the most common of which is posttraumatic stress disorder (PTSD). These conditions will be explained in more detail later in section five of this document.

Those who had been physically injured were more easily identifiable and treated by hospital teams who became highly proficient in treating injuries caused by bombings, shootings and punishment beatings (McLauglin & Kelly, 1998). However, the psychological and emotional injuries have not always been as adequately recognised and many have suffered in silence without receiving proper care and attention. A number of victim and survivor reports emerged after the 1998 Good Friday/Belfast Agreement and highlighted the importance of acknowledgment for victims and survivors such as: The Bloomfield Report, (Bloomfield, 1998); Living with the Trauma of The Troubles (Social Services Inspectorate, 1998); and the Healing Through Remembering Project, (2002).

Those who died have left behind thousands of bereaved relatives and friends, many of whom have suffered severe and enduring emotional pain (Dillenburger, 1992). When one loses a loved one in a sudden, human-inflicted violent incident, the grief process is complicated by the traumatic nature of the event and a proportion develop a complicated or traumatic grief reaction (Prigerson et al, 1999). The grief process is complicated further in circumstances of on-going conflict and for some the grieving process is interrupted or delayed until conflict subsides and the bereaved feel more confident that their loss is acknowledged in a more peaceful environment (Manktelow, 2007).

# 3. Methodology

## 3.1 Literature Search Strategy

### 3.1.1 Review methodology

Due to the restricted time frame for this literature search and review a rapid review search strategy was employed. Timeliness and a reduced requirement of resources are the main benefits of a rapid review which make it more relevant for some projects. Typically, a rapid review takes about four months or less and this review had a time span of two months to complete.

A rapid review follows most of the principal steps of a systematic review, using systematic and transparent methods to identify, select, critically appraise and analyse data from relevant research. However, to provide timely evidence, a rapid review, by definition, differs from a systematic review in a number of respects as

follows: the scope of the review is more targeted and focused; processes are either simplified or omitted, for example, by targeting or reducing the number of databases; a single reviewer is assigned at each step whilst another reviewer verifies the results; grey literature may be excluded or have limited use, for example targeting specific policy, Government or clinical sites. All of these elements formed part of this review methodology.

The literature review was contained and focused on two components:

1. Currently, what disability assessment schemes exist and which schemes, or elements of existing schemes, are likely to be helpful to the TPDBS scheme?

2. What are the most common mental health conditions associated with traumatic experiences and most likely to relate to a prolonged civil conflict such as the NI Troubles?

### *3.1.2 Selection criteria for assessment schemes*

In order to inform the development of the strategy, the authors have been requested to undertake an analysis of existing disability schemes that were deemed to be most relevant to this specific population. Therefore the search and review have focused on schemes that will have been expected to include assessments for individuals who have suffered from traumatic incidents or events. These schemes were categorised into the following groups:

- post-conflict situations
- post-military service situations
- post- industrial injury situations
- post-criminal injury situations.

The new TPDPS addresses both mental and physical health / disablement therefore the search included assessment instruments for both forms of illness/injury. Key databases (MEDLINE, Embase, PsycInfo), worldwide health department/ministry webpages and a general web-based search was conducted in March 2021. Webpages of previous schemes containing several documents pertaining to a specific scheme were also included in the search. The key phrases and words, used in the search are the following: ‘Veterans’, ‘army’, ‘military’, ‘terrorist’, ‘industrial’, ‘disability compensation scheme’, ‘disability scheme’, ‘disability pension’, and ‘disability fund’. Combinations of the search phrases and words were often used, for example ‘Industrial disability compensation scheme’ or, ‘Military disability pension’.

### *3.1.3 Data Extraction and Analysis of existing schemes*

Each scheme identified in the literature search was inspected for relevant detail, and data was extracted and placed into tables for further analysis. The data extracted included information on how each scheme identified, involved and assessed individuals with disability. The data for the schemes can be found in Tables 1-4.

The extracted data was then analysed with a focus on what might be relevant and applicable to the TPDBS scheme. The authors considered what elements were effective and less effective in existing schemes with specific interest in identifying how previous schemes defined and administered the concepts of proximity, permanence and assessed the level of disablement. Descriptions of specific schemes that are deemed to be most useful to TPDPS can be found in section 4 of this document, the most prominent of which are the UK Armed forces Compensation Scheme (AFCS) and the Industrial Injuries Disablement Benefit (IIDB), as these are particularly similar schemes to TPDPS, albeit in different ways.

# 4. Learnings from Other Schemes

The findings of this review are based on rapid reviews of the workings of relevant schemes both in the UK and from other countries, and on a rapid and targeted review of the clinical literature. We can certainly learn from schemes in other places, but the bespoke nature of this scheme will necessarily result in unique solutions. Solutions are achievable if we base the implementation of the Scheme on sound clinical principles, in so far as legal considerations allow this.

A number of relevant schemes are described in the text under four broad headings:

a. Post-Conflict/Terrorist Incident Schemes

b. Post-Military Service Schemes

c. Industrial Injury Compensation Schemes

d. Criminal Injury Compensation Schemes

Key aspects of the included schemes are tabulated, with specific attention paid to aspects most likely to be relevant.

## 4.1 Relevant Post-Conflict Schemes

### *4.1.1* ***Spain***

The Spanish government has established a “Support for Victims of Terrorism” unit. This operates as a single access point for the co-ordination of all official bodies including the victim assistance unit, courts, health professionals and victims’ organisations. The unit was established to address the consequence of the campaign of the Basque separatist group ETA which began in 1968, in which over 800 people died. It also addresses the consequences of other attacks, including those linked to Islamic extremism (for example, when 191 people were killed and thousands injured in a series of explosions on commuter trains in Madrid); campaigns by Galician and Catalan nationalist armed groups, and campaigns prosecuted by a number of right-wing groups. Many citizens have become victims through physical or psychological injury. The direct and indirect consequences of such significant suffering have been reflected in the implementation and design of Spain’s public policy.

The Introduction and development of Act 29/2011 “the Recognition and Comprehensive Protection of Victims of Terrorism” is designed to enable Spanish society, through its central government, to pay tribute to such victims: “*This Act is, therefore, not only a sign of recognition and respect for their memory, but also a gesture of deserved solidarity*”. The provisions of the current legislation allow for retrospective compensation applications dating back to 1960, including the early impact of ETA’s campaign.

From initial conception to now, the Spanish scheme has evolved considerably to include an extensive catalogue of financial state assistance offered to victims of terrorism. Victims are defined as *“those deceased or having suffered physical or psychological harm as a result of terrorism acts; Persons with family ties, cohabitation or dependency relationship with deceased”*. A direct connection between the terrorist act and the injury sustained is required for state aid to be awarded in any such case. Injuries or items which are eligible for specific compensation include:

- Bodily injuries, both physical and mental inclusive of medical treatment, prosthesis or surgery
- Material damage to property or vehicles- repaired to original state
- Cost of temporary accommodation while repair work is being carried out
- Material damage to businesses or industry

Table One illustrates how specific financial compensation is offered to victims dependent on the level of disablement (including death). Injuries giving entitlement to financial compensation are classed as having caused the victim temporary incapacity either a) lasting more than six months or b) causing at least 33% disablement.

Table 1 Compensation for death and permanent disabilities in Spanish Scheme

| Concept | Euros |
|---|---|
| Death | 250,000.00 |
| Severe disability | 500,000.00 |
| Absolute permanent disability | 180,000.00 |
| Total permanent disability | 100,000.00 |
| Partial permanent disability | 75,000.00 |

Furthermore, it is noted that in the case of temporary disability, twice the daily IPREM[1] shall be paid to a limit of 18 monthly allowances.

Is of note that the amount of payable compensation is offered to victims in addition to court claims or private insurance settlements.

As laid out in article 9 of the aforementioned Act, those persons affected by a terrorist attack must be provided with immediate psychological assistance for as long as medically indicated to the point of their recovery. There appears to be well co-ordinated and comprehensive system in place to ensure public administrations or private bodies are able to facilitate these endeavours.

### *4.1.2* ***Israel***

The purpose of Israeli compensation schemes is to cover Israeli citizens and residents who have suffered through terrorist attacks, both in Israel and while abroad. The compensation schemes have in recent years been extended to cover certain foreign nationals who may become victims by reason of their association with Israel or Israeli entities. Thus, the law covers all foreign nationals harmed by a hostile act while in Israel or in the Territories administered by Israel provided that they entered Israel legally. That coverage extends, inter alia, to tourists, business travellers, and legal foreign workers. Illegal foreign workers are generally not considered to be covered by the law.

[1] Index used in Spain for granting economic aids or allowances. The current annual IPREM rate is 6,778.80 EUROS. Website- https://upsticks.es/what-is-iprem-and-how-does-it-relate-to-a-visa-or-residency-application.

Some employees of Israeli entities abroad are covered, including those employed by the state of Israel (embassies, consulates, and other formal delegations representing the state) or by an employer pre-approved for that purpose by the Minister of Labour.

Compensation

Victims who are injured by a hostile act are entitled to medical care and to a stipend while receiving medical care. Those who remain permanently disabled are entitled to disability benefits. All benefits under VHAPL are administered by the National Insurance Institute ("NII"), which is the equivalent of the Social Security Administration in the United States.

Medical Care.

Injured victims are entitled to state-funded medical care. Medical care is defined broadly and includes hospitalisation, clinic visits, dental care, medicines, medical devices, medical care-related travel expenses, medical rehabilitation and rehabilitation. Israel has a national medical insurance plan: the benefits provided under the law exceed the benefits under national insurance. Foreign residents injured in a hostile act while in Israel and then returning to their own country may receive the necessary medical care at the expense of the Israeli government unless they receive the medical care from the country in which they reside.

Living Stipend While Receiving Medical Care.

An injured victim who is unable to work while receiving medical treatment is entitled to a stipend during that period, provided he is not collecting his salary, or in the case of a self-employed individual if he stops working. The stipend is based on the victim's pre-injury income, subject to a limit set at a rate of five times the average salary in Israel. Victims who are unemployed at the time of the injury receive a stipend based on the (relatively low) salaries of mid-level government employees, factoring in their age and family situation. The living stipend during medical treatment is provided for an unlimited amount of time as long as the victim is unable to work because of the medical treatment.

Compensation given to the applicant is directly correlated to the Intensity, frequency and duration of the disorder caused by the terrorist act. An independent medical committee determines whether the victim is temporarily or permanently disabled, and at what rate (expressed as a percentage of disability). Victims judged to be 20% or more disabled qualify for monthly disability benefits. The amount of compensation is calculated by multiplying the rate of disability by 105.1% of the salary of a low-level government employee. A 40% increase is paid to victims of specific and very severe types of disability

### *4.1.3* ***UK Victims of Overseas Terrorism Compensation Scheme***

The Victims of Overseas Terrorism Compensation Scheme is a government funded scheme designed to compensate victims who sustain a relevant injury which is directly attributable to their being a direct victim of a designated act of terrorism overseas.

The following claims can be made for compensation:

- mental or physical injury following a designated act
- sexual or physical abuse
- loss of earnings - where they have no or limited capacity to work, lasting more than 28 weeks, as the direct result of a designated act
- special expenses payments - these cover certain costs the applicant may have incurred as a direct result of a designated act (only if injuries mean the applicant have been unable to work or have been incapacitated to a similar extent for more than 28 weeks)
- a fatality caused by a designated act including bereavement payments, payments for loss of parental services and financial dependency and funeral payments.

Applicants may be eligible for an award if they sustained a relevant injury which was directly attributable to being a direct victim of a designated act. A designated act means an act designated under section 47 of the Crime and Security Act 2010.

Applicants may also be eligible to make a claim for a mental injury if they witnessed, and were present at, a designated act in which a loved one was injured. They may also be eligible if they were present at and witnessed the immediate aftermath of a designated act in which a loved one was injured.

If the applicant is a close relative of a person who died as a direct result of sustaining a relevant injury as a result of a designated act, they may be able to apply for a payment.

Applicants may claim for a dependency payment if they were a qualifying relative who was financially or physically dependent on the deceased at the time of their death.

The scheme may be able to make a payment after a victim's death even if they received a payment for their injury before they died. If the victim has died because of their injury, qualifying relatives may be eligible to claim.

The responsibility for making a case for compensation lies with the applicant. This means that they need to provide the evidence necessary to decide the case. In particular, the scheme may ask them to provide the following evidence:

- proof that they meet the nationality and residency requirements
- medical evidence that shows they suffered a relevant injury that can be compensated under the Scheme
- evidence to support a claim for lost earnings
- confirmation that they were injured in a designated act
- confirmation from the appropriate authorities and/or witnesses that their behaviour did not contribute to the designated act in which their injuries were received
- confirmation from the prosecuting authorities that they co-operated

### *4.1.4* ***Canada***

Canada has a clearly defined financial reparation scheme that came into being in response to a specific act of terror: the 1984 Air India terrorist attack planned and executed in Canada by Sikh extremists. 329 people were killed onboard the passenger plane which exploded mid-flight, 120 miles off the southeast coast of Ireland. Following completion of the Air India Inquiry in 2011, the Commissioner stated that victim's families should be granted ex- gratia payments of $24,000 each. 275 victim payments were issued over the course of 2011/2012 to families of the deceased. Applications for financial reparation were cross matched alongside the names of the deceased and one-off payments were made.

### *4.1.5* ***September 11th Victim Compensation Fund of 2001***

This was a compensation scheme to help those in need due to the 9/11 terrorist attacks in New York (https://www.justice.gov/archive/victimcompensation/).Over 7,300 claims for death and physical injury were processed. Over 98% of eligible families who lost a loved one voluntarily decided to participate and submitted claims to the Fund.

This fund focuses specifically on helping those who were left physically harmed or the families of the deceased due to the 9/11 attacks. It does not take into account mental disabilities, and so these were not assessed. It was a fund provided in the immediate years preceding the September 11 attacks to those who needed the help most. The fund did not focus on the long term physical or mental disabilities of those who were directly involved at the time. This was measured from medical, or court case reports provided soon after September 11, 2001.

Further schemes were developed after the initial scheme was closed.

### *4.1.6* ***Australian Victim of Terrorism Overseas Payment***

Under this scheme a one-off payment is made to Australian citizens who suffer harm from a declared overseas terrorist attack. Those who apply must have been in the place and hurt by the attack or have a close family member who died in the place, as a result of the attack. The payment is exclusively financial. Applicants may

receive up to 75,000 Australian dollars depending on whether they are a primary, or a secondary victim.

The scheme emphasises the need to be within close proximity of a named overseas terrorist act to be considered for the payment. For the purposes of this payment, in the place where the declared overseas terrorist act occurred means the applicant was:

- in close proximity to the place where the terrorist act occurred
- witnessed the terrorist act first-hand

A person is in close proximity to the place where the terrorist act occurred if they were close enough to be physically injured, harmed or killed by that act.

Witnessing the terrorist act first- hand means being present, and personally seeing or perceiving the terrorist act direct from the original source.

Harmed includes any physical or psychological injury suffered as a direct result of the overseas terrorist act.

People who went to the place where the terrorist act occurred immediately following the act, to assist victims, are considered to be in the place for the purposes of this payment. This includes arriving at the scene of the act before the victim is moved to another location. Applicants must provide proof of identity and proof of proximity to a named, recognisable terrorist act.

A social worker paid by the Overseas Payment Scheme will contact the individual who is applying for the scheme. They are tasked with assessing the functional impairment of the applicant. The applicant must provide documentation proving they were mentally or physically injured, and also documentation that they were in close proximity to the terrorist act.

## Table 2: Post-Conflict Disablement Schemes

| Scheme | Inclusion Criteria | Are the bereaved excluded | Are those who have already received 'suitable' treatment' excluded. | How is proximity to event assessed? | How is permanent disability measured? | Is their physical disability assessed? How? | Is their psychological disability assessed? How? | How is mental health disability determined and measured? | How is the impact of the disability measured? |
|---|---|---|---|---|---|---|---|---|---|
| [a]**Spanish State compensation scheme Victims of terrorism** | Victims of terrorism. Defined as "Those deceased or having suffered physical or psychological harm as a result of terrorism acts; Person with family ties to deceased, cohabitation or dependency relationship with deceased"<br><br>Various amendments, changes in acts and royal decrees between 2002-2013 allowing for additional financial support. These include 1) Educational grants 2) Psychological treatment 3) Job placements 4) Exemption from school fees | Yes | Compensation in addition to court claims or insurance | Those most likely to be affected are the injured, those present or nearby (first responders), those exposed to trauma as a result of attempts to help victims' | Not Specified | For physical injuries, medical reports used. | For psychological injuries, appears self-reported. No further details given. | Not described | Not described |
| [b]**Israel National Insurance Act: Chapter 2: Hostile Action Victims: Victims of Terror** | Victims of terrorism and their families'. Resident of Israel, injured in Israel. Outside of Israel can be included if less than a year has passed since the expiry of residency. Those who | No | Unknown | N/A | Not Specified | Degree of disability is determined by a medical committee. | No | No | Individuals were assessed to see how likely they would be to recover, and if they could work to make a living wage. How they |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | have entered Israel illegally who have been injured abroad due to working with an Israeli employer. | | | | | | | | were assessed is unclear. |
| [c]**UK Victims of Overseas Terrorism Compensation Scheme: a guide** | Those who suffered Mental or physical injury, sexual abuse, if you are bereaved or a loss of financial earnings | No | Not mentioned | relevant unjust which was directly attributable to being a direct victim of a designated act. 'direct act is defined through section 47 of the Crime and Security Act of 2010'. You may. You may be eligible to make a claim for a mental injury if you witnessed, and were present at, a designated act or the aftermath in which a loved one was injured. | We may be able to make a payment after a victim's death even if they got a payment for their injury before they died. If the victim has died because of their injury, qualifying relatives may be eligible to claim. 'temporary' anxiety would not be enough. | Must provide relevant external medical evidence | Yes, but they are not assessed here. They must have been previously assessed and provide evidence to get the grant. Claims officers decide cases on what is called 'the balance of probabilities. This means that their decision is based on their view of what is more likely than not | N/A | N/A |
| [d]**USA The September 11th Victim Compensation Fund** | Physical Injury caused by the airplane crashes at 9/11. | Yes | Not mentioned | They need documentation of harm caused by the 9/11 attacks. Documents provided must be close to the time of the 9/11 attacks | It is not | Medical or court reports | No | No | It is not |
| [e]**Australian Victim of Terrorism Overseas Payment** | in the place and hurt by the attack. Or have a close family member who died in the place, as a result of the attack.' | Yes | No | They must be in close proximity, in that they must have witnessed the terrorist attack first-hand. | It is not | Yes | Yes. | Individuals must provide appropriate documentation for physical or mental injury. | A social worker will contact the individual who is applying for the scheme. They will interview the applicant and assess the impact it has. |

[a] **State compensation scheme Victims of terrorism in Spain (https://core.ac.uk/download/pdf/148789924.pdf)**

[b] **National Insurance Act for victims of terror in Israel (https://www.btl.gov.il/English%20Homepage/Publications/AnnualSurvey/2014/Documents/Chapter%203_hostile%20actions.pdf)**

[c] **The guide for the Victims of Overseas Terrorism Compensation Scheme in the United Kingdom (https://www.gov.uk/guidance/victims-of-overseas-terrorism-compensation-scheme-a-guide)**

[d] **September 11th victim compensation fund in USA (https://www.justice.gov/archive/victimcompensation)**

[e] **Victim of Terrorism Overseas Payment in Australia (https://www.servicesaustralia.gov.au/individuals/services/centrelink/australian-victim-terrorism-overseas-payment)**

## *4.2 Relevant Post- Military Service Schemes*

### *4.2.1* ***United Kingdom – War Pension Scheme (WPS)***

The War Pension Scheme (WPS) compensates for any injury, illness or death which was caused by service before 6 April 2005. This is separate from The UK Armed Forces Compensation Scheme (AFCS) as that scheme focuses on injury caused after April 2005. There are many similarities between the two schemes, as the AFCS emerged from the WPS.

Compensation:

There are 2 main types of WPS awards. Which one the applicant receives depends on the level of their disablement:

- a gratuity is a lump sum payment for disablement less than 20%
- a pension is an ongoing payment paid weekly or monthly for disablement more than 20%.

Eligibility

Applicants can claim under the WPS if they are no longer serving in Her Majesty's (HM) Armed Forces and their claimed disablement arose before 6 April 2005.

Individuals do not need a paid representative such as a solicitor or claims management company to apply for compensation. Individuals may bring this if they deem it necessary. There are no time limits for claiming, but any award will only be paid from the date of their claim.

If an applicant has served (whether directly or in a support role) with United Kingdom Special Forces (UKSF) must seek advice from the MOD A Block Disclosure Cell before completing the claim form. If they have served at any time after 1996, they will be subject to the UKSF Confidentiality Contract and must apply for Express Prior Authority in Writing (EPAW) through the Disclosure Cell before submitting a claim where they may be asked to disclose details of their service with UKSF or any units directly supporting them.

If an applicant is medically discharged from HM Armed Forces, the service documents may be referred to Veterans UK. The WPS will consider any injury, illness or disease identified as the main reason for their medical discharge, and any associated conditions.

In order to consider their claim, the scheme collects relevant information from sources both inside and outside the Ministry of Defence. Other information is then sought, for example, a report from the GP or Medical Officer, and information on any recent hospital treatment. If copies are provided quickly of any supporting documentation such as reports from their Medical Officer, copies of orders, accident/incident reports this assists the process. If the case cannot be decided on the up-to-date medical information alone, or if the applicant has not visited their GP for some time, a medical examination with an appointed doctor will be arranged. .

### *4.2.2* ***The UK Armed Forces Compensation Scheme (AFCS)***

The Armed Forces Compensation Scheme (AFCS) provides compensation for injury, illness or death which is caused by Military service on or after 6 April 2005. The Armed Forces Pension Schemes are designed to reflect the unique nature of Service life, to provide a retirement income for ex-personnel and their dependants, and to incentivise retention in Service as a key part of the overall remuneration package. A brief overview of this scheme follows.

Who is eligible?

All current and former members of the UK Armed Forces, including Reservists, may submit a claim for compensation. Unlike the War Pension Scheme, it is possible to submit an AFCS claim while still serving, as well as after an individual have left the Armed Forces.

In the event of service-related death, the Scheme pays benefits to eligible partners and children. An ‘eligible partner’ is someone with whom an individual is cohabiting in an exclusive and substantial relationship, with financial and wider dependence.

What does the scheme entail?

Claims for injury or illness which were sustained as a result of service. Claims can range from relatively minor fractures to amputations and other more serious conditions, including mental disorders.

An individual can submit a claim for injury or illness which occurs while they are participating in a service-related activity. This includes injury as a result of Adventurous Training (AT), physical exercise and organised sport, for example inter-Service athletics.

How are individuals assessed?

Awards are based on a fixed tariff, usually in the form of a one-off lump sum payment. If they are entitled, they may be paid one of 15 fixed amounts, depending on the severity of their injury. The applicant's situation may be assessed through a medical examination performed by a doctor who is appointed by Veterans UK.

What benefits are offered?

There are two main types of AFCS benefits:

*Lump Sums*

For injury or illness, AFCS provides a tax-free lump sum for pain and suffering, the size of which reflects the severity of the injury or illness. Lump sum payments range from £1,200 to £570,000.

If multiple injuries are sustained from the same incident, then the Scheme awards compensation for each injury, up to a maximum of £570,000.

*Guaranteed Income Payments (GIPs)*

For those with the most serious injuries and illnesses, AFCS also provides an income stream known as the Guaranteed Income Payment (GIP). This is a tax free, index-linked monthly payment which is paid from the point of discharge for life.

A number of factors are taken into consideration when calculating the GIP. These include the effect of an injury on future promotion prospects.

The Independent Medical Expert Group (IMEG) 2020 (5th Edition) provided an update to the 2013 report with recommendations on the medical and scientific aspects of the Armed Forces Compensation scheme. The key elements of this have been collated and are laid out below in the relevant headings.

Mental health symptoms and disorders

Compensation for mental health symptoms and disorders is a complex topic with different perspectives and the need for wide consultation. The IMEG review involved a literature search, discussion with military and civilian experts and with veteran organisations, including Combat Stress.

The areas identified in the 2013 (Boyce) review for particular scrutiny were:

1. the differences between mental and physical disorder and whether a wholly separate compensation approach was appropriate.
2. whether there should be a tailored interim award power for mental health disorders because there can be particular difficulty in determining the prognosis of mental health disorders soon after diagnosis.
3. how to address the challenge of establishing attribution confidently and accurately given the multifactorial nature of mental health problems.

4. the diagnostic process for mental health problems and basis of diagnosis in the scheme.

5. how to assess severity of mental health disorders.

In addition, IMEG reviewed delayed onset and delayed presentation of disorders.

On the substantive issues listed above IMEG came to the following conclusions:

1. While appreciating the reasons for the proposed separation of compensation approaches to mental and physical disorders, IMEG did not recommend a separate approach. The major focus of the AFCS is functional compromise for civilian employment, paid as Guaranteed Income Payment (GIP), which is applicable equally to physical and mental health disorders.

2. IMEG considered the requirement and options for a dedicated interim award. It concluded that there was no need for a tailored provision for mental health problems because the present interim award system should be sufficient.

4. Mental health disorders are subjective and multifactorial with causal factors which are predisposing, precipitating and maintaining. In addition, mental health symptoms are part of a continuum and need to be viewed as “more or less” rather than “present or absent” conditions. These features mean that decisions on attribution can be challenging and should be always accompanied by reasons for the evidence for attribution.

5. Robust accurate diagnosis of mental health symptoms and disorders is important to ensure appropriate treatment. Diagnosis should be based on a recognised classification system, preferably World Health Organisation (WHO) International Classification of Diseases (ICD) 10, with diagnoses made by a clinical psychologist/psychiatrist at consultant grade with trauma and, ideally, military experience.

6. Given the link in the Scheme between GIP and civilian employability, assessment of severity for AFCS should focus on loss of functional capacity and include information on clinical management and treatment received.

As with most occupational personal injury schemes and civil damages, awards under the AFCS depend on establishing a causal link between the claimed injury/disorder and some aspect of service. The AFCS is an individual jurisdiction with awards paid where attribution to service on or after 6 April 2005 can be established, on the balance of probabilities. To do this requires collection and analysis of evidence on the case facts, service and medical, knowledge of contemporary medical understanding of the causes of the disorder and, finally, a judgement as to whether in the particular case, service factors, events, exposures or circumstances are more likely than not to have caused the disorder to develop or worsen.

The issue of judgements by lay assessors was discussed by IMEG. Decisions in the AFCS are made by lay staff. This is also true of the War Pensions Scheme, however, for War Pensions, the law provides that administrative staff act on certificates on attribution and assessment from the Scheme medical advisers. For AFCS, administrators have the option to seek medical advice in any case.

Following the Boyce review, as Departmental policy, there are a number of situations where to ensure robust defensible decisions, advice on the collection and interpretation of evidence is routinely obtained from the Scheme medical advisers. Scheme medical advisers are appointed following a successful career in a clinical or other relevant medical speciality and undertake further training in medico-legal determination, the Scheme legislation and Departmental policy.

It is of note that while sharing the underlying need to establish a causal link to service, decisions in US Department of Veterans' Affairs (DVA) disability benefits are not informed by medical advice to the decision-maker, and for direct service connection disability benefits to be paid, the following applies:

"To establish a scientifically robust causal connection between a physical or mental health disorder and alleged environmental or occupational exposure requires four main types of evidence.

-Evidence of a generally accepted scientific association i.e., the exposure involved is generally accepted as associated with the claimed illness or injury.

-In an armed force context, the relevant exposure/circumstance should be during and due to military service.

-The illness or injury must have had its onset or worsening after the relevant exposure or event.

-To show that the service exposure was at least as likely as not to have been the specific cause there should be evidence that the service-related exposure was high or prolonged compared to other possible causes".

IMEG considers attribution as probably the most difficult single aspect of the determination of AFCS compensation for mental health disorders. Problems arise because of the very nature of mental health symptoms and illness. Major challenges include the reliance on self-report and lack of objectively verifiable features. In contrast to physical injury and disorders, their disabling effects tend to permeate many aspects of a person 's identity, behaviour and attitudes. Emotional symptoms occur in normal people and cover a wide continuum, ranging from normal reactions to pathological states. In the view of IMEG this means that diagnosable mental health disorders are rarely categorical e.g., compared to many physical disorders where a peptic ulcer or cancer is either present or absent. Making a firm diagnosis must take account of personality traits, the phasic nature of symptoms and the person's normal state.

IMEG argues that diagnosable mental health problems should be thought of not as "all or none" but as "more or less" disorders. In addition, mental health disorders are always multifactorial, shaped by a person's constitution,
early life, family values and experiences, intelligence, education, as well as the wider societal and cultural factors. Furthermore IMEG considers that for most people, combat is distressing, especially in the short term, but adverse reactions, including distress, naturally reduce over time. There is also evidence, including in the context of the recent and current conflicts, that, despite their pain and suffering, many individuals come through traumatic events the stronger with co-existing positive and negative consequences.

Accurate Diagnosis

If attribution of disorders is to be decided accurately the disorder must be present and correctly diagnosed. The experts consulted by IMEG agreed that reliability of certain psychiatric diagnoses (especially non-psychotic ones) can be poor. This is

partly attributable to such factors as the experience
and background of the clinicians, which classification system is used, the phasic nature of most psychological symptoms and the quality of psychometric measures. IMEG is concerned about the challenges in diagnosis of mental health problems, with much scope for different diagnoses on the same facts.

In terms of evidence to inform claims determination and the role of self-report, the experts confirmed that some patients, both civilian and military, under-report while others may exaggerate or occasionally feign symptoms and effects. There is always opportunity for innocent misinterpretation and misattribution of symptoms to events and circumstances; because symptoms follow an event, they are attributed to it. Client permission to access clinical records and reports from clinicians is obtained as part of the AFCS claims process and decisions in the Scheme are firmly based on the case medical and service facts, contemporary medical understanding of the causes of disorders and the relevant law. The most robust case formulations in AFCS will be multidisciplinary and multidimensional informed by documented information from military and medical records as well as by partners and families. IMEG consider it vital to have a full clinical, social, occupational and family history, covering personal habits, consumption of alcohol etc using a through life approach. This will allow the identification of pre-service discrete problems as well as predisposing, precipitating and maintaining factors.

Self-report will continue to be the mainstay of clinical history in the Scheme As recommended best practice, examinations should routinely include family history and adopt a through life approach to clinical and social history, starting with childhood, recognising the possibility of under-reporting and elaboration. Clinicians providing expert opinion should routinely have access to service medical and personnel records and to documented exposures, accidents etc. Advice from significant others can be helpful in certain situations but issues of confidentiality mean that this approach cannot be recommended as mandatory or routine.

Who should make diagnosis?

It is recommended that claim determinations should be informed by evidence-based opinion from established specialist clinicians, clinical psychologists or psychiatrists at consultant grade, with experience of trauma -related problems and ideally management of military cases. IMEG considers it important that civilian experts with appropriate expertise must be aware and respectful of military culture, values, needs and lifestyle. At present most claimants are still serving and under the care of

Defence Medical Services. In time, and as the proportion of post-service claims increases, the feasibility of setting up a regionally based national panel of clinical experts, civilian and military, to provide accurate diagnoses and assessment for the Scheme, should be explored. Where a special examination is required, consideration should be given to introducing client choice in terms of consultant background. In addition to a medico-legal function, such a group with national status but based throughout the UK, could play a major role in health professional education.

Assessment

Compensation decisions in AFCS should provide consistent and equitable awards both within the tariff award tables and category of injury, and across the range of injuries and illnesses, and should reflect the principle that the more severe the disorder, the higher the award. There is no international consensus on the most effective method of assessment of severity for non-psychotic mental health problems, either in clinical terms or therapeutic outcomes or determination of compensation.

To support consistent equitable awards, an assessment protocol for mental health problems should be developed and be applicable in other circumstances, such as for social security benefit determination. The resultant single multipurpose report would be less disruptive to claimants as well as being more consistent, efficient and cost effective. IMEG considers the production of a robust instrument as requiring considerable investment of time, effort and expertise and input from a range of experts and stakeholders. Assessment of severity of mental health disorders for AFCS should focus on function, as reported by the claimant and ideally confirmed by other evidence.

Permanence in the AFCS assumes access to appropriate clinical management over a lifetime.

IMEG made a number of further recommendations:

1) AFCS case assessment for mental health disorders should routinely include information on clinical management and treatment received. This might involve completion of a simple form by the treating clinician, covering the dates, nature and duration of treatment received and outcome, and the experience and expertise of the clinician.

2) Consideration should be given to the use of a limited battery of standardized psychometric measures of functional capacity particularly to judge progress over time. There are a large number of available tests but those selected should be standardised, valid and reliable

Delayed onset and delayed presentation

The AFCS has normal time limits for claiming. Mental health problems in veterans, particularly in earlier years, may be first diagnosed sometime after service termination. It is hoped that whilst this pattern may continue for some time, awareness raising and campaigns to reduce stigma will hopefully reduce delay in seeking help amongst AFCS clients. There is a special AFCS provision for physical and mental health disorders with delayed onset or, more commonly, delayed presentation.

Article 3(b) and (c) of the 2011 Order provides that the definition of “late onset illness” includes:

a) a mental health disorder which is capable of being caused by an incident occurring seven or more years before the onset of the illness; or

b) a mental health disorder capable of being caused by an incident occurring less than seven years before the date of onset of the illness, which disorder is capable of causing the person suffering from it to be unable to seek medical help for the disorder within seven years of the date of onset of the illness. The legislation also provides that claims for injury benefit for late onset illness should be made within three years of the day the late onset illness was first diagnosed. In such cases, at present, diagnosis of a mental health disorder should be by a relevant accredited medical specialist.

### *4.2.3* ***United States of America VA Disability Compensation Scheme***

Who is it for?

The applicant's disability must be the result of an injury or disease that was incurred or aggravated while on active duty or active duty for training; or from injury, heart attack, or stroke that occurred during inactive duty training. A disability can apply for physical conditions and mental health conditions, such as post-traumatic stress disorder (PTSD).

Who is eligible?

To be eligible for the disability compensation, applicants must have served on active duty, active for training, or inactive duty training. Also, applicants must have a disability rating for their service-connected condition.

Applicants must also:

- Got sick or injured while serving in the military—and can link this condition to their illness or injury (called an Inservice disability claim), or
- Had an illness or injury before they joined the military—and serving made it worse (called a preservice disability claim), or
- Have a disability related to their active-duty service that didn't appear until after they ended their service (called a post-service disability claim)

How are they assessed?

Individuals must provide private medical evidence of their injuries. The Department of Veterans Affairs encourages all Veterans to submit their private medical records for consideration during the processing of their benefits claim. VA values evidence from their private treatment providers because they are familiar with their medical history, often over a long period of time.

The scheme assigns individuals a disability rating based on the severity of their service-connected condition. They use the disability rating to determine how much

disability compensation they will receive each month, as well as their eligibility for other VA benefits.

If they have multiple disability ratings, they use them to calculate the individuals combined VA disability rating. Calculating their combined disability rating involves more than adding up their individual ratings (a combined rating may be different from the sum of their individual ratings).

They base an individual's rating on:

- The evidence applicants provide (like a doctor's report or medical test results), **and**
- The results of the VA claim exam (also called a compensation and pension, or C&P, exam), if the VA determines that an exam is required, **and**
- Other information from other sources (such as federal agencies)

Over the years, the Ministry of Defence set up a specific division to deal with IDF veterans with disabilities, the Rehabilitation Division, which has been faithfully putting the Invalids Law (1949) into practice ever since. This unit is responsible for assessing and determining the veterans' degree of medical disability and entitlement to benefits. In addition, the unit provides medical and comprehensive psychosocial rehabilitation services, including vocational rehabilitation and career development counselling. The size and scope of the benefits is updated according to the public-sector wage index. Additionally, a broad spectrum of monetary grants and a variety of personal and professional rehabilitation services are provided (e.g., assistance with university and other tuition fees, vocational training, business and house loans, funding medical and rehabilitation equipment, medical treatment, and rehabilitative and psychological consultation).

## Table 3: Post-War Disablement Schemes

| Reference | Inclusion Criteria | Are the bereaved excluded | Are those who have already received 'suitable' treatment' excluded. | How is proximity to event assessed? | How is permanent disability measured? | Is their physical disability assessed? How? | Is their psychological disability assessed? How? | How is mental health disability determined and measured? | How is the impact of the disability measured? |
|---|---|---|---|---|---|---|---|---|---|
| [a]**Israel Pension for Veterans with Disabilities** | Veterans of the Israeli Army who have disabilities. | Not specified | Not specified | Not specified | Not specified | 0-100% medical disability. Measured by physicians. 20% or more receive monthly payments | If the veterans were previously diagnosed with psychiatric disabilities (such as PTSD), they would qualify for it. | Not specified | Not specified |
| [b]**UK Armed Forces Compensation Scheme** | Veterans of the United Kingdom Military or special forces who have sustained an injury. It includes mental health disorders. | No | Yes. If the applicant has received treatment and is not showing symptoms, they cannot claim. If there is a chance that their disability is still showing, then the individual can claim from the AFCS. | Details and evidence must be provided on the date and location of the injury. | Needs further specification | Not specified | Mental disorders must be diagnosed by a relevant accredited medical specialist. | Needs further specification | Functional limitation or restriction is severe where the claimant is unable to undertake work appropriate to experience, qualifications and skills at the time of onset of the illness and over time able to work only in less demanding jobs |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| [c]**USA Veteran Disability Compensation Scheme** | Must be a current or past serving member of the US army and must have gotten injured or sick while serving in the military. | Yes | No | They must provide documentation proving they received the injury or illness directly due to serving in the military | It is not | Through documentation. Applicants must provide physical and medical assessment from their private doctor or medical practitioner. | Through documentation. Applicants must provide psychological assessment from their private doctor or medical practitioner. | Overall functioning is assessed, and the severity of the functioning (both mental and physical) indicates how much compensation the applicant receives. The assessment is not specified further. | Not specified |
| **UK War Pension Scheme** | Must have served in Her Magesty's Armed Forces and been injured before April 6 2005. | No | Yes. If the applicant has received treatment and is not showing symptoms, they cannot claim. If there is a chance that their disability is still showing, then the individual can claim from the AFCS. | Not specified | Not specified | It is assessed through previous medical records provided. | Mental disorders must be diagnosed by a relevant accredited medical specialist. | Not specified | Not specified |

[a] **Disability pension for veterans in Israel (https://www.tandfonline.com/doi/abs/10.1080/1536710X.2011.622967)**

[b] **Armed forces compensation scheme in the United Kingdom (https://www.jmw.co.uk/services-for-you/armed-forces-claims/armed-forces-compensation-scheme-lp?gclid=Cj0KCQjwo-aCBhC-ARIsAAkNQisJvp6nfVH2KlqIWj5q95WdjDDA6hVynwpSZD2nNljwFFms1AQZWu8aAovREALw_wcB)**

[c] **Veteran disability compensation scheme in the USA (https://www.usa.gov/disability-veterans-benefits).**

[d] **War Pension Scheme in the United Kingdom (https://www.gov.uk/guidance/war-pension-scheme-wps#:~:text=The%20War%20Pension%20Scheme%20(%20WPS,main%20types%20of%20WPS%20awards.&text=a%20pension%20is%20an%20ongoing,for%20disablement%20more%20than%2020%25.)**

## *4.3 Relevant Industrial Compensation Schemes*

### *4.3.1* ***United Kingdom Industrial Injuries Disablement Benefits (IIDB)***

What is the scheme?

The Industrial Injuries Scheme provides non-contributory no-fault benefits for disablement because of an accident at work, or because of one of over 70 prescribed diseases known to be a risk from certain jobs. The scheme also covers people working on approved employment training schemes or courses. The amount of financial benefit an individual gets depends how badly they are disabled as a result of the industrial injury or disease. The scheme is split in to injuries and prescribed diseases.

Who is it for?

Benefits are paid to employees who were employed earners at the time of the accident or when they contracted a prescribed disease, or to people who were working on an approved employment training scheme or course.

Only employed earners, or people who can be treated as employed earners, are covered by the Industrial Injuries Scheme, or people who were on an approved employment training scheme or course when the accident or event happened. The individual must be a resident of the UK.

Process of application

Confirmation is needed of the following:

- the time, date and place of the accident
- that the accident arose out of and in the course of the employment or whilst on an approved employment training scheme or course
- that employment was employed earner's employment or on an approved employment training scheme or course

- that the employment was in Great Britain or was covered by special provisions

How are applicants examined?

Medical examination will be carried out by one or possibly two experienced medical practitioners (A Doctor trained in IIDB). The medical examination will be held in private, but individuals may be able to take a companion if the doctor allows it. Applicants can give the doctor any evidence which was not included with the claim form. If the applicant has attended a hospital following an industrial accident, the doctor may seek further information from the hospital. Hospital case notes may be requested by the doctor to assist in giving an opinion. The doctor could also ask for a report from the applicants GP.

The doctor will take a statement from the applicant and send a written report to the decision maker based upon the examination and any other medical evidence. The doctor will give an opinion on whether they have suffered a loss of faculty as a result of the accident and, if so, advise on the level of their disablement and how long it is expected to last. The doctor will also provide an explanation for the decision maker about how they arrived at that opinion.

The degree of disablement for certain defined injuries (‘scheduled injuries’) is laid down in the Social Security Regulations (1982). For example, for serious disablement such as loss of both hands or loss of sight the degree of disablement is 100%, for the loss of one hand it is normally 60%, and for the loss of an index finger it is usually 14%. These percentages can be adjusted where justifiable by the assessing clinician. The same schedule of injuries and flexibility of scoring depending on functional restriction is mandated to be considered within the TPDPS regulations.

Similarly, assessing clinicians are expected to consider whether the disablement has a cause other than the relevant injury and adjust the percentage disablement to reflect that only caused by the relevant injury and subsequent loss of faculty. This is similar to the expectations set out in the TPDPS regulations. Therefore, there are statutory and process related similarities to this scheme and the TPDPS.

**How is Permanence Assessed?**

Applicants may be given a ‘final’ assessment of disablement for life if the disability is assessed as permanent and is unlikely to change. Or where they are likely to make a full recovery the assessment may be final but for a limited period. Sometimes however the applicant may be given a provisional assessment for a limited period at the end of which they will be re-examined, and their disablement assessed again.

### *4.3.2 Italian Insurance for Employment Injuries*

Who is it for?

This is a scheme that focuses specifically on helping those who have suffered physical injuries while working. This includes accidents which cause physical harm, but also if the employees contract an occupational disease.

These are the services in kind, provided exclusively by INAIL, to which they may be entitled:

- health services, such as aids, prosthetics and assistance and rehabilitation aimed at ensuring the maximum possible recovery of their independence and mental and physical resources, and therefore their reintegration into daily life, family, social and working environments.

If the individual becomes deceased, the family receives financial compensation. The percentages are the following:

- 20% is awarded to each of the two parents, if they were responsible for the deceased at the time of death;
- 20% is awarded to each brother or sister, if they were responsible for the deceased at the time of death.

### *4.3.3 Belgium scheme of accident compensation.*

The Belgium scheme of accident compensation deals with individuals who have been injured during their employment, primarily focused on those involved in industrial jobs.

No special agency has been established in Belgium to administer the Accident Compensation program, it is administered by the Minister for Labor and Social Welfare.

- An accident at work is defined as “any accident that happens to a worker during the course and by the fact of the performance of his contract of employment and which causes an injury”.
- If the occupational disease is on the official list and the victim is employed in a sector where he or she is exposed to that risk, the causal link between the exposure and the disease is presumed. An open system coexists alongside the list.

Applicants may be entitled to one of the following compensations:

- for permanent loss of working capacity
- for temporary loss of working capacity
- for reimbursement of medical costs related to the treatment of an occupational disease
- for the assistance of another person
- after a death caused by an occupational disease, the compensation is then paid to the persons entitled on their behalf.

### *4.3.4 Denmark Industrial injury scheme*

The objective of this scheme is to grant compensation to injured persons or their surviving dependants in the event of an industrial injury. The injury shall have been caused by the work or the working conditions. This fund mainly seeks to assess and compensate those who have acquired physical injury or 'occupational diseases' due to their work and does not focus on mental health problems such as PTSD, Depression or Anxiety.

Occupational diseases under this Act shall be - (i) Diseases which - according to medical documentation - are brought about by specific influence to which certain groups of people, through their work or working conditions, are more exposed than persons not having such work.

Assessment

The Minister for Employment has laid down rules and regulations determining that physicians and dentists shall notify the National Board of Industrial Injuries and the National Working Environment Authority of all clear and presumed cases of occupational diseases of which they become aware in their work. As soon as possible after the occurrence of the injury the injured person shall submit himself to a medical examination and, subsequently, undergo the medical treatment or the training deemed necessary by the physician or the National Board of Industrial Injuries. If necessary, the injured person shall enter hospital or a similar institution for observation. Subject to the decision of the said Board, the injured person shall furthermore be required to submit himself to an examination by a physician appointed by the Board, to be work-tested and, upon request, give a verbal statement to the Board.

Benefits.

Benefits under this Act include –

(i) reimbursement of expenses for medical care, rehabilitation, aids.

(ii) compensation for loss of earning capacity.

(iii) compensation for permanent injury.

(iv) transitional allowance at death.

(v) compensation for loss of breadwinner.

(vi) compensation for survivors

## Table 4: Post-Industrial Disablement Schemes

| Reference | Inclusion Criteria | Are the bereaved excluded | Are those who have already received 'suitable' treatment' excluded. | How is proximity to event assessed? | How is permanent disability measured? | Is their physical disability assessed? How? | Is their psychological disability assessed? How? | How is mental health disability determined and measured? | How is the impact of the disability measured ? |
|---|---|---|---|---|---|---|---|---|---|
| **Workmen's Compensation in Belgium** | Must be older than 18 years old. 'Permanent functional impairments. Incapacity of 33% or more. | Not mentioned | Not mentioned | Not specified | it is not specified | In their ability to complete their tasks or jobs: Total or partial loss constitutes a 100% or x-100% loss of physical capacity in general". | Medico-social assessment by doctors | it is not | It is not |
| **Danish Disability Pension** | Over 40 years of age. capacity to work has been reduced permanently and so substantially that you are unable to do a regular job or a flexi-job. | Yes | Yes | It is not | Not specified. | Local authority' will assess. Must provide resource clarification of the individuals capacity to work. Includes assessment of education, work experience and health | Local authority' will assess. Must provide resource clarification of the individual's capacity to work. Includes assessment of education, work experience and health | Not mentioned | Not assessed |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Italy - Benefits in case of accidents at work or occupational diseases** | If the individual suffered an injury or disease due to working. | Yes | No | Detailed exposure and assessment and presumed causation must be provided | Not specified. | assessment of the biological damage by INAIL doctors with specialisation in forensic or occupational medicine; information from treating doctors or other experts can be considered. | Not assessed | Not assessed | Not assessed |
| **UK Industrial Injuries Disablement Benefits (IIDB)** | Must be a resident of the UK. Must be employed by the company/business that they have been injured at. | Not specified | No | Applicants must provide an evidence that the cause of the disability was from working in the specified employment. This can include doctors notes and eye. witnesses | Disability is assessed as permanent and is unlikely to change. Or where they are likely to make a full recovery the assessment may be final but for a limited period. Or, the applicant may be given a provisional assessment for a limited period at the end of which | Medical examination will be carried out by 1 or possibly 2 experienced medical practitioners. The medical examination will be held in private but individuals may be able to take a companion if the doctor allows it. Occasionally applicants may be asked if an observer can be present. | Medical examination will be carried out by 1 or possibly 2 experienced medical practitioners. The medical examination will be held in private but individuals may be able to take a companion if the doctor allows it. Occasionally applicants may be asked if an observer can be present. | The same as physical health, with a list of pre-existing disorders and each one is rated on severity. | Impact is assessed on a 0-100% scale. |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | they will be re-examined and their disablement assessed again. | | | | |

[a] **Workmen's Compensation in Belgium (https://www.howdengroup.com/be-en/cover/workers-compensation)**

[b] **Danish Disability Pension (https://www.legislationline.org/download/id/1287/file/82daad22d0da7733049a53cbce86.pdf)**

[c] **Italy - Benefits in case of accidents at work or occupational diseases:**

**(https://ec.europa.eu/social/main.jsp?catId=1116&langId=en&intPageId=4621#:~:text=If%20you%20have%20been%20the,and%20annuity)%20provided%20by%20INAIL.)**

[d] **UK Industrial Injuries Disablement Benefits (IIDB) (https://www.gov.uk/industrial-injuries-disablement-benefit**

## *4.4 Criminal Injury Compensation Schemes*

### *4.4.1* ***Northern Ireland***

If an individual has been injured or their parent, child, husband, wife or partner has died because of a violent crime, they may be entitled to compensation for criminal injuries in Northern Ireland.

Eligibility

if a person:

- has been injured seriously enough to qualify for at least the minimum award of £1000.00
- were injured in an act of violence in Northern Ireland – an offender does not necessarily have to have been convicted of, or even charged with the crime
- suffered a loss of earnings or special expenses as a result of a criminal injury
- are making an application within two years of the incident that caused an injury

A person may also be eligible to claim if a parent, child, husband, wife, or partner died as a result of a criminal injury.

Applications may still be accepted after two years if, in a particular case, it wasn't reasonable to expect an application to be made within this time.

A person may be eligible to make a claim for a mental injury if witnessed, and were present at, an incident in which a loved one was injured as the result of a crime of violence. A person may also be eligible if involved in the immediate aftermath of an incident in which a loved one was injured (by 'immediate' normally referring to the period of time immediately following the incident in which a loved one was injured and not where someone is later told about the incident either by the victim or another person).

If a person is claiming a payment because witnessed or were involved in the immediate aftermath of the injury of a loved one, must have suffered a mental injury as a result. There is a requirement for medical evidence from a psychiatrist or a clinical psychologist confirming that this is the case.

When an application is received the applicant's details are registered and a request is made for a police report about the incident. Once the police report is received, a caseworker looks at the claim and decides whether further information is needed, for example, medical evidence or loss of earnings details.

Each application for compensation is determined on its own merits and in keeping with the relevant legislation. When all the information needed to make a decision on a claim is received, the caseworker will assess all the material and decide whether compensation can be paid.

Claims officers decide cases on what is called "the balance of probabilities". This means that their decision is based on their view of what is more likely to have happened than not to have happened.

Compensation Services can decide to reduce or completely refuse the compensation for the following reasons:

- due to the applicant's behaviour before, during or after the incident in which were injured
- applicant's criminal record
- applicant's failure to co-operate with the police, or with Compensation Services
- applicant's delay in informing the police, or other organisation, or person of the incident

Where appropriate the applicant is asked to provide medical evidence. If there is a cost attached to obtaining the medical evidence the applicant is expected to meet this.

If additional medical or other evidence is required (if injuries are complex or if claiming for a mental illness) it may be necessary to check if any pre-existing conditions, if that has not already been covered in the initial medical evidence. In these circumstances the applicant will either be asked you to obtain a report from treating practitioner or scheme may arrange for applicant be seen by an expert.

### *4.4.2* ***UK (Scotland, Wales and England)***

The Criminal Injuries Compensation Authority (CICA) is an executive agency of the UK governmentThe Authority, established in 1996 administers a compensation scheme for injuries caused to victims of violent crime in England, Scotland and Wales. It is funded by the Ministry of Justice in England and Wales and the Justice Directorate in Scotland.

The payment system is based on a 35-tier system split into two parts. Part A of the CICA tariff covers injuries such as burns, paralysis, medically recognised illness, mental injury, peripheral sensory nerve damage and motor nerve damage as well as injuries to the head and neck, upper limbs, torso and lower limbs. Part B of the tariff covers fatal injuries, physical abuse in adults, sexual abuse, child abuse, infection as a result of sexual abuse and loss of foetus.

Compensation may be reduced or withheld altogether from applicants who: - contributed to or caused the incident in which they were injured - failed to co-operate with the police or prosecuting authority - failed to or delayed in reporting the incident to the police - failed to co-operate with the CICA in handling their claim - have one or more unspent criminal convictions

it is also possible for decision makers to refuse claims on the basis that the victim still lives with their assailant, or that the assailant may benefit in some way from their award. In the latter case it is usually possible to overcome this issue by placing the award in a trust.

The time limit for claiming compensation is two years from the date the injury occurred. There are slightly different rules in the case of applicants who are children, or who were children when they were injured. The time limit may be extended in exceptional circumstances but is treated very strictly. Ignorance of the existence of

the scheme and the availability of compensation is not usually accepted as an excuse for a late application.

The 2012 scheme[1] came into force on 30 September 2012 and applies to all claims received on or after 27 November 2012. It is less generous than previous schemes, with certain minor injuries removed altogether and others reduced in value. Residency criteria now mean that most applicants must be ordinarily resident in the UK, or a British or EU citizen. The rules on criminal convictions are more restrictive in that having an unspent criminal conviction that resulted in a prison sentence will mean automatic rejection, no matter what the offence. And claims for loss of earnings, previously always based on the applicant's actual losses up to a maximum of one-and-a-half times the national average wage, are now assessed entirely at the rate of statutory sick pay regardless of the applicant's actual losses. The total maximum award for a claim remains at £500,000, a figure that has remained unchanged since the original tariff scheme in 1996

### *4.4.3 USA*

Every state administers a crime victim compensation program that provides financial assistance to victims of both federal and state crimes. State Crime Victims Compensation programs reimburse victims for crime-related expenses. Such expenses include medical costs, mental health counselling, funeral and burial costs and lost wages or loss of support. Although each state compensation program is administered independently, most programs have similar eligibility requirements and offer comparable benefits.

Compensation is paid only when other financial resources, such as private insurance and offender restitution, do not cover the loss. Some expenses are not covered by most compensation programs, including theft, damage, and property loss. State compensation programs are not required to compensate victims in terrorism cases.

Maximum awards generally range from $10,000 to $25,000, although a few states have higher or lower maximums. This is a purely financial compensation for those who have suffered crimes. The compensation can come in the form of payment for a variety of expenses or losses related to the crime. Beyond medical care, mental health treatment, funerals, and lost wages, a number of programs also cover crime-scene clean-up, travel costs to receive treatment, moving expenses, and the cost of housekeeping and child-care if a victim is unable to perform those tasks.

To receive compensation, victims must comply with state statutes and rules. This requires victims to cooperate with reasonable requests of law enforcement and submit a timely application to the compensation program.

### 4.4.4 Germany

Anyone who falls victim to a wilful violent crime within the territory of the Federal Republic of Germany and suffers health damage as a result is entitled to file for compensation. The same goes for the surviving dependents of any deceased as a result of a violent crime. Under certain conditions, foreign nationals are also entitled to victims' compensation. The aim of the law is to compensate for the health and economic consequences caused by acts of violence.

A violent crime in this scheme is defined as a wilful, unlawful physical assault against an individual.

Sexual offences and sexual assaults against minors are also regarded as violent crimes.

The following are equivalent to a physical assault:

- Intentional administration of poison
- The at least negligent creation of a danger to the life and limb of another person by commission of a crime by means causing a common danger (e.g. arson, bomb attack)

Not only victims, but also people who were indirectly affected by the crime as well as surviving dependents are entitled to compensation via the Crime Victims Compensation Act.

Victims are defined as: A person who has suffered damage to his/her health on account of an intentional, unlawful physical assault or as a result of lawfully

defending himself/herself against such an assault. This also includes persons who suffer an impairment of health due to shock by witnessing said crime.

Indirectly affected are defined as: Victims' dependents, who weren't present at the scene of the crime, but have a close personal relationship or are related to the victim.

Surviving dependents: If the victim is deceased, certain close relatives have a claim to surviving dependents pensions, regardless of damage to their own health.

Compensations include:

- Curative and medical treatment, long-term care
- Aids (e.g. prostheses, dental prostheses, wheelchairs)
- Compensation paid to victims and surviving dependants
- A funeral allowance
- Other welfare benefits in the event of economic need (e.g. long-term care benefit, subsistence allowance)

After filing an application it will be examined if the claim-causal facts are relevant for compensation via the Crime Victims Compensation Act. This includes the question if the damage to health was the result of a "physical assault". Proof is often obtained via medical and psychological assessments. Additionally, there should be no grounds for refusal, which means the victim has to actively assist in the clearance of the crime, meaning the victim should not have played a part in causing the crime or show behaviour which would make compensation seem unreasonable.

## Table 5: Criminal Compensation Schemes

| Reference | Inclusion Criteria | Are the bereaved excluded | Are those who have already received 'suitable' treatment' excluded. | How is proximity to event assessed? | How is permanent disability measured? | Is their physical disability assessed? How? | Is their psychological disability assessed? How? | How is mental health disability determined and measured? | How is the impact of the disability measured? |
|---|---|---|---|---|---|---|---|---|---|
| [a]Compensation for criminal injuries Northern Ireland | If they have been injured seriously enough to qualify for at least the minimum award of £1000.00, were injured in an act of violence in Northern Ireland,suffered a loss of earnings or special expenses as a result of a criminal injury are making their application within two years of the incident that caused your injury. | Yes | No | Participants must provide evidence of injury being caused by a criminal act. This includes police reports and medical records. | Not specified | Caseworker assessed disability. Claims officers decide cases on what is called 'the balance of probabilities'. This means that their decision is based on their view of what is more likely to have happened than not to have happened. It is important that you give the claims officer all the evidence that they ask you to provide in order for them to be | Caseworker assessed disability. Claims officers decide cases on what is called 'the balance of probabilities'. This means that their decision is based on their view of what is more likely to have happened than not to have happened. It is important that you give the claims officer all the evidence that they ask you to provide in order for them to be able to make a | Not specified | Not specified |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | able to make a decision in your case. | decision in your case. | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| [b]Criminal Injuries Compensation Act (CICA) in England, Scotland, and Wales | Not specified | No | No | Initially applicants should report any crime against you to the Police. If they report an incident to the Police, you should obtain the Police Incident number to be submitted to CICA. | Not specified | Not specified | Not specified | Not specified | Not specified |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| [c]State Crime Victims Compensation in the USA | Varies from state to state, but generally: Compensation is paid only when other financial resources, such as private insurance and offender restitution, do not cover the loss. Some expenses are not covered by most compensation programs, including theft, damage, and property loss. State compensation programs are not required to compensate victims in terrorism cases. | No | Yes | Medical records | Not specified | Medical records | Medical records | medical records | Not specified |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| [d]Crime Victims Compensation Act in Germany | Those who are directly and indirectly affected by crime, as well as surviving dependents. | No | Not specified | Documentary evidence must be provided of crime. | It is not | Medical Records | Medical Records | Not specified | Not specified |

[a] **Compensation for criminal injuries Northern Ireland (https://www.nidirect.gov.uk/articles/compensation-criminal-injuries)**

[b] **Criminal Injuries Compensation Act (CICA) in England, Scotland, and Wales (https://www.gov.uk/guidance/criminal-injuries-compensation-a-guide)**

[c] **State Crime Victims Compensation in the USA (https://www.benefits.gov/benefit/4416)**

[d] **Crime Victims Compensation Act in Germany (https://www.odabs.org/en/finanzielle-entschaedigung/compensation-via-the-crime-victims-compensation-act.html#:~:text=In%20the%20case%20of%20violent,from%20such%20damage%20to%20health.)**

### *4.5 Summary: Learnings from Other Schemes*

There are specific learnings from other schemes (in particular from the AFCS and IIDB schemes):

1. A separate approach (or scheme) for physical and mental health conditions is not defensible.
2. Decisions on attribution can be challenging and should be always accompanied by reasons for the evidence for attribution.
3. Robust accurate diagnosis of mental health symptoms and disorders is important to ensure appropriate treatment. Diagnosis should be based on a recognised classification system, preferably World Health Organisation (WHO) International Classification of Diseases (ICD) 10, with diagnoses made by a clinical psychologist/psychiatrist at consultant grade.
4. Assessment of severity should focus on loss of functional capacity and include information on clinical management and treatment received.
5. Judgements by lay assessors are defensible in a tariff based system (for attribution and assessment of disablement). For AFCS, administrators have the option to seek medical advice in any case.
6. The appointment of AFCS medical advisors helped to ensure robust defensible decisions (through the provision of advice on the collection and interpretation of evidence). AFCS medical advisers are appointed following a successful career in a clinical or other relevant medical speciality and undertake further training in medico-legal determination, the Scheme legislation and Departmental policy.
7. In the US Department of Veterans' Affairs (DVA) disability benefits are not informed by medical advice to the decision-maker. Instead, four main types of evidence are collated: evidence of a generally accepted scientific association; the relevant exposure/circumstance should be during and due to military service; the illness or injury must have had its onset or worsening after the relevant exposure or event; the service exposure was at least as likely as not to have been the specific cause there should be evidence that the service-related exposure was high or prolonged compared to other possible causes.
8. IMEG views diagnosable mental health disorders as rarely categorical. IMEG argues that diagnosable mental health problems should be thought of not as "all or none" but as "more or less" disorders. This is a debatable point.
9. In order to obtain an accurate diagnosis it is important to ensure that diagnosing clinicians are sufficiently experienced; access to clinical records and reports from clinicians is essential; claims process and

decisions are firmly based on the case medical and service facts, contemporary medical understanding of the causes of disorders and the relevant law; examinations should routinely include family history and adopt a through life approach to clinical and social history, starting with childhood, recognising the possibility of under-reporting and elaboration.

10. Advice from significant others can be helpful in certain situations but issues of confidentiality mean that this approach can be difficult.
11. There is no international consensus on the most effective method of assessment of severity for non-psychotic mental health problems, either in clinical terms or therapeutic outcomes or determination of compensation.
12. Assessment of severity of mental health disorders should focus on function, as reported by the claimant and ideally confirmed by other evidence.
13. Permanence in the AFCS assumes access to appropriate clinical management over a lifetime. It is thus important that case assessment for mental health disorders should routinely include information on clinical management and treatment received. This might involve completion of a simple form by the treating clinician, covering the dates, nature and duration of treatment received and outcome, and the experience and expertise of the clinician.
14. Consideration should be given to the use of a limited battery of standardized psychometric measures of functional capacity particularly to judge progress over time.
15. There are particular learnings from the IIDB scheme. The social security (General benefit) regulations 1982, which defines the levels of disablement within the IIDB scheme is the same as that which governs the scheduled assessments within the TPDPS.
16. Similarly, this scheme mandates the inclusion of only the percentage disablement associated with the accepted industrial injury (Troubles related incident in TPDPS) within the clinician's assessment, with similar processes employed to assess the amount of disablement attributable to non-relevant injuries.
17. The disablement caused by conditions or injuries sustained either before or after the accident are not considered in the overall assessment of disablement, however their interaction with the accepted relevant injury is. This is the same as the expectations outlined in the TPDPS regulations.
18. The ability of the assessing clinician to increase or decrease the scheduled assessment contained within the social security (General benefit) regulations 1982, depending on the individual applicant's functional ability is also consistent across the schemes. The social security (General benefit) regulations 1982 serves as a guide to what

level of functional disablement is expected when the use of appropriate aids and appliances has been considered and where there are no complications associated with that injury. Should there be evidenced changes from this expected level of functional restriction, the clinician can adjust the percentage and justify this decision. The use of the social security (General benefit) regulations 1982 to act as a benchmark when assessing other, none scheduled injuries is also consistent across the 2 schemes.

# 5. Review of Relevant Literature relating to Mental Disorders associated with traumatic events and conflict

## *5.1 Mental Health Diagnoses related to Traumatic Events*

Conditions such as Post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (cPTSD) require exposure to one or more significant traumatic incidents to meet diagnostic criteria. However, *other* psychiatric conditions may be related to a traumatic event and may thus count as a psychological injury within this scheme. Depression, anxiety, specific phobias, adjustment disorders, dissociative disorders and psychosis can also develop after traumas (NICE, 2005). The vast majority of people with PTSD have at least one other mental disorder of which depression is the most common co-morbid condition (Resick, 2001). These disorders may manifest separately or in combination (co-morbidity) and can co–occur with physical health problems.

### *5.1.1 PTSD*

Post-traumatic stress disorder (PTSD) is the main mental disorder that is associated with exposure to traumatic events such as assaults, natural disasters, severe accidents, bombings and other events. The main symptoms of PTSD are repeated and unwanted re-experiencing of the event, hyperarousal, emotional numbing, and avoidance of stimuli that could act as reminders of the event.

PTSD was first introduced as a new diagnostic category1980 in the third edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (DSM-lll, APA 1980). PTSD was formerly classified as an anxiety disorder in the DSM-IV (APA, 2000) but has since been reclassified as a "trauma- and stressor-related disorder" in the DSM-5 (2013). The DSM-5 diagnostic criteria for PTSD increases the symptom clusters from three to four, three further symptoms were added, and a dissociative subtype was included.

In the recent version of the European Diagnostic system ICD-11 (WHO, 2018) the criteria for PTSD has been simplified to include those core symptoms that best differentiate PTSD from other disorders but also distinguish PTSD from the new ICD-11 category of complex PTSD (Maercker et al., 2013a). The ICD 11 now defines PTSD with the following elements: re-experiencing the traumatic event in the

present; deliberate avoidance of reminders likely to produce re-experiencing; and persistent hyperarousal as perceptions of heightened current threat. The inclusion of the requirement for re-experiencing the cognitive, affective or physiological aspects of the trauma in the here and now rather than just remembering the event is expected to raise the diagnostic threshold for PTSD from ICD-10 (WHO, 1992).

The majority of individuals who develop acute stress reactions after a traumatic event will recover from their initial distress, however a substantial minority (30–40%) will develop chronic PTSD in which symptoms persist, often for many years (Rothbaum et al, 1992; Kessler et al, 2017).

**Prevalence**

Estimates of PTSD prevalence and incidence have been derived from large-scale epidemiological studies mainly conducted in the USA and Australia since the introduction of the PTSD diagnostic criteria (Breslau, et al., 1991; Creamer, et al, 2001; Kessler et al., 1995; Stein et al., 1997). Kessler et al. (1995) found that most people will experience at least one traumatic event in their lifetime and estimated a lifetime prevalence of PTSD of 7.8% with the risk of developing PTSD after a traumatic event at 8.1% for men and 20.4% for women. Breslau and colleagues (1991) found an overall risk of developing PTSD after a traumatic incident of 23.6% in an urban population of young adults with a gender difference of 13% for men and 30.2% for women (Breslau et al., 1997).

In the more recent world mental health survey data (Koenan et al, 2017) the cross-national lifetime prevalence of PTSD was 3.9% in the total sample and 5.6% among those exposed to trauma. Half of respondents with PTSD reported persistent symptoms over time. Key factors found to be associated with increased risk of lifetime prevalence for PTSD included: social disadvantage, younger age, female sex, being unmarried, being less educated, having lower household income, and being unemployed.

The world mental health data (Benjet, et al., 2016) indicated that over 70% of respondents reported exposure to a traumatic event with 30.5% reporting four or more traumas. The range reported across countries was wide from a low of 28.6% in Bulgaria to a high of 84.6% in Ukraine, although the interquartile range (IQR; 25th–75th percentiles) was narrow (60.7–76.2%) across countries. Five types of trauma-

witnessing death or serious injury, the unexpected death of a loved one, being mugged, being in a life-threatening automobile accident, and experiencing a life-threatening illness or injury - accounted for over half of all trauma exposures. Within this study PTSD rates in Northern Ireland were found to be in the higher range compared to many other countries (Bunting et. al, 2012).

There is a strong evidence that PTSD risk is significantly higher among individuals exposed to interpersonal violence (Breslau, et al 2004; Forbes et al, 2014).However Liu and colleagues (2017) reported that risk of PTSD was increased only for repeated physical assaults and in fact some types of prior trauma exposures are associated with increased resilience rather than increased vulnerability. These findings may be of particular relevance to the Northern Ireland population exposed to prolonged and repeated episodes of violence.

Caution has to be taken in interpreting epidemiological data. An example, is the analysis by Liu and colleagues of World Health Organization World Mental Health Survey. On first impression, respondents who were civilians in war zones or regions of terror had lower-than-mean Odds Ratios of meeting PTSD criteria compared to other forms of trauma. When the authors investigated the data it became more clear that many of the respondents were elderly respondents reporting about childhood experiences during World War II and had little direct exposure to trauma. In contrast, studies of refugees from more recent conflicts indicate that PTSD and other mental disorders tend to be highly prevalent in war refugees many years after the war experience and resettlement.

Other studies point to the capacity for resilience to develop after trauma exposure. Liu and colleague's review (2017) reported that prior participation in sectarian violence was associated with low levels of PTSD similar to other studies reporting low PTSD prevalence among policemen (Levy-Gigi et al., 2016) and other first responders43 and among Israeli settlers exposed to repeated bombings (Somer et al, 2009). Liu and colleagues suggest that such findings may be due to either selection and/or to prior exposures promoting resilience.

**Personal Social and Economic costs related to PTSD**

The societal and economic costs of PTSD internationally (Kessler et al, 2009; Kessler, 2009) and in Northern Ireland specifically (Ferry et al., 2015) have been well documented.

PTSD often leads to very serious interpersonal and occupational problems and has been estimated to result in 3.6 days of lost productivity per month (Kessler, 2000). The disorder is associated with increased risk of chronic disease (Boscarino, 2006), accelerated aging (Kubzansky et al. 2007) and accelerated ageing (Miller & Sadeh, 2014).

Bothe and colleagues (2020) examined several thousand claims data from a German research database in relation to direct and indirect costs for individuals with PTSD. Costs were analysed over a 5-year period from 2 years preceding until 3 years following a diagnosis of PTSD. Overall costs for PTSD were three times higher than costs for non-exposed controls and whilst 59% of these costs were related to mental disorders in general 18% specifically related to PTSD.

These high costs may relate to the pattern of onset, relapse and remission that accompanies PTSD, depression and other mental health conditions. Kessler et al (2017) report that war-related trauma is associated with a slower speed of PTSD-remission compared to other trauma types such as intimate partner violence, sexual violence or accidents in the first six years after traumatization, with war-related trauma victims being the subgroup with the least PTSD-remissions. Conversely at about six years after traumatization, this study reports a steep increase in PTSD-remission rates compared to other traumas. However, these findings indicate a major challenge for the TPDBS demonstrating that PTSD symptoms can remit but remission from PTSD at a certain point may not indicate complete recovery from the disorder. In a major review of PTSD remission rates, Morina and colleagues (2014) reported that PTSD tends to remit in only about half of individuals after a period of more than three years, and the prognosis deteriorates if PTSD is diagnosed later than five months following trauma. PTSD. This review suggests that spontaneous long-term permanent remission from PTSD is likely to be lower than reported average remission rates of 44.0%.

A similar question relates to major depressive disorder which typically presents with a relapse remission pattern over time

### *5.1.2 PTSD and Complex PTSD*

The ICD-11 introduces a new category of complex post-traumatic stress disorder (CPTSD) now defining PTSD and complex posttraumatic stress disorder (cPTSD) as separate disorders. The ICD 11 panel decided that the new criteria for cPTD more accurately represented the profiles of those who have experienced several, sustained or childhood and tend to have greater functional impairment than those with PTSD (Brewin et al., 2017; Karatzias et al., 2017).

Complex post-traumatic stress disorder (cPTSD) most typically follows severe stressors of a prolonged nature, or multiple or repeated adverse events from which escape is difficult or impossible, such as torture, slavery, genocide campaigns, prolonged domestic violence, or repeated childhood sexual or physical abuse. Individuals who have experienced complex trauma often have additional problems in their ability to self-regulate that are unrelated to this trauma, such as difficulties in emotional regulation, dissociative experiences, or somatic complaints (Briere & Scott, 2015; Cloitre et al, 2009; van der Kolk et al.,1996).

Given the recent introduction of the new ICD 11 criteria for PTSD and cPTSD as separate diagnostic categories, there a not yet an abundance of prevalence studies published. However, using the draft guidelines estimates in community and nationally representative samples for PTSD range from 2.3% to 3.0% whilst estimates for cPTSD range from 0.6% to 1.0% (Hyland et al., 2017; Wolf et al., 2015). Wolf and colleagues (2015) reported CPTSD prevalence estimates in a sample of veterans (13%) were double the rate of cPTSD in a community sample (0.6%).

Estimates of PTSD and cPTSD are substantially higher in clinical settings with prevalence rates of 7.8% to 37% for PTSD and 32.8% to 42.8% for CPTSD reported in trauma clinic samples (Hyland et al., 2017; Karatzias et al., 2016; Nickerson et al., 2016). In a nationwide representative German sample (N = 2524; 14-99 years), exposure to traumatic events and symptoms of PTSD, CPTSD and a lower threshold clinical variant of CPTSD were assessed with the International Trauma Questionnaire. One-month prevalence rates were as reported follows: PTSD, 1.5%; CPTSD, 0.5%; and CPTSD variant, 0.7%. In relation to PTSD, the highest rates were associated with kidnapping or rape, and the highest CPTSD rates were associated with sexual childhood abuse or rape. PTSD and CPTSD were best differentiated by sexual violence (Maercker et al., 2018). Interestingly, in a survey of non-institutionalized Irish adults (N = 1020) Hyland and colleagues (2021) reported

higher rates of both PTSD and cPTSD finding a past-month PTSD rate of 5.0% and 7.7% for CPTSD.

Dissociative symptoms are considered indicative of more complex PTSD. In the world mental health study dissociative symptoms were recorded in 14% of respondents and did not differ between high and low/middle income countries. Symptoms of PTSD dissociation were associated with high counts of re-experiencing symptoms, male sex, childhood onset of PTSD, high exposure to prior traumatic events and childhood adversities, prior histories of separation anxiety disorder and specific phobia, severe role impairment, and suicidality (Stein et al., 2013).

### *5.1.3 Prolonged Grief Disorder (PGD)/Persistent complex bereavement disorder (PCBD)*

There has been a debate about whether prolonged grief is a distinct diagnostic mental ill health category (Prigerson *et al.*, 2009; Strobe *et al.*, 2001). The authors of the fifth edition of the *Diagnostic and Statistical Manual for Mental Disorders* (DSM-5; APA, 2013) decided that the evidence was not yet sufficient to merit a formal diagnostic category but agreed that *prolonged complex bereavement disorder* is a condition for further study.

In ICD 11 however, a new diagnostic category of *Prolonged Grief Disorder* has also been accepted (WHO, 2012; Maercker *et al*., 2013a). The DSM-5 category (Prolonged and Complex Bereavement Disorder, PCBD) proposes a minimum of 12 months duration of symptoms whereas to meet the proposed ICD-11 diagnostic criteria, the symptoms need to persist beyond 6 months after the death. Amongst researchers and clinicians, there is ongoing debate about whether abnormal grief should be defined as prolonged (lasting for an extended period of time beyond the acute grief phrase) or complex (a deterioration of the symptoms experienced during acute grief reactions).

Prolonged grief disorder relates to abnormally persistent and disabling responses to bereavement that follows the death of a partner, parent, child or other person close to the bereaved. The response is a persistent and pervasive grief reaction characterized by yearning for the deceased or persistent preoccupation with the deceased, accompanied by intense emotional pain. Symptoms include intense sadness, guilt, anger, denial, blame, and difficulty accepting the death, feeling that the individual has lost a part of one's self, an inability to experience positive mood,

emotional numbness, and difficulty in engaging with social or other activities. The grief response must persist for an atypically long period of time following the loss (more than six months) and clearly exceed expected social, cultural or religious norms for the individual's culture and context.

Although most people report at least partial remission from the pain of acute grief by around six months following bereavement, those who continue experiencing severe grief reactions are more likely to experience significant impairment in their functioning. In studies, between 10% (Kersting et al, 2011) and 20% (Shear et al, 2011) of bereaved individuals experience complicated grief responses, a debilitating clinical condition) that causes clinically significant impairment in personal, family, social, educational, occupational or other important areas of functioning. (Boelen et al, 2007).

In a national study of psychiatric disorders across the life course Keyes and colleagues (2014) reported that 50.3% of respondents reported experiencing unexpected death of a loved one. Unexpected death was associated with heightened vulnerability for onset of all psychiatric disorders including major depression, PTSD, and panic disorder, and is particularly concentrated in older age groups for manic episodes, phobias, and alcohol use disorders. The most common lifetime mental disorder was alcohol use disorders (35.9%) and major depressive episode (23.7%), with mean age of onset 28.6 and 32.8 years, respectively.

A key challenge for the TPDBS is that a section of the population who arguably lost most during the recent NI conflict (the bereaved) do not readily fit into the eligibility criteria and this may be excluded from the scheme. The regulations only the bereaved to be eligible for the scheme if they can demonstrate that they were "present in the immediate aftermath of a Troubles-related incident in which a loved one died or suffered an injury"

One option may be to interpret the phrase "present in the immediate aftermath" to include presence for body identification purposes at a mortuary or seeing the loved one in hospital immediately after the traumatic event.

### *5.1.4 Depression*

Stressful life events, such as losing a job or a relationship ending, may trigger an episode of depression. Particularly stressful life events include death of a spouse, divorce and marital separation, redundancy and compulsory retirement. An excess of life events has been shown to occur in the three months prior to an episode of depression – and it has also been found that the risk of depression can increase six-fold in the six months after experiencing markedly threatening life events (Paykel, 1978).

Depression is one of the main mental health disorders that is associated with traumatic incidents. Hoppen and Morina (2019) accessed the Uppsala Conflict Database for all countries that suffered at least one war within their own territory between 1989 and 2015. The authors estimated that worldwide, approximately 354 million adult war survivors suffer from PTSD and/or Major Depression and specifically 117 million suffer from comorbid PTSD and Major Depression.

It is highly likely that many of the NI victims will suffer from co-morbid presentations of MDD and PTSD and this has been the pattern of victims treated in specialist trauma centres. In one randomised controlled trial (Duffy et al., 2007) high rates of co-morbid PTSD and depression were recorded and the levels of depression in this chronic sample were at the severe level.

These complex and co-morbid presentations will present a challenge for diagnosticians. Such chronicity and co-morbidity poses a question whether the emphasis in the TPDBS should be on attaining an accurate diagnosis or a more generic assessment of mental impairment and an associated deleterious impact on functioning.

In a review of prevalence of depression in children and adolescents after exposure to trauma Vibhakar and colleagues (2019) found that 24.2% of children and adolescents exposed to a traumatic event met criteria for depression and the risk of developing depression was 2.6 times greater for children and adolescents exposed to trauma as compared to those unexposed or less exposed. Participants exposed to interpersonal violence had a higher prevalence and level of depression compared with those exposed to non-inter personal violence traumas.

The above statistics are important given the large number of children and young people exposed to violence and traumatic scenes during the 30 plus year NI conflict.

### *5.1.5 Psychotic Illness*

It is still widely held that persons with schizophrenia and other psychotic illnesses are more or less impervious to their environment despite the growing literature suggesting otherwise (Van Os et al, 2010; Bentall and Varese, 2012; Howes and Murray, 2014). A high proportion of patients with a psychotic diagnosis have been exposed to traumatic experiences including sexual abuse and physical abuse (Varese et al, 2012; Read et al, 2014) but despite this, little is known about the impact of trauma on the clinical course of illness in such patients.

A series of studies have examined the impact of trauma exposure on individuals with a diagnosis of psychotic illness in the Northern Ireland setting. One study found higher rates of childhood trauma in patients with a diagnosis of schizophrenia, as compared to patients with a non-psychotic psychiatric diagnosis (Spence et al, 2006). Exposure to traumatic events related to the "Troubles" has been demonstrated to with increased levels of depression, anxiety, dissociative experiences and hospital admissions in patients with chronic schizophrenia (Mulholland et al, 2008). Further studies have demonstrated impacts on brain structure (Hoy et al, 2012) and neuropsychology (Shannon et al, 2011; Campbell et al, 2013) resulting from exposure to trauma in individuals with a diagnosis of schizophrenia. Similarly, a negative impact of exposure to trauma on outcomes in bipolar disorder has been shown (Maguire et al, 2013). These studies did not focus on “Troubles” related trauma but on trauma of all types, including Troubles related trauma.

Turkington and colleagues (2017) found a high rate of exposure to traumas related to the conflict in Northern Ireland in patients with psychosis. This finding suggests two possibilities: individuals who are prone to psychotic illness are also more likely to be independently exposed to political violence; or that political violence directly impacts on the onset and/or course of psychotic illness. In general, previous research suggests that psychological morbidity is more likely if a respondent had been individually and directly exposed to the “Troubles” (for example, witnessing a shooting or bombing incident in close proximity). Turkington’s findings are consistent with this. Turkington demonstrated that living in areas affected by the “Troubles” has no effect on outcome at three years (except that rates of substance misuse are significantly higher) but those who report a direct impact of the “Troubles” on their

lives have significantly worse outcomes at three years. Furthermore, exposure to the "Troubles" was associated with increased rates of positive psychotic symptoms which suggests that such exposure has a direct adverse effect on the course of psychotic illness itself.

Or alternatively it may be that exposure to political violence does not act as a causal factor in the inception of psychosis but contributes negatively to the course and outcome of psychotic illness. Living in areas affected by the "Troubles" and reporting a direct effect of the "Troubles" on life were both associated with significantly increased rates of substance misuse in those with a diagnosis of schizophrenia.

*Mental Impairment and Functioning*

As the diagnostic criteria for all mental health conditions require an assessment of impact on social functioning, a clinician must make a judgement that significant impairment has resulted from the disorder. This may have implications for a subsequent separate assessment process of disability and functioning.

### *5.1.6 PTSD and Chronic Pain*

The TPDPS addresses disability related to both physical and psychological effects of the Troubles. It is likely that this will be of relevance many victims, in particular those who experience enduring, chronic pain and psychological impairment.

### *5.1.7 Definition of chronic pain*

Chronic Pain (CP) is a complex multifactorial condition which has a myriad of implications not just for the patient as an individual but also for society as a whole.

The International Association for the Study of Pain defines pain as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" this pain becomes CP when it "persists or recurs for longer than 3 months" (IASP, 2011). Recent epidemiological analysis has estimated the prevalence of CP in the United Kingdom (UK) population to be 43.5% (Fayaz et al, 2016).

### *5.1.8 Chronic Pain and PTSD*

A proportion of victims of the recent Troubles have suffered from both psychological and physical problems as a consequence of violent attacks, beatings, shootings and explosions (Muldoon et al., 2005) and witnesses to traumatic incidents have reported with PTSD and chronic physical pain symptoms. Coupled with and complicated by Post Traumatic Stress Disorder (PTSD), these CP conditions prove particularly intractable and difficult for patients to endure.

A prior history of anxiety, physical and/or psychological insult and depression are significantly predictive of onset of chronic pain later in life (Nahit, et al, 2003). Asmundson and colleagues (2009) describe the role that anxiety and fear avoidance play in the development and maintenance of chronic pain. Depression is also a feature of chronic pain with a reported incidence of 32-54%. If mood is altered there is an increase in fear avoidance with an increase in reported pain (Kind & Otis, 2019).

PTSD or PTSD related symptoms can interfere with physical and /or emotional functioning. 3.5%-4.7% of people in the US experience PTSD each year (Goldstein et al, 2016). The rates of PTSD in chronic pain patients varies from 9-50% depending on the setting, population and the type of pain reported (Fishbain, et al, 2017). People reporting pain and PTSD exhibit much greater PTSD symptoms, pain, anxiety, depression and disability and are more likely to be a heavy user of pain medications (Jenewin, et al, 2018). Another feature of chronic pain is catastrophizing (Vlaeyen & Linton, 2000) and this is considered a risk factor for PTSD. Returning US veterans (Alschuler & Otis, 2012) with PTSD show poor pain control and emotions and catastrophizing have a greater influence on their pain.

In clinical practice an interaction has been well documented between physical and psychological conditions. As an example; a patient may awaken in the morning, experience mild chronic pain linked to a shrapnel injury, in turn the pain induces an intrusion/flashback to the scene of the trauma so the patient is now back in the trauma memory and now re-experiences the intense pain sensation felt at the time of the index trauma. Such reciprocal interactions have been reported in NI pain clinics with patients who have been victims of the NI Troubles and will present challenges for those deciding upon the primary condition in order to assess disabling effects and impairment of functioning.

### *5.1.8 Addictions*

One of the most common coping mechanisms use suppress the distressing symptoms of mental ill health including PTSD and related disorders is alcohol and drug use/abuse.

In a nationwide USA study Grant and colleagues (2004) reported positive and significant associations between alcohol and drug use disorders and all mood and anxiety disorders.

In a large Danish study of 463,003 psychiatric patients (Toftdahl et al, 2016) the prevalence of any lifetime Substance Use Disorder (SUD) was: 37 % for schizophrenia, 35 % for schizotypal disorder, 28 % for other psychoses, 32 % for bipolar disorder, 25 % for depression, 25 % for anxiety, 11 % for OCD, 17% for PTSD, and 46 % for personality disorders. Alcohol use disorder was the most dominating SUD in every psychiatric category (25 % of all included patients). Patients with SUDs were more often men, had fewer years of formal education, more often received disability pension and died due to unnatural causes.

In a large study of adults who had experienced childhood traumas (Khoury, et al., 2010) high rates of lifetime dependence on various substances were found (39% alcohol, 34.1% cocaine, 6.2% heroin/opiates, and 44.8% marijuana). The level of substance use, particularly cocaine, strongly correlated with levels of childhood physical, sexual, and emotional abuse as well as current PTSD symptoms.

The effects of alcohol and drug abuse are devastating. The World Health Organization (WHO) rates alcohol as the third biggest global risk for burden of disease (WHO,2009)and it is a causal factor in a large range of medical conditions, including: mouth, throat, stomach, liver and breast cancers; high blood pressure, cirrhosis of the liver, and depression.

In 2018, Northern Ireland had recorded the second-highest alcohol related mortality rate of the four UK nations (16 per 100,000) after Scotland (20.5), with England (10.7) the lowest (Russell, 2020). The 2009 estimates of alcohol related costs were reported as: £171 million of direct health and social care costs; £224 million for fire and rescue and police service costs; £84 million for courts and prisons; and £202 million of costs to the wider economy. This latter figure includes the costs of

absenteeism at work, plus unemployment and premature mortality due to alcohol - related conditions (DHSSPS, 2010).

An important part of the TPDBS assessment protocol will be to attempt to ascertain how any presenting alcohol or drugs addictive behaviours commenced as unhelpful coping strategies to deal with Troubles related traumas.

## *5.2 Clinical Approaches to Stress Related Disorders – an historical perspective*

Post-Traumatic Stress Disorder (PTSD) emerged as a diagnostic category in the 1970's coinciding with the growth of the civil rights, women's rights, and anti-war movements, particularly in the USA. An increased social awareness and clinical understanding of the profound psychological effects of abuse such as rape on children and women accompanied the highly publicised accounts of the Vietnam War veterans about the traumatic effects of war. In this sense, the emergence of PTSD as a concept was influenced by socio-political processes. Post-traumatic stress disorder was introduced as a diagnostic category in DSM– III (American Psychiatric Association, 1980), recognising that traumatic events such as combat, rape and man-made or natural disasters can produce a specific cluster of psychological symptoms. Northern Ireland has some of the highest rates of PTSD anywhere in the world, with some 8.8% of the adult population estimated to have PTSD at some point in their life (Mental Health Foundation, 2016).

Prior to the introduction of PTSD as a diagnostic category, victims of the NI conflict were diagnosed with other forms of mental ill health. In one study of 100 patients affected by the "Troubles" Lyons (1974) reported that 92% experienced serious affective disturbance with phobic reactions, especially agoraphobia and exaggerated startle response., These behaviours may well have represented symptoms of a Post Trauma Stress Disorder. In a later large study of victims of explosions, (n = 1,532) undertaken during the same period before PTSD was officially recognized, Hadden and colleagues (1978) found that 50% of participants had suffered from "emotional shock".

In recent years, access to evidence based psychological services has improved in comparison to the early decades of the Troubles when there was a lack of policy and

service provision for those in need (Cairns & Wilson, 1984; Dillenburger et al, 2007; 2008; Ferry et al., 2008; Park, 1998). In the past, this lack of a standard service model has meant that many victims and survivors and their families did not receive the necessary help and support to aid recovery. In 2003 the Northern Ireland DHSS Clinical Resource Support Team (CREST) produced guidelines for the management of PTSD in adults (CREST, 2003) and produced recommendations similar to those published by UK NICE expert panel two years later (NICE, 2005).

Prior to the development of more specified diagnostic categories such as PTSD and PGD it was not possible to develop disorder specific psychological therapies for these conditions. Therefore, pharmacological therapies were mostly used to treat trauma related mental ill health in the early stages of the Troubles. King et al. (1982) found that significantly more tranquilizers were prescribed in Northern Ireland compared to the rest of the U.K. During the period immediately preceding the recent conflict, between the years 1966 -1969, King and his colleagues (1982) reported an annual 20% increase in prescriptions of tranquilisers, yet interestingly, the rate dropped to 10% between the years 1969-1972 during a peak period in the Troubles. In an earlier paper Fraser (1971) reported a detailed study of drug prescribing rates in Belfast during the same peak period of the conflict and found a significant increase in the prescription of tranquillizers within the areas of high conflict, with a wide variance ranging from 26% - 135% between GP practices. There has been conflicting evidence regarding prescribing rates in Northern Ireland. In the 1970s hypnotic prescribing (Elmes et al 1976) and antidepressant prescribing (King et al, 1977) were shown to be lower in the Northern Ireland than in the rest of the UK but by 1982 King was describing a situation where “benzodiazepine tranquillizer prescribing was consistently 20-30% higher than in the rest of the UK, in contrast to hypnotic and antidepressant prescribing which has been consistently lower”. Recent reports suggest that Northern Ireland has one of the world's highest prescription rates for anti-depressants (The Detail 17th Nov 2014).

International studies have recorded that treatment seeking by those with PTSD is problematic. In high-income countries only half seek and receive treatment (53.5%) and the proportion is even lower in low-lower middle income (22.8%) and upper-middle income (28.7%) countries (Koenan et al., 2017). This may prove to be a challenge in relation to victims of the NI conflict and a large number of victims may not have been accurately diagnosed or treated.

Many factors such as: social withdrawal due to level of community violence; lack of differential diagnostic criteria; lack of specialist treatment centres; over-reliance on primary care services suggest that a proportion of victims will either have been under diagnosed, misdiagnosed or received a non-specific generic diagnosis at primary

care level and thereafter have been treated on a long term basis with pharmacological therapies. Several studies have recorded that Northern Ireland has substantially higher rates of prescribed psychotropic medications compared to elsewhere in the UK (King et al., 1982; Benson et al., 2015). Mental health clinicians and researchers have proposed that this pattern of drug use is quite likely to be at least partly attributable to a legacy effect of the Troubles.

## 5.3 Permanence in Mental Health Disorders

Research on mental illness demonstrates that they can be chronic, and in some cases permanent. This is true for some of the most common disorders such as depression, anxiety, post-traumatic stress disorder and schizophrenia. Mental illnesses are the leading cause for permanent disability. Behrens-Wittenberg and Wedegaertner (2020) outlined that older age, inadequate income, and previous disabilities are all factors that contribute to a mental health disorder becoming permanent. Relating specifically to Post Traumatic Stress Disorder, the average duration of PTSD is 3 to 5 years, with many patients experiencing PTSD for more than 10 years (Kessler et al., 1995). PTSD usually begins right after the traumatic event, but it can also be delayed for many years (Hamblen, 2009). Those who suffer from permanent mental health disorders may not show alarming symptoms at all times, but present in a wave like pattern over extended periods of time.

Measuring days on work leave and early retirement from work is often an adequate way of assessing permanence in mental health disorders but would not work well for this particular scheme. Instead, previous disability schemes have shown that assessing permanence should be done by describing permanent where following appropriate clinical management of adequate duration; 1) an injury has reached steady or stable state at maximum medical/clinical improvement, 2) no further improvement is expected.

## *5.4 Assessment Methods*

There are several ways to assess mental health disability. Clinical assessment and diagnosis using an internationally recognised manual such as the DSM is extremely valid and has high levels of reliability. Multiple surveys have shown that DSM-defined PTSD is diagnosable in diverse cultures around the world using several types of clinical interviews (Hinton and Lewis-Fernandez, 2011).

Self-report measures have been developed to identify a range of mental disorders including PTSD (e.g., Blanchard et al., 1996; Dobie et al., 2002; Foa et al, 1997) anxiety (Beck Anxiety Inventory (BAI, Steer et al., 1993) and depression (Beck Depression Inventory (BDI, Beck and Steer, 1993). Specifically, in relation to PTSD a number of self-report measures are used to assess individuals for symptoms of PTSD including: Impact of Events Scale (IES) (Horowitz et al., 1979); the PCL5 (Blevins et al, 2015) the posttraumatic diagnostic scale (PDS) (Foa et al. 1997). Such self-report measures for PTSD are commonly used in clinical trials (for example, Duffy et al, 2007; Ehlers et al, 2003).

Self-report measures have been widely used in clinical trials and have been shown to have high levels of reliability and validity in clinical trials for post-traumatic stress disorder (Ehlers et al, 2003; Ehlers et al, 2005) and in trials for other anxiety disorders (Clark et al, 1994; Clark et al, 2005). In such studies results from independent assessor ratings and self-report scores have been similar.

Clinicians and researchers commonly use a range of self-report questionnaires in routine clinical practice (Conybeare et al, 2012), including the GAD-7(Kroenke at el, 2007) (a measurement of anxiety) and the PHQ-9 (Kroenke et al, 2001) (a measurement for depression). These are now standard measures and are often used by GP's, therapists and psychiatrists as screening tools and have been proven to be reliable indicators of the primary disorder, symptom severity and recovery. Such measures are used to great effect to monitor rates of recovery in the IAPT programme in England *(https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-iapt-pathway-for-people-with-long-term-physical-health-conditions-and-medically-unexplained-symptoms/)*.

Similarly self-report measures allow for the assessment of the disabling effect of conditions such as PTSD. For example, the Sheehan Disability Scale (SDS) (Leon et al., 1997). The SDS has been shown to be a highly reliable and functional scale that records work and family related recovery (Connor and Davidson, 2001).

The literature suggests that self-report and clinical assessments can complement each other to assess mental health disability in a reliable, valid and functional way. The PCL 5 (Blevins et al, 2015) and the accompanying guidelines provide a useful example of how a self-report measure can be used effectively alongside clinical assessments. The PCL 5 is a 20-item self-report measure that assesses the presence and severity of PTSD symptoms using *DSM-5* criteria for PTSD and has been designed for 3 main purposes: screening individuals for PTSD; quantifying and

monitoring symptoms over time; making a **provisional** diagnosis of PTSD. The authors of the instrument state that “the PCL-5 should not be used as a stand-alone diagnostic tool… and the clinician will still need to use clinical interviewing skills, and a recommended structured interview (e.g., Clinician-Administered PTSD Scale for *DSM-5*, CAPS-5) to determine: whether the symptoms meet criteria for PTSD by causing clinically significant distress or impairment, and whether those symptoms are not better explained by or attributed to other conditions”.

## 5.5 Re-traumatisation

Many researchers, Institutional Review Boards, policymakers and others have raised questions about the impact of trauma-research participation on research participants' well-being. Whilst it is correct to consider potential negative effects of re-visiting past traumatic events there is little evidence to suggest that such research or examination of past traumas will have a substantial or enduring negative effect.

A review of studies in this area by Legerski and Bunnell (2010) found that only a minority of participants experience distress when participating in trauma-focused research. Furthermore, these negative feelings tend to dissipate quickly over time, with the majority of participants self-appraising their participation as positive, rewarding, and beneficial to society.

Another review by Jaffe and colleagues (2015) found that trauma-related research can lead to some immediate, low-to-moderate distress but participants generally find their involvement in trauma research to be a positive experience. The review group concluded that asking individuals about prior trauma represents a rather minimal risk to adult participants, including those who have been victimized or diagnosed with PTSD.

A review by Carlson and colleagues (2003) relating to childhood physical and sexual assault experiences of psychiatric inpatients reported that 70% experienced relatively low levels of distress, and 51% found participation to be useful in some way.

Finally, Griffin and colleagues (2003) reviewed participant reactions to different trauma assessment procedures in domestic violence (N = 260), rape (N = 108), and physical assault (N = 62) samples. Results indicated that participation was very well

tolerated by the vast majority of the trauma survivors. Participants generally found that the assessment experience was not distressing and was, in fact, viewed as an interesting and valuable experience.

### *5.6 Summary: Learning from the Clinical Literature*

There are specific learnings from the clinical literature:

1. Post-traumatic stress disorder (PTSD), complex post-traumatic stress disorder (cPTSD) and prolonged grief disorder (PGD)/persistent complex bereavement disorder (PCBD) are defined by the presence of a significant traumatic incident. Other psychiatric conditions may be related to a traumatic event including other anxiety disorders, depression and psychotic illnesses.
2. These disorders may manifest separately or in combination (co-morbidity), including in combination with physical health problems.
3. In recent years, access to evidence based psychological services has improved in comparison to the early decades of the Troubles when there was a lack of service provision for those in need. This lack of a standard service model has meant that many victims and survivors and their families did not receive the necessary help and support to aid recovery.
4. International studies record a low uptake of treatment by those suffering from PTSD, therefore it is likely that a substantial number of Troubles victims will never have received a diagnosis nor treatment, especially as specialist trauma services did not exist until the latter part of the Troubles
5. Prior to the development of more specified diagnostic categories such as PTSD and PGD it was not possible to develop disorder specific psychological therapies for these conditions. Therefore, pharmacological therapies were mostly used to treat trauma related mental ill health in the early stages of the Troubles. “Appropriate treatment” with reference to permanence must be considered in the era in which it was received.
6. Mental illness is often chronic, and in some cases permanent. Mental illnesses are the leading cause for permanent disability.
7. There are a number of ways in which mental health conditions might be assessed, including use of self-report measures, clinical assessment by non-medical assessors, and medical assessment. Each has its strengths and weaknesses. Disablement assessment is a scope of practice in itself and does not often use standardised measures.
8. Whilst there are reasonable concerns regarding the impact of asking about trauma on well-being there is little evidence to suggest that such examination of past traumas will have a substantial or enduring negative effect.

## 6. Decision-Making with regards to the TPDPS

The Regulations set out that a person is entitled to a victims' payment in defined circumstances:

*5. (1) A person is entitled to victims' payments in respect of* ***injury caused by a Troubles-related incident*** *if (a) the injury results in* ***permanent disablement*** *and (b) the assessed degree of relevant disablement amounts to* ***not less than 14 percent***

The injury may be either physical or psychological. The focus in this review is on psychological injuries but in all places the question of physical injury should be taken as read.

From a clinical perspective there are a series of key decisions which derive from Regulation 5 (1):

### 6.1 Step One: A person must have been impacted by a Troubles-related incident.

For purposes of the Scheme, it is necessary for a decision to be reached regarding proximity to a Troubles related event. This decision will be reached by staff employed by the VPB.

This will be relatively easy to determine in many circumstances but in others will be less than straight-forward. Determining a person's proximity to a traumatic event is often key in clinical decision making and is usually accepted on the basis of a personal account in a clinical context. Where proximity is considered clinically, this will be to contextualise clinical decision making and will not be for the purposes of eligibility to the scheme.

Note on the question of eligibility

A more fundamental problem may arise with regards to entitlement. In the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5; American

Psychological Association [APA], 2013), psychological trauma is defined as exposure to actual or threatened death, serious injury, or sexual violence. Exposure may occur in one or more ways: directly experiencing the event; witnessing the traumatic event in person; learning that the event happened to a close person; or experiencing first-hand repeated or extreme exposure to aversive details of the traumatic event (APA, 2013).

T*he Regulations specify:*

*7.(1) For the purpose of these Regulations, a person's injury may only be considered to be caused by a Troubles-related incident if it is suffered by that person when (a)* ***present at a Troubles-related incident****; (b )****present in the immediate aftermath of a Troubles-related incident in which a loved one died or suffered an injury****; (c)* ***responding****, in the course of employment, to a Troubles-related incident, in which the person reasonably believed a loved one had died or suffered significant injury.*

*(2) In this regulation "employment" includes service of the Crown; "immediate aftermath" includes any time when a loved one is in the same condition as they would have been at the scene of the Troubles-related incident; "loved one" means another person with whom a person has a close relationship of love and affection, and such a relationship will be presumed to exist between (a) two people who are married to each other, or are civil partners, or live together as husband and wife or as if they were civil partners, and (b) a parent and child; "responding to a relevant incident" includes preventing, mitigating, or otherwise addressing the incident.*

Clinicians work to criteria such as the DSM 5 and it is possible that discrepancies will arise between clinical opinion and the interpretationof the regulations. For example, some applicants will have been bereaved as a consequence of the Troubles but will not have been present at the scene of death. For the purpose of the Regulations, a person's injury may only be considered to be caused by a Troubles-related incident if it is suffered by that person when the person "was *present in the immediate aftermath of a Troubles-related incident in which a loved one died or suffered an injury".* A broad definition of the meaning of "*present in the immediate aftermath*" to include for example presence at a mortuary or hospital for identification of the body would assist in the delivery of the scheme globally. This is not however a critical consideration when specifically designing the disablement assessment process.

### *6.2 The Troubles Event must amount to a significant trauma*

Determining whether a person has suffered a psychological injury depends on identifying a **significant** psychological trauma, or traumas, in the person's personal history. Thus, it is not sufficient to clarify if a person has been in the proximity of a Troubles-related event, it must also be determined that the event amounts to a significant trauma. For the purposes of the assessment process this will necessarily be a clinical decision and it is currently envisaged that this will be determined by a consultant psychiatrist or clinical psychologist.

### *6.3 A physical or psychological injury must have been caused*

For a successful application an injury must have resulted in a physical or psychological injury. A psychological injury (also called a psychiatric injury) is a concept with both legal and medical meanings. It equates to **the development of a mental health problem** (a psychological or psychiatric condition) after a traumatic event or series of events. Legally, psychological injury is considered mental harm, suffering, damage, impairment, or dysfunction caused to a person as a direct result of some action or failure to act by some individual. The psychological injury must reach a degree of disturbance of the pre-existing psychological/ psychiatric state such that it **interferes in some significant way with the individual's ability to function**. An impairment, disorder, or disability results, perhaps as an exacerbation of a pre-existing condition. Whilst identifying the injury will form part of the diagnostic process, determining the functional effect of this will be assessed as part of the disablement assessment.

### *6.4 Did a diagnosable condition result from the traumatic incident?*

In order to determine if a psychological injury has occurred it is often (but not always) necessary to reach a diagnosis. Normally a psychiatrist performs a clinical assessment to reach a diagnosis of a psychiatric disorder, as set out in two specific medical classification systems: the DSM-V: Diagnostic and Statistical Manual of Mental Disorders, of the American Psychiatric Association and the International Classification of Diseases (ICD-11) of the World Health Organization.

Psychiatrists reach a standardised diagnosis, based on a clear assessment of signs and symptoms, based on assessing psychological processes. Signs are generally abnormalities which are visible to an observer (such as marked weight loss) and

symptoms are what a person complains of (for example, sadness). When symptoms and signs are recognised, they are then grouped together to make a particular diagnosis.

For the purposes of the Scheme the President has indicated that a diagnosis must be provided by a consultant psychiatrist or a consultant clinical psychologist. The applicant may be able to provide evidence of an already established diagnosis, but when this is not possible the process must allow for an assessment and the provision of a diagnosis. As Capita cannot engage in any diagnostic process this will require the establishment of a separate process under the auspices of the VPB.

### *6.4.1* ***Alternatives to a Consultant Diagnosis I: Self-report scales***

In order to determine if a psychological injury has occurred it is usually thought necessary to reach a diagnosis, but an assessment of presence and severity of symptoms suffices in certain circumstances.

For example, the use of self-report scales is sometimes helpful. The 17-item PTSD Checklist – Civilian Version (PCL-C; Weathers et al., 1994) is a self-completion questionnaire of key PTSD symptoms. The PCL-C scale items are totalled (possible range of scores: 17-85, with higher scores indicating greater severity of PTSD). A threshold of 45 and over on the total scale score establishes the presence of PTSD symptoms: this approach is recommended by the VA National Center for PTSD for use within settings such as specialty mental health clinics (based on 'Using the PTSD Checklist [PCL]' provided by the VA National Center for PTSD: www.ptsd.va.gov; last accessed 17th January, 2020). The PCL-C is a screening measure, and a full clinical assessment is useful to confirm a diagnosis. The application of rigorous assessment processes would confirm that many but not all of those individuals who scored 45 or greater on the PCL-C would meet diagnostic criteria for PTSD. The PCL-C tends to over-estimate PTSD (Wilkins et al., 2011), though the risk of this occurring is minimised by using a high threshold.

There is good evidence to support this approach. This would not result a "diagnosis" per se, but rather a "symptom profile indicative of diagnosis". This equates to normal clinical practice. Many individuals who are referred to mental health services will never meet a psychiatrist and thus never receive a formal diagnosis. Treatment proceeds on the basis of an assumed diagnosis. A psychiatrist is available to provide a diagnosis when necessary. The meaning of the Regulations and the relevance of

the Hoy Decision will need to be taken into consideration and may preclude this option.

### *6.4.2* ***Alternatives to a Consultant Diagnosis II: Use of structured interview approaches by non-psychiatrists***

Self-report measures and structured assessments by mental health professionals have previously been implemented in an Omagh based research study with a sample probably similar to the older population who may apply to the Scheme. In the study many patients were chronically ill: some were treated up to 33 years after the initial trauma (median 6 years). A high proportion had experienced multiple traumas (59% had experienced more than two traumas), half had failed other treatments and many had high levels of concurrent depression. All referrals (n=60) were assessed for psychiatric disorders using the SCID (semi-structured clinical interview for the Diagnostic and Statistical Manual of Mental Disorders) (DSM-IV) (First et al, 1995) and the clinician administered post-traumatic stress disorder scale for DSM-IV. Primary outcome measures were severity of post-traumatic stress disorder, assessed by the post-traumatic stress diagnostic scale (Foa et al, 1997) and severity of depression, assessed by the Beck depression inventory (Beck et al, 1996). The secondary outcome measure was the Sheehan disability scale (Sheehan, 1983).

The assessments in the Omagh Centre were undertaken by five therapists (one psychiatrist, one social worker and three nurse therapists) under the supervision of a Consultant Psychiatrist using semi-structured interviews after self-report measures were completed by patients. All staff were trained to a satisfactory level of diagnostic assessment by the American authors of the SCID linked to DSM. All sessions were video recorded and assessed by senior clinicians for inter-rater reliability. The self-report scores mapped accurately onto the structured assessments and the staff assessments were confirmed by senior clinicians' observations of session video recordings. Whilst it could have been argued that many of these very chronic patients (many were on disability benefits) had a motivation to "over-report" and retain a PTSD diagnosis by resisting recovery the results proved otherwise (Duffy et al., 2007).

A disorder does not necessarily constitute a psychological injury in itself of course. For psychological injury to be proven, there are several factors that need to be considered. The psychological injury must reach a degree of disturbance of the pre-

existing psychological/ psychiatric state such that it **interferes in some significant way with the individual's ability to function**.

Both of the above clinical suggestions need to be considered in the context of the Regulations for the scheme as consideration of such approaches is within the scope of this document and research phase of assessment development.

### *6.5 Determining "Permanence" of Mental Health Conditions: "Appropriate Clinical Management of Adequate Duration"*

Permanence is not a widely used concept in clinical practice whilst chronicity is widely used (acute versus chronic conditions). Persistence is a broadly similar concept. The term "severe" does not appear in the regulations but does appear in the Stormont House Agreement, and has utility with regards to concept of permanent disablement (a less than severe condition will not result in permanency).

Central to the definition of permanence in the Regulations is a determination that a person has received appropriate treatment of an adequate duration, and that after this treatment no further improvement can be expected:

Article 5 (7) (a) - *Functional limitation or restriction is "permanent" where following appropriate clinical management of recommended duration, an injury has reached steady or stable state at maximum medical improvement; and no further improvement is expected".*

This is a very difficult aspect of Regulations-clinically, legally and politically. As outlined above what was seen as appropriate in the 1970s or 1980s would not be seen as appropriate treatment today. In any case often treatment was simply not available or was not sought (for good reasons). For many victims it can reasonably be argued that it is now "too late". A creative and generous approach to the interpretation of regulations is important.

For example, if appropriate clinical management is taken to mean:

“received or sought appropriate clinical management”

or “unable to access appropriate clinical management due to factors beyond applicant’s control”.

Furthermore, we recommend that “appropriate” is taken to mean “accepted as appropriate at the time by a reasonable body of clinical opinion”

Further treatment at the time of assessment ought only to be recommended if there is a probability of significant improvement with no undue distress caused to the applicant by the initiating of such treatment. Recommendation of treatment is outside the scope of disablement assessment professionals.

### *6.6 The injury must result in permanent disablement*

Making the decision that a permanent disablement is present requires an assessment of functional capacity / disablement. It is also necessary to consider what is meant by disablement.

In clinical context mental health conditions often result in a significant negative impact on activities of daily living; and/or inter-personal relationships/social and occupational functioning, and on quality of life.

The Regulations comment in detail on the question of assessment of disablement (excerpts below):

*SCHEDULE 2 Regulation 15(8) Assessment of disablement*

*Assessment of degree of disablement 1.*

*(1) The degree of the disablement caused by a relevant incident is assessed by making **a comparison** between the condition of (a) the person so disabled, and (b) an average, healthy person of the same age and sex who is not*

*disabled. (2) In making the comparison in accordance with sub-paragraph (1), the following must not be taken into account (a) the earning capacity of the person so disabled in the person's trade or occupation or any other trade or occupation, and (b) the effect of any individual factors or extraneous circumstances. (3) Where disablement is caused by more than one relevant incident,* ***a composite assessment*** *of the degree of disablement is to be made by reference to the combined effect of all such incidents.*

With regards to the degree of disablement:

*3.(1) The assessed degree of disablement* ***must be expressed as a percentage****. (2) Subject to paragraph (3), if the assessed degree of disablement is a percentage between 0 and 100 which is not a multiple of 10, it is to be treated (a) if it is a multiple of 5, as being the next higher percentage which is a multiple of 10, and (b) if it is not a multiple of 5, as being the nearest percentage which is a multiple of 10. (3) Where the assessed degree of disablement is less than 20 percent, but not less than 14 percent, it is to be treated as 20 percent.*

The case described below addresses some of these issues but also explores the potential utility of the Global Assessment of Function (GAF) and the World Health Organisation Disability Assessment Schedule (WHODAS 2.0), both of which require further analysis and discussion.

### *7. Case example*

*A 75-year-old woman whose son was shot dead at her front door 35 years ago applies to the Scheme. She has not worked since the day of her son's death. She has seen her GP intermittently over the three decades and has been prescribed antidepressants since that time. She has never been referred to mental health services or been in contact with any of the relevant community or voluntary sector groups. In her application she states that she is troubled by "depression" and that she has "never gotten over" her son's death. Her GP notes are sparse and intermittent, merely noted that she is "upset", "tearful", "anxious" and "depressed" on multiple occasions. She has been prescribed four different antidepressants over the years. She was referred for "counselling" on two separate occasions but did not attend appointments when offered.*

The papers are evaluated. Proximity is not an issue-she witnessed her son's death and there is no doubt that his death was Troubles-related incident. The records from primary care are not very informative. A diagnosis is provided ("depression") but it has not been made by a consultant psychiatrist or a consultant clinical psychologist.

As it is not possible to extract any further information from the papers it is decided to request an assessment from a consultant psychiatrist.

The psychiatrist is made aware of the Regulations-*A person is entitled to victims'* payments in respect of injury caused by a *Troubles-related incident if (a) the injury results in permanent disablement and (b) the assessed degree of relevant disablement amounts to not less than 14 percent*-and is asked specifically to **determine** the diagnosis, and to **comment on** the questions of permanence and impact on functioning (which equates to "capacity" in the Regulations).

### *7.1 Determining whether injury caused by a Troubles-related incident has resulted in permanent disablement:*

To illustrate the way in which 1) diagnosis 2) severity 3) persistence and 4) impact on function might be determined, and thus permanent disablement determined, the diagnosis of depression is considered below:

### *7.2 Making the Diagnosis*

Depression is a heterogeneous condition broadly referring to the absence of a positive affect and a range of associated emotional, cognitive, physical and behavioural symptoms. The severity and type of symptoms can vary widely between individuals and can change over time.

There are a range of possible diagnoses available to a psychiatrist after the completion of an assessment, and contained within the two established diagnostic systems, DSM 11 and DSM 5.

There are two diagnoses which a psychiatrist might reach in this case which would mean that the applicant is eligible for further consideration under the Scheme.

**Major depressive disorder (MDD)**: this disorder involves repeated depressive episodes. During these episodes, the person experiences depressed mood, and/or loss of interest and enjoyment, and a number of other symptoms which may include reduced energy, anxiety symptoms, disturbed sleep and appetite, diminished activity and feelings of guilt or low self-worth and poor concentration. These symptoms must have been present for at least two weeks (for each episode).

Depending on the number and severity of symptoms, a depressive episode can be categorized as mild, moderate or severe. An individual with a mild depressive episode will have some difficulty in continuing with ordinary work and social activities but will probably not cease to function completely. During a severe depressive episode, it is unlikely that the sufferer will be able to continue with social, work or domestic activities, except to a limited extent.

In recurrent major depressive disorder, there are multiple episodes which meet the above criteria.

In DSM-IV there was a useful concept known as **chronic major depressive disorder** (MDD that lasts two years or more). DSM 5 has combined dysthymia (mild, lingering depression not as severe as MDD) and chronic major depressive disorder (MDD that lasts two years or more) into one condition called **persistent depressive disorder (PDD)**. This long-term form of depression lasts two years at minimum.

The criteria for DSM-5 Persistent Depressive Disorder (Dysthymia) 300.4 (F34.1) are as follows:

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, **for at least 2 years.**

B. Presence, while depressed, of two (or more) of the following:

1. Poor appetite or overeating.

2. Insomnia or hypersomnia.

3. Low energy or fatigue.

4. Low self-esteem.

5. Poor concentration or difficulty making decisions.

6. Feelings of hopelessness.

C. During the 2-year period of the disturbance, **the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time**.

D. **Criteria for a major depressive disorder may be continuously present for 2 years.**

H. The symptoms cause **clinically significant distress or impairment in social, occupational, or other important areas of functioning**.

It is still the case that there are forms of chronic depression which are not mild to moderate but are rather moderate to severe in intensity and impact significantly on functioning. Research shows that compared to MDD, PDD causes more functional impairment and is more likely to be accompanied by other psychiatric conditions such as anxiety disorder, and it is more likely that patients will report childhood trauma or a family history of mood disorders.

This Victim would meet criteria for either **Recurrent Major Depressive Disorder** or **Persistent Depressive Disorder.** If the psychiatrist considered that this disorder was **related to the Troubles-related event** the applicant is possibly eligible for the Scheme.

### *7.3 Permanence I: Severity*

Depression can be classified when being diagnosed as mild, moderate or severe. The thresholds for these forms differ between the International Statistical Classification of Diseases (ICD) and The Diagnostic and Statistical Manual of Mental Disorders (DSM) but are broadly similar.

According to NICE guidelines:

- Mild depression is when a person has a small number of symptoms that have a limited effect on their daily life.

- Moderate depression is when a person has more symptoms that can make their daily life much more difficult than usual.

- Severe depression is when a person has many symptoms that can make their daily life extremely difficult.

To meet criteria for the Scheme the person should be troubled by a moderate to severe illness. Thus, for **Recurrent Depressive Disorder there should be more than one moderate-to-severe episode of depression** (determined both by symptom profile and the impact on functioning). For Persistent Depressive Disorder (PDD) the symptom profile should be consistently moderate to severe.

### *7.4 Permanence II: long-lasting forms of depression*

Some people with depression have ongoing symptoms that never fully subside. There are two groups that this applies to:

**Chronic major depression.** Patients with chronic major depression continually meet the full criteria for a major depressive episode for at least two years. This situation is common. About 20% of patients who develop major depression have not recovered in two years, while 12% have not recovered after five years. Some depressed people experience severe chronic symptoms every day for years-they don't get back to "normal" in between depressive episodes.

**Partial recovery.** Some patients continue to experience subthreshold symptoms after treatment for major depression, or relapse within two months. Residual symptoms remaining or occurring less than two years after an episode of major depression is thought of as a major depressive episode in partial remission.

As noted above the DSM 5 concept of persistent depressive disorder (PDD) allows for a diagnosis of long-term, chronic depression.

In this case the applicant is determined to meet criteria for PDD of at least moderate severity for ten months or more of every year since the death of her son.

### 7.5 Permanence: Appropriate Treatment

Antidepressants have been an accepted treatment for depression since the early 1960s. Until relatively recently psychological treatments were not widely available. Whilst antidepressants may sometimes have been prescribed at too low a dose or for too short a period, in general many or most individuals who developed a depressive illness after a Troubles-related illness will have received appropriate treatment. Because chronic depression lasts longer and tends to be more severe than episodic depression, treatment is often more intensive.

In this case the psychiatrist reviews the patient's GP notes and confirms the treatments received in the interview. The psychiatrist determines that appropriate treatment has been received.

### 7.6 Level of Functioning

The psychiatrist is asked to comment on the patient's level of functioning. Functional ability is part of diagnostic criteria and so it is relevant to explore this in more detail, however no percentage and standardised score is requested as it is the scope of the disability assessment professional to determine the level of disablement.

### 7.7 Result of Assessment

The psychiatrist d*etermines that a Troubles-related incident has resulted in a permanent mental health condition (diagnosis), namely PDD, and has commented on current and recent levels of functioning.*

The Disablement assessment professional then completes a disablement assessment and determines the overall disablement attributable to the TRI, confirms the level of permanent disablement after taking in to account other causes.

# 8 Further standardised Disablement assessment scales.

The social security regulations (1982) do not standardise assessment of psychiatric conditions. Other schemes that utilise the same regulations (IIDB) have not attempted to standardise the assessment of such conditions with respect to the 'benchmarking' mandated between the scheduled physical injuries described, and none-scheduled injuries, including those of a psychiatric nature. Two such scales have been reviewed in light of this and are described in this section. The TPDPS regulations state:

*"For the purpose of assessing the degree of disablement resulting from an injury not specified in Column 1 of Schedule 2 to the Social Security (General Benefit) Regulations 1982, the health care professional may have such regard as the health care professional considers appropriate, to the prescribed degrees of disablement set against injuries specified in that Schedule"*

Therefore there may be scope to utilise such approaches within the disablement assessment process and further analysis as to their utility in this scheme is required.

## 8.1 Global Assessment of Functioning (GAF)

The GAF is a rating scale which gives one single score for an individual's social, occupational, and psychological functioning, rated on a scale from 0 and 100.

Broadly speaking, normal function is coded in the 70-to-100 range, mild psychiatric symptoms fall in the 70-to-80 range, and moderate symptoms are assigned a number between 60 and 70. Severe symptoms are coded as 50 and below. Higher levels of psychiatric support (intensive community-based treatment, residential settings, or inpatient hospitalization) are often required as function drops further down the scale.

The GAF stipulates that functional difficulty that results from "physical (or environmental) limitations" should not be considered in assigning a score as the intent is to focus on the effects of mental illness. The related SOFAS (Social and Occupational Functioning Assessment Scale) scale is similar to the GAF, but it only

looks at social and occupational functioning, does not consider symptom severity, and does not exclude the impact of physical or environmental limitations.

The GAF score changes over time and thus reporting the highest and lowest GAF score in the past year along with the current GAF score is helpful.

The main advantage of the GAF is its brevity but as with any single global assessment of functioning it has limitations and in clinical practice is a useful addition but not a replacement for comprehensive history taking and clinical judgement. Nevertheless, the GAF is widely used in clinical and research settings and has been adopted as meaningful by psychiatric, legal, administrative, and insurance systems and institutions. For example, GAF scores have been used by the Veterans Benefits Administration (VBA) to help determine disability ratings.

[Note: The GAF scale was a key component of DSM IV but is not part of the DSM 5. The WHODAS (WHO Disability Assessment Schedule) is recommended in the DSM 5 but is not obligatory. As yet it has not been widely adopted.

### *8.2 World Health Organisation Disability Assessment Schedule 2.0 (WHODAS)*

WHODAS 2.0 evaluates the patient's ability to perform activities in six domains of functioning over the previous 30 days and uses these to calculate a score representing global disability. These domains are:

- Understanding and communicating
- Getting around (mobility)
- Self-care
- Getting along with people (social and interpersonal functioning)
- Life activities (home, academic, and occupational functioning)
- Participation in society (participation in family, social, and community activities)

WHODAS 2.0 comes in 36- and 12-item questionnaires, each of which is available in self-administered, proxy-administered, and rater-administered versions. Interviewer training is recommended using the WHODAS 2.0 training manual.

WHODAS 2.0 provides a summary measure of functioning and disability in all six domain categories and globally. There are two scoring options: simple and complex. The complex scoring method requires use of a computer program and gives an output of a score between 0-100 where 0 = no disablement and 100 = total disablement.

The WHODAS does have certain advantages over the GAF. It is more detailed and objective than a single global impression. Studies have found WHODAS 2.0 to be reliable, responsive to change, to have good face validity, and to be replicable across countries, population groups, diagnostic groups, ages, and genders. It has also demonstrated reliability and validity in discriminating variations in profiles of disability across subgroups of the general population, among people with physical disorders and among those with mental health problems or addictions.

There are problems with the WHODAS 2.0 however. When the simple scoring method is applied it produces a number just as the GAF does. There are no normative values or comparative studies that indicate the meaning or interpretation of a specific value for individual domains or for global functioning.

Neither the GAF or the WHODAS consider cause or permanence and neither are designed to map on to other scales. They result in a global expression of disablement and so can only be considered a proposal for understanding gross disablement in a standardised way. Further work is required to determine if this would be appropriate and if so, how the outputs could be considered in relation to the social security regulations (1982).

# 9. Summary, Recommendations and Next Steps

## 9.1 Summary of main points from the review

1. The terms of reference for the TPDPS and procedures for implementation are set within the Victims' Payments Regulations 2020
2. This review is part of a disablement assessment design process which presents an opportunity to develop and deliver an assessment service to the victims of the Troubles based on the current evidence
3. Design and delivery of the TPDPS presents challenges due to the different legal, medical, and societal perspectives underpinning the development of the scheme, expectations of the scheme deliverables and interpretations of the regulations.
4. There are potentially large numbers of citizens who have suffered physically, psychologically and emotionally as a consequence of the recent conflict in Northern Ireland.
5. Many of these potential applicants to the scheme will have experienced Troubles related incidents many years prior to this scheme commencing so details of mental health history and treatments may be sparse
6. This rapid review has been conducted within a very short timeframe and has of necessity targeted the most relevant sources including peer reviewed journal articles (academic, scientific, clinically relevant publications) and "grey" literature including policy guidelines, governmental/policy briefing reports and web pages.
7. The review has undertaken an analysis of a number of schemes specifically for guidance relating to assessment of; mental illness, degree of impairment and level of disability, including:
    a. the UK Armed Forces Compensation Scheme (AFCS)
    b. the War Pensions Scheme
    c. the United States of America VA Disability Compensation Scheme
    d. the United Kingdom Industrial Injuries Disablement Benefits (IIDB).
8. Each of the above schemes seems to fit a specific context or specific population relating to that context. Whilst there are elements of the above schemes (IIDB and AFCS predominantly) that will be relevant to the victims and survivors of the NI Troubles, the TPDPS will need to design a unique

scheme to assess the specific characteristics and needs of a population exposed to decades of violence and civil conflict.

9. There are elements of the AFCS and IIDB assessments domestically that have specific relevance to the TPDPS. For example, permanence is considered within the AFCS and the statutory definition applied is similar to that applied to TPDPS; learning from and adapting the strategy applied within this scheme could be considered. However, the AFCS applies a tariff-based assessment as opposed to a percentage disablement assessment which is not helpful when considering the regulations for the TPDPS.

10. The scheduled assessments table mandated within the IIDB scheme and contained within the social security (general benefit) regulations (1982) is also mandated within TPDPS. Similarly, the assessment and expression of disablement in percentage terms is consistent across both schemes and approaches to the assessment of disablement with other cause is also mirrored within both schemes

11. Whilst an approach to the assessment of physical disablement is described within the social security (general benefit) regulations 1982, functional psychiatric disablement assessment is not described nor standardised.

12. IIDB has a methodology to assess Psychiatric conditions, however this is not specifically designed to a chronic, conflict related context.

13. A requirement for an assessment of disablement in percentage terms and whether or not this disablement is permanent is in addition to any formal diagnosis. These two scopes of practice are different.These to scopes of practice are different.

14. The scope of clinical practice of those health care professionals who can provide formal diagnoses is generally significantly different to those who are trained and experienced in disability assessment medicine. It is therefore proposed that the scheme has the facility to refer for diagnostic services, whilst also having the ability to assess disablement.

## *9.2 Recommendations*

We propose the following actions in relation to assessment/diagnosis

1. Disablement assessment methodologies utilised in IIDB and war pension / AFCS may be applicable to this scheme.

2. It is possible to define psychological injury in a meaningful way by using either of the two standardised diagnostic manuals (DSM 5 or ICD 11) which define

psychiatric conditions clearly related to traumatic events. This mechanism will allow the presence of psychological injury to be established

3. As much as possible psychiatric assessments should be as light touch and non-intrusive as possible using desk-top methods, drawing upon GP notes, mental health reports etc.
4. A clear process with defined roles is essential (see Table 6 for suggestion).
5. A diagnostic assessment process delivered by consultant psychiatrists (and possibly clinical psychologists) will be credible but needs to be considered to determine if this is practicable within limited resources. Inadequate capacity will lead to unfair delay and attract unwelcome criticism of the scheme.
6. A diagnostic assessment process led by Consultant Psychiatrists overseeing a system whereby trained mental health professionals undertake assessments using structured interviews and standardised measures would replicate the type of assessment processes currently employed within NHS mental health services and thus be defensible to clinical scrutiny (see Table 7).
7. A diagnostic assessment process led by Consultant Psychiatrists overseeing a system whereby non-consultant psychiatrists undertake assessments using structured interviews and standardised measures would be able to access a wider layer of psychiatry resources (see Table 7).
8. Consideration could be given to utilising the GAF as part of the assessment process
9. Consideration could be given to utilising the WHODAS be included as part of the assessment.
10. Consideration should be given as to how the GAF and WHODAS could map on to other scheme anchor points (see Table 8 for an example), with the understanding that this would not replace robust history taking and clinical decision making but instead add to the overall assessment.
11. Accessing medical records is likely to prove challenging (see Table 7).
12. Appropriate treatments must be defined as what was appropriate at the time that treatment was provided. In this scheme the assessor or psychiatrist will review the patient's medical notes and confirms the treatments received in the interview and determines that appropriate treatment has been received. For example, antidepressants have been an accepted treatment for depression since the early 1960s and until relatively recently psychological treatments which are now recommended by NICE guidelines, were not widely available.

13. Permanence could be recognised in terms that have greater clinical utility such as chronicity of condition and severity of impairment to assist with diagnostic assessments and subsequent assessment of level of disability. However, this is unlikely to hold legal weight.

14. A mechanism (s) could be developed to allow access by those bereaved by Troubles related incidents to gain access to the scheme. For example, under regulation 7 (1) For the purpose of these Regulations, a person's injury could be considered to be caused by a Troubles-related incident if the phrase in article 7 (1) b (present in the immediate aftermath of a Troubles-related incident in which a loved one died or suffered an injury) could be interpreted as identifying the deceased at a temporary morgue or hospital setting after the incident.

### *9.3 Next Steps*

This document is based on a rapid review of selected literature. All of the above issues require further review and there are a number of issues requiring further consideration including:

- Guidance for health care professionals
- Awards to families of deceased persons
- Combined effects of relevant incidents
- Effects of non-relevant incidents/events.

**Table 6: Determining Key Clinical Issues**

| | WHO WILL DETERMINE | HOW WILL DECISION BE MADE |
|---|---|---|
| **1 – Proximity to a Troubles Event** | **Stage One: This will be a decision for the Victims' Payments Board.** | **Decision will be based on self-report with support from documentary records including police reports and historical records.** |
| **2 – Medical Impact of Troubles Event** | ***Clinician completing diagnostic assessment*** | ***DSM 5 or ICD 11 criteria*** |
| **3 – Diagnosis** | ***Clinician completing diagnostic assessment*** | ***DSM 5 or ICD 11 criteria*** |
| **4 – Medical Severity** | ***Clinician completing diagnostic assessment*** | **DSM 5 or ICD 11 criteria** |

| | | |
|---|---|---|
| **5- Appropriate Treatment** | ***Clinician completing disablement assessment*** | **Primary care and secondary care services provide information on request, including diagnosis if available, for known patients (current and historic).** |
| | ***Clinician completing disablement assessment*** | **Where diagnosis provided as part of initial evidence bundle, and further diagnosis not required. This element is in the scope of both the diagnostic and disablement assessor.** |
| **6- Impact on Functioning** | ***Clinician completing disablement assessment*** | **Consideration could be given to use of GAF / WHODAS**<br>**Standard disability assessment methodology would remain.** |

## Table 8: Social Security regs 1982 to assessment and GAF

*Mapping GAF scores on to IIDB scores: Consideration ought to be given as to how GAF scores will assist assessors in determining the level of disablement. The table below suggests an approach which is clinically defensible and would meet the intent of the legislation (that there should be face validity for any comparison between physical and mental disorders. The key anchor point is the 11-20% range. This is an early proposal and further modifications could be considered to include WHODAS outputs if such an approach is considered appropriate. There are limitations to this approach, in this context and so this may not be applicable pending further analysis.*

| IIDB | IIDB | SS regs 1982 scheduled injury | GAF Score | GAF | GAF Descriptor |
|---|---|---|---|---|---|
| **less than 1%** | Virtually no disablement | | **80 - 100** | Little or no symptoms | |
| **1-5%** | minimal | eg loss of a toe through the metatarso-phalangeal joint. | **71 – 80** | Symptoms transient and expectable | If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning. (e.g., temporarily falling behind in schoolwork). |
| **6-10%** | very mild | eg loss of two phalanges of the middle finger | **61 – 70** | Some mild symptoms | Some mild symptoms (e.g., depressed mood and mild insomnia) or some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | functioning pretty well, has some meaningful interpersonal relationships. |
| **11-20%** | mild | eg loss of the index finger | **51 – 60** | Moderate symptoms | Moderate symptoms e.g., flat affect and circumlocutory speech, occasional panic attacks) or moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers). |
| **21-30%** | mild/moderate | eg loss of vision of one eye, without complications or disfigurement, the other being normal | **41 – 50** | Serious symptoms | (e.g., suicidal ideation, severe suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job, cannot work). |
| **31-50%** | moderate, | eg below knee amputation | **31 – 40** | Some impairment in reality testing or communication<br>or major impairment in several areas such as work or school, family | Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) or major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed adult avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school). |

| | | | | | |
|---|---|---|---|---|---|
| **51-80%** | Moderately severe | eg amputation below hip with stump not exceeding 13 cms in length measured from tip of great trochanter | **21 – 30** | Serious impairment | Behavior is considerably influenced by delusions or hallucinations or serious impairment, in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) or inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends) |
| **81%+** | severe | eg loss of both hands or amputation at higher sites. | **11 – 20**<br><br>**1 – 10** | Gross impairment<br><br>Persistent risk | Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) or occasionally fails to maintain minimal personal hygiene (e.g., smears feces) or gross impairment in communication (e.g., largely incoherent or mute).<br><br>Persistent danger of severely hurting self or others (e.g., recurrent violence) or persistent inability to maintain minimal personal hygiene or serious suicidal act with clear expectation of death. |

10.

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# Appendix 1.

## Global Assessment of Functioning Scale

### Global Assessment of Functioning (GAF) Scale

(From DSM-IV-TR, p. 34.)

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

| Code | (Note: Use intermediate codes when appropriate, e.g., 45, 68, 72.) |
|---|---|
| 100 \| 91 | **Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.** |
| 90 \| 81 | **Absent or minimal symptoms** (e.g., mild anxiety before an exam), **good functioning in all areas, interested and involved in a wide range of activities. socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g. an occasional argument with family members). |
| 80 \| 71 | **If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational or school functioning** (e.g., temporarily failing behind in schoolwork). |
| 70 \| 61 | **Some mild symptoms** (e.g. depressed mood and mild insomnia)<br>**OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty well, has some meaningful interpersonal relationships.** |
| 60 \| 51 | **Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks)<br>**OR moderate difficulty in social, occupational, or school functioning** (e.g.. few friends, conflicts with peers or co-workers). |
| 50 \| 41 | **Serious symptoms** (e.g.. suicidal ideation, severe obsessional rituals, frequent shoplifting)<br>**OR any serious impairment in social, occupational, or school functioning** (e.g., no friends, unable to keep a job). |
| 40 \| 31 | **Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant)<br>**OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school). |
| 30 \| 21 | **Behavior is considerably influenced by delusions or hallucinations**<br>**OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation)<br>**OR inability to function in almost all areas** (e.g., stays in bed all day; no job, home, or friends). |
| 20 \| 11 | **Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement)<br>**OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces)<br>**OR gross impairment in communication** (e.g., largely incoherent or mute). |
| 10 \| 1 | **Persistent danger of severely hurting self or others** (e.g., recurrent violence)<br>**OR persistent inability to maintain minimal personal hygiene**<br>**OR serious suicidal act with clear expectation of death.** |
| 0 | Inadequate information. |

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