HOUSE OF COMMONS

Work and Pensions Committee

Oral evidence: Health assessments for benefits, HC 604

Wednesday 30 March 2022

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Watch the meeting

Members present: Stephen Timms (Chair); Debbie Abrahams; Shaun Bailey; Siobhan Baillie; Neil Coyle; Steve McCabe; Nigel Mills; Selaine Saxby; Dr Ben Spencer; Chris Stephens; Sir Desmond Swayne.

Questions 180 - 210

Witnesses

I: Caroline Cooke, Head of Policy, Forces in Mind Trust; Philip Martin, Research Fellow, University of Salford/Sanctions, Support and Service Leavers; and Andy Pike, Head of Policy and Research, The Royal British Legion.

Written evidence from witnesses:

University of Salford/Sanctions, Support and Service Leavers

Examination of witnesses

Witnesses: Caroline Cooke, Philip Martin and Andy Pike.

Q180 **Chair:** Welcome, everybody, to this meeting of the Work and Pensions Committee for this evidence session in our inquiry on health assessments for benefits. A warm welcome to the three witnesses who are joining us today to talk to us particularly about the issues facing veterans in applying for benefits. Can I ask each of you first briefly to introduce yourselves to us?

Andy Pike: I am head of policy and research at the Royal British Legion, which is the largest welfare provider in the armed forces charity sector.

Caroline Cooke: I am head of policy at Forces in Mind Trust, which was established in 2011 by the National Lottery Community Fund to support a better transition to civilian life.

Philip Martin: I am a research fellow in the Sustainable Housing and Urban Studies Unit at the University of Salford.

Q181 **Chair:** Thank you all very much for being with us. You have all made quite long-term observations of the experience of veterans with health assessments for DWP benefits. How do each of you characterise those experiences and how, if at all, is the experience different for veterans compared with others?

Andy Pike: The experience of veterans going through the benefits system is varied. For some it will work out well. For others it will be a different experience from that of a civilian potentially going through it.

To say a brief bit about why it is different, there are compounding factors. First, you have to remember that the time when a veteran may be accessing benefits from a civilian system will be at a point when they have just discharged or medically discharged out of service, which means that they will access a civilian world for potentially the first time in their lives. They will go through a medical discharge potentially unexpectedly as they leave that culture behind. They will also potentially go through an assessment for being medically downgraded and then discharged, plus go through a compensation scheme, plus work out their armed forces occupational pension. All these things compound at a point when they have to then access a benefit application at the same time.

That moves to another reason why it is then a slightly different experience. They come from a military culture. A veteran with a military culture ingrained in them may find themselves accessing a benefits system but they are not used to being able to describe their symptoms due to the stigma that they may find in service around talking about mental health conditions, for example. They were maybe used to downplaying that condition and wanting to present themselves smartly, which could then mean that they do not get the outcome that they want or are looking for from their benefit assessment.

They will be faced with a benefit assessor who potentially does not have a good working knowledge of armed forces life and of more common armed forces conditions.

The last point I want to make on this is that if you are a civilian and you access a benefit, you have throughout your life had your care provided continually by the NHS. Of course, that is different for a veteran. While you are in service, Defence Medical Services will provide healthcare, which means you have your service medical record taking up a large proportion of the period of time when you may have got your injury or illness. Then it is incumbent on the veteran to get that service medical record out and to submit that as further information into the benefits assessment rather than having it all in one place.

A number of factors can compound there, which means that if you are a veteran accessing it, it may be slightly more complex or different and

there may be a lack of understanding on the other side compared to a civilian doing it.

Caroline Cooke: As I think Andy said, the effect of a military mindset—having a lot of pride and not wanting to seek help—is a key factor that may be slightly different.

It is important to say that only a small minority of veterans will ever go through the benefits system but, when they do, often their needs and situations are quite complex and complicated. They may have recently left. They may be in and out of work, struggling to find a career that suits. It is not a linear progression, which can make things more complicated sometimes.

When it is a case of medical discharge, often the service leaver will be in a state of shock. They may not have expected to be discharged when they were. They may not have had any information about the benefits system. They might be going through a forces compensation assessment all at the same time, meaning that they are quite confused when they go through the benefits claim process.

The research that we funded at the University of Salford showed a level of lack of understanding, I suppose, and people saying, "I have already been assessed as medically unfit to work. Why am I being assessed again?" They are surprised when that assessment is made by someone who is not a qualified clinician as well.

That is soon after service but the transition to civilian life continues throughout somebody's life once they have served. Our research also has an example of somebody claiming and being assessed for PTSD. The assessor said to them, "What year did you leave service?" They said, "1998", and the direct quote in our report says, "Well, shouldn't you be over it by now?" No. Of course, there is good practice in the assessment process as well, but those are some quite powerful examples. I will leave it there.

Q182 **Chair:** Thank you. Philip Martin, perhaps you can explain your work. You have been doing some long-term work for the Forces in Mind Trust. Tell us about that.

Philip Martin: Yes, thank you. I second what Andy and Caroline said. Forces in Mind generously funded us to undertake a QLR or qualitative longitudinal study into veterans' engagement with the benefits system. It started back in 2017. At that point we interviewed 68 veterans in our first wave, but there have been successive waves. We have had dropouts along the way. The initial cohort was a combination of people on employment and support allowance, jobseeker's allowance or universal credit, but many were on legacy benefits. In 2021 we recruited a parallel cohort of 41 veterans who were just claiming universal credit because we wanted to compare their experiences. Within that project are two parallel

cohorts of veterans whom we are interviewing. The project started in 2017, as I said. It is due to finish next year in 2023.

Salford has also been doing other projects, including one looking at the impact of physical injury, again funded by the Forces in Mind Trust. We have done other research in the past as well, looking more specifically at things like the housing needs of veterans in areas of Greater Manchester, where we are based. We have a bit of a track record of looking at different aspects of veteran life.

If I can add to what Andy and Caroline were saying, veterans can access the benefits system at any time. They could have left maybe 20 years ago. Our cohort has men and women who served in the 1960s, 1970s, 1980s and 1990s. Some left last year. Their experience can be different, as Andy and Caroline said. We are talking about only a minority. However, most of those in our cohort are Army veterans. We have much smaller numbers from the Navy and the RAF. That partly reflects the higher bar at entry to get in there, and the skills and technical qualifications that people get within the forces.

If we have time, we will look at other issues as well. There is no one universal veteran who has a similar experience. The experience of women can also differ from the experience of male veterans.

You can come into contact with the benefits system 30 years after you have left because of a particular crisis in your home life or simply because of the changing labour market in the area that you are in. It could be the first time you have ever come into contact, and we see that. Others have left last year in the middle of the pandemic and there are no jobs to go to. The default is to try to claim universal credit in the mass of other people claiming universal credit at that time.

Q183 **Chair:** Specifically, based on your research among veterans who have undertaken health assessments for benefits, how has that experience been for them?

Philip Martin: The majority have a negative experience of health assessments. Do you want me to go into some of the details?

Chair: Yes, for a couple of minutes, some of the things you have found.

Philip Martin: We have seen a slight improvement in more recent times in terms of how empathetic the assessors are. Certainly, when we started, many people's experiences of assessments, either work capability assessments or the assessments for personal independence payment, were dire. A lot of veterans talked about how they were anxious and nervous going to the assessment. The assessment often retraumatised them and made things a lot worse afterwards. They were aware that often the assessors in the past were not medical professionals—some were but not all of them—and the assessment primarily concentrated on physical issues. That has changed. It has got

better. There seems to be now more empathy and more focus on mental health issues. But people often went prepared with evidence about their mental health, and then were not asked about it and were perplexed as to why.

Following on from the issue about military culture, a lot of the veterans in the research talked about not wanting to appear weak, certainly in public. In some interesting tales, veterans went into a room and they said, "Can you walk 100 yards?" They said, "Yes", and got down and did press-ups to show how fit they were. They scored zero and said, "What about my mental health and my PTSD?" They said, "No, clearly you are fit for work." That was not uncommon. That is an extreme example but it was common for people to go in, not naively but perhaps unaware the first time they went, especially if they went on their own, about what they would be asked and what responses would, if you like, ensure they passed the assessment.

Individuals talked about comparing their first assessment with their second assessment or their appeal and how it was different. People said they did not know anything about it the first time but when they went back they had more idea about what they were looking for. In some senses, that might sound like a cynical approach, but they felt the system was cynical in that way. They felt they needed to jump through those hoops. The first time if someone asked if they could walk 100 yards, they would say, "Yes, of course I can walk 100 yards. How do you think I got here? But I have PTSD." They did not realise that saying that then went against them.

That was the direct assessment process, but we also found that the lead-up and the environment in an assessment centre, sitting there and waiting, built up a lot of anxiety. As I said, it helped to retraumatise people so that after the assessment it knocked them back for weeks or sometimes months at a time. That was a bit of an overview there.

Q184 **Chris Stephens:** We have a number of veteran charities in Glasgow South West and we always discuss these health assessments.

To pick up where you left off there, you said that people who have both physical and mental health conditions are poorly served by existing assessments because they do not take sufficient account of people's mental health conditions. What does DWP need to change for there to be parity between mental and physical health in assessments? For example, is it the pre-interview information gathering and how the interview is conducted or is it assessing the outcome? Would you suggest anything else to the Committee?

Philip Martin: There is no easy answer in that sense. Veterans have asked why they cannot use information from GPs or why they cannot use service medical assessments. I always say that for many of the people we come across, their condition did not emerge in service. It only emerged years later. You will be aware of the classic 12-year period for

PTSD emerging. The transition was fine and they did not have any issues then. It was only much later.

In terms of how the DWP can work better, there has been some research on whether training is needed for assessors but rolling that out has a resource implication. The DWP, to be fair, has invested quite a lot in the Armed Forces Champions Network and I have also introduced the armed forces marker on the UC system now, but we have not seen how that will play out in the longer term.

My colleague Lisa Scullion has produced an article that I can send to the Committee about the use of a trauma-informed approach. It has been used in the NHS and has been used with veterans originally in Australia, New Zealand and possibly America. It uses a trauma-informed lens to work with people in different settings, whether health, housing or education. But as far as we know it is not used in the social security system. It is about minimising trauma, using principles of compassion, ensuring people's personal safety, giving them choice, and enabling them to feel they are in a trusted environment, can trust the individual, are able to collaborate in the decisions being made about them and are treated with respect. This trauma-informed lens has various pillars. Rather than having something done to you, you are part of that process and you are treated with respect.

That goes back again to that military culture. We find a lot of veterans that we research will say, "The military was the best job I ever had. I had respect. I had self-esteem. But in the benefits system I do not have esteem." That does not just apply to veterans, obviously, but there is a huge fall from a position where you are part of a respected team, you have status and you have kudos, to this position where you feel you are a nobody, as people have said. We definitely recommend the trauma-informed lens as an approach and we advocate for better training around how assessors handle veterans.

There is a separate question about how veterans are accompanied to assessments. You can take someone with you. I am not exactly sure whether they can actually advocate on your behalf. My own opinion is that people should have a right to take someone of their choice with them and to take away a transcript of what was said, rather like you can ask your doctor for your medical record. It is your record. It is your information. You should be able to do that.

Chris Stephens: Thanks for that, Philip. I am certainly conscious that veterans' charities always try to ensure someone is there with them.

Philip Martin: That has a huge resource implication.

Q185 **Chris Stephens:** Exactly. Andy, veterans will have undergone experiences that many of us cannot contemplate. Is the fact that an applicant is a service leaver sufficiently flagged up early in the assessment process so that an interview can be suitably structured with

appropriate questions asked?

Andy Pike: The short answer to that is no. There is an opportunity on assessment forms to ask the question, "Have you ever served in the UK armed forces?" It has now been rolled out on the universal credit forms, although we are yet to see what is happening with that data. It is asked on the ESA form but it is not asked on the PIP form.

At the moment, nothing describes what happens when somebody ticks that. There is definitely scope for improving that journey so that if a veteran applies for a benefit, they can identify themselves early if they wish to.

It goes back to what Philip was saying about trauma-based care. You get an understanding. It was telling that in some research we carried out a couple of years ago only 8% of PIP claimants and only 6% of ESA claimants felt that their assessor had any knowledge of the armed forces or of armed forces-related conditions.

I am not saying necessarily that every assessor has to be a veteran and fully versed in all of these things, but if you can identify people early and make sure that the correct flags are put on the systems, the support that is out there could be brought in and service medical records could potentially be brought in. From the point of assessment, you have a month to turn around your application and it could take longer than that to access all the records that you need. There is definitely scope for making sure that people are flagged and that that data actually means something for the veterans themselves.

If I can just add a bit about what Philip was saying previously about mental health versus physical health, our benefits, debt and money advisers see a lot of concentration on physical health over mental health. We have had people who have made a claim primarily on the basis of a complex mental health condition who are then asked, "Can you hold a pint of milk above your head?", instead of anything about their mental health.

It goes back to making sure there is understanding, greater training and mechanisms put in place to ensure it is not just all reliant on a veteran who may face greater stigma from explaining their condition fully. Can we bring in more narratives from friends, families and carers? We know that somebody having PTSD has an impact on their spouse or their partner. Some evidence there could potentially be brought out.

If we could flag people, if information was provided and if training was provided, some of these things could then be brought out to make a smoother journey and create a better outcome for the veteran.

Q186 **Chris Stephens:** Thanks. Caroline, when veterans go to these assessments, they measure multiple conditions on occasions. Each person must have their own levels of physical and mental health issues.

It seems we measure two variables to get to one number for their assessment score. Does that make any logical sense? Do we combine the scores sensibly for each of someone's multiple conditions?

Caroline Cooke: Certainly, there are improvements that can be made but, essentially, it is the way the scores are accrued. Veterans need to know that at the health assessment there is an adequate level of expertise. That is not to say that it has to be someone who is hugely clinically qualified but someone with sufficient knowledge of physical and mental health conditions that specifically affect people who have served and what that means in practice, alongside having knowledge of how the forces compensation and pension scheme impacts benefits, too. If someone is in an environment where they are comfortable enough to disclose their medical information at the assessment and supported in the way described, whether it is physical or mental, if their real health issues are properly communicated, the scoring becomes not less important because that is what results in the benefit but not the central tick-box approach that sometimes happens.

Q187 **Chris Stephens:** What is one productive change to assessment scores or anything like that that would be straightforward in achieving parity?

Caroline Cooke: Better training and information that can contribute to that assessment.

Q188 **Chris Stephens:** Given the points that were made earlier about people being accompanied, certainly by a veteran charity, are you conscious that that must happen and that someone should have a right to have someone with them?

Caroline Cooke: Who accompanies is important. We funded some research into advocacy by The Advocacy People. I can circulate something later[1]. It showed that when someone is accompanied by another veteran and when they have access to peer support, it makes a big difference.

Q189 **Siobhan Baillie:** Just quickly, during some casework I have been doing for some veterans—and I have veterans in my family as well—I have been shocked to find out that Veterans UK does not have specific policies or any requirements to look after the mental health of veterans. Where does that come into this? Is that a gap? It is another big government agency that, in my view, could help to inform DWP and help with your work. Did you know about that policy issue?

Andy Pike: Veterans UK is a big touchpoint for veterans coming out of service because it provides primarily the pensions as well as the compensations for injured veterans. It is one piece of the puzzle.

[1] "The witness highlighted to the Committee after the session that she was referring to the research linked to here - https://s31949.pcdn.co/wp-content/uploads/Final-SROI-Report.pdf"

Equally, this leads to making sure that the systems are linked up. Veterans UK will have some information on a veteran. Defence Medical Services will have some information on the veteran. DWP will have some information on the veteran. Yet those systems do not necessarily talk very well. If somebody is going through with a mental health claim and has compensation for mental health, there are complexities in getting that compensation in the first place because they need to get a clinical diagnosis, which is not always easy for a mental health condition, especially when you are in service. If somebody has that, it can then inform the benefit claim that comes out the other side. Also, the NHS will have primary care support for that veteran going forward and that can help the process.

Q190 **Siobhan Baillie:** A veteran with mental health conditions going to VUK would expect it to have some sort of care, knowledge, duty or policy. Caroline, do you have anything to say about that?

Caroline Cooke: At least being able to signpost to the right people at the right time does not always happen. The changes happening at the moment and the introduction of Op Courage are making a difference but it will take time to come through.

Philip Martin: Yes. It is important to add that nobody lives their lives in categories. People will access things like Op Courage or, as it was before, mental health support at the same time as accessing a GP or housing support.

I want to add a couple of other things before I forget. Reassessment is a big thing as well. You can have a work capability assessment or a PIP assessment and then have another one two years down the line and then another one two years down the line. You reopen that whole issue again and again, which can be serious. Veterans will say, "You have that information already." Likewise if you do a work capability assessment or a PIP assessment, they say, "Why can you not share the information? I am telling you the same things." But it is a different system.

Chair: We will be coming back to those points. Thank you.

Q191 **Nigel Mills:** I am trying to just work out whether we should make a change to the assessor or the assessment or a change to the information the decision maker has and how they then use that assessment. It sounds a bit like you are saying the decision maker needs to know the background of the claimant. The assessment could be the one that everybody else would have but, perhaps for some people with mental health and trauma issues, the assessor needs to know more. How do you find the balance between changing the process for those two situations?

Philip Martin: It is tricky. I was thinking about that on the train down. If you ask GPs or mental health professionals to transfer information, it puts a burden on them to send that information over. It is a combination

of having the assessors better trained and more empathetic and also having the information used more smartly.

Some of the assessors were medical professionals historically and some were not. You would assume that medical professionals were more empathetic than administrators. It is not always the case, though.

I do not know whether you have anything to add to that, Caroline.

Caroline Cooke: A lot of it is about having the right information at the right time. On the physical conditions side, we have some research coming out at the end of April, which shows that it can take up to 18 months for the service health records of someone who is going through the medical discharge process or has been discharged to follow through and arrive with their GP. In the meantime, if they make a claim, the GP does not have the full picture. It is about bringing records together and having that information submitted at the right time and the person being assessed knowing the right time for jobcentres to have given them advice so that they do not just turn up on the day to be assessed with their bundle of papers thinking they will be taken into account then.

Going forward, digital health records will be more accessible and information sharing and collaboration will all make a big difference.

Andy Pike: Caroline and Philip have covered it well. It is not an either/or about whether the decision maker or the assessment provider needs to ensure that they have greater training and awareness of the armed forces and what they do with the evidence presented. Both elements potentially need to have that training in place. It is rare that somebody can get their service medical record within that short timescale as part of their application. Even when they do, again from our research, only 20% of those claiming PIP believe that the assessor or decision maker even considered that service medical record fully, in their opinion. For ESA, just 8% of the people that we surveyed said that.

The assessment needs to reduce stress where it can for the veteran because that will have a longer-term impact on the veteran's mental and physical wellbeing and will create and enforce a barrier to accessing support. The assessment process needs to have that knowledge.

Also, the decision maker needs to know what to do with the information that is then provided when it gets to that end as well.

Q192 **Nigel Mills:** How many veterans go through these assessments a year? Do you have any feeling for the numbers at all?

Philip Martin: It is an interesting question. We do not know. As part of the research, we have attempted to engage with the assessment agencies. When we started the research we were not engaged with the DWP directly, but that has changed now and we have much more communication with the DWP. The level of interaction with us is much better.

The missing link or the bit of the puzzle that we have not yet engaged with is the assessment agencies. There have been challenges in talking to them for the purposes of the research. I am not sure exactly why that has occurred. We do not yet have that insight into understanding how their decision-making structures operate, how assessors are trained and how the system works on a practical, day-to-day basis or the data out of it. While the DWP is moving towards being more open, the assessment agencies are not at the moment. That is a sticking block.

Q193 **Nigel Mills:** I ask because it is quite hard. If we have enough veterans claiming and needing assessments to have one or two specialist assessors, they will not be in the right geography and then they will not have the other specialist knowledge that you want. If you try to blanket train everyone, it will be one of those training courses that you did two years ago and you cannot remember when somebody comes around because you never see them.

What balance do you want? Do you want to have a specialist veterans assessor and accept inconvenient geography or video assessments, or do you want better across-the-board training and hope people remember it if they do not use it often?

Caroline Cooke: The approach that has been rolled out at the moment by DWP is to be commended. The additional funding that came in—a small amount for armed forces champions to be properly trained—is a good approach but it needs to be rolled out more quickly and it needs more investment. Having those key individuals with that role is a good solution.

It is variable, though. Some people working in jobcentres will say, "Yes, I was told that I am the champion now but I do not really know what that means", whereas others will have amassed a good level of expertise that they can share. Not everyone has to have it but they know who the champion is and, if they have a claim from a veteran, they can seek that information themselves.

Andy Pike: Again, I completely agree with my colleagues here. To add to it a bit more, we at RBL have had some engagement with the assessment providers via generic forums they hold and they have been good. They have condition insight reports, which we have helped to contribute to. Armed forces and veterans champions are being rolled out. But as Caroline says, there has been a huge amount of investment in armed forces champions within Jobcentre Plus in DWP, which we fully welcome, but we do not actually know how well they work at the moment. It seems variable.

Back to your original question about how many veterans go through these assessments, the crux of the issue is that we just do not know. If people are not recorded or having the opportunity to identify, not only are they cut off from potential avenues of support but also we do not know the scale of the problem. We have a benefits, debt and money

advice service, which supports about 2,000 people a year, but those are the ones who have come to us.

Philip Martin: A related issue, Andy, is that because the assessments have a bad reputation, veterans have said to us, "I am not applying for it. I might be entitled to it but I will not do it because I have heard from other veterans that it is such a nightmare." People out there have not gone through the assessments because they do not want to have that experience even though they might be entitled to it. That legacy of what has happened to other veterans then has an impact. You could ask how many veterans go through assessment. If you had the number, it would not necessarily represent the true level of need in that sense.

Caroline Cooke: Could I finish off on the number?

Chair: Briefly, if you would.

Caroline Cooke: The veteran marker was only recently introduced but, as time goes on, analysis of how many veterans will come through the system. Also, the question, "Have you ever served?" is now included in the census, which means that we will have better knowledge on numbers going forward.

Q194 **Sir Desmond Swayne:** Would a right on the part of the applicant to request an assessor with appropriate knowledge of the condition that they suffer from improve the quality of the decision making? Is that deliverable in practice? Do not all speak at once.

Philip Martin: Yes, I think we all support the introduction of such a thing. It would take time, though, and the allocation of sufficient resources to do that.

Caroline Cooke: Yes and yes.

Q195 **Sir Desmond Swayne:** Do you accept, then, that that fundamentally changes the nature of the assessment from a functional test to some form of medical examination with medical expertise?

Caroline Cooke: No.

Andy Pike: If, say, complex PTSD is the reason you go for an assessment, it is not necessarily always about making sure that the person you speak to is an expert in complex PTSD. That is not necessarily, in your words, practical to roll out for every condition and every variable.

We need to make sure that assessment providers have points of contact where an assessor can find out the information that is necessary and, if we flag that somebody coming forward is a veteran, they are able to see that in advance. They will know that potentially they need to have a greater knowledge of the armed forces culture so they know what to look

out for. Regular training and awareness sessions within all assessment providers would be useful.

We can probably get to a halfway house on this, which would be a practical way of rolling it out. Armed forces champions are a way of doing that, as are more condition insight reports. With the good practice that we have heard, people have come back from assessments and have reported it as a good experience because they were speaking to a former nurse and veteran. I am not going to ask that everybody who provides an assessment is a veteran but has an understanding.

Philip Martin: I second that. In our research, we have never had a veteran say, "I want a medical expert there." They have said, "I want somebody who understands what I have been through and what I am going through and can understand where I have come from in terms of the armed forces." People do not necessarily want a medical expert who will examine them but someone who has empathy, compassion and understanding of where they are coming from.

Chair: Thank you. Selaine Saxby?

Q196 **Siobhan Baillie:** Sorry, Selaine has to go, so I will pick up her question to Philip. You have recommended trauma-informed care. You have touched on it already. How would the work capability assessment look different from the existing in practical terms with the assessor and the process? What do you suggest?

Philip Martin: You can take practical tests to make the environment less stressful and more compassionate. We were talking earlier about how some veterans' choice is a key part of trauma-informed thinking. Some veterans prefer face-to-face meetings because they can look people in the eye, which can be important for certain conditions. Some prefer over-the-phone assessments because they do not have to physically go somewhere. As we were saying before, if a trauma-informed lens was used and implemented, it would give much more choice to the individual going for the assessment. For those who do go physically, it would be an environment that puts people at ease and would not simply be processing people as part of an administrative process.

The assessment would not start from a position of probing and trying to find out the severity of a condition. The questions are framed differently. It starts from a position of believing the person and then trying to understand how that affects them. It involves a change in the structure of the assessment questions and maybe even a change in the physical layout of the room that the person is in, so it is not an adversarial environment in that sense.

Q197 **Siobhan Baillie:** Would you need the veteran to have had a diagnosis of PTSD to get to this point with this trauma-informed approach or should it just be off the back of the "veteran" flag?

Philip Martin: It is an interesting question because not everybody has a diagnosis of PTSD. It can depend on where they are in the—

Siobhan Baillie: PTSD is just an example. It could be another diagnosis.

Philip Martin: It certainly needs to be—pardon the pun—flagged up. If they have been recorded as a veteran, it should be taken into consideration. There has been some number crunching of the 41 people in the UC cohort. About 30 of them said that they had some kind of serious mental health condition, whether it was anxiety, depression, bipolar or PTSD, not all of which were diagnosed formally. Again, you go back to that point. Do you say, "I am not sure if I believe you unless I can see a formal diagnosis"? People may be accessing some kind of service anyway. Not everybody is. Some people access veteran support organisations because of past bad experiences with the health service.

Q198 **Siobhan Baillie:** If it is okay with you, Chair, I will wrap my next question into this because we talk about assessment so much. It is an open floor to both of you.

How would a trauma-informed approach look? Also, what would you like to see changing with the assessments? This is about DWP and the health transformation programme. We are looking at making changes like fewer reviews and paperwork versus face to face. What are your views on that?

Caroline Cooke: Flexibility is needed. An upside of the pandemic is people choosing whether they come in to be assessed in person or whether they do that on screen or by phone, as Philip said. Flexibility in place, having someone who is empathetic on the panel and feeling supported are things that will help veterans with common mental health disorders but every other person being assessed as well.

There is some good practice that could be rolled out more widely. Certainly, a trauma-informed approach to assessment is needed for people who do not have a formal diagnosis. It can take so long to get that diagnosis but it can still be traumatic to come to an assessment centre and to be asked to sit in a position that someone is not comfortable with. The veteran might only be comfortable sitting against a wall and not having anyone sitting behind them. All of those things are quite simple adjustments that could be made and would be good.

Philip Martin: To be honest, I have little to add to what Caroline and Philip have already said and I cannot add anything on trauma-informed care. I completely back up Caroline's point that flexibility is the key here. We found during the pandemic that veterans missed having a face-to-face assessment and preferred to have a face-to-face assessment. We also found veterans who preferred to do it remotely or have a paper-based assessment. It is about trying to meet the needs of the claimant rather than necessarily go through the same process each time. It potentially is part of trauma-informed care to pick up on these things early. If somebody has suffered a significant trauma, has a mental health

condition and cannot leave their house, calling them to a face-to-face assessment will not help the situation. In fact, it can exacerbate it. Build in that flexibility on locations, timescales and all of those things and take a more person-centred approach.

Siobhan Baillie: Most witnesses across all the panels will agree with that choice. Thank you.

Q199 **Debbie Abrahams:** Good morning, everyone. To pick up on something Caroline said in her opening remarks, I noted down that you said that a small proportion of veterans go on to claim social security. Is that just your view or do you have some numbers to support that?

Caroline Cooke: We do not have specific numbers but we can send you wider data on the trajectory post service.

One point I wanted to make is much broader about media portrayal of veterans and the mindset of the general public. In reality, most people who have served go on to have successful, fulfilling lives. I wanted to make that point as context.

Q200 **Debbie Abrahams:** Thank you. I appreciate that. We have heard in previous evidence to the Committee about huge problems in providing discharge and medical records and using the assessment. We recognise that. When a service board decides that somebody needs to be discharged as a severe disability, service personnel have accessed the new ESA, which does not require that assessment. How is that going? Is it useful? Is it working well?

Caroline Cooke: I will start by saying that the research that we funded on physical conditions on leaving service will not be published—I keep flagging it, though—until 27 April. Again, it shows that people's experiences are variable. It is working well for some and not for others. When it does not work well, it can be awful.

Debbie Abrahams: Okay, even with that new ESA. Philip, do you want to give a bit more detail on that?

Philip Martin: I have not actually been involved in that particular research project, but in general across all of the projects a defining theme is variability of experience. Some people get good experience and some people do not.

Caroline Cooke: We could send you more information in writing.

Philip Martin: Yes. We could send you the report as well when it is out.

Debbie Abrahams: That would be helpful. It is meant to smooth things for somebody who has been discharged as a result of severe disability but how it is going varies.

Andy Pike: I should say nothing because it is still fairly early on and we have not really seen how that interaction is working.

But I will flag that it will not ever be as simple as getting medically discharged and then being given ESA. If you were injured before 2005, you can get a war disablement pension. If you were injured after 2005, you get the armed forces compensation scheme instead. Then the armed forces pension scheme has a service invaliding pension element. All of these things will interact with an ESA claim. If you have a war disablement pension, you might get an allowance called UnSupp, which will crosscut it.

It is quite complex. We would always encourage people to get in touch with somebody such as RBL to talk to a specialist about it.

Q201 **Debbie Abrahams:** You are talking about other financial support. You are not talking about the actual process. What about the process? This is meant to, supposedly, smooth things out, isn't it?

Andy Pike: We do not have any evidence at this point to say whether it does or not. We would like to see, always, less unnecessary assessment and for information to be transferred smoothly between Government Departments. In theory there are positives within it, but we have not seen them coming through yet.

Philip Martin: We can send the report to you next month when it is published.

Q202 **Debbie Abrahams:** Are there any key things you might be able to tease out for us or is it premature before the report launch?

Philip Martin: I will ask the boss.

Caroline Cooke: Our lead professor, Lisa Scullion, was not able to attend today. She would be able to tell you more.

Q203 **Dr Ben Spencer:** Thank you for your evidence so far. I will ask you some questions on advocacy but, before I do that, I wanted to pick up on a couple of points you were making about the assessments and specialist expertise. I was interested to hear that quite a few people do not have any formal diagnoses of those mental health conditions, and may receive informal support and find difficulties going through the assessment process.

Is there an opportunity here for the assessment to act as a gatekeeper to get formal diagnosis and treatment so that it is not purely an assessment but also getting veterans the support that they need as part of the process? I can see you nodding.

Caroline Cooke: I am nodding because that is part of the role of the armed forces champion. If someone has served and comes to an assessment and has needs clearly unmet, having that level of knowledge of signposting is built into that model. But there is not enough of it at the moment.

Philip Martin: I will read a sentence from the article by Lisa Scullion, my line manager, "Referral to appropriate services (e.g. therapeutic treatment) is also a key component of trauma-informed care". If that is rolled out and if it works properly, part of it is saying, "Would you like me to link into certain services?" Of course, that depends if those services are available and have capacity. We know there is huge demand on the Op Courage services in any case.

I suppose I could flip the question around. Where we see things working well in certain places tends to be where an ecology of services exists. They might have some voluntary sector agencies, maybe a Jobcentre Plus nearby with a good track record and experience of working with veterans and NHS services also on the ball with that. Those tend to link into each other so that the veteran does not fall off the radar and somebody tends to pick them up. They all have awareness of each other.

That develops organically sometimes. Sometimes it develops because of where they are, like Richmond or Aldershot, and they have done it for ages. Sometimes it develops because it is a big area for recruitment of people into the forces and, therefore, lots of people return to that area. Many of the clientele being veterans is just a historic factor. That keys into the whole variability thing we talked about before.

Yes, if the trauma-informed care model works properly, then part of that model is referring people in if you deem that, first, they want that and, secondly, they need it.

Andy Pike: Again, I agree with my colleagues here. Once a veteran has left the armed forces and gone outside the wire into the civilian world, they will have multiple points of contact with various statutory or charitable agencies. Lots of different places can pick something up.

There was reference earlier to the 12 years potentially before somebody comes forward with PTSD. They may have left service without knowing that they have a condition and then failed to have had a clinical diagnosis by the time they access support. The assessment may be the first point they do that. If at that point we can flag that they are a veteran, there are some fantastic services across the piece, whether in the voluntary or the statutory sector, for veterans.

Op Courage was referenced earlier within the NHS. If people are made aware of it at the right time, it can help with getting that care to people who need it. The armed forces charity sector is a fantastic sector that can provide specialist support such as RBL, but we can only provide support to people who come forward saying that they need it.

Q204 **Dr Ben Spencer:** Thank you. My second question builds on this. You are clearly fantastic in terms of advocacy. Have you looked at the DWP's Green Paper and the proposals around advocacy? What is your take on them?

Andy Pike: Just to jump in on it, in terms of advocacy within that Green Paper, within the armed forces sector that is fulfilled primarily by the armed forces champions that we have talked about previously. DWP has put a fantastic amount of money into the armed forces champion network. They can act now as a client-facing point of contact or champion for members of the armed forces community who come forward.

But we just do not know how well those work. There is variability of service still. The training somebody has had to undertake to take on that role is not clear. We want to see consistent training throughout the country for that, and an independent evaluation of them that is published so we call look and jump in and help where there are still gaps in that system.

Caroline Cooke: There is a wider point on advocacy about self-advocacy and better preparation before leaving service. As the wider work that the Ministry of Defence is doing on life skills gets further developed and rolled out, hopefully, a clear and simple guide to benefit entitlements that people have access to at the right time needs to play into the wider support that is available.

Q205 **Dr Ben Spencer:** Would that be for everyone or particularly for people who have developed medical conditions as part of their service?

Caroline Cooke: For everybody but with a more specialist annex that covers medical discharge.

Philip Martin: It is an interesting point because veterans have entitlements to enhanced learning credits through the ELCAS, which they can access depending on the length of service. I do not want to think on the hoof, as it were, but a long-term advocacy service that you can access should you need to, similar to the TILS Op Courage model, is an interesting idea.

In terms of transition, I do not want to knock the transition support because especially now there is better support than there was in the past, but some veterans we talked to said that they were not in the right headspace to access that. Should there be more information on benefits at the time of transition? Yes, there should be. Not everybody is in a position to take it up at that time if they are not ready for it in some ways or are not in the right headspace to do it or are dealing with all the practical issues of leaving the forces. Often that takes precedence, especially if they have a family and are trying to find accommodation, employment and so on.

Q206 **Chair:** Thank you. Some of what you have said to us this morning is clearly specific to veterans but, Caroline, you made the point with one of your remarks that what you argue for would benefit the system as a whole and others. What lessons would you highlight from the experience of veterans about how DWP can support other claimants better?

Caroline Cooke: Ensure the claimants are as well prepared for their assessment as possible. Use a trauma-informed care approach of empathy and support so that people can communicate their circumstances, and are empowered and enabled to do so in a way that means that their full circumstances get disclosed the first time around and there is not the resource-wasteful need to go to appeal.

Chair: Any other points or lessons that occur to anyone?

Andy Pike: Looking outside the veteran sphere, it is back to that flexibility point. There was more choice offered about how to undergo an assessment during the pandemic, which is a lesson that could be learned going forward.

Within the research that we have carried out, veterans have found in some ways the best part of the process is going through an appeal. They will be blocked by various things like pride for taking forward an appeal but, if they get there, having the disability expertise on an appeal panel helps and makes them feel understood. It means that you start to understand a condition that potentially has not been brought out during the assessment process until that point. If there are ways to learn the lessons of what works at appeal and bring them earlier into the process, we could definitely look at that.

Philip Martin: Yes, there is clearly an overlap with people with disabilities because most mental health and physical health challenges fall into that category. Just being a veteran does not exclude them from that.

To go back to the trauma-informed care model, it effectively supports people to help them navigate the system with compassion and care. We have not talked about other issues like literacy, which affect some veterans as they do the wider population. We all know about navigating all the paperwork. As someone who once claimed many years ago when they had an old booklet that was quite big, it was difficult to complete it all. That can be a difficult process to navigate.

We see again and again that people have good days and bad days when they have mental health issues. Again, that does not affect just veterans. If you are called to an assessment on a bad day and you do not turn up, or you turn up and cannot function effectively, you will suffer as a result of that. Having the flexibility within the system to understand that is key.

In the global sense, I do not know if you will talk about the covenant and the new Armed Forces Act or ask any questions about that.

Chair: We will not.

Philip Martin: Okay. Within that, we focus on veterans because we are trying to build a system that treats veterans fairly and minimises disadvantage. That is now coming into legislation. I would wrap up by saying that that is what makes veterans unique in that sense. We are

trying to build a system that provides the flexibility to minimise the disadvantages they might experience.

Q207 **Chair:** From what you have said this morning, it sounds as though advocacy that understands the reality of service life is more important than advocacy around specific disabilities. Is that right?

Caroline Cooke: It all depends on individual circumstance. Some people will need that advocacy about their specific disability. To generalise in a way that probably does not work, the support of someone who understands the armed forces environment is key.

Q208 **Chair:** Okay. I have just a couple of final points. I had not heard before that 12 years was the norm. Is that the average time between something happening and post-traumatic stress disorder kicking in?

Andy Pike: That figure used to be used a lot. That timescale is decreasing, as far as we know. Combat Stress, which is the mental health expert in our sector, is the one to help you on that.

Caroline Cooke: It is slightly disputed but approximately that, still.

Q209 **Chair:** Okay. Caroline, you made the rather shocking point that it takes 18 months for the service military records to be sent to the GP. Has that always been the case or has it got worse? It seems a long time.

Caroline Cooke: In some instances, not in all, but recent research made that finding.

Andy Pike: To quickly jump in on that point, Programme Cortisone has been ongoing now since at least 2014. It is meant to digitise the records so that when somebody leaves service their armed forces Defence Medical Service record can be swiftly transferred across to the NHS. That was launched in 2014 and is still not complete to this day. It has been knocked back. We have had some progress on it and are possibly getting closer to a solution, but the longer that situation goes on, the longer there will be this delay in the system.

Caroline Cooke: There are some awful examples where they have been chased and chased and nothing has happened. That is not always the case.

Q210 **Chair:** Quite apart from claiming benefits, if you want to go and see your GP having been discharged, the fact that the GP does not know anything about you must be a problem.

Caroline Cooke: Yes, and having to tell your story over and over again.

Andy Pike: I realise we are probably running out of time. Can I make one last point?

Chair: Please do, yes.

Andy Pike: Thank you. It is just to touch on what Philip mentioned earlier. Last year the Government passed the Armed Forces Act, which includes a duty for local authorities or some local bodies to pay due regard to the armed forces covenant in the design and delivery of policy and services. Within that, though, we argued heavily that that should not just be local authorities delivering health, housing and education, but should cover the wider gamut of services. We have explored today how veterans will access a wide range of statutory services.

The national Government are currently excluded from that remit. If it were not—if the DWP were included—it would mean that they would have to think about veterans before designing services in the first place. There is a solution but it requires amending that Act at some point.

Chair: That is an interesting point. Thank you all very much for the interesting answers you have given to all our questions and helpful input to our inquiry on health assessments for benefits. That concludes our questions and our meeting this morning.