HOUSE OF COMMONS

Defence Committee

Oral evidence: Armed Forces and Veterans' mental health: follow-up, HC 1133

Tuesday 12 January 2021

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Watch the meeting

Members present: Mr Tobias Ellwood (Chair); Stuart Anderson; Sarah Atherton; Martin Docherty-Hughes; Richard Drax; Mr Mark Francois; Mr Kevan Jones; Mrs Emma Lewell-Buck; Gavin Robinson; Derek Twigg.

Questions 1-50

Witnesses

I: Mandy Bostwick, Specialist Trauma Psychotherapist, and Dr Gary Green, Emeritus Professor, Department of Psychology, University of York.

II: Sue Freeth, Chief Executive, Combat Stress, Sarah Jones, Head of Psychological Wellbeing, Help for Heroes, and Meagan Levin, Policy Officer (Welfare and Employment), Royal British Legion.

Written evidence from witnesses:

– *MHF0001 Professor Gary Green (Emeritus Professor) and Mandy Bostwick (Specialist Trayma Psychotherapist)*

Examination of witnesses

Witnesses: Mandy Bostwick and Dr Green.

Chair: Welcome to the Defence Committee hearing on Tuesday 15 January 2021. This is a hybrid session. Its aim is to seek an update on mental health treatment for veterans and members of the Armed Forces, and to examine whether the Ministry of Defence and other Departments have improved their performance since the publication of the Committee's report on mental health and the Armed Forces. We will also be looking at the impact of the pandemic on veterans and members of the Armed Forces in relation to mental health.

Our time this afternoon is split between two panels: the first will look at specific aspects of mental health; and the second will focus on the wider provision that is provided to our Armed Forces and veterans. In the first panel, I am very pleased to welcome Mandy Bostwick, who is a specialist trauma psychotherapist, and Dr Gary Green, who is a professor at the department of psychology at the University of York. Welcome.

In our second panel, we have Sue Freeth, chief executive of Combat Stress; Sarah Jones, head of psychological wellbeing at Help for Heroes; and, finally, Meagan Levin, who is the policy officer at the Royal British Legion. You are all welcome. Thank you for your time this afternoon.

We will go straight to Stuart Anderson, please, to start us off.

Q1 **Stuart Anderson:** It is great to see you both, and very nice to see you again, Mandy. I have been fortunate enough to have a very insightful brief from you. When we start, will you outline for the Committee what traumatic brain injury is, and where we should not get it confused with mental health or PTSD? Will you expand on that to set the scene, before we go on to further questions, please?

Mandy Bostwick: Yes, of course. The two are very different—TBI and PTSD are very different. In the world of TBI, I think it is fair to say that TBI is central to the development of PTSD. When we are trying to assess and diagnose the two conditions, they are brother and sister. The same incident may cause both diagnoses, making assessment and diagnosis all the more difficult. They have the same aetiology in terms of what we are being presented with face to face, and they share several of the non-specific symptoms, so the symptoms of both overlap.

In terms of the conditions, they are very different indeed. Complex PTSD is a permanent brain injury, with a permanent change in brain chemistry, leading to the complete dysregulation of every possible system. It is classed as a mental health disorder at the moment, but we need to look at this because the way that we approach it needs to change, and the assessment of that in itself needs to change.

In terms of mTBI and kinetic blast injury, these were found to be the signature wounds of Iraq and Afghanistan. Further research, as these conflicts started and continued in Afghanistan, was done mainly in the US by various leading clinicians in their fields. This is in the field of neurology, not in the field of psychiatry as we see here in the UK, which is muddying the problem and stopping any advancement of services for our military and ex-Army service personnel.

Kinetic blast is the shockwave of a blast that is coming through your body, through your brain, vibrating your brain and separating systems in your brain, causing cavities where we can see micro-haemorrhaging and micro-scarring in the brain. Traumatic brain injury is a knock to the head where we see a specific area that has been damaged as a result of a flying projectile, which can cause haemorrhage and, again, further scarring of the brain, separating the white and the grey matter.

It is very difficult to look at these injuries. Professor Green, who is on the panel with me today, will be able to describe in better detail the difficulties that we have in looking at these with a scan. The problem that we have had and that we continue to have in the UK is, as I have said, that this area of the work has been dominated by psychiatry, and the research that I have in front of me right now that looked at it was headed up by psychiatrists. It was very concerning indeed to hear, last year or the year before, when the issues were taken forward with Defence Medical Services, that the person currently setting up that service on TBI at the Defence Medical Rehabilitation Centre at Stanford was actually a consultant rheumatologist, not a neurologist.

Q2 **Stuart Anderson:** Mandy, can I just come in there? We will expand as we go through the questions. I am just looking for clarity, which you have done so well, around traumatic brain injury—TBI. You have talked about blast and projectile. Let us say, for example, a soldier serving on overseas operations is involved in a car crash. Would that also count as TBI?

Mandy Bostwick: Yes. We see that during Iraq and Afghanistan lots of people in vehicles were jolted through these blasts, or had car accidents, and that of course is included.

Q3 **Stuart Anderson:** Thank you. Professor, is there anything you would like to add to that?

Dr Green: I would go along with that. Head injuries in general are to do with changes in function in the brain. That is what we will hear a lot about later, but they can be due to road traffic accidents, assaults and falls, and they will occur in the military as well as in the civilian population. As Mandy Bostwick has said, one of the big differences is the real increase in the number of people who have suffered from blast injuries, particularly due to IEDs.

Stuart Anderson: Thank you. That leads us nicely on to our next question, Chair.

Q4 **Chair:** If I may elaborate on that a bit further, when we speak about an acute event in comparison with, let us say, PTSD, in that acute event we speak of blast injuries, and there is a shock wave that then comes through. Is it the shock wave that causes the damage, or is it an actual strike—a kinetic engagement with the brain itself?

Mandy Bostwick: The two go hand in hand. We are seeing both. We are seeing the shock wave that comes in through the body, through the head, and the head will continue to vibrate long after the body. It is the jolt that takes us through that that causes the injury, so we do not separate one from the other. It is the two that come through that event.

Q5 **Chair:** Professor, do you have anything to add to that?

Dr Green: In America they have the Defense and Veterans Brain Injury Center. They have looked at some 413,000 individuals in the military, who have been diagnosed with a head injury. They say that a person will just have a head injury due to an accident, an assault or something hitting the head, but we can also have people who have a blast, as well as that. The blast can give rise to the head injury and it can affect other parts of the body. The result is that you can have just a head injury, you can have post-traumatic stress disorder from being exposed to that traumatic event, or, as Mandy Bostwick has said, you can have both.

Q6 **Chair:** That is very helpful. You just mentioned a figure. Could you repeat it? Over what period of time is that?

Dr Green: From 2000 to 2019, the Defense and Veterans Brain Injury Center recognised that in America 413,000 military personnel were diagnosed with a traumatic brain injury.

Chair: In the United States, not here in the UK. I just wanted to clarify, because that was rather a large number. To explore how this is affecting people over here, I will hand over to Sarah.

Q7 **Sarah Atherton:** Professor, you have just mentioned some statistics for America. Do we have any figures here of how many veterans and soldiers are affected by this?

Dr Green: Yes. We do not have as many figures. For example, the King's Centre for Military Health Research and the Academic Centre for Defence Mental Health reported on the incidence and prevalence in the UK military. They say that new incidents are about 3.2% of the military. The number who have the effects of a head injury is something like 9.5%. However, in their document they said something extremely important: they are the people who were not evacuated from the scene of the incident. For people who have a moderate or severe head injury and are taken away from where the incident occurred and are casevaced back, they did not have access to them. Those figures do not include moderate and severe head injuries, they include the milder head injuries, which are much more common.

Q8 **Sarah Atherton:** Mandy, mild traumatic brain injury—I take it that many of those do not get diagnosed. Would you expect those figures to be much higher than the 3.2%?

Mandy Bostwick: Yes, I would. In the piece of research that Professor Green has just alluded to—the piece of research we are alluding to was from 2012 and quoted in your last Select Committee hearing—the sample groups that were used were not relevant; they were not TBI cases. They were people with alcohol or drug misuse, and they were just random samples that were taken. Those figures, I believe, are skewed. That is not a correct representation, as Professor Green has said, because they do not include people who were casevaced from the scene, who would equally have had not only severe or moderate, but mild traumatic brain injury as well. So those figures are totally unreliable.

Q9 **Sarah Atherton:** It is quite complicated, because you have patients and veterans with a lot of diagnoses that you have to disentangle. Can you give me some idea, for someone with mild TBI, of what their symptoms would be compared to TBI/PTSD? It is the mild bit that I am trying to explore.

Mandy Bostwick: They would have sensitivity to light, problems concentrating, sleep disturbance, anger management issues and difficulty finding their words in sentences. In lots of cases I have seen, they cannot remember the process of making a cup of tea or a sandwich. They are the ones that struggle massively daily to be able to function on any level.

Equally, we know that PTSD comes partly with this diagnosis. Given the incidents that they were involved with, of course they have PTSD. Those overlap in symptoms. One will trigger the other. So they live in this absolute abyss of hell, with these symptoms daily, with real problems trying to function, and of course their symptoms manifest even further and their condition gets worse and worse.

Q10 **Sarah Atherton:** These are the people that are probably out in our communities that are not seeking or looking for help or getting help.

Mandy Bostwick: Looking at the large amount of cases that I have collected—well over 1,000 now—they have all seemed to follow the same pattern. They have been prematurely discharged from the military without any level of assessment, even though they were displaying these symptoms, or they have been misdiagnosed, which has led to mistreatment, and they have remained in these psychological services, being labelled with, as you have just said, all sorts of disorders, with inadequate treatments. Many are labelled as treatment resistant or malingerers and they are discharged from these services back to their families, who are then sent beyond breaking point, trying to cope—they are left with the burden of trying to cope. Many of the wives have had to go back to work, because they can't afford to stay in the family home and their husbands are not able to work.

As a result of that, they have no evidence to be able to apply for their Armed Forces compensation. All the cases—I am not saying a majority or a minority of the large number of cases we have—have not been able to apply for compensation. No one has.

Q11 **Chair:** Can I explore this a bit further? Is it very obvious when this has happened that you can diagnose straightaway? Or is it something that you need to go back to six months or a year later? Is there a latency to this? Does it incubate?

Dr Green: Maybe I could say a little bit about that. One of the things that it is important to understand is that in the definition of head injury—you will see this in the NICE guidelines and in many definitions—there is a big difference between the initial diagnosis to do with the acute injury. The definition of, say, mild versus moderate is based on how long the person had lost consciousness or the period of amnesia associated with the event. Mild often is a short period of loss of consciousness, or none, and only a short period of amnesia. Moderate is longer and severe is longer still. Severe may also have a penetrating head injury.

These definitions are extremely important in the acute phase and determine what happens in the acute management, but, as Mandy Bostwick has said and we have put in our notes, the difference is what happens later.

The vast majority of people with mild head injuries will recover in a short period—in three months or so—but then there are a whole group of people in all these groups who will go on to have chronic problems. That is the difficulty, because these are complicated and complex. They affect perception. They affect cognitive function. The person may have headaches and migraines, mood changes, anxiety changes, fatigue, sleep disturbances.

So we get a complex of effects on the brain, which can go on for a very long time. There are very good guidelines, which are in practice in the military and civilian population, about what you do in the acute phase. The difficulty is, as many organisations have said, including the Lancet Commission this year and the NATO commission a few years ago, that patients who are discharged are very unlikely to get much more follow-up and yet they continue to suffer from problems.

Chair: Thank you for that. Can we move onto diagnosis?

Q12 **Gavin Robinson:** Good afternoon to you both. Professor Green, why are we so bad at diagnosing traumatic brain injury in the UK?

Dr Green: That is a very good question. Why are we so bad at it? I think we are very good at managing the acute situation. There are very good guidelines for doing this. I think it is the recognition that these problems persist and how you manage that, rather than how you diagnose it. If you look at the really good guidance about what is really going on, a lot of the initial work is to do with whether or not there is physical damage to the brain and whether you can do something about it; whether you can manage a bleed or other aspects of the injury.

The problem is that, as the Centers for Disease Control and Prevention in America have said, and as the American Congress of Rehabilitation Medicine has said, what we are looking for is a disruption of brain functions leading to this plethora of problems. So how do we diagnose brain problems and changes in brain function? You cannot do that with the technology that currently exists in hospitals—you cannot see that with an MRI scanner and you certainly cannot see it with a CT scanner, which is the current guidance for what you do in the diagnosis. You need a way of looking at brain function—this is the difficulty. In the world, we are good at that—there is technology that exists to look at brain function—but what is really a shame is that the military discovered how to use this technology in 1941: you can measure brain activity by putting electrodes on the scalp. Now, more modernly, you do not have to do that; you can do it entirely non-invasively.

In 1941, military surgeons showed that after a head injury you get a change in brain activity, giving rise to very large amplitude slow wave activity in the brain. In fact, we were the leaders in that in 1941. What a shame that is not in everyday practice here. Why not? The technology for doing that has not passed regulatory approval for clinical use in this country, yet it is used around the world for looking at brain function in relation to epilepsy, it is recognised by the FDA and the American College of Physicians, and it is used throughout Europe, with thousands and thousands of cases of epilepsy diagnosed using these machines that can look at brain function non-invasively.

So, yes, we have the technology in this country—there are 10 centres that have this technology. Two of them actually do perform assessments on epilepsy, but not yet for head injury. I have been associated with one of those centres for a long time, and we have been providing technical reports on that for some time.

Q13 **Gavin Robinson:** Professor Green, you mentioned the United States and other European nations. Who internationally is dealing with the diagnosis of traumatic brain injury better than us? Which country should we be looking to to replicate and emulate the sort of service of diagnostics that they have?

Dr Green: In this context, one should look at the Americans, because the Department of Veterans Affairs has established specific departments for head injury and brain injury and they have funded research that is not just leading to further research, but being used in practice with veterans for the assessment. It is now being used for the objective assessment of therapies, and there are very large numbers going through that. So I think that is where the best practice is.

Last year, Mandy Bostwick was among others who organised a summit between the Defence Medical Services, American clinicians and members of the Veterans Affairs association. They all got together to bring their expertise together. They published a report, and of course what they called for is the uptake of objective measures of diagnosis, which would help everybody. Of course, NICE themselves have said that what we need is a method of early detection that could minimise or avoid the complications. The opportunities and the willingness to do this are there; there are just not the resources yet.

Q14 **Gavin Robinson:** Thank you, professor. Mandy, that is a good segue to you. You were obviously instrumental in this report. How much progress has there been and what stumbling blocks do you see at this time?

Mandy Bostwick: It is quite concerning, actually. There has been absolutely no progress. In fact, in speaking with the Defence Medical Services in late 2019, it was decided that we would have a summit and bring the expertise here to the UK.

In looking at the history of this, as I said earlier, psychiatry still dominates this area of the work, when they actually have no right to be in this area; this is the world of neurology. It is neurology that should be taking this forward. When I looked at that further, I think there had been three reports, none of which had provided accurate sample groups. Some of the outcomes of the research were highly questionable.

I then took that to the Defence Medical Services and spoke to the senior health adviser to the military about this issue, and it was his decision that we would have a summit. We invited Professor Roland Lee, over in San Diego, who is doing all this work and whose research is leading the world. We invited Dr Daniel Perl, who dissected veterans' brains during Afghanistan and found a biomarker—the difference between blast TBI, CTE and CQE. We invited Dr Mark Gordon, who is leading the way in rehabilitation in neuroendocrine and endocrine. Obviously, Professor Green spoke, and so did Ben Dunkley from Canada, who has been researching with special forces over there. Those are the world leaders in their field. After that, it was agreed that MEG would be the new tool for diagnosis, and that we would start to look at neuroendocrine and endocrine function for rehabilitation, better than what we were doing right now in the UK.

What happened after that summit was quite concerning. I raised a formal complaint against Imperial—I have a copy of that—about the lack of reporting that came out of it. We had all these world leaders there, yet none of their work was even referenced in the report that followed. I also raised concerns with the *British Medical Journal* and provided evidence to them about what was left out of the report. All communication with Imperial became more difficult, as it did with Defence Medical Services.

As a result, that report today sits on a shelf. Its recommendation is just to produce more research. We do not need more research; the research has already been done in this area. They listened to it on the day. What we need is a solution for our military—we now have a legacy of veterans who have been left with these terrible conditions and these terrible, debilitating syndromes—and to be able to provide accurate assessment and diagnosis.

The *BMJ* actually raised their own concerns about the report and refused to publish it. It was quite concerning that it ended up like this, but it has. Where does that leave us now? It leaves us still sitting here today. Hence, we are in this debate. We have brought it back to the Defence Committee to look at all the evidence we have on this and to take it to the Government to provide a funded pathway for scanning, which Professor

Green has set up with his colleagues, so that we can actually start assessing and accurately diagnosing.

I just want to add quickly that in the last Defence Committee, Dr Julian Lewis raised this issue on 18 December 2018, and it was noted in the report following that debate that we should not misdiagnose; we should aim to be accurately diagnosing people with traumatic brain injury. It has been a bit of a turbulent time. It has been very disappointing. I think we can still move forward, and hopefully we can.

Q15 **Gavin Robinson:** Thank you. You have encapsulated the importance of this session, and the drive and determination that you, Professor Green and others are bringing to this area. I certainly thank you for that, and I am sure my colleagues would do likewise. You have partially outlined the difficulties in misdiagnosis. You have also fairly categorised the distinction between a neurological and a psychological problem. Once diagnosed—if you can receive a diagnosis of TBI—is the treatment itself difficult thereafter?

Mandy Bostwick: Not really, no. Once we have an accurate diagnosis, we are no longer dancing in the dark and we can look at a wider eclectic treatment regime and apply the right treatments at the right time for an individual, and of course to monitor them.

However, what is equally important here is support for the family and their ability to apply for compensation, because a lot of these families have now been left in poverty. So the treatments are there and, again, the treatments are advancing in the US. Because there has been no development or advancement in the UK since the conflicts in Iraq and Afghanistan, treatment now equally does not exist here in the UK. And the gap to bridge that treatment now is so wide that we would need a specific facility—a treatment centre—to be able to take the individual and support them in the level of treatment they would need, and medication and long-term monitoring, and support for their families.

Q16 **Gavin Robinson:** Just in reverse then—perhaps Mandy first and Professor Green second—may I ask you just to outline, in a bite-sized way, the consequences of misdiagnosis? You would say it is continual, indeed enduring, medical difficulty, potential family breakdown, lack of intervention for what you say is entirely treatable, and no financial support as a consequence?

Mandy Bostwick: Yes, absolutely. What we see is really driving these individuals to suicide. Over the last several years, since I have been looking at this, I have seen men who have taken their own lives as a result of this, as a result of being left in a washing machine system, or a revolving door system, of misdiagnosis and mismedication, which has made their condition worse.

I have also seen complete breakups of families. We have a large percentage of these men who have left the family home and who are homeless, who then have to try and get access to their children through the courts. We have men at home looking after their children—with these men, there are safeguarding issues in relation to this. Their wives are having to return to work, to try to bring some money in to keep the family home going. These are serious crisis situations that we have right now in the UK, and they have been impeding and they continue to do so.

Equally, at the start of the Iraq war, veterans in the criminal justice system—the number of veterans in the Prison Service was 3% at the start of the Iraq war. They are now reaching 13% to 14%. They are the largest sub-cohort group in the criminal justice system and we know that a number of these veterans will definitely have brain injuries as a result of their service.

What is very, very sad here is that these were the men who were on the frontline in direct combat—the bravest of our men and women—and who have been left with absolutely nothing. That is the very sad thing about this. They are completely abandoned and bereft. That is very sad.

Q17 **Gavin Robinson:** Thank you. That is a very powerful point. Professor Green, do you wish to add anything, or are you happy with the response Mandy gave?

Dr Green: I certainly agree with her. I think there are two other benefits that I should mention. If you have an objective method of diagnosis—as we propose in this document that we have sent you—using this particular kind of brain scanner that can measure brain activity directly, then yes, you can have more accurate diagnosis. Once you have that, it allows you to evaluate treatments and management procedures much better than is currently possible.

It would also help the military in recognising difficulties and looking at preventive measures in combat. It would help them in managing their teams, because you do not want a person who has had a head injury, with problems of attention or executive control, affecting their team members, and also being at risk of repetitive injuries, which we now know leads to neuro-degeneration and early dementia.

Last of all—this is important—NICE was very clear in 2020, in one of its documents, about the urgent need for objective diagnosis for the civilian population. Here is another example where taking things forward in the military could have major consequences for the 1.4 million people a year who visit an emergency room with a head injury. Over 200,000 get admitted—that is one person being admitted every three minutes for a head injury, who has to be diagnosed through self-reporting of what has happened and a CT scan, which may or may not show anything, in the majority of cases.

Chair: Thank you. We have three supplementary questions on this pertinent area, from Martin Docherty-Hughes, Kevan Jones and Mark Francois.

Q18 **Martin Docherty-Hughes:** I will try to be objective, given the fact that my brother served in Iraq and he has often talked about some of the challenges that his colleagues have faced. He is still in the forces.

Professor Green, you mentioned NICE. It would be remiss of me, as an MP for a Scottish constituency, not to ask about SIGN, the Scottish Intercollegiate Guidelines Network, and its involvement, and specifically about the traumatic brain injury in adults standards for NHS Scotland, and where they sit in this debate. Mandy, you might want to come in on that as well.

Dr Green: I will say a little bit about that. There are similar guidelines. They are remarkably similar to the ones in England and Wales. I would also point out that Glasgow and people in Lanarkshire have been leaders in working out what the protocols are for the acute management and long-term management of head injury. There is a particular team in Lanarkshire that has been working on the assessment of different management procedures—for example, cognitive behavioural therapies and cognitive communication therapies. It would be remiss of me to say that these facilities and issues are not well recognised in Scotland, because they are.

Scotland also has one of these brain scanners, in Glasgow, that can measure magnetic fields. Scotland has a consortium of imaging centres, which work together to translate what goes on in Scottish universities into clinical practice. I know about that because I was an adviser to them for some years.

Mandy Bostwick: I would say that the guidelines are there and they are very clear and they are updated. What we do not have is the action that follows them. That is what we don’t have. We are stuck in this perpetual cycle of very poor research in this area, being led by psychiatry, and therefore no advancement really. I think that is why, although the guidelines are there, there is very little action that comes behind them, because of that.

Q19 **Mr Jones:** Mandy, you mentioned earlier the issues around the Armed Forces compensation scheme. Have individuals you have dealt with actually applied to the scheme, and what was the response? Has there been any litigation against the MoD in this area? Are you aware of the comparison with, for example, the United States, in terms of the compensation that individuals there receive?

Mandy Bostwick: Let’s take the first part of that question. We have scanned three individuals on the scanners—on MEG and the 3G fMRI—and all three had a brain injury. There was one particular case that was eight standard deviations away from the normal. This gentleman was showing, for example, mini-seizures, blackouts, headaches and management issues. A full report with all the evidence of the scans and a full neurological report was given to the Armed Forces compensation scheme, along with a claim for complex PTSD. To my knowledge, I am aware that the Armed Forces compensation scheme refused to consider his neurological claim. He needed further assessment, and they said that they would wait for that further assessment—so we needed to scan him again.

In the meantime, in between him being scanned, he was contacted—which was quite worrying, and we have the evidence for this case—by the head of the Armed Forces compensation scheme. He was invited in to speak with them. I believe they did a direct deal with him: they gave him a higher compensation award for his complex PTSD, as long as he never returned to apply for a neurological disorder. I have that file, the evidence in that file and the individuals involved in that meeting.

That is extremely concerning, that the Armed Forces compensation scheme blocked an award for a neurological claim—not only blocked it, but then did a deal to advance a claim for complex PTSD on the basis that he would never return. That is extremely worrying indeed. To date, as a result of no assessment and diagnosis pathway—although, saying that, as we sit here right now, we have Professor Green, who set up the assessment and diagnosis pathway, but previous to that—there is no litigation at the moment against the MoD.

Over in the US, there have been a number of cases, but their system seems to be a lot clearer than ours, in the fact that they have this level of assessment and diagnosis—those world leaders came to present it this time last year actually—so, therefore, their claims go more smoothly. Their offer is much better at processing than ours.

We will of course look into that client who was treated in that way and into the individuals involved in doing the deal that they did. It was extremely concerning.

Q20 **Mr Jones:** The problem that that individual will have is if the Overseas Operations (Service Personnel and Veterans) Bill goes through. With that, after six years the case would be automatically struck out. Are you concerned that the provisions in that Bill will limit some of these individuals, even if we are going to take claims forward?

Mandy Bostwick: No, not at all. We have looked at that with our legal representatives and barristers, because it is a serious issue and one that quite rightly needed to be brought up here. If there has never been an assessment and diagnosis pathway for these individuals, and their cases clearly show that they were prematurely discharged although they were reporting symptoms, or that they were misdiagnosed and mistreated, then, equally, that can be challenged in court.

Q21 **Mr Jones:** Well, it can, but under the overseas Bill, it will mean that the MoD will use the defence that these individuals are out of time, because of the six-year limit. Do you think that that might be used as an excuse to debar some of these people?

Mandy Bostwick: No doubt it will be used, as it has been used for those with a psychological injury. In those cases, right now, I have clients who are still waiting eight or nine years down the line for their compensation. They have had to jump through massive hoops, they have had no financial assistance to do so, and they have had to get independent psychiatric and psychological reports, only then to be told that they are out of time. So, the same thing has happened to them.

It is the whole way that the Armed Forces compensation scheme was set up for this level of client, including the TBI clients. If we have no pathway, and if we have no assessment and diagnosis—no body, no crime. So, if we do not measure it, it does not exist. Therefore, for those individuals who need this level of compensation, and are owed this level of compensation, how could they ever have possibly claimed for it if the pathway never existed in the first place? The evidence for that is the same in every case we have.

Q22 **Mr Francois:** I am a complete medical layman, but my partner is a neuroradiographer in the NHS, so I know a little bit about scanners. The scanning technology that you have been describing to us is absolutely at the cutting edge. I have two quick questions. First, how much does one of these bits of technology cost? I ask just so that we as politicians can get our head round how much it would cost to provide them. Secondly, I think it is true to say that the Americans are way ahead of us on this and have been for a number of years. I think you both mentioned that there is at least one centre of excellence in the United States in this field of technology and medical treatment, and you also suggested that there should be an equivalent in the United Kingdom. If so, where would you recommend that it should be? Should it be at the DNRC or should it be at some other specialist facility in the UK, and if so, where would you recommend? So, how much and where?

Mandy Bostwick: I will just do the "where", if that's okay, and then hand over to Professor Green for the "how much". In discussions that we had with Defence Medical Services at the start of this journey, in late 2019, it was agreed that the services should sit with the Defence Medical Rehabilitation Centre at Stanford. That is what it was built for, and it is not too far from scanners, so there is less distress for the individual who has to travel to the scanners and come back for the treatment. Equally, it is a place that now, I believe, is open to veterans, not just serving military personnel, and therefore it would be able to support and look after the legacy of cases we have now who have been left like this and who desperately need this level of treatment and of assessment. So it was discussed with DMS, and we did get to the point where we agreed that, yes, it should be in the Defence Medical Rehabilitation Centre at Stanford. I will hand over now to Professor Green to talk about the cost.

Dr Green: The technology costs about the same as a state-of-the-art MRI machine, so it's about £1.5 million—nearly $2 million. That's the current state of the art. There are new technologies coming that make it cheaper. There is a system at University College London and Nottingham University that, in the end, should be a cheaper facility. But at the moment, the clinical facilities for doing this exist in, for example, Birmingham, close to the centre that is dealing with military head injuries. We are using that facility now and providing scans on individuals—not just the military—and then reports on them. The cost of the reporting is roughly equivalent to that of the assessments of neuropsychiatry and neuropsychology that exist at the moment.

Q23 **Mr Francois:** Professor, very quickly, because we must move on—if my partner were here, she would remind me that the issue is not just the equipment; it's the specialist staff to operate it as well. But from what you have said, for £1 million to £1.5 million—as technology advances, the cost will hopefully fall a bit—we could even, theoretically, put one of those machines in the DNRC, provided that we had sufficiently highly skilled people to operate it, yes?

Dr Green: Yes. I ran a centre for many years; I established a centre where we trained people in running these machines. We trained them actually in a matter of weeks to run these machines. Nowadays the analysis of the data that comes off them is automated, so it does not require specialists to be able to look at it in quite the same way. It is very similar to many of the ways in which modern technology is now looking at brain scanning in general.

Q24 **Mr Francois:** If you won the lottery and got £1.5 million, where would you put it?

Dr Green: I would put it near where the military defence services are.

Chair: That is very helpful, Mark; thank you very much indeed. Richard, are there any final questions from your side?

Q25 **Richard Drax:** Yes, hello. Good afternoon to you both. Could the UK's existing services diagnose and treat TBI if they were properly focused. Mandy, I will come to you first, if I may.

Mandy Bostwick: Yes, but I think it is important that we define "properly focused". There is no reason why they couldn't. As Professor Green has just alluded to, staff can be trained and specialists can be brought in, but that would need to happen and there would need to be a collaboration. We have very few clinicians right now in the UK who can operate at this level, because services have not advanced. So, there would need to be a defined group of individuals put together to be able to do this, and to set up services and set up shop to support this level of assessment, diagnosis and then treatment. It is support for families, which I need to keep saying, and a direct line to apply for compensation. These men will not be working for the rest of their lives.

Equally, they will need support from community services. We can harness some of the services that are already there, but it is a piece of work within itself now, as the gap is so wide. It will take a specialist group of people to be able to put this together.

Dr Green: Personally, I think that, yes, we do have 10 centres in the United Kingdom that have these scanners. They are all research centres. Although two of them have been providing technical reports for clinical services, if the number of people who have had head injury in the military in the past—the backlog of cases—as well as the new cases, and civilians, were to have access to this, none of those centres would be able to cope in terms of the numbers.

Q26 **Richard Drax:** Would this be something that should be included in the military covenant, do you think?

Mandy Bostwick: The military covenant covers these areas and yes, it should be included. But then, when we come back to the military covenant, I think we need to go up and out, in terms of us now putting this together. All these grant-making bodies and organisations could play a part, but it needs to be properly organised. We do not need to go off at a charge doing this. It needs to be well thought out, well placed and well supported. We need staff who can manage this. Therefore, we need to look at the networks we already have that can support it, including the Armed Forces covenant, but not just that alone.

Q27 **Richard Drax:** I am interested in your answer to this, because I have always felt that we politicians send our Armed Forces into harm’s way and ask them to do things that few of us can understand, in appalling conditions, not least in places like Afghanistan. They come home and, on the whole, they are looked after by charities. Do you think that the MoD should be responsible for not only sending them, but looking after them completely when they get back? Or is that an unrealistic ask and charities should share a proportion of that burden?

Mandy Bostwick: It is not an unrealistic ask at all. You are absolutely right. The MoD carries the burden of this. I strongly believe that when we look at the NHS, which is already buckling providing its own services, that these services need to be held by the MoD. These are specialist injuries, and these men have been in unique conditions, including operations that are top secret. These men need to be kept within the fold and looked after.

The MoD needs to take responsibility, as do Government and the politicians that send them off to these wars. If you send them there, and they come back, then they are equally the responsibility of the people that have sent them there in the first place. Distributing them out to charities and to the NHS is abdicating every level of responsibility.

As we seen within the TBI area of this work, services are falling down and there is absolutely no level of service anywhere in the UK right now for these military personnel or veterans to be properly assessed or diagnosed. They are a unique group, whether they have TBI, complex PTSD or whatever injuries they have. If we have set up the Defence Medical Rehabilitation Centre to look after those with physical injuries, then equally we need to be setting up, within that centre, a department that looks after trauma and traumatic brain injured soldiers. Why would we not?

The fact that we have not describes the landscape we are looking at today: high levels of suicide, veterans in the criminal justice system, homelessness and families being split up, and pressure on the police and social services having to deal with this, not to mention the human cost to the individual who we sent to war in the first place. That is not acceptable, and it needs to change. I would be very interested to know what the TILS and CTS outcomes are, given that, in those levels of psychological services, the IAPT model already has an 83% failure rate in this area for the civilian population. I would very much like to know what the outcome of that service is. The fact that we largely leave charities to support people with that level of injury is not acceptable.

Today, we have a pathway for scanning set up—thanks to Professor Green and his colleagues—so we can assess and diagnose those men. I currently have a large caseload waiting for that level of assessment. Those men, right now, are having to raise money to get the scans they need. I do not think that anybody in the Committee or listening to this debate online would agree that it is acceptable that men are having to set up GoFundMe pages to have brain scans to establish whether they have a brain injury. That within itself is just not acceptable.

Q28 **Richard Drax:** I want to ask just one last question, if I may. Mandy, you are talking about more clinicians, more expertise. Can you put a figure on the sort of funding required, and would it include more military hospitals, which, of course, we used to have? Yes, they can help with the NHS as well, but we used to have military hospitals to quite a large degree, and they have all gone now. Are they also needed in addition to extra funding?

Mandy Bostwick: What we need to look at is setting up a defence medical rehabilitation centre and a department to start looking at traumatic brain injury with the level of assessment and expertise that we need. We can harness Professor Green's colleagues and other colleagues who can be brought into this, in collaboration with our international partners, to set up that department, to begin to get a clear picture of what is needed. That is the first thing. Too often, big sums of money are thrown at all sorts of things, yet we are not looking properly at the level of need. That is what needs to happen first.

From then, once we start to get a perspective on this, we will know exactly how much money we will need to take it forward. When I spoke to Defence Medical Services previously, a senior health adviser asked me the same question. I gave the same answer: we would need to look at this and we would need to look at what we needed. We have a large number of legacy cases here; the military does not have this level of assessment. We need to look at what we have got and at what resources we have, and then start integrating the expertise through that and develop it from there.

That has to be done in collaboration with the DMS; it has to be in the MoD; and it has to be in collaboration with defence medical rehabilitation centres. Only through collaboration can we achieve an outcome here.

Richard Drax: Thank you, Mandy. Sorry, Chair, did you want to come in on that?

Chair: It is just that we need to make progress, an important subject though it is. Martin wanted to come back in, Richard, if you are done on your side.

Richard Drax: Yes, that is fine.

Chair: Thank you. Over to you, Martin, for the final question of this panel.

Q29 **Martin Docherty-Hughes:** Thank you, Chair. Mandy, you have exposed some of the deep and profound issues that go to the heart of some of these debates and discussions about abdicating responsibility for such important matters within the Ministry itself. In other countries, such as Denmark, a member of the Armed Forces or a veteran does not need to rely on what are technically veterans services, because they, like every other citizen, can access services delivered, supported and funded to deliver their recovery. Is that the kind of model that you would expect in a modern, liberal democracy in the 21st century, or one, as you said, where we are still relying on charities—thankfully they, at least, are there—to help deliver some of this stuff?

Mandy Bostwick: Absolutely. Wouldn't that just be the ultimate dream, if we had services that operate at the level and standard required? Unfortunately, we do not have those services. Blind Veterans, which has also been progressing in this area of work with Dr Michael Grey, reported that TILS and CTS are not even asking the question of whether you may have a traumatic brain injury or have been in any significant events. These people are tipped into the IAPT model, which, at the moment, is showing an 83% to 86% failure rate. The men that we are talking about are at the most complex end. These services cannot deal with this level of injury and have shown that they cannot. They are not even asking the question of whether or not you have been in these events, so that is quite serious.

Charities are doing their bit, and regimental charities are seriously doing their bit, but none of them has the medical understanding, the resources or the funding to respond appropriately to what we are talking about. This needs a radical change in our approach to what we have done and what we need to do in future. I believe, in collaboration with the DMS, we need to look at a service based at the DMRC, the Defence Medical Rehabilitation Centre, for us to begin this work. Professor Green has set up the pathway. The men I have now are raising their own money to go and have brain scans. We can honestly agree that that in itself is just unacceptable. I can assure you now that for people tuning in to this debate, my colleagues around the world listening in to it, know that this is unacceptable. Their families are listening in to this debate. They are the ones who have been left here holding up this end of the work. This has to stop.

We have high numbers in the criminal justice system, high numbers of suicide, and families breaking up. Then we have another service that has come online in the NHS, the intensity service, which relies on you ringing the police. That puts more pressure on to the police. We really do need to start reading the writing on the wall. What I am asking for at the end of this debate are the funds to be able to take this forward, the funds for these men to be scanned, to have the proper assessment and diagnosis that they need. If these men continue to have to raise the money themselves, this will only go one way. This will not end well.

I think it's better that we all work in collaboration with one another and that we all start to move this much needed area of the work forward. The charities are there. They have been doing a tremendous job. They have themselves buckled under the pressure of what they have been faced with, but they can only do so much here.

Chair: Mandy, thank you very much indeed. You and Dr Green have both made a powerful case for the urgency with which we need to address this issue. Indeed, that is why we invited you here today. We are very grateful for your time this afternoon, Mandy Bostwick and Dr Gary Green.

That concludes our first session. I should say that we are shortly to meet the veterans Minister, Johnny Mercer, and Nadine Dorries, the public health Minister. We will put many of the questions that have been raised today to them, so they have fair warning that that is coming round the corner. Thank you very much indeed to our first panel.

Examination of witnesses

Witnesses: Sue Freeth, Sarah Jones and Meagan Levin.

Q30 **Chair:** I now say hello to Sue Freeth from Combat Stress, Sarah Jones from Help for Heroes, and Meagan Levin from the Royal British Legion. Before we go into the detail, and the heaviness and importance of the issue that we are focusing on today, I just want a quick one-liner from you all. All three charities have been hit by the pandemic—your ability to wiggle the tins and so forth. Can you just give us a quick one-liner on how you are surviving? Help for Heroes, you are the new one on the block. The other two have been around for 100 years or so. Hopefully you will be there, but I know other veterans charities are finding it very difficult. In fact, some might close. Sue, do you want to kick off?

Sue Freeth: Thank you very much; I appreciate the opportunity to come and talk to you today. We, fortunately, because we had to make some significant changes the year before, have not experienced difficulties this year. We have managed, due to the generous support of both the state and our supporters and donors, to stay cash positive, but that was because we took very difficult decisions the year before and had to resize what we were capable of delivering. The Directory of Social Change report, which is there for members to read, recently highlighted that a large number of charities in the Armed Forces sector are reporting financial difficulties and experiencing a loss of income.

Q31 **Chair:** Thank you very much. Sarah from Help for Heroes?

Sarah Jones: Thank you very much for the invitation to be present this afternoon. Sue, I think, has outlined the situation very well. Help for Heroes has experienced an approximately 30% reduction in what we would have expected to raise in terms of charitable funds this year, due to the pandemic, and as a consequence of that we have had to shrink, in size, our provision, in order to continue our promise to our beneficiaries to deliver our services for life. That is our promise to our beneficiaries: we will continue to support their needs throughout their life. This is the reevaluation that we have had to make this year, due to the dramatic drop in our income due to the pandemic and covid. Also, combined with that, the significant increase in need that we have also observed over the last year, that we can go into detail, further in the conversation, about.

Q32 **Chair:** Thank you very much indeed. Finally, Meagan from the Royal British Legion.

Meagan Levin: For our services, we mainly had to adapt the way we worked. We moved a lot of services online and worked closer with partners. I am not clear on the finances yet, as the final figures for our poppy appeal haven't come through yet.

Chair: Okay, thanks very much indeed. We should also say that through COBSEO you are in touch with so many other veterans charities and, indeed, you—three of the biggies, if you like—do so much to support those others that do such a fantastic service on the frontline. Our focus today is mental health. You listened in to the first session, as we were discussing that. If I can turn to Derek Twigg to take us forward.

Q33 **Derek Twigg:** Maybe I could put the question first to Sue. I think we are trying to get a handle today on whether the provision of mental health services for veterans was improving before the pandemic, and what it is like now.

Sue Freeth: I think it is fair to say that slow progress was perhaps being made, particularly talking about England, through the commissioned services that have been mentioned: through the TILS and the complex treatment, and high-intensity services, which started to be introduced last year. Where they have been set up in parts of the country those services are being provided, but I think the problem in our experience is that even in those areas they have limited access to experienced clinical practitioners—experienced in treating veterans, particularly with complex military psychological conditions, as you heard earlier.

I think also accessing culturally sensitive support is still very patchy and that is where veterans, particularly with complex needs, or undiagnosed mental health needs, and chronic needs, are still falling through the gaps, and the only recourse for lead services is to refer them on to organisations like ourselves and a number of others. There is some progress, I think, that is being made in terms of co-ordinating effort, but really—later I am sure you will encourage us to speak to the point that Mandy was raising—I think a co-ordinated effort is essential, because of the scarcity of expertise, particularly in these complex areas.

I want to be positive, too, because it is not as if effort hasn't been put in. Prior to covid that was really starting to show through, but covid has slowed a lot of this down. What has been positive, I think, is that a patient involvement group has been set up. NHS England has done that. I think that is working very well, or starting to work well. It is starting to identify those groups of veterans, female veterans, black and ethnic minority and LGBTQ veterans, who are not coming forward or not feeling that they can access these services, and who we believe have mental health needs they need support with. So I think those are areas where I hope to see us make some real progress, because I think those groups of people are getting a very ad hoc service—if they are accessing a service at all. On a positive note, I think the trauma networks that each of the nations have are now starting to mobilise, and I think they can make a difference and be part of that co-ordinating solution. There is no doubt the progress that was started has been and will be impacted by covid-19, because of the impact that it has had on the NHS generally

Q34 **Derek Twigg:** I will ask Sarah and Meagan in a moment: just one follow-on question for this point. In terms of the relationship with the NHS—you have touched a little bit on that—how is it, and do you think GPs are much better informed and have a better vision of what can be done from the likes of your own organisations in the charity sector?

Sue Freeth: Was that a question for me?

Derek Twigg: Yes, and then maybe Sarah and Meagan can come in.

Sue Freeth: There is certainly more awareness, and there is more material. A number of us have produced—in fact, a number of trusts have produced—online material that GP practices can direct people to, and I think there is a growing awareness. There is a champions scheme that NHS England has introduced, but it is a small number of GP practices around the country unfortunately. Where there is an established military community, there tends to be a more culturally sensitive, open and accessible service, but the main offer, which is IAPT, is provided by the NHS. If you need something more complex, it is much more difficult, and in our experience, GPs do not know where to go. One of the reasons GP refer people to us is for advice on where to go next.

Derek Twigg: Do Sarah or Meagan want to come in?

Sarah Jones: I am happy to comment on that, and add to what Sue was saying. I think there has been advancement, which is positive, and I absolutely echo all the positives that Sue has just pointed out. That has also brought about increased awareness and increased support. Where we have had questions historically about the scale of need, and measuring that need against capacity and hence being able to match that appropriately—to hopefully avoid the long waiting lists that we are all familiar with and regional variations in statutory care—we are now having a much better appreciation of the scale of the need.

For example, with the TILS and CTS, similarly to what Sue was saying, we are now seeing within the Hidden Wounds service at Help for Heroes—which is our psychological wellbeing service—quite a high number of referrals into our service from TILS and CTS for those who perhaps do not meet the eligibility criteria of CTS, or those that have experienced that service but have not had adequate provision. It is a very important area to see that there has been some progress, and the awareness piece is absolutely central and key.

However, that needs to go hand in hand with provision. We have made progress raising awareness among GPs and primary care within the NHS, for example, and having better partnership working, but we also need to respond to that by being able to provide assessment, diagnosis and treatment in a timely manner. Very similar to Mandy's point, we have that same difficulty, if you like, within the wider mental health sphere. We can detail that a little bit more as we discuss things, but for me, that is really the crux of the issue: meeting the demand and having a better appreciation of the scale of the demand that we are collectively observing.

Q35 **Derek Twigg:** On the cases who are particularly complex, how does your relationship work with the NHS when people come to you and you refer them back to the NHS? If they are really complex, I suspect the NHS has to deal with those individual cases. What is your experience? I know this can be complex and difficult, because I have had constituents in this situation.

Sarah Jones: I am happy to answer that, and Sue might want to continue and give the Combat Stress position. What is typically very difficult with these individuals is that often, they are bounced between services, which is the worst-case scenario. You may have constituents who have reported that to you themselves. The difficulty is often in the diagnosis piece, and the difficulty is usually also in having the right treatment pathway for those individuals. It links in with the compensation piece we were speaking about earlier as well.

I would put particular emphasis on being able to strengthen the care pathways that we are seeing increasingly strengthened in terms of the TILS, CTS and HIS programmes. There is a central point around the assessment and diagnosis piece being very severely under-resourced currently, which creates a real bottleneck that we consistently observe. Many of those complex cases, like you say, ideally should be seen in the NHS. I have worked in the NHS, and the ideal scenario is that we have the capacity to respond in the NHS to much of this need.

We also have the difficulty of the categorisation of service attributable. Many individuals who would be seen in the CTS—if their index symptomology or main presentation is not deemed service attributable, they fall between the gaps. Often they find themselves referring to us, or they are referred to us—for Combat Stress, typically. There is quite a high proportion of these individuals, because of the diagnosis of trauma and the symptomology of trauma. Being able to differentiate what is attributable to one or other instance is quite a complex task in itself. Sue might want to add to that.

Sue Freeth: Yes, this bouncing between the NHS and the charities is something that needs co-ordination and improvement. I do not think we have proper case management—shared case management—between the organisations. Yes, we are certainly specialising in treating those with complex needs, but individuals who have crisis or pre-military traumas are often people who need the support from specialist services inside the NHS providing organisations. What is missing and is often left either to the individual GP or sometimes to the individual practitioner, either in the NHS or in the charity, is the co-ordination of a proper care package that lasts throughout the whole of their pathway. That is why the service is patchy and why people do not get that co-ordination and often get lost. Those are where the risks lie.

When we are working with complex patients, it is very important that each of the organisations operates safely. For charities, which have less experience and less capability to do that, it tends to make the organisations much more careful about what service they provide, to ensure that the NHS keeps responsibility for that individual. What we need is a much more co-ordinated and integrated service, which I would suggest—we have certainly proposed this previously—should be co-ordinated from when you join up, all the way through and out into transition, and then into later life. For people with complex or chronic needs, I think that is the best way to co-ordinate the resources that we have and to make sure the best service is provided.

Derek Twigg: Thank you. Over to you, Chair.

Chair: Thank you. Maybe the next question will illuminate where the answers should come from. Emma, over to you.

Q36 **Mrs Lewell-Buck:** Good afternoon, and thank you for everything that you do to help our veterans. I know it has not been around for that long, but has the Office for Veterans' Affairs made any difference to your work? If so, what difference has it made? I am happy for either one of you to jump in and take that question.

Sue Freeth: From my personal perspective—I have been in the sector for 16 years—I think it is far too early to say. The OVA was starting to establish itself, develop relationships and collect experiences. It was at that stage when covid struck—therefore, for the first six months. Progress since then has really slowed. We are yet to see what progress can be made and whether it is going to be made. Some of the more recent initiatives that it started to form look encouraging, but there is nothing tangible yet for us to measure. The principle of a cross-Government co-ordinating organisation or entity has value and could be useful, but I am afraid that, so far, we have not really seen any tangible effect.

Sarah Jones: I would agree with that. It is a great initiative. Similar to the way we were referring to the US model and the approach to the Department of Veterans Affairs in the US, I think there is great potential. It is very early days, but we have seen some great recommendations. We have seen many ideas beginning. In terms of impact or seeing any potential change in resources, we have not yet seen any of that. We continue to have positive discussions and positive influence. I think we are at that stage where we are looking at the right methodology so that we can continue to inform, with the data that we have from the ground and the frontline, the services that we provide to help best inform the OVA. I look forward to hearing more. I think that is probably the best place to leave it.

Meagan Levin: Like Sue says, we are encouraged by the formation of the body and its co-ordinating aspect, and we are quite encouraged by some of the priorities—in particular, collecting veterans' data from the census, because that has long been a campaign of ours. The use and collection of data on a more detailed level is something we would ask the office to look at.

Q37 **Mrs Lewell-Buck:** Thanks for that. You have said that some initial groundwork has been done and some good things are coming forward. I am quite an impatient person. What would you say is the one thing that the OVA could make progress on now rather than doing more scoping work and talking about it more? Our previous Committee found that around 76 charities operate in the veterans' mental health space, so there is clearly an issue here and a gap not being filled by the Government that needs to be filled. What is the one thing that they could get some progress on now?

Sue Freeth: The intention to see the Government deliver an operational plan, following on from the veterans strategy, and getting the data and measurement metrics into position—those are the things that we are looking to the OVA to produce. They have been promised. I think some of their capacity was limited during covid—particularly, the Cabinet had to prioritise all the resources of the Government to support the effort behind covid—but Parliament is not going to get a really good handle on whether the current programmes are really delivering their desired effect, what the gap is and what part each of the parties is playing until we get some metrics in position. That is what we are waiting to see. There has been a lot of talk, as you say, and yet nothing really tangible. I think it needs to be happening as quickly as possible; otherwise, I think you will find it very difficult to measure whether the resources that are being invested are having any effect.

Mrs Lewell-Buck: Thanks for that.

Chair: We have follow-up questions from Martin and Kevan.

Q38 **Martin Docherty-Hughes:** In terms of measuring the outcome of the OVA, will you be using any measurements against the Scottish Veterans Commissioner and how they play a part in veterans' policy north of the border? While the OVA will be a Whitehall and Defence-led process, it does not really have an impact in terms of health policy, education or social work—and, frankly, there is very little that is not reserved. I wonder if there is any opportunity for the OVA to learn from what I constantly hear on the Committee from the charities is the very effective, well thought-through Scottish Veterans Commissioner.

Meagan Levin: To be honest, I do not really think I can comment on that.

Sarah Jones: I think Sue will probably want to follow up—I see her keenness to respond. From my perspective, I think it is a very valid point. It ties into the point that Sue was making in terms of data collection and having, first, a fair appreciation of the need and scope of need, particularly in the devolved nations, and the appreciation of how that should be responded to, representative of the needs that are actually rising. Being able to scope that has been the initial challenge. I think the subsequent challenge to that is related to a care pathway that ties into healthcare provision, education and the wider provision you alluded to: the way in which veterans' services fit into wider health and social care services.

I feel I have to limit the perspective I am offering because I do not represent the OVA, but I can make a recommendation from the perspective of a psychologist and Help for Heroes. For me, it is the ability to tie the data that is being resourced and assessed at the moment to a very pragmatic care pathway approach that is appreciative of the varying needs in the devolved nations. For me, that is the critical point that I would like to support and help to drive forward in a timely manner.

Sue Freeth: I do not think it is for us to answer that question, to some extent; it is to be put to the OVA. We are certainly told regularly, in meetings I attend at which the OVA are present, that they are seeking to do that, and that they are seeking to make sure that they connect with colleagues in each of the four UK nations, and when we finally see the operational plan for the veterans and the Armed Forces strategy we will see a co-ordinated effort. Obviously, as national organisations that are present in each of the four nations, we want to see that co-ordination, because otherwise we are left individually to co-ordinate our own effort with each of those nations differently.

We can see how that experience is poor for veterans themselves, who often move between nations during their lifetimes. I think the OVA is starting to try to draw that together, but as to how much success it is having, I have to say that I do not think we get a very strong feeling that it is as well co-ordinated as it needs to be. At the moment, the focus seems to be at the initial stage, which is on the governance of how this strategy is going to be implemented in order for each of the Parliaments to be able to hold the Government to account.

Martin Docherty-Hughes: I suppose my only concern is what we mentioned in the previous panel, if we took the Danish model. The Scottish Government and the Scottish Parliament's process is that when they are serviced through, I think, First Point Scotland that is delivered, managed, staffed, with services delivered by the NHS, bringing charities working in partnership. I hope that the OVA learns that lesson, not just from Scotland but our key allies in places like Denmark.

Q39 **Mr Jones:** I agree with what Martin has just said, but as Sue will know you do not need to go to Denmark to find that model. I think we were talking about it back in 2009 in terms of a welfare pathway. I want to get some understanding of where we are at in terms of the pathway for individuals with mental health. There has been a lot of talk about the new veterans Department, which I think is a bit of a self-licking lollipop, I understand from what is happening at the moment.

In terms of the individual, are there any clear, worked-out pathways with the NHS, and with yourselves, and where do you fit in? I would be interested to know about, for example, the transfer of medical records from the military to GPs. This was an issue that was promised back in 2010, I think, to ensure that veterans were flagged on the NHS system. Have we made any progress on that, for example?

Sue Freeth: I believe that for veterans now leaving that is happening. I cannot answer in terms of every veteran we come across, because we see a whole range of people from different eras. We still see many veterans who have had to re-establish contact after leaving. Sometimes that is because veterans themselves choose not to register when they first leave. One of the things that I think we all still recognise is that veterans' willingness to help us to cement this integrated approach is also necessary, but it is a bit chicken and egg. If they are not confident that the system is going to be sensitive to them, and expert enough to support them, they will not engage with it.

I would perhaps say three things. One is that my perception is that at the moment there are different pathways in different nations. That is because those different nations have different ways of delivering services. I think they are at different stages of formation. Certainly, one of the places I see them co-ordinating at is in the Contact mental health group. We now have representatives from all the trauma networks, and in the last 12 months, for the first time all the different nation representatives are joining and actively participating in the initiatives. That itself has revealed that they are at different stages.

In terms of whether there is a veterans' mental health pathway, the NHS's model for mental health is the model it is adopting for setting out the mental health pathway for veterans. I don't think it is sufficiently well co-ordinated in the transition place. We have argued for some time that it needs to be integrated much more deeply during service. At the moment—and I don't understand why—there still is a separation between the mental health service that you get while you are serving, which is now increasingly delivered by the NHS, and the service that you have when you leave. We are creating an unnecessary cliff edge, and lots of veterans fall off it and take years to find their way back on to it. By that time, they are often in a much worse state than they need to be.

Chair: Thank you for that. We now turn back to Martin. We spoke a bit at the start about your own situation. Let's now turn to veterans themselves. Martin, over to you.

Q40 **Martin Docherty-Hughes:** Thank you, Chair. I am sure Sue saw this, but anyone watching might not have seen that I was nodding away rather fast there at some of the answers you gave to my colleague Kevan. Perhaps we can go a wee bit more into the impact of the pandemic and the provision of mental health care for veterans. Specifically, I am really interested in black, Asian and minority ethnic veterans and members of the Armed Forces, and female and older veterans.

Every time the Armed Forces ombudsman comes in front of the

Committee, the one consistent narrative is the number of women, black and minority ethnic veterans and older veterans coming to them with complaints about service provision. I wonder whether that is mirrored in access to mental health services.

Sue Freeth: I will kick off, and then Sarah may come in. To pan back a little for a minute, our data shows that the groups that are most affected during a pandemic are those that have low-level social support. It does not really matter what group they come from. Everyone who has a low level of support is finding dealing with this more difficult.

People who have increased stressors—people who have pre-existing significant stressors, and particularly people who have pre-diagnosis—are finding this very difficult. We published some research in *The BMJ* before Christmas[1]. Although what we are reporting is experienced by people generally who, pre-covid, had mental health needs, they are finding it more difficult. Because veterans have a greater propensity to anxiety and trauma, they are experiencing it at a greater volume.

We have done a piece of work on female veterans, and I can really only talk about that because it is the one I am most familiar with. We started a piece of work last year, and we have been able to continue it, fortunately, by collaborating with the Women's Royal Army Corps Association. We are in the final phase of writing that study up, so it has been collected during covid. Over 600 females have participated in it[2], and they are veterans of all ages and all eras. I don't have all the details of the findings of that, because they are literally being written up, but they will be available in early April. It is a piece of work that we have done collaboratively.

Yes, it is from a fixed audience, but I think it is probably the first study of its kind in the UK. Certainly, if it produces anything like what some of the studies that have happened in other nations have produced, we are going to find that it is not necessarily that female veterans have different traumas, but that they need access to services, and they just need that in a different way. Childcare is a particular problem for that group, in terms of accessing services.

We have to wait to see the findings, but we need to better understand the presenting issues for female veterans with mental health needs and how to adapt services so that they are more accessible to them. Sarah, perhaps, may be able to talk to the other two areas better than I can.

Sarah Jones: Absolutely, I would echo that. Trust is the word that comes to mind, as a simple preliminary answer to that. We are increasingly learning a lot more about the existence of unconscious bias and how that has ripples throughout so many aspects of society—the MoD included. I use that word because we see many people presenting to us from harder-

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[1] Murphy, D., et al., *Exploring the impact of Covid-19 and restrictions to daily living as a result of social distancing within veterans with pre-existing mental health difficulties.* BMJ Military Health, 2020.Epub doi:10.1136/bmjmilitary-2020-001622: https://militaryhealth.bmj.com/content/early/2020/11/25/bmjmilitary-2020-001622

[2] The actual figure for participation is more than 700 women

to-reach populations and more difficult-to-reach groups who have experienced this in one or multiple ways. Women may be one representation of that, but I would expand that to include multicultural and multifaith groups, and to diversity in terms of ethnicity. It raises the question of a wider appreciation of the bias that continues to exist and the difficulties that individuals encounter in accessing mental health support or presenting with mental health difficulties while serving, through to their experience of being a veteran and that process of transition.

I used the word trust as well because it echoes the conversation we had earlier on the relationship between the MoD, the NHS and charities. I see the responsibility—it is a large role we have to play—of charities in establishing more confidence in the NHS and re-establishing trust if individuals have had a negative experience or, perhaps, no experience of their difficulties and symptoms being picked up or being honoured, if you like, by being appreciated while they were serving.

I echo the word trust because, for me, it suggests that we need to be explicit in our efforts. We cannot respond to need as it arises; we must recognise that there has been a systemic difficulty. We cannot collude with continued assumptions and must make conscious efforts to change to make cultural shifts, not only in terms of mental health but the diversity of the individual needs presented.

Meagan Levin: I agree with what Sue said in her answer.

Q41 **Martin Docherty-Hughes:** I will ask the three of you this, but you do not need to answer as it may be a bit of a challenge. Given the complexity and the layers of bureaucracy and differing levels of support supposedly out there—again I go back to the Danish model, where a member of the Armed Forces who leaves has already been a member of an Armed Forces representative body who does a lot of this work already for them. I know it will be a challenge for you to say, as charities, to say whether you think the members of the UK's Armed Forces should have a fully Armed Forces representative body, but would it help to enable better direction for mental health services?

Sue Freeth: I have never had any experience of them. I am aware of those bodies in other nations, particularly in the US. Having come into the sector and seen that in other occupation groups, I understood that there were compensatory areas and approaches for that lack of representation. I originally saw the Armed Forces covenant starting to pull that together and improving how that is delivered. I have to say that I do not think it has achieved that and am not confident that what is coming forward is going to do that either. Charities, frankly, are left with the responsibility to achieve that. They are not enabled to do that. If that is really what the state wants to happen in this country, then they have to be enabled and funded. What happens is that a number of charities take on specific aspects of representation, but the end result is disorganised. When it is effective, I think that is the exception, unfortunately.

Chair: Thank you for that. I am conscious of the time, and we have a few other areas and themes to cover. If all of us—questioners and answerers—curtail ourselves as best as possible, we will be able to get through this. Over to Stuart now.

Q42 **Stuart Anderson:** Thank you for everything you all do for veterans. I need to declare an interest: I have spoken openly in the Chamber about my own mental health issues after my time in the Army, getting shot, and about coming through that. I need to declare that now.

How much have the Government relied on charities during this pandemic? Sue, will you start me off please?

Sue Freeth: I would say a very significant amount, particularly in the Armed Forces sector. That is why with the latest Directory of Social Change report—there have been two now, initiated by COBSEO—you can see how much extra work the charities are being asked to take on, and at a time when it is much more difficult to raise charitable funds to do that. There has been some targeted support from Government, for which I think the sector has been appreciative, but it has not been anything like as much as it would have liked to have or, indeed, asked for. A number of the larger and wealthier organisations have had to dig very deeply into their pockets. As the chief executive of a complex charity but a medium-sized one, we would not have been able to continue to deliver services unless they had.

I do not think that that is necessarily any different in the veterans sector than it is generally in the third sector. In the voluntary sector generally, a great deal of work has gone on formally by charities, and an enormous amount of work of informal volunteering in local neighbourhoods has gone on. The neighbourliness we have seen during covid has been absolutely phenomenal. I hope that we continue to develop some of that when we come out of the pandemic. Without it, a lot of people would not have had support and been in greater difficulty. Indeed, they would definitely have had to face things in isolation, had they not had the support of organisations they could turn to.

Stuart Anderson: Thank you. Meagan, would you like to add anything to that?

Meagan Levin: No.

Sarah Jones: May I come in on that point?

Q43 **Stuart Anderson:** I want to come in with another point, because I am conscious of time, as we said. I imagine, Sarah, that you were going to give a similar answer to Sue's—please correct me if I am wrong—but I am keen to know how you are all co-ordinating your work. You talked about bouncing back and no specific case management. How do we know that we are using this time as effectively as we can? What is the co-ordination between all the different charities and the Government? How is that working?

Sarah Jones: I feel very confident that we are co-ordinating our efforts much better than in previous years. Certainly, we have regular conversations with regards to joint cases and also strategically, using the form of a contact group that we all attend.

A particular example of that would be our efforts towards a common assessment for veterans entering mental health services. We have put a lot of time and effort into that and have been piloting it this year. It creates a simpler process for an individual to access robust assessment that can then be carried to another partner service provider. If a veteran was to encounter our service and be assessed for the Help for Heroes Hidden Wounds programme, they could take that assessment with them to Combat Stress, for example, for their CTS. It then makes their wait for the treatment part of the process much shorter.

I will add to that: we have a very close relationship with our local TILS and CTS services. That is an essential connection, and what we were referencing earlier. To give you a real-life example, I was sitting in an allocation meeting this morning and cases were being presented. We have numerous individuals who present to us because they have tried to seek support through their NHS services but been told that the waiting list extends from nine months to two years for their specific needs. That is the typical wait time that many people present to us with, in terms of the range of their needs.

We work very closely with our TILS, CTS and NHS services. It is most important for that individual to get the support that they need as quickly as possible, but I would also round that off with what I was referencing earlier: this is also case management. It is not simply or—"simply" is not the right word—purely related to mental health in terms of assessment diagnosis and treatment, but about the socioeconomic challenges that those individuals may be encountering. That holistic case management is something that we pride ourselves on. We try very much to work with our colleagues at RBL, Combat Stress and statutory services for—most importantly—the best experience for the individual who is seeking help. At the end of the day, that is the central focus that we should all have.

Chair: Thank you very much. Sarah, on to the NHS.

Q44 **Sarah Atherton:** I am a Welsh constituency MP, sat on the border with England. I am noticing an emerging disparity between the provision of available services, which is a concern of mine that I am looking at. Let us concentrate on services in England—a question for Sarah.

If I were a veteran and seeking mental health support, how would I go about it, and what would it look like? The reason I ask is that I am struggling to piece together this jigsaw of the services available. I am particularly interested in complex treatment services and the transition, intervention and liaison service. What is that all about, and how would I access it?

Sarah Jones: Typically, ideally, the first place that someone should present is the surgery of the GP, for that primary care presentation, but we know that that is a weak link in the process for many in our veteran population, because of the difficulty, often, of whether they are registered with a GP. Again, I can refer to two cases that I was managing this morning, where the individuals had not registered with GPs. That is a part of the equation that is a challenge.

The TILS they can self-refer to—they can be referred by a professional or self-refer. The whole idea of that is that it is an assessment and triaging service—not to misrepresent it, because I am not representing TILS or CTS, but to explain the services in a nutshell. What I would say is that the scale they are experiencing is overwhelming. For example, four clinicians reported to me this morning that TILS in their region has reported that it is simply sign-posting, because it has no provision to assess. That is the reality of the situation that we are facing with many of the individuals who come to us. That is what is being anecdotally reported to us.

Q45 **Sarah Atherton:** Why have they got no provision to make an assessment?

Sarah Jones: I could not tell you the detail; I only know that I had four clinicians reporting that to me this morning, from the same region. Of the referrals that I was processing this morning, 40% were directly from TILS and CTS to us, because they had no provision for anything further.

In an ideal world, this is sometimes where that individual would access TILS. If their need was seen as being complex, within the criteria, they would then be referred on to the complex treatment service. However, as we were speaking about earlier, many people will fall outside those criteria. Then it is often for them to decide where they would go to for help.

That is where the complexity arises, because it is very difficult for someone to navigate which services they should go to, could go to or would be suitable for. Thankfully, many people find their way to our service or our partner agencies' services, but for many people the struggle often escalates because of exactly that problem—they are not quite sure where to go.

There is no transparency about the process. People have not been given the same information at the point of transition, so there is this confusion of process and about where one goes for support. That speaks to the consistent care pathway, which really needs to be established, made clearly transparent and to be adequately resourced. Most important is the transparency of how individuals access support, because many people find it extremely confusing, particularly if they are in the midst of a mental health crisis.

Q46 **Sarah Atherton:** Yes, that picks up on what we were saying before about the fragmented care pathways and the lack of case management. Sue, is there enough going on for families and carers of veterans with perhaps more complex, higher-end needs? What provision is out there for them?

Sue Freeth: Families were included in the scope of the commissioning documents for the TILS and CTS, but what is actually available is really only what is already available within the providing trust of their area. I do not believe that any of these CTS or TILS providers, other than bringing in the relationships that they may have already had with charities that are already in the sector and are already providing that service, are able to bring anything into the equation. This is really the problem: while it looks as though we have an investment, it is, in effect, a co-ordination of existing resources.

One of the reasons why TILS and CTS have had to ration how they provide their service is because they are having to use their mainstream capacity. In effect, the funds are helping to continue to provide that. There are no new resources being put into this, and that is why I think they get continuously constrained and they stop, in part. The same applies for the charities. A point I have made for some time is that if you really want a complex service and you want charities to take part in delivering that, you have to give them long-term funding; otherwise, they cannot retain and develop the expertise and the staff. Neither can the NHS, unless you have continuing funding for this. This is another further strand of the argument for having a properly dedicated, integrated and co-ordinated national service that crosses all four nations.

Sarah Atherton: Thank you, Sue.

Q47 **Mr Francois:** It is great to see all three of you, and we are all very proud of what you do for our veterans—thank you. When our predecessor Committee looked at this whole issue about two and a half years ago—I served on it at the time, and this is part of what we came up with—we found that the nub of the problem was that, first, there was a challenge to diagnose those veterans who were suffering from mental illness, particularly severe mental illness, in good time. Even when you diagnosed them and knew that they needed help, and you had persuaded them that they needed help—sometimes they were reluctant to admit that they needed help—there were often severe delays in actually getting them into a treatment pathway. The system said, "We know that you've got a problem and that you need treatment," but then they could not get the treatment. Very often, many of them deteriorated while waiting—in some cases, up to a year—to enter a treatment programme.

The statistics on veteran suicides are patchy, but the one that sticks in my mind was based on an ITV documentary from a little over two years ago: in the most recent year that the programme had numbers for, 80 veterans had unfortunately taken their own lives. Every one was a tragedy, and many of them were avoidable. Two and a half years on, is there still a fundamental problem that we can diagnose these people—although you said even that is a stretch, Sarah—but when we do so, often there is not enough capacity to treat them? Even for the ones that we can treat, often they have to wait too long, and some of them deteriorate while they are waiting to be helped. Is that a fair summary of the problem? Let's hear from Sarah first and then Sue.

Sarah Jones: I think that is a very good summary. That continues to be the challenge. As we began speaking about, the provision has started to improve. Unfortunately, due to the covid pandemic, that has deteriorated quite rapidly again. The number of referrals that we experienced over the last year was a 35% increase on the previous year. If you think about that in terms of capacity and responding to treatment, there is an inherent difficulty in accessing assessment and diagnosis. That is a central problem for a lot of the individuals who we support, because that is also linked to access to social care and resources. For you to identify that is absolutely accurate.

On the treatment side of it—again, from a clinician's point of view, my heart sits in being able to help these individuals live happier, fuller lives—that is also a central difficulty for many individuals who come to us. They have experienced or been able to access the primary stage, if you like, of assessment, but have not been able to access treatment, for one or other reason.

I think the difficulty where we sit at the moment is that the need is far exceeding the capacity that we have, so we run the risk of—not only within the statutory services, but within the third sector—repeating the same difficulty. Individuals will often come to the third sector or private practice—for example, I have worked as a psychologist in private practice for 15 years, and part of the passion that drove me to work for the charity that I do was that I saw too many individuals who were having to pay privately for the help that I felt that they should be entitled to, and should be provided now. This is inherently a central part of the problem, and I think it is something that we need to address, because we are running into the same issue in the third sector that we are seeing in the NHS. I think we need to be very honest about that and very honest about the scale of the need that really exists.

Sue Freeth: I think we underestimate demand, partly because it is a difficult thing to acknowledge that we have a community that actually has needs and is reluctant to come forward. We tend to size it on what we can see.

We can tell that there is a problem, because of what charities themselves—I would include our own—are having to do. We are having to really tighten our criteria for eligibility, in terms of who we can support. We have had to do that at Combat Stress—we have done it very, very reluctantly—over the last few years.

During covid, we deliberately developed some things online that could help people, so that they had something to continue to work with while they were waiting. Some people are only willing to be treated face to face, and while that is not possible, that is exacerbating the problem. We were preparing to open and start to see people in person again, and then of course we went into this third lockdown, so we are genuinely very concerned that there is a surge of people waiting behind. We really do need to resize the capacity and the demand and actually work out how we are going to deliver this. I would be surprised if that did not involve identifying new resources.

Mr Francois: Thank you. Meagan, I did not mean to leave you out—sorry. Was there anything you wanted to add on that?

Meagan Levin: No.

Q48 **Mr Francois:** Sorry, it is just because we are tight for time; I don't mean to be rude.

Our predecessor Committee went to see the Health Secretary, Matt Hancock, and we said—we didn't need to be emotive; this was the truth of it—that we had veterans who had served their country, some of them in frontline combat, who were taking their own lives in dingy bedsits in the rough end of some of our biggest cities, because they had gone to get help and the help wasn't there.

We wanted a place that could specialise in treating these people and where they could go and be safe, be assessed and be put rapidly on to a treatment pathway. We suggested to Matt Hancock that that place should be the DNRC. We went as a private delegation, headed by the previous Chairman, Dr Julian Lewis. Matt Hancock told us that he was minded to do it, that he had recently—at that time—received £70 million from the then Chancellor to go into the DNRC and that he would use that money to create this facility, this centre of excellence for the mental health of veterans, where they could go and be treated. Obviously, with covid, all of that did not take place, but the Secretary of State gave his word, and I think we should hold him to it.

Do you believe that such a facility could help to save lives and also help to accelerate getting people into treatment? Sue, do you want to go first?

Sue Freeth: In terms of the need to improve the service and to have a more joined-up service, I absolutely support that. I think we see having one centre particularly for mental health as potentially problematic. I understand from events I have been to recently that the DNRC is talking about delivering some form of psychological treatment work. Because it is not co-ordinated and we are not closely connected with it, I don't know what it is and I don't know what has happened since that delegation proposal.

I believe that a co-ordination of different locations around the country that can provide what you are describing is needed. I would hope that charities would have a contribution to make; I certainly think we do. Having one centre, particularly for mental health, may be less useful than it is for physical health, because the nature of treatment is different and needs to be, in some cases, continuous, and needs to involve the family. The best place to support a veteran with complex psychological treatment needs is alongside their family. That is difficult—

Q49 **Mr Francois:** To come back on that, because this is important, and I don't want to lose the thread, if you make a parallel with physical rehabilitation, the DNRC is the national gold standard centre, but there are then a number of regional centres—what were known as Murrison centres, because our previous colleague, Andrew Murrison, came up with the idea. The national centre of excellence was Stanford Hall and you could be treated there and then be referred on to a Murrison centre for follow-up treatment.

We are talking about something akin to that. You would have a national centre of excellence, where people could be saved, assessed, put into treatment and referred back to the region where they live, close to their home, with their family, and be put into a treatment pathway. That was the model we were discussing and the Secretary of State said that he was attracted to it. Remember, the fundamental principle of the Armed Forces covenant is special treatment where appropriate for those who have given the most, such as widows and the wounded. In the 21st century, what we cannot have is a situation that allows these men to continue to take their own lives because we have all been too busy doing something else to save them.

Sarah Jones: It is recognising the point of treatment and assessment. Linked to what you are saying, I absolutely support the idea of a more centralised effort towards the bottleneck of assessment and diagnosis, which opens the door of possibility for so many individuals. There is a lack of resource there. Potentially a centre of that nature would provide that. I would particularly link that to our conversation on TBI and the necessity for the neuropsychological and neurological component to that assessment. It is very important not to separate the issues entirely. I would absolutely welcome the capability to do that and to increase access to robust assessment and to start that pathway.

The reality of the mental health issues that we are looking at is that they are long term—they are often lifelong—so the majority of that care absolutely needs to take place in the community, with their families. It needs to be integrated in a systemic way with their family. It is a combined effort, if you like.

I would absolutely support the efforts that have been made previously to identify a potential solution to this absence of being able to recognise the individuals most in need and to start them on a pathway. But I would feed into what Sue was saying, which is about moving away from a model of residential care, which we know has limited impact on mental health difficulties, towards that wider appreciation of caring for and providing the provision in the community, not only to the individual but to the family as a whole, because it is very important that we appreciate the generational impact of trauma. We know increasingly through research, particularly with our veteran community, that we run a real risk in terms of the generational impact on their families and their children, which we are hoping to avoid by attending to the very real needs—

Q50 **Mr Francois:** Thank you. We are slightly tight for time. Does the Legion support that idea too?

Meagan Levin: Yes. We would prefer to have something that works for both the veteran and their family, in a location that suits them, rather than them having to travel to get their treatment.

Mr Francois: We understand that, but the problem is that the current model is swamped. It doesn't work. It is all very well to gather all the data, but you have to do something with it. The NHS has got a system for giving mental health support to veterans that doesn't work properly, and too many of them are taking their own lives. Rather than just pore over the data, we would rather do something to save some of these people from taking their own lives. What I have heard from all three of you is at least qualified support, and in some cases enthusiastic support. That is extremely valuable to us. Hopefully, Matt Hancock will keep his word and will put his £70 million to good use.

Chair: Thank you very much indeed. That brings us to a conclusion.

I visited Stanford Hall as Minister for Veterans. I was astonished at how empty the place was. It is designed to take on a huge number of injuries, not just mental health issues, including other aspects to do with stress in the combat zone, and to deal with the aftermath of a major campaign such as Iraq or Afghanistan, but for the moment, it is pretty empty. There were plans to put an NHS operation on the same campus as well. We will investigate how things have progressed with the Minister for Veterans when we see him in a couple of weeks.

The last word must go to the veterans. During this difficult pandemic, we recognise that loneliness and isolation and so forth affect everybody, but we need to spare a thought for those veterans who are perhaps not able to receive the same level of support through the charities because of the limitations that we are all affected by because of covid-19.

Thank you to the three service charities that have come before us today and to all those who are supporting our brave veterans. We have a duty of care, when they are in uniform and when they depart, as Mark Francois said, via the Armed Forces covenant. Sue Freeth, Sarah Jones and Meagan Levin, thank you very much indeed for your time this afternoon and for concluding our study into mental health.