HOUSE OF COMMONS

Defence Committee

Oral evidence: Armed Forces and veterans mental health, HC 1133

Tuesday 26 January 2021

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Watch the meeting

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

Questions 51-132

Witnesses

I: Johnny Mercer MP, Parliamentary Under-Secretary of State for Defence People and Veterans, Ministry of Defence, Ms Nadine Dorries MP, Minister of State for Mental Health, Suicide Prevention and Patient Safety, Department of Health and Social Care, Kate Davies CBE, Director of Health and Justice, Armed Forces and Sexual Assault Referral Centres, NHS England, and Colonel (Retd) David Richmond, Director, Office for Veterans' Affairs, Cabinet Office.

II: Professor Sir Simon Wessely, Co-Director, King's Centre for Military Health Research, and Professor Nicola Fear, Co-Director, King's Centre for Military Health Research.

Examination of witnesses

Witnesses: Johnny Mercer MP, Ms Nadine Dorries MP, Kate Davies and Colonel David Richmond.

Chair: Welcome to this Defence Committee hearing focusing on veterans' mental health. It is a follow-up to studies that we have done in the past. We have two witness panels this afternoon. The first is with Minister Johnny Mercer, the Minister for Defence People and Veterans, and Minister Nadine Dorries, the Minister for Patient Safety, Suicide Prevention and Mental Health in the Department of Health. We are also joined by Kate Davies, who is the director of health and justice, Armed Forces and sexual assault referral centres for NHS England. Kate, welcome; it is good to see you again. Finally, we have Colonel David Richmond, who is the director for the Office for Veterans' Affairs in the Cabinet Office. Our second panel is with Professor Sir Simon Wessely and Professor Nicola Fear. We will turn to them later.

Thank you very much indeed, all of you, for your time this afternoon. You will be aware that this Committee has studied this subject on a number of occasions. Therefore, there are a number of follow-up questions that we will look at to see the progress of support for mental health to do with those in the Armed Forces, but particularly veterans.

If I may say so at the outset, so that we do not need to repeat it, the Armed Forces do an incredible job in looking after the mental health of those who serve. In comparison with the general public, you are actually less likely to be affected by many mental health conditions, but some are affected, and it is the support that is provided to those who need it that we will focus on this afternoon.

I also thank Committee members for joining us this afternoon. I will now hand over to Stuart Anderson to kick us off with question No. 1.

Q51 **Stuart Anderson:** Thank you, Chair. Minister Mercer, prior to coming into this House, I watched with great enthusiasm the noise that you made around standing up for veterans, and I commend you for that. Now that the Office for Veterans' Affairs has been set up, does it have the tools to deliver what it needs to? Basically, does it have any teeth behind it?

Johnny Mercer: Good afternoon, Stuart and Chair, and thank you very much for having me this afternoon. I will get straight to your point. I think that the OVA does have teeth behind it. I think it has been constituted in an interesting way. It sits in the Cabinet Office, outside the MoD. It is a new organisation. At times we fight for our place, as you would expect for any new organisation within Government, but I can confidently say that, having been constituted for just over a year, we have strategically and irreversibly changed what it feels like to be a veteran in the United Kingdom, cognisant of the fact that we have some way to go. I am very clear on that, and I have made that clear to the Prime Minister. I look forward to continuing that fight, to make sure that this country does its duty by those who serve.

Q52 **Stuart Anderson:** Thank you. So it has been set up right and the intentions are right. Can you demonstrate to the Committee that it has made a difference in the year since it was set up?

Johnny Mercer: Oh yeah. What have we done this year? We started off by publishing our "Strategy for our Veterans" consultation response, which is the first time we have formalised that in the UK. We funded Cobseo to improve collaboration, which used to be a nice go-to word but now is absolutely mandatory. We played a pivotal role in securing and allocating the £6 million of funding to support service charities during the covid-19 pandemic.

We launched a new employment scheme, making it easier for veterans to join the civil service—a guaranteed interview for them. We worked across Government to deliver the railcard—over 10,000 of those have already been given to veterans and their families. We provided funding for the King's College London longitudinal study. There has been a huge challenge around data because we come from such a low base when it comes to veterans' data in this country.

We set up the Veterans Advisory Board to provide advice and, crucially, that strategic challenge to Government. We funded the King's Centre for Military Health Research to look specifically at the impact of the covid-19 pandemic on veterans. We took forward the UK's place in the Five Eyes veterans, and the chair of the veterans' employment working group in the Five Eyes community. We created and chaired the strategy delivery group, which is a cross-Whitehall forum to drive and co-ordinate that really important document of strategy for our veterans.

We co-chair the service charities partnership board with the MoD and we have invested in the Veterans' Gateway—

Q53 **Stuart Anderson:** On that point, Minister, you are able to demonstrate lot of good areas, but how heavily are you still relying on charities, and how are you co-ordinating that reliance, if it is still there?

Johnny Mercer: There is undoubtedly a shift going on in this country at the moment. When I, and you, were serving and coming home from operations in 2006 and 2010, there was a huge overreliance on the third sector when it came to veterans' care in this country. There is a shift under way at the moment. As demand increases for veterans' services and giving, particularly public giving, decreases, to my mind and the Prime Minister's mind, the nation's duty to her veterans is clearly going to increase, because we as a country have a duty to ensure—not to deliver, but to ensure—that those who serve are looked after and given a fair chance after they have served this country.

Is there an overreliance? No. Do we rely on some service partners to deliver services? Yes. The key and the challenge in all this is the fusion of the two; to make sure that I can build a network with partners in the NHS and across Government that private enterprises and charities can bid in to run parts of those services—for example, the high intensity service and the complex trauma service—and blend together third-sector statutory

provision to make this the best place in the world to be an Armed Forces veteran. Are we there yet? No. Are we well on the way? Yes. Will we get there? Absolutely.

Stuart Anderson: I am sure my colleagues will come back to some of those points, but thank you for those opening comments.

Q54 **Mrs Lewell-Buck:** Good afternoon, everyone. My question is for Minister Mercer, off the back of what my colleague has just said. In our last evidence session, a lot of the witnesses said that the Office for Veterans' Affairs had not yet had any tangible effect. In your response just now, you wheeled off strategies, plans and what have you, but when will we actually see some tangible benefits? What is the plan to start delivering from the Office for Veteran's Affairs, as opposed to making strategies and plans?

Johnny Mercer: I would suggest that every one of the 10,000 veterans who gets a railcard will feel something from the Office for Veterans' Affairs. I would suggest that every individual who gets a guaranteed interview if they apply for a job in the civil service will feel something. Those who are working in the charity sector, where we are funding key parts of collaboration around case management systems and so on, to put the entire sector on a long-term strategic footing to meet the challenge of veterans' care in this country, might disagree with that view.

I saw the evidence session, and I am not quite sure that that is what was said. We have undoubtedly hit challenges around covid and Brexit, and we have been established for only a year. Do I think that we have done everything that we wanted to? No. But have we made a significant irreversible difference in this country? That is beyond doubt by every markable datapoint.

Q55 **Mrs Lewell-Buck:** Thanks for that, Minister. What I got overall from the last evidence session was that, in terms of funding, things were being done in the charity sector that could have been done without the Office for Veterans' Affairs. The question I am driving at is this: what are your plans for the future, specifically for things that could not be done if the Office for Veterans' Affairs did not exist?

Johnny Mercer: Had this office not existed, the Government would have had to create something that was in a position to lead collaboration with Cobseo going forward. Cobseo—the Confederation of Service Charities—is an organisation that does a hell of a lot of good work. Did it always feel that it was on a sustainable footing in terms of finance and real authority to shine a path for change? No. We are doing that now. Cobseo is one of my most regular meetings.

What does that actually look like? It looks like things such as granularity on the ground, a common casework management system, and a single point of entry, making the Veterans' Gateway the vision that it was designed to be when it was first envisaged. Those things would not happen without an Office for Veterans' Affairs, and if you had a chat with

Cobseo and others in the sector, you would be hard pressed to find people who disagree.

Mrs Lewell-Buck: I will leave it there, Chair, because others want to come in. Thank you, Minister.

Q56 **Chair:** It is important, though, Minister, that we are honest about what can be achieved by the office. The Veterans' Gateway was actually set up by me and Mark Lancaster, and it was moving forward quite merrily. On the railcard, I think I actually had the conversations with the rail companies. I am not taking credit for that; I am just saying that many things can happen through the Veterans Minister without the need for the Cabinet position. The Cabinet position was to knock heads together across Departments because, for example, the Treasury was not able to provide Cobseo with the money that it is calling for as we speak. There was definitely a breakdown, which we will explore shortly, between the support given by the NHS and what was given after by the MoD. That is why the Cabinet position was created, and you touched on that yourself. How often are veterans' affairs raised at Cabinet level?

Johnny Mercer: The office has been constituted in the Cabinet Office. I have certainly never attended Cabinet and raised veterans' issues.[1]

Chair: Okay. It was actually based on the American model of having an actual veterans' affairs department, if you like. That is why it was moved across there. We will explore more the relationship between the NHS as we move forward. Sarah, will you take the next question?

Q57 **Sarah Atherton:** What impact has the MoD transition support programme had in assisting back into civilian life personnel who are suffering mental health problems and who need to engage with the NHS?

Johnny Mercer: We launched a new transition programme last year, which essentially looks at our most complex service leavers and allocates them a transition caseworker for when they transition to wherever they go when they want to leave. It is not only about employment; employment clearly remains the biggest factor that improves the life chances of any veteran, but for some of our most complex individuals there are lots of wraparound services, whether housing, special educational needs for their children, or whatever it may be. We have seen some significant successes, but it has been less than a year, and when we hit that year mark I will, as I did with the Wigston review, initiate a review to see how we are doing and whether we need any course corrections or any more money, or whatever it may be, to ensure that we are reaching those people who the programme itself is designed to reach.

Q58 **Sarah Atherton:** Does this programme include the Defence Transition Services? It is looking holistically, by the sound of it. Is that correct?

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[1] *Note by witness:* The Chancellor of the Duchy of Lancaster, Michael Gove MP, is responsible for veterans' affairs at Cabinet level.

Johnny Mercer: Yes, that is correct. Defence Transition Services was a new service launched last year, and that is the one that I want to audit, and check that it is doing what we want it to do.

Q59 **Sarah Atherton:** What is it doing specifically for people leaving the Army with enduring mental health concerns who want to engage directly with NHS services?

Johnny Mercer: We now have the transition and liaison service, which has been going for some years and is a success. In certain areas of the country it works extremely well. There are other areas where there is more to do, but that is one part of someone's resettlement. There will be employment around that and, obviously, we have the career transition partnership, which does a lot of work on that.

As I say, there will be complex individuals who require more wraparound holistic care. That is what the transition service is there to do, and we have had some good success stories already. However, as I said, I will be auditing that a year on from when it was announced—I believe it was May 2020—I will be more than happy to come back to this Committee to talk about that in further detail then.

Q60 **Sarah Atherton:** For how long does this service engage with veterans? Is it time limited?

Johnny Mercer: It is for their first year initially, but we are looking to see the most effective time that that may be. If you leave the military now, you can access DCMHs—the community mental health providers—for six months after you leave. It is a consistently changing theme that we are looking at, whether or not we are providing the optimal solution for those who are leaving. As I say, we will review that at the year mark and check that it is doing what we want it to.

Sarah Atherton: Okay, can I just make a statement to leave with you? The Committee has been told that the symptoms of PTSD emerge, on average, four years after leaving service, so it might be a good idea if these services could monitor up to the four-year point, but I will leave that with you. Thank you, Minister.

Q61 **Chair:** Can I just check on that? Do you go back to veterans after they have left the Armed Forces, having served in combat—in theatre operations? Is there a proactive call to check on their welfare?

Johnny Mercer: Again, it is an area we are looking at, at the moment, and a piece of work is going on. For example, if you leave the military there will be a period of Reserve service that people will receive letters from, confirming their address and so on. We are looking at different ways of incentivising people to have annual checks on their health and wellbeing. That is certainly an area we are looking at. It is quite a complex piece of work, because some people do not want that, and then how do you get a really accurate data set to then form your programmes and policies around. But yes, it is under active consideration as to whether we reach out to people once they have left.

Q62 **Chair:** Given the stoicism you find in the Armed Forces, it could be that the people who don't want the call are the ones who may actually require it more than others. On the veterans' ID card, do you now leave with some documentation to show that you are indeed a veteran?

Johnny Mercer: Everyone now gets a veterans' ID card when they leave. There is a challenge, and I have been very clear with the Department that I am not happy with the progress on this. We should have had it out by the end of last year. There is a challenge around backdating it, with fraud checks and so on, and there is a challenge with those who left some time ago and are retrospectively applying for the veterans' ID card. We are not there yet. My vision for it is a sort of tool on gov.uk—anyone could go to that website, type in someone's details and have verification of whether someone has served in the military. That is obviously a big ask from the charities at this time. It is something that we are working hard on, but I am behind schedule on it. It is something that we are working on every day.

Q63 **Chair:** When do you think the veterans' ID card, backdated, will come about?

Johnny Mercer: I wanted it out at the end of last year, but we are struggling with the amount of checks and the IT infrastructure required to conduct checks on people while not breaching data-sharing agreements. It is not as easy as it sounds, but we will get there and we will get to a point where we can retrospectively award veterans' ID cards to those who served but have left the military in this country.

Q64 **Derek Twigg:** Mr Mercer, will you give us some specific examples of measures you have introduced to improve mental health care for serving personnel?

Johnny Mercer: Yes, of course. The single biggest thing I have done is to introduce mandatory mental health training for those who are serving. In the military we have annual testing, whether it is on the range, on fitness or on the law around conflict. There will now be an additional module on mental health care. An ongoing narrative around mental fitness and mental resilience will be delivered every year, so that people cannot now serve in the military, leave and then say that no one ever spoke to them about their mental health, resilience or mental fitness. That is probably the single biggest step forward that we as an organisation will make. I pay tribute to the service chiefs and others who helped get that through.

A whole suite of training tasks are going on at the moment—Op Smart in the Army, or Regain in the Royal Marines—that actively go after mental fitness and resilience. We are light years away from what it was like even when I was serving, 10 years ago, but I am very clear that I want people who join the military to know that they are joining an organisation where they will be the best version of themselves. As much as joining for the kit, the aeroplanes and the ships, they will want to join to be the best version of themselves—they will be looked after. That is my aim and my ambition, and we will get there.

Q65 **Derek Twigg:** How are you measuring or auditing the impact of those measures on mental health?

Johnny Mercer: That will appear over time. We clearly face a set of statistics now, on mental health and the incidence of mental health conditions in the military, and over a period of time, once we have introduced those measures, I would expect them to reduce.

Q66 **Derek Twigg:** Will you give us an example of how that will work?

Johnny Mercer: The majority of our mental health work in the military at the moment is not on PTSD, but on anxiety, depression and things like that. If we can get to a space where we have reduced numbers of people accessing those healthcare programmes, we will clearly be having an impact.

Q67 **Derek Twigg:** I assume you will do that annually, checking whether the statistics show any increase or decrease.

Johnny Mercer: Yes. We measure that now anyway, every year. Today, I can tell you that 0.2% of the serving population are being treated for PTSD. I know that is not the rate of PTSD in the military, but this is an ongoing series of things that we measure. Yes, of course we will continue to do that once we have brought in the measures.

Q68 **Derek Twigg:** How many people in the MoD specifically work on mental health?

Johnny Mercer: I can write to you about that, but a great number—like hundreds.

Derek Twigg: But you have not got the exact figures at the moment.

Johnny Mercer: I will write to you with those figures, Derek.

Q69 **Derek Twigg:** On staffing numbers, have you had any issues of having enough resource necessary to carry out the changes, improvements and monitoring that you need to do?

Johnny Mercer: It is not so much an issue of resource; it is an issue of standardising the approach, if you like, to make sure that we have a pan-Defence platform to deliver mental health and wellbeing. So it is not an issue of resource, particularly within the military. There is clearly an issue of resource if you look outside the military to our various charity groups. They would say there are issues of resource at the moment, and that is an area of acute challenge that we are all working on.

Chair: Emma Lewell-Buck wanted to come in quickly.

Q70 **Mrs Lewell-Buck:** Thanks, Chair. My question is for Mr Mercer again. The previous Committee recommended in 2018 that some research be done into the vulnerability of personnel recruited under the age of 18 in relation to mental health problems. Has that research been commissioned yet and, if not, are there any plans for it to be done?

Johnny Mercer: Emma, I will write to you about that.

Mrs Lewell-Buck: Okay, thanks.

Q71 **Chair:** Thank you. Turning to Nadine Dorries, can you explain to us the difference between TILS and CTS and how they are faring in supporting mental health issues?

Ms Dorries: I probably should begin by saying thank you, Chairman, and also thank you to Johnny, who is, in the Office for Veterans' Affairs, the lead on mental health in our Armed Forces. Looking at when I arrived in my post 18 months ago, and at where we are now in terms of the mental health provision, which has become available both through the investment in the long-term plan and in the bespoke services that have been developed by people such as Kate Davies, who you have on the line today, and her team, we have come a very long way just in those 18 months. There was almost nothing available when I arrived 18 months ago. Now, we have TILS—the transition service—and the complex treatment service, as well as the high intensity service, which is being piloted at the moment.

I think the most reassuring fact that I can give you today on all of those services, before I go on to them individually, is that any member of the veteran community, or, in fact, our Armed Forces community, would probably only need to ask one other person where they would go to get mental health help, and they would have the number to call to access those services. That is a tribute to everybody—to Kate's team, to the Office for Veterans' Affairs, to DHSC and to the mental health team over at NHS England and within DHSC.

I say this also as a former nurse, but the NHS is not good at developing bespoke or smaller services that service individual or particular groups. That is because, NHS-wide, any service has to service as many people as possible for the investment that is going in and the entire community. For the NHS to have developed services that deal with the specific needs of veterans, which are as comprehensive as TILS, the complex treatment service and the high-intensity support service, is something that we should all be proud of. I pay thanks to Kate and her team for doing that.

I think you are all aware of what the transition service and the complex treatment service do. The complex treatment service is for those people who are suffering from PTSD or, as Johnny quite rightly said, those people who have more severe levels of depression and anxiety. I always like to make the point that we talk about mental health, but what we are really talking about is wellbeing or mental illness.

For example, in reaction to the pandemic, we have had lots of rhetoric about tsunamis of mental health and suicide rates, none of which has transpired to be true. What we had was that people experienced poor mental wellbeing as a result of apprehension, fear and a lack of knowledge and understanding. Everybody experienced that—both veterans and everybody in the community—but most people, using their own resilience over a period of time and accessing free NHS services such as Every Mind Matters, got the tools to help them through that. That is about wellbeing.

Mental illness is when we have people who suffer from real mental illness. In that, I would include clinical depression and severe anxiety. They are two mental health illnesses that veterans can and do suffer from, and severe PTSD—

Q72 **Chair:** Sorry, Minister, I am going to have to cut you off. I appreciate that that is helpful background, but the analysis that we are doing in this Committee is a probe about the conduct and efficiency of TILS and CTS. Thank you for that background; it's very, very helpful, but I just want to focus on these two functions, how they relate to each other and how a veteran gets access to them. To begin with, how many CTS centres are there in the country?

Ms Dorries: Specific additional resources have been put behind all those services. How do people access them? They can self-refer, or they can go to their GP and their GP can refer them. That is why I made the point that the telephone number that they use to ring and gain access is available and known by most veteran families. Considerable funding—£16.5 million of investment per year—has gone behind the services, and they had collectively received over 10,000 referrals up to the end of 2019; that is via GPs and self-referrals. And that is in addition to the mainstream Improving Access to Psychological Therapies, which you may know as IAPT. They receive over 23,000 veteran referrals a year, and anybody can self-refer to an IAPT service. With the extra £10 million of funding announced in the long-term plan, capacity has grown across all sites.

Q73 **Chair:** Sorry, Minister, I am going to have to cut you off again. I am asking specific questions. A lot of that we have got in evidence, and it is helpful, but I am asking you specifically about TILS and CTS. You mentioned GPs—that you can go to your GP. How does a veteran get referred to a TILS and then, from TILS, move up to CTS? And I repeat the question: how many CTSs do we have in the country?

Ms Dorries: I would have to ask Kate to give you the exact number; I don't have the exact number of CTS sites—

Q74 **Chair:** Okay, let's turn to Kate. Kate, welcome. Could I just ask you that? How many TIL services versus CTSs are there in the country?

Kate Davies: It's not about saying the number of actual services. We actually commission across the whole of England, through the seven regions, access points for TILS, so they have a single access point for the transition, intervention and liaison service. As the Minister has said, it absolutely is about an easy contact, single point of access, so that all people who are veterans or families, whether the mental health needs are combat-related or not, can access the transition, intervention and liaison service. They will be seen in person. Obviously, because of covid and other restrictions at the moment, we have increased the amount of digital and blended services, but we are continuing with face-to-face services. We particularly commission those in collaboration with the Armed Forces charities, so that we can increase the venues and people can work close to home, because that is absolutely the essential issue. So some of those services are running out of particular trust venues, from GP practices or

from charitable services, because we absolutely want to make it not a limited number but an extensive number and as close to home as possible.

The difference between a transition, intervention and liaison service and CTS—as the Minister said, the complex treatment service—is that the complex treatment services were particularly developed to support those veterans who have complex mental health needs that are related to combat. That was absolutely something that was fundamental when we asked the men and women who served what they felt they needed and wanted. They were very pleased to get a quick, supportive access service that looked at housing and employment and collaboration, as TILS does, but they also wanted, for their combat-related mental health service, a service that was there for them, and that is why it has been set up with mental health trusts across the country, with very clear parameters within the service specifications, to work with multi-agency teams, including psychologists and psychiatrists, to support the most complex service needs. And they access them through TILS, as part of those individual assessments.

Q75 **Chair:** I am still trying to get the number of CTSs. I am getting the impression that there is one or maybe a couple per region, and that there are many more TIL services, which then feed into, if required, CTS. Is that correct?

Kate Davies: Yes, certainly. It's the same model that has been successful with the complex treatment service and with TILS: we are very much making quite sure that those services are accessed—sometimes an individual will say, "I want to access those and see someone within a GP surgery." That is why we are also doing the work with the GPs around accreditation—so that we link up those services and they are more local. And sometimes they may well be in a charitable sector venue. Seven regions are commissioned to support an extensive network of availability for those men and women who are part of the complex treatment service. We know, for example, that we have had over 1,820 men and women who have actually accessed the complex treatment service. I am asked this often by Select Committees—quite rightly—but there is an unlimited time in which people continue to get that treatment and care co-ordination for complex treatment.

Q76 **Chair:** The point I am trying to make, though, is that it is absolutely fantastic that we are getting numbers through, but the feedback we are getting from Cobseo and from the other charities is that there are not enough of them, and they lack the expertise to deal specifically with veterans, with military-related issues. How would you respond to that? Is that something we need to work on?

Kate Davies: Certainly. We would be the first to say that we have to improve and increase. In fact, through the long-term plan, we have additional plans and resources to increase all those services across the country. As the Minister for Veterans, Johnny Mercer, said, we have also recently increased the amount of services through the high intensity service, which is very much about crisis intervention and patient care and

support. That is a really welcome addition for some of the more immediate needs and risk, particularly.

Going back to the Cobseo feedback, all our services are now contracted—it is not a voluntary agreement, but a contracted, funded one—to work with Armed Forces charities. Those charities are also members of Cobseo. So, all of those charities are now working with us—we cannot do this alone, in the NHS—to support the extent and to increase the development. We are not all the way there, you are completely right, and that is why we want to do that with our military partners as well.

Chair: We need to make progress but, Johnny, do you want to come in quickly on this one?

Johnny Mercer: No, that's fine. If you are happy, that is fine. There is no such thing as a centre, a complex treatment centre; it is a service, a network of services, as Kate alluded to. As for measuring its production, it is about referrals, which is what she said—just to clarify that point.

Chair: I visited a centre—or service, depending on how you call it—in King's Cross. It was an excellent outfit. There was concern, though, that they would need greater expertise there, and that we needed more of these services or centres across the country. I will not get caught up in semantics. Let us move forward to look at the regions. Gavin Robinson, will you move forward with question No. 4, please?

Q77 **Gavin Robinson:** Thanks, Chair. To focus on semantics once again, I heard a number of references to services or centres in "the country". To confirm, may I assume that the country you are referring to is England, as opposed to the United Kingdom?

Kate Davies: I apologise. I should have said that that was particularly for NHS England. The work with the devolved Administrations across Wales, Northern Ireland and Scotland is absolutely part of the work that we do to support good practice. In fact, I have visited many of those services in Northern Ireland, Scotland and Wales in order to share that practice across the devolved Administrations. To clarify, obviously, for me, that is NHS England. I hope that is clear.

Q78 **Gavin Robinson:** Thanks, Kate. In fairness, you have been before us before, and I think that we are impressed by your passion for this subject, so there is no reproach there. The Committee was also very encouraged by Minister Mercer's platform piece in the paper on Sunday, and by the aspirations associated with the Armed Forces Covenant Bill. We look forward to its introduction and to the protections across the country. Last year, as a Committee, we highlighted the variations on service delivery for veterans in the various parts of this United Kingdom. May I ask Minister Dorries first, then Minister Mercer, are there still significant variations across the four nations of the United Kingdom? Do you recognise them, and what are you doing collectively to address them?

Ms Dorries: Gavin, I am not aware of variations, but that is something that is dealt with at director level, between DHSC and MoD. This might put you on the spot, Kate, but I think it is Kate who liaises at that level. I am not aware of that. I am obviously aware of the services and the policies that are implemented in England, but because it is a devolved matter, it is dealt with at director level within DHSC. Johnny has his hand up so, as the OVA, he might deal with that level as well.

Gavin Robinson: In fairness, Minister, you are a Minister for the England NHS; Johnny is a UK-wide Defence Minister—that is the nature of the Department.

Johnny Mercer: That's the point I was going to make.

Q79 **Gavin Robinson:** That is the nature of the Department, and I do think, in these sessions, and while Kate's evidence has been very useful previously, it would be useful to have a presence from the other devolved areas as well, when we are trying to assess these variations. Johnny, you wanted to come in.

Johnny Mercer: There are variations across the UK. As you know, the aftercare service in Northern Ireland tries to replicate some of what we are doing elsewhere. A couple of things I would say to that are that we now have a Veterans Commissioner for Northern Ireland. That came out of the "New Decade, New Approach" model, which is extremely good news. We have similar in Wales and in Scotland—I speak to my counterparts on a regular basis, and certainly the office is in contact with them on a monthly, almost daily basis, at times. [2]

Today we are presenting the Armed Forces Bill to Parliament. For the first time, you will see the most significant step forward in provision for veterans in Northern Ireland, where we are introducing a UK-wide approach. So I recognise your point. Is there a disparity in provision? There are different people that provide different services to different levels, yes, but do we work together to try and ensure the best level of service and the best outcome for our people? Yes, absolutely.

Q80 **Gavin Robinson:** Thanks, Minister. Perhaps, Kate, we could just ask you then, directly: has the situation, to your mind, recognising you are not responsible for this, improved in Northern Ireland, particularly since the highlighted variances that we discussed at our last session?

Kate Davies: Obviously it is very difficult for me to say categorically, in detail, but I think one of the things that we have seen through the Armed Forces partnership board, which is co-chaired through the MoD and through the director within the Department of Health and Social Care, is a real drive to get constant and consistent modelling of good practice across

[2] *Note by witness:* There is no Veterans Commissioner for Wales. The Minister for Defence People and Veterans has met the Scottish Veterans Commissioner and the Veterans Commissioner for Northern Ireland. He also met with Welsh Government Ministers and officials.

the devolved Administrations. It is a very strong board when it comes to looking at Wales, Northern Ireland, Scotland and England collaboratively.

Northern Ireland obviously is a different model and needs to be a different model for many reasons, as you know much better than I do. What we have seen, particularly with some work that we have done with GPs both in Northern Ireland and England, is a massive improvement in feedback from veterans themselves—that is the important thing—or from ex-serving in Northern Ireland, who have actually said that they felt that that has really helped. I think that there is a resource issue that is still something that is highlighted to us, certainly when you are asking a direct question on Northern Ireland. That is something that we have talked to the Minister for Veterans about, as well, and I know he has been very supportive.

Q81 **Richard Drax:** Can I ask Ms Dorries and Mr Mercer—welcome to all three of you this afternoon—starting with you, Minister Dorries, if I may, to get the NHS perspective on this question first: what effect has the pandemic had on the provision of services?

Ms Dorries: I suppose I should begin by saying that no mental health services have ceased to continue to offer services at all during the pandemic, apart from a small number of memory clinics that were closed down at the beginning of the first wave. In fact, there has been an increase in terms of—an acceleration of—the long-term plan and the mental health provisions within the long-term plan, which are there for all veterans and all.

To give an example of that, we have set up 24/7 crisis helplines, mental health trust crisis helplines for everybody to use, and although we do not have the collective data on that yet, because it is too soon, what we are aware of via feedback from organisations such as East of England ambulance, which I heard about just recently, is that they have been well used. We have funded the Every Mind Matters website—which had a launch in September last year and during the first wave of the pandemic, and which I think 2 million people in total have used—in order to provide those tools that I spoke about before, to help them through the pandemic and times of lockdown, anxiety, apprehension, fear and all those factors that we know come into play when people are facing something like a pandemic.

We know there are two groups of people who have been most affected by the pandemic in terms of their mental health, and that has actually been young women and people with pre-existing mental health conditions. Where that would affect veterans particularly is that those who had pre-existing mental health conditions, in terms of clinical depression, anxiety or more complex mental health needs, would have been impacted by the pandemic. Services have been there for all of those people—veterans and not—to use, and they have used them. There has been no tsunami of mental health problems, certainly not of suicide. Our evidence is that there has been no increase in the suicide rate, based on comprehensive research by the University of Manchester, which is also looking in particular at suicide impacts on veterans, in the context of the pandemic.

There is work going on to analyse how the pandemic has affected veterans, in particular, and everybody. We know from the research over nine STPs and more than 9.5 million people, of which a percentage will be veterans, that there has been no increase in suicide. But, of course, everybody has had their mental health affected in some way by the pandemic, whether it is just feeling out of sorts, slightly anxious or not sleeping as well. Many people have reported nightmares.

Q82 **Richard Drax:** Minister, forgive me, I must interrupt because I know time is of the essence. Thank you. I think we have got the gist of all that, so thank you very much.

Minister Mercer, may I just pop across to you? Andy Price, who would very much like to talk to you, is a wonderful expert. He set up the Veterans Hub in Weymouth that you may have heard about, which has just got charitable status. I appreciate that you are doing a huge amount but there is still a hole with, in this case, 30 to 40 veterans relying on this charitable set-up. Why, with all the effort that is going on, are so many veterans still falling through the sieve?

Johnny Mercer: I think it's a question of pulling together these services. There is a lot of misunderstanding around the general debate, and also around what the Office for Veterans' Affairs is there to do. It is precisely to do just that: to pull together these services and make a kind of network available.

People who access Andy Price's brilliant work down in Weymouth want to access mental health courses. They couldn't give a fig whether it was delivered by Combat Stress, Help for Heroes or any of the other groups. They want to know that they are going to get professional, evidence-based care; that they are not going to have to retell their story; that they are going to get supported throughout their journey along the care pathway, whether with their mental health challenges or around housing or work. That is exactly what the OVA is there to do.

One of the most crucial bits of work we're doing is working with Cobseo to design what the future of this sector looks like in five years' time, get that money out of the Treasury and then put the whole sector on a sustainable footing, where you have statutory provision, co-ordinated by the state, in the shape of HIS, TILS and things like that, but the services are delivered, and contracted if you like, by groups such as the Veterans Hub in Weymouth, Help for Heroes, Combat Stress or the RBL. It is a fusion of all those services; that's always been the answer. The OVA is very clearly placed to deliver on that. If we manage to get some of the way there, we will have been successful.

Q83 **Chair:** I am just looking through some of the evidence that we received. Help for Heroes, for example, speaks for many charities when it talks about a 30% reduction in reach during the pandemic. That's simply because they can't raise funds and they can't actually get out to see the people they support.

Many charities that are not as financially buoyant as Help for Heroes

could very well not make it through the pandemic. Are you working with Cobseo to express these concerns to the Treasury? We know that they are seeking extra support.

The financial support that Rishi Sunak has produced across the piece is quite incredible, but it hasn't been tailored, perhaps, as purposefully enough as it could be for the charitable sector that is working with veterans themselves. They have had some time bars on spending the money by September, for example, which does not fit in to the cycle of support that they need.

Johnny Mercer: We have ongoing conversations with the Treasury. We have been asked to go away and look at a model whereby we can come back and fund and lead collaborative work through some of the biggest charitable organisations in the country. I am not going to speak publicly on who they are or what that looks like, but that is the direction of travel, and the Treasury has been very forthcoming with that.

Financing this sector has not always been the biggest challenge. It has always been collaboration, points of access, professional level of care, case management, care pathways, and things like that. We will always fight for more money, of course we will, but putting that on one side, we have a hell of a lot of other work to do as well and that is what we are getting on with.

Chair: Thank you.

Q84 **Stuart Anderson:** Minister Mercer, I want to follow up the points you have just made on veteran suicide with Minister Dorries. You will remember the first day we met, Armistice Day—me, you and the Prime Minister in Wolverhampton. It was an outstanding day. A few hours after, not many people know, I go and sit in a car ready to campaign and I hear that James Le Mesurier has taken his own life. He was my first platoon commander who helped me very much after I got shot.

A few months later, it was Gaz Case, another outstanding soldier I served alongside. Many more suicides from the Green Jackets and Rifles have happened in short succession. Please tell me you are doing far more to address the collection of data and deal with it, because we are seeing far too many veterans' suicides, particularly from my regiment. It should not be from any regiment, but a whole host has come from the Green Jackets of men I have served alongside.

Johnny Mercer: Stuart, we work on this perhaps more than anything else at the moment. One of these suicides is a tragedy for the individual, clearly, for their family and friends, but for us as an institution. We want people to come to the military, be the best version of themselves and leave having had a wonderful time, greatly enhanced by their service. We take this hugely seriously.

The first money we ever spent in the Office for Veterans' Affairs was to look at the data behind suicides. We start from such a low base. The veterans' data and suicide data in this country did not really exist. We now have some very clear studies going on. We have a cohort study of 20,000

people by King's College London looking at what happened in their lives in 2003 onwards. We now own that as the Office for Veterans' Affairs.

We commissioned Manchester University working with the NHS to look at all deaths since 2003, pick out the suicides from that and study what happened in the 12 months before that individual took their life, to understand if there was anything we could have done. I meet almost all the families—the husbands and wives of those who take their own lives—to try to understand each individual case. We are cognisant that the answer is often a no, I am afraid, but we try to understand if there is anything we could or should have done to intervene in that space.

It remains the case that you are less likely to take your life if you serve, but an interesting study has come out in the last few weeks from King's College London that looks at rates of PTSD. As that matures, we will look at that. I was the first Minister to speak on veterans' suicide and give a statement to the House of Commons earlier this year. We take this hugely seriously. The issue is not as it is presented in the media, but it is a serious issue and we are absolutely prepared to deal with it.

Stuart Anderson: Thank you. I look forward to seeing more of this data as it becomes available. I know you have worked with some families I have known. Thank you for your work on that.

Chair: Stuart, thank you for speaking up on that. I should echo the Minister's comments here. People commit suicide, very sadly, who have been in the Armed Forces, not necessarily because they have been in the Armed Forces. There is a distinction between the two. Sometimes, the media tends to jump immediately from the fact that they were in the services to the cause of the suicide itself.

Q85 **John Spellar:** Could we have some clarity on what priority treatment means, for veterans and their families, but also for clinicians?

Johnny Mercer: The Armed Forces Covenant is clear that we seek to place no disadvantage on those who serve, with special consideration for the bereaved and seriously injured. I am confident that is met across the NHS. We have had the specific programmes that Minister Dorries has mentioned. Whether it is the complex treatment service, TILS, or the high intensity service, that balance is being met. Clearly, it is always a fine line where clinical need is there, but in the areas where it is designed to work, for example around prosthetics and things like that, it works very well and the NHS is a very, very strong supporter and advocate of the Armed Forces Covenant.

Q86 **John Spellar:** What about accessing services, particularly when people come out of the forces and might move into a new area and have difficulty getting registered?

Johnny Mercer: This is the critical thing about the Armed Forces Covenant. It was designed to ensure no disadvantage. Not an advantage, but no disadvantage. That is why, in the legislation that I am laying before the House today, it will, if it passes, be unlawful to discriminate against individuals because of their service. So speaking to your specific point, if

you have a child with special educational needs in Plymouth and you are posted to Arbroath, you cannot not have those services delivered to you by a public body in health, housing or education. It will be unlawful for that local authority to refuse you.[3] We are equalising the experience for service personnel, veterans and their families, as well as making it unlawful for individuals to be discriminated against.[4] It is a challenge and you are right to highlight it. We will address it in this year's Armed Forces Bill.

Q87 **John Spellar:** Given that we have a national health service, why do we need legislation rather than administrative direction?

Johnny Mercer: We need legislation because the Armed Forces Covenant as it currently stands is a voluntary mechanism that is applied and useful to the vast majority of people who rely on it. There are small cohorts where someone's experience of the Armed Forces Covenant will not be the same or as good as we would want it to be. What we have to do is try to level up the floor through legislation to make sure that local authorities understand they have a due regard—that is a legal term to make sure that they follow through on the principles of the Armed Forces Covenant in the delivery of their public services in health, housing and education.[5] That will really mean something to individuals who are posted all over this country.

Q88 **John Spellar:** That may be helpful, but particularly with the NHS and even with local authorities, the local government Department issues directives on almost a weekly if not a daily basis. In the health service where we have Secretary of State for Health, why cannot directives be issued? Legislation may add some teeth to it, but fundamentally Ministers should be able to direct Government policy. Surely the point of Ministers co-ordinating this is to get Government policy set out rather than waiting for legislation.

Johnny Mercer: You are absolutely right, John, but you will know that Government policy directives do not always mean something to people who are trying to access those services and finding it doesn't work for them. I have had countless people write to me who have invoked the Armed Forces Covenant or spoken about it. The Government and departmental policy may well be that we have signed the Armed Forces Covenant and we will adhere to it, but the reality as to how that feels on the ground for our men and women is not the same as that. That is why we are legislating to ensure that it is.

[3] *Note by witness:* The relevant service provider in the new area will be required to consider the Covenant principles. A more accurate statement is "It will be unlawful for that service provider to refuse to *consider the principles* of the Covenant."

[4] *Note by witness:* The proposed legislation will encourage an increased awareness of the Covenant and a better understanding of the impact of Service life on members of the Armed Forces Community in these key areas.

[5] *Note by witness:* It would be more accurate for this to be described as "make sure they consider the principles of"

John Spellar: Do you have anything to add, Nadine?

Ms Dorries: John, I am not an expert on the military Covenant, I'm afraid, so I defer to Johnny's answer on that. But if I can beg your tolerance and make just one point, Chairman: nobody commits suicide; sadly, and desperately, some people take their own life. I know we talk about suicide figures, but when we are talking about people who find themselves in that situation, we say they have taken their own life, not that they have committed suicide. I just thought I would make that point, as we are discussing mental health and it always helps for people to be aware of that. I don't have anything further to add, John.

Chair: Thank you, John.

Q89 **Mr Francois:** Minister Mercer, like the Chairman and you, I am a former Veterans Minister and I think everyone in the Committee would agree instinctively with what you said at the beginning of this session, which was, "We have a duty to ensure that those who served are looked after". Unarguable. One of the greatest detriments to the mental health of our service personnel is the sword of Damocles that hangs over those who served in Northern Ireland. The Government have repeatedly promised to legislate in this area. The 2019 Conservative party manifesto that you and I were elected on said, "We will also never forget the immense contribution of the police and Armed Forces in standing firm against terrorists in the past and the debt we owe them for peace today."

I know that it's the Northern Ireland Office lead, not the MoD, and I know that you've done your bit with the Overseas Operations (Service Personnel and Veterans) Bill to protect Iraq and Afghan veterans—you are not the problem. Where is the Bill, Minister?

Johnny Mercer: It is fair point. I haven't done my bit; I won't have done my bit until we get this legislation. It is something that I am engaged on with the Northern Ireland Office at the moment. You will know that that has been the situation for about six months. The Prime Minister is very clear about my views, and is absolutely clear that we will honour our manifesto promises.

I accept the frustrations about the delays in it. This is a complex piece of work that has not been done for 40 years, but we will deliver on that manifesto promise. I am more than happy to come back and speak more in depth about that, the Overseas Operations (Service Personnel and Veterans) Bill and any other issues in that area.

Q90 **Mr Francois:** I press you, Minister, because this is something that this Committee and its predecessor Committees have chased literally for years. When he stood to be leader of the Conservative party, Boris Johnson signed the double page article in the middle of *The Sun* saying, in terms, "if I become Prime Minister, I will legislate to protect veterans, including Northern Ireland veterans." He said specifically against vexatious prosecutions, so the Prime Minister has promised. You can still draft legislation at home if you are a parliamentary draftsman, even

during a pandemic. When will the Secretary of State for Northern Ireland stop talking a good game and start playing one, and bring us a Bill?

There is immense frustration among veterans who have served and among politicians in this place. Here is a letter that I and Mr Drax helped to co-ordinate in late 2018 to Theresa May—100 MPs, 50 peers, three former chiefs of the defence staff—called "Defending those who defended us", calling for legislation. We were told it would come; the Prime Minister said it would come. Where is the Bill?

Johnny Mercer: Mr Francois, this Prime Minister will deliver on that manifesto pledge.

Q91 **Mr Francois:** When?

Johnny Mercer: Well, he has a defined period of time from the general election to deliver that. If there is another general election and he has not delivered it, then he will have failed in that, but that is not going to happen. I expect to see something in the first half of this year.

Q92 **Mr Francois:** Can you be any more specific, Johnny? I know it is not your Department.

Johnny Mercer: I can't, because it is not my Department, but this is something that I am engaged on every week, and you can imagine the level of fight I am currently having.

Q93 **Mr Francois:** Could you pass our frustration back—

Johnny Mercer: My view has not changed from when I was sat on those seats with you, or when I was the only Member or Parliament to say that I was not prepared to support the Government's legislation until this was sorted out. I respect your view and the passion behind it, but not many feel more strongly about it than me, and I will make sure we deliver that promise.

Q94 **Mr Francois:** Well Brandon Lewis is the roadblock, can we do something to move or clear the roadblock please?

Johnny Mercer: To be fair to Brandon, he is dealing with an intensely difficult situation. He is not a roadblock. He is engaged in this process and I reiterate, Mark, for 40 years no Government have done anything on this. This is intensely difficult, but we will get there. The Prime Minister will keep his promises.

Mr Francois: We just want to know when, Johnny. Thank you.

Q95 **Chair:** Minister, we need to make it clear that it is not 40 years when someone has done something about it. The stumbling block is in the Northern Ireland Assembly, because what you need to get through has to pass there and Sinn Féin will not allow that to happen. We have avoided that in this debate, and that needs to be made very clear. That is ultimately the stumbling block here, otherwise this would have been achieved a while ago.

Mark, may I invite you ask a quick question about Stanford Hall please?

Q96 **Mr Francois:** Very quickly, the Defence and National Rehabilitation Centre at Stanford Hall—what are we doing to utilise that for the treatment of veterans who have mental health issues?

Johnny Mercer: At the moment, that is predominantly focused on rehab. I read the previous report from the Defence Committee that talks about establishing it as a centre of excellence for mental health provision. There are areas of that that we are looking at. The current model of best practice in mental healthcare is care in the community—we have seen Combat Stress have had to make that transition as they gone from residential services towards care in the community.

We will be ruthlessly committed to best practice to get best outcomes for those who need it. If that includes Stanford Hall, we will use Stanford Hall, but we have a very good, professional programme in the CTS, TILS and high intensity services. The key now is to make sure that they are funded and resourced properly and that everybody knows, first, that they are there, and secondly, that when they go there, they get a professional service. That is the way to deal with the veterans' mental health challenge.

Q97 **Chair:** Can I just add that I have visited Stanford Hall, as I am sure you have, Minister? It is an incredible set-up. If you are a serving soldier and then transfer to become a veteran and use the facilities, you are able to have access to it and that is fantastic, but the frustration and stumbling block is that veterans who have long retired from the Armed Forces cannot get access to it. When you visit the place, you see that, absolutely, the facilities are fantastic, but it was just about empty when I was there. It was not utilised to its full capacity. The request is that you have this excellent, state-of-the-art facility, so let's take full advantage of on behalf of all veterans, not just those who are transitioning out of the Armed Forces.

Ms Dorries: May I come in on that? As this inquiry is about mental health, can I say that I am citing the words of Professor Tim Kendall here, and I am sure that Sir Simon Wessely, who you have on later, will endorse this? No mental health treatment is better delivered in a hospital or a centre or a unit than it is in the community. That is why we have the policy for services such as TILS, CTS and high intensity treatment services. The fact is that I am not totally surprised that you found that the centre was not full, particularly with mental health patients, because mental health patients need their services to be delivered either face-to-face or digitally, which we are doing more now. They need them delivered in their own communities, in partnership with the NHS and community services and with families and supporters in the community. Having inpatient units for people suffering from mental ill health is something you do as a last resort. It is not really something that is either appropriate or suitable when dealing with mental health patients.

Q98 **Chair:** I hear what you say, but there are prostheses and all sorts of things for rehabilitation. This centre is state of the art and I would love to see it used—

Ms Dorries: I am just talking about mental health.

Chair: We are talking about Stanford Hall and the utility of that exceptional facility. That is all we are encouraging.

I am afraid our time is up. Ministers, thank you very much indeed for your contributions this afternoon. This is an important subject and we are very grateful for what you are doing in this area and for bringing together the efforts of Government. Colonel, I think you got away lightly this afternoon; we are clearly going to have to call you back on another occasion. Kate Davies, thank you for your contributions as well.

Examination of witnesses

Witnesses: Professor Sir Simon Wessely and Professor Nicola Fear.

Chair: I welcome Sir Simon Wessely and Professor Nicola Fear to take us forward with the second part of this evidence session.

Q99 **John Spellar:** Having heard the previous exchange, do you think Ministers have given an accurate picture of the situation? *[Interruption.]*

Chair: You are on mute, Sir Simon.

Professor Wessely: I thought I might stay on mute for that question, actually. *[Laughter.]* That is a really hard question to answer at all. In general, I think so. Both Ministers did pick up on the difficult areas. First of all, on the very last thing that Minister Dorries said—I have just finished the Mental Health Act review, which is about continuing to decrease the number of people in institutions, particularly under coercion—she is quite right: in an ideal world, we would not have any inpatient hospital facilities for people with severe mental illness, but we do need them occasionally. They are very rarely related to military service—sometimes, but very rarely.

We should also remember that military psychiatry in the First World War was what gave us our modern military healthcare systems. That involved treating people near to where they were, as quickly as possible and as close to home as possible—which was then in the military—with the expectation of recovery. That is why we have crisis intervention and why we have home treatments. We would not have had that without the military, and that has not changed.

Centres of excellence work very well for research and they work well for teaching and training, but in the delivery of most mental health services, we have spent the last 60 years trying to reduce those into what has just been said. Where it can be good—and where I would like to think that Stanford Hall would have a role—is where you have mixed physical and mental. For example—I think this is going to come up, actually—head injury is both a physical and mental problem, where you need really quite specialised expertise and a lot of expensive kit. In general in mental health—we are very cheap, by the way—we don't use lots and lots of big

machines and lots of big tests, but we do sometimes do that around brain injury, and that is not freely available outside specialist centres. I think that would be an exception, and in a military context that would be the main one where we have complicated mixed physical and mental problems that are beyond the remit of local services.

It is not as if there is a kind of Mayo Clinic—the best in the world—that does the best mental healthcare. The best mental healthcare is local and delivered by people like me, actually: it's delivered in teams, is multidisciplinary and involves families at all times. I think Minister Dorries got that right, actually. We go to Stanford Hall a lot because of ADVANCE, which is a research project but it also delivers care. That is where you need the amazing stuff that they have there. It is amazing—you are quite right—and is not available to most.

John Spellar: So long as we don't call it "world-beating."

Professor Wessely: No, and if you ever hear me say "world-beating", you have my permission to shoot me on the spot.

Q100 **John Spellar:** Nicola, do you have anything to add to that?

Professor Fear: I was listening to all the statistics they reported and was happy that they aligned with much of our research. From that perspective, I was ticking things off.

Q101 **John Spellar:** You say it qualifies from that perspective, but what about more in the round?

Professor Wessely: That is very unfair, John!

John Spellar: You have known me as a Minister: fairness is not my key characteristic!

Professor Wessely: There was one bit that I thought Mr Mercer was going to get wrong when he talked about 0.2% having PTSD, which is a figure I have seen in briefings for quite a while. It is a ridiculously low figure, but actually he qualified that by saying that is the number in treatment. That is accurate, but it is usually quoted to say that we do not have much of a problem with PTSD, but it is quoted wrongly. To be fair, he got that right, and that has not always been the case. I do not mean with him or with other Ministers, but in other contexts that figure has been quoted wrongly.

We do know a bit about people who joined up very early. I have forgotten what the term is—

Professor Fear: Junior entrants.

Professor Wessely: Yes, junior entrants. We have written a paper on that and have sent it to the MoD for their information, but it has obviously not gone through the system yet. Do you want to summarise the results of that?

Professor Fear: Within our cohort, we were able to look at junior entrants and non-junior entrants. We found that junior entrants had no worse mental health than non-junior entrants, but there was some evidence of increased alcohol misuse and self-harm. Junior entrants remained in service longer than non-junior entrants, and there were no differences in the post-service outcomes that we were able to look at. As Simon says, we have written a paper on that, which is hopefully going through the academic publication process, but we are very happy to provide written evidence with the actual stats, if that would be helpful.

John Spellar: It certainly would be. Thank you.

Q102 **Chair:** Just to confirm, when you compare yourself with the public cohorts right across the list—PTSD, stress, alcoholism, self-harm and mental health as a whole—could you argue that, right across the piece, you are less likely to be affected by these things than you would be if you had not entered the Armed Forces?

Professor Wessely: No, I don't think you can say it quite like that. It depends on what outcome you mean. For example, if you take contact with the criminal justice system, this is one of our favourite pieces of work. For those who don't know, and I know that lots of you do and it's very nice to see so many familiar faces, we have this huge cohort that has been running, first from Gulf 1 and then from Telic and Herrick. It is a random sample of around 10% of the people who served during those periods. It is a very good source of data, particularly on mental health; in fact, it is often the only source.

We link that to criminal records and we show that, if you join the Armed Forces, far from becoming more likely to be in prison or more likely to have a criminal record, you are actually less likely—completely contradicting what everyone believed, from all sorts of different sources. And that is even before you take account—again, this Committee knows that the military, particularly the Navy and the Army, recruit people from disadvantaged backgrounds. It is not random. It is not like you make a choice: "I'm going to go to Cambridge to read medicine, or I'm going to join the Armed Forces. What shall I do today?" It does take people from deprived backgrounds who often already have risk factors for poor outcomes in their life trajectory. And that is before you adjust for that. Even then, you still see that their life trajectory has been improved. But—I am afraid that there is always a "but"—what the military also does is to increase the risk of violence, so if you have deployed in a combat role, you will then be more likely to get a violent conviction when you leave, which is strongly mediated by PTSD and alcohol. It is a complex picture, where on the one hand you make better citizens, but on the other hand you do increase the risk of violence.

Then it depends on who you are comparing with. PTSD rates are nothing like as high as the general public believe. But, depending on which group you are looking at—and if you are looking at those who have left the Armed Forces, who have been in combat, which is, as you know, not that huge a number—you will have a rate of PTSD of 17%, which is higher than

you would get in random populations and about what you are getting in the healthcare system at the moment, actually, although hopefully that is more transient. That is in that particular group. Then you get higher in Reservists, but overall it is around 6%. It is really hard to know but it is not dramatically different from the general population—probably a little bit higher. But again, in certain groups it is higher, in others it is lower.

Q103 **Chair:** I think it is important that we continue to try to bury these myths, because otherwise they do damage to those who can go through the Armed Forces, have an incredible career, come out the other side and then continue to have a wonderful civilian career as well. It is perhaps not helped by Hollywood and the images that it portrays in this area.

Professor Wessely: Overall—I think someone alluded to this—70% of people who serve just do not get PTSD, even when we follow them up over many, many years. Of the other 30%, some of them have it for a period of time and then it goes away; others get it later. But the majority—70%—will not get PTSD, and at any one time the figure may be around 8% to 10%. I am not entirely sure I have got that right, actually, Nicola. Anyway, it is nothing like what happens if you ask random members of the population—they will say, "70% have PTSD." Actually, it is the other way around—70% don't.[6]

Q104 **Stuart Anderson:** I wonder whether the Committee could have insight to that report or have a look at it. From a personal perspective, I was a junior entrant and would actually fit several of those categories that you have spoken about. It would be really good if we could see that.

Professor Wessely: Of course.

Professor Fear: Yes, we can share that with you.[7]

Q105 **Stuart Anderson:** Thank you very much. I have already asked this question to Minister Mercer, but it would be good to hear your views. What difference do you believe the creation of the Office for Veterans' Affairs has made? Has it made a difference?

Professor Wessely: We are academics—we are the boring boffins. We provide the OVA and you and anyone else with what we think is very good, reliable, independent data. I should also say that I am on the Veterans Advisory Board, but so far we have met once and it is very early days.

We have a pretty good rule that we are not here to give advice or to comment on things like that; we are here to provide data for them to use. And we are providing them with data. How they will use that, we will have to see. We hope they will take notice, but we also know that decisions

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[6] *Note by witness:* https://s31949.pcdn.co/wp-content/uploads/FiMT-TRIAD-Report-2020-FINAL.pdf

[7] *Note by witness:* Unpublished paper – paper currently under review with BMJ Military Health

taken at policy level are, hopefully, informed by the kind of stuff we do, but they are not dependent on what we do at all, and we know that.

Q106 **Stuart Anderson:** Okay. If I may put it in a slightly different way, based on reliable, independent data, have you seen a difference made to veterans by the OVA?

Professor Wessely: Not yet, no. But then again, we are seeing in some of the other research that I have done, or when I was leading the psychiatric profession, evidence now of change in areas that we started working on five years before. This is outside the areas of perinatal mental health and eating disorders. I have just got used to the fact that it is a slow process. We have certainly seen differences from decisions that have been taken a lot earlier, but to expect a change in mental health services in a very short period of time—I do not think is a fair test, to be honest. Anything that was that easy would have been done already.

Q107 **Stuart Anderson:** I get that. Professor Nicola, do you have anything to add?

Professor Fear: I agree with Simon. As you heard from the Minister, OVA has funded the next phase of our combined study, so we are very grateful for that funding. We will be able to look at some of these new initiatives that have come in since OVA has been in existence when we do the follow-up. We might have some evidence for you further down the line. *[Interruption.]*

Chair: Sir Simon, are you being heckled?

Professor Wessely: No. Sorry, that was the end of dry January—that was a delivery of wine.

Chair: You are a bit early. It's premature.

Professor Wessely: True—times are hard.

Q108 **Chair:** You mentioned the Veterans Advisory Board. Could you explain its function? You said it has only met once. In what period was that?

Professor Wessely: It was only set up—Colonel Richmond, if he is still around, will be able to answer that. We are due to meet again in two or three weeks' time. It is due to meet four times a year. It met the first time in November, I think. Colonel Richmond is still on. He organises it and will know. We are due to meet next month. The first one, as with all these things, was a "getting to know you" session and all that stuff, and to try and focus on what will be the key objectives. That is as much as I can say. I am pretty sure the second meeting is in two or three weeks' time.

Q109 **Chair:** Colonel, I see that you are still there. Do you want to add anything?

Colonel Richmond: The Veterans Advisory Board was conceived, recruited, signed off by CDL and had its first meeting. That whole process took from mid-summer to the first meeting in November. The second meeting is on, I think, 16 February. It is very early days. It is there to

provide a variety of different perspectives, an independence of thought and insight and challenge to Ministers, and to advise the OVA on next steps and some of the major muscle moves necessary over the coming years. But it is very early days for the board.

Q110 **Chair:** Are the minutes published? Can we see them?

Colonel Richmond: They are.

Chair: If it's possible to ensure that the Committee gets a copy, that will be very helpful indeed.

Q111 **Derek Twigg:** It is good to see you both. We are trying to get a handle on whether there has been an improvement in mental health services for veterans. Given all your investigations and analysis prior to the pandemic, was there a noticeable improvement in mental health services for veterans?

Professor Wessely: Yes, I think it is fair to say that there has been. I will start with one or two of the markers we have seen. Again, were these the results of interventions? Who knows? But what we have seen is two things. One you have already heard: people are coming forward a heck of a lot earlier than they used to, and that is good. That is what we like to see. Secondly, the proportion of serving personnel who have presented for help with mental health has been steadily increasing over the last 10 to 15 years. I think some of that has been due to a consistent pattern of, first, attempting to improve the services—people will not come to a service that they think is rubbish—and secondly, de-stigmatisation, which is a general society issue. Far from the stereotype of the military being very intolerant of this, our experience is that that may have been true some time ago, but I do not think it is true now. You get roughly the same rates of people presenting in the Forces as you do in the general population and, dare I say it, much better rates present for help than in my profession of medicine or your profession of politics. So I think that is a good story.

If Kate Davies is still there, the access to talking therapies for veterans now—I think 20,000 have been treated through the reasonably new IAPT system, which has made a big contribution. It simply was not there when we started this work or when you were the Minister, Derek. It has changed since then, but again it is a slow process. Nicola, do you want to add to that?

Professor Fear: The only thing I would add is, picking up on Gavin's points in the earlier session about the differences across the nations, the work that Professor Cherie Armour of Queen's University Belfast has conducted there shows that veterans are concerned about seeking help and disclosing their military experiences, which is different from the context in the rest of the UK.

Q112 **Derek Twigg:** So there are variations across the nations.

Professor Wessely: Yes. Northern Ireland obviously has its particular issues that you touched on when you were discussing other issues that are

not our business. But yes, there are more serious barriers to seeking care there.

Q113 **Derek Twigg:** Anything particular on Wales and Scotland?

Professor Wessely: I cannot remember off the top of my head. Nicola, do you remember?

Professor Fear: I am not aware of any differences. I think the biggest difference we have seen is in the work from Northern Ireland.

Professor Wessely: I am going to have to go because there is an urgent meeting on the mental health of the NHS workforce, which is a crisis at the moment—and I have to say that I think that is more important in the next few weeks—but before I go I want to say one thing, about one of the reasons why I was pleased to be asked. Your last hearing was on mild to moderate traumatic brain injury, and, from listening to that, a couple of things said about the research we have done disturbed me. One of your witnesses said we did not know anything about the prevalence of mTBI, as it is called, in our serving or non-serving populations and then said some things that were just completely wrong about the research we have done. I would like two minutes, if I may, to say that we do know how many people have mTBI and we do know a lot more about it than was said. It would be good to correct the record on some of those things, because you were clearly very interested in that. You might like to know what the actual facts and figures are.

Q114 **Chair:** Professor, thank you for that. Could you explain how much investment is being made in this area?

Professor Wessely: Investment? I do not know the investment—

Q115 **Chair:** The United States is putting a lot of money into this area. Are we doing the same?

Professor Wessely: Well, the United States has a completely different way of providing services. As you know, once you have left the US Armed Forces—it was after two years and then five years—you rely on the veterans administration, whereas here we do not have a veterans administration, so it is simply not comparable. What is more interesting, from my point of view, is that the rates of mTBI in the USA are three to four times higher than those in the UK, whereas our rates are very similar to those in Canada, so there are many other factors.

What we know is that, when we do surveys and we ask about mTBI, we use the same measures as the US—we do not just study those with drugs and alcohol, as your witness said; we study everyone—and the background rate is 4.5% and the rate in combat is about 9%, which is considerably lower than in the US. But when we go out to theatre to see how many people have actually had head injuries—I am to allowed to do this; this is dodgy stuff that we do in roll 1 and roll 2, where most are seen with concussion—we find a lower rate of around 3% to 6%. We also find—this is really important to what Mark Francois was saying—that there is huge overlap between mental health conditions. The symptoms are very

similar to those found in PTSD, which is actually an outcome and a predictor, and whatever you do, you must not try to separate out neurology, psychiatry, neuropsychiatry, rehab and imaging. Services have to be provided on both a mental and a physical basis, because separating them out is really a very, very poor thing to do.

Q116 **Chair:** Is this the overlap between the two?

Professor Wessely: We know that people's recall of head injuries changes over time. If you do not screen everybody with mTBI for possible PTSD, you will miss it. Why does that matter at the moment? Well, because we have treatments for PTSD, but at the moment we do not have much for mTBI. Hopefully, that will change, but it will not change if you do not carefully separate where you can, but you must also accept, because this is the brain, that the two go together. To have a separate service, or indeed no mental health service, as I think was being proposed, would be a major error.

Q117 **Mr Francois:** Simon, is that why you were dropping us a pretty strong hint about mTBI and Stanford Hall?

Professor Wessely: Not quite, no. I was actually dropping hints that I was slightly annoyed because we have very good data and can say the mTBI is not the biggest problem that we face. It is a problem, for sure, and it is changing, but as Professor Green said, most people recover very quickly. The number of people who are left with problems for six to 12 months is an issue, but not a huge one, and one that it is mixed up with mental health. Also, as I was saying at Stanford Hall, you have the ability to do a very good research pathway, which is needed, because at the moment we do not have a definitive test for mTBI. Neither we nor the Americans have one, but hopefully we will get one. If we were to leap in with a mixture of different tests, protocols, procedures and non-standardised stuff, we would just add to the already existing chaos. mTBI is a post-concussional syndrome. In some people it can be long-lasting—in most it is not—and there will always be a mental health component.

Q118 **Derek Twigg:** Sir Simon, I know you are going, but could you provide us with a full dataset, then?

Professor Wessely: Yes, of course. It has been around in big published literature for years—it is not new! I now really have to go.

Chair: Sir Simon, thank you so much for your time.

Q119 **Derek Twigg:** Professor Fear, in mental health services for veterans, is there anything missing that stands out for you and Simon?

Professor Fear: Again, that is quite a big question to think about. There is the issue around families, which was touched on by the previous panel. I know that lots of work is going on at the moment with NHS England to look at what is out there to support families of service personnel and veterans, to make sure that they are included. Our work on families has shown that you cannot look at one member of that family on their own,

because if something is going wrong in one person's life, it is likely to be having a knock-on effect on how that family functions. That is one issue.

One of the outcomes that we have constantly looked at is alcohol misuse. Within the serving community and the veterans community, the rates are higher than we would expect compared with the general population, even when we take age and gender into account. The rates are going down, but they are still high, so there is perhaps more that we could do in that space. We also find that alcohol misuse is comorbid with a number of other conditions. Often, we first look very much at treating PTSD or depression, but actually there may be alcohol or other substance abuse going on that we are missing. Those are, from my perspective, the gaps.

Chair: Gavin, do you want to come in on this one?

Q120 **Gavin Robinson:** I want to thank Nicola for referring to Cherie Armour's work, from the University of Ulster. You mentioned Queen's, but I think she is at Ulster University.

Professor Fear: She was at Ulster, but she is now at Queen's.

Q121 **Gavin Robinson:** Oh well, there you are. You are ahead of me in the curve. She did great work. We, as a Committee, should never forget that one of the distinct differences for veterans of Operation Banner who live in Northern Ireland, is that they continue to live in their theatre of service. Very often they bump into people who may have been persons of interest to them, or who were actively targeting them, as they now try to go around in their civilian life. That normalisation process isn't as easy as for veterans, living in Northern Ireland or elsewhere in the UK, who served overseas. That is one of the profound issues that they have.

It would probably be useful for us to hear more about that research, Chair, to refresh ourselves, because there is a political dynamic to it, rather than ask questions of Nicola, in an unfair way, if she doesn't have an ongoing grasp of what delivery has been like in Northern Ireland. That is something that we pick up particularly as an ongoing concern.

Professor Fear: Yes, I think Professor Armour would be the ideal person to talk to about that. I know the reports from the study are due to be published relatively soon, so I am sure she would be willing to share those with you as well.

Gavin Robinson: Thank you.

Q122 **Richard Drax:** Nicola, we asked this question to the two Ministers before; you may have heard that. Using the data you have, how has the pandemic affected the provision of mental healthcare for veterans? Are some of the groups—female, BAME, older veterans—more affected than others?

Professor Fear: Thanks, Richard. The Office for Veterans' Affairs funded us to undertake a snapshot of the health and wellbeing of veterans who had taken part in our long-term cohort study, so we were able to go out to those individuals. With covid, we weren't allowed to send out the

questionnaires, so the responses were all done online. Because we have longitudinal data on these individuals, we could say, "What was their mental health like a couple of years ago and what is it like now, during the pandemic?"

We were able to see that there was no change in the reporting of common mental disorders, such as anxiety and depression. We saw a slight increase in PTSD, and we saw a reduction in alcohol misuse. Although the rates, as I said earlier, are still high, there was some evidence that during the pandemic—the data was collected over the summer of 2020—the rates were going down.

In some ways, the veteran community are experiencing the pandemic in similar ways to the general population. We asked about help-seeking; we can provide the evidence after this meeting, if it is helpful. There were groups of veterans who did need access to mental health support and alcohol services, but who were having difficulties with that due to the pandemic. I have a lot of numbers here, but I don't have those numbers to hand. I am happy to provide them after the meeting.[8]

Richard Drax: That would be helpful. Thank you very much indeed.

Q123 **Sarah Atherton:** Hi Nicola. We have heard about CTS and TILS, and we have touched on the high-impact service. I would have liked to go into that a bit further, but I don't think we have time now.

We know that veterans fall through the net. Help for Heroes has said that they are bouncing from one NHS service to another. I am also cognisant that some GP practices in England are now veteran-friendly. Unfortunately, I don't think that is relevant to Northern Ireland and Wales, and we would like to see that propagated over the border. Do NHS clinicians have an understanding of the uniqueness of military mental health? Is it improving?

Professor Fear: I am not a clinician myself, but from discussions with clinical colleagues and others who I know are part of the veteran-friendly GP practices, I would say yes, it is improving. The numbers of practices that are joining that scheme are increasing on almost a day-to-day basis.

As I mentioned earlier, the initiatives under way at the minute within NHS England to look at what we need for families, so that we are passing on that awareness not just to GPs but to the wider health service, will make great strides.

From the work that we have done with families and veterans themselves, I think you need to offer veteran-focused or veteran-delivered services and civilian services, because some veterans and their families say, "The military broke me, I now don't want anything to do with someone who has a connection with the Armed Forces," whereas others say, "You know what, actually, I want that because we speak the same language." It is

[8] *Note by witness:* Unpublished paper – paper currently under review with BMJ Military Health

great that we are increasing that awareness, but it is just giving people the choice so that they have options available.

Q124 **Sarah Atherton:** You have spoken about families. I wonder whether we are doing enough, or there is enough legislation, to encompass the issues related to families and the family strategy within the Ministry of Defence. Do you have any suggestions about how we can better meet the needs of families and perhaps divorced spouses going forward?

Professor Fear: Families is a big area of interest to me. When I joined King's, we focused solely on the service person. Then we extended to the veteran and then the penny dropped that we need to look at families. It is a relatively new area of research from our perspective. In the past, speaking honestly, I think families were forgotten. The focus was on the service person and the veteran, but that recognition has increased.

The research to date has been very good at focusing on that traditional family: they are married and they have got their obligatory two children, and it is normally the male who was serving or is now a veteran, and it is a female spouse. We need to be thinking about these non-traditional families. We are not there yet. We don't actually know the size or needs of that community. I think we need to do that to understand what services we need to provide.

Q125 **Sarah Atherton:** I don't know whether you can just clarify something for me about traumatic brain injury. Shall I go further with that? Are you able to speak a little bit about that?

Professor Fear: It depends what it is—I was like, "Simon, please don't go before they've asked about mTBI!"

Sarah Atherton: I'll just give it to you and then if you can explain it and clarify for me, that's great. If you can't, no worries. We were told in the previous evidence session that mild traumatic brain injury is a neurological disorder, as opposed to PTSD, which is a psychological disorder. It is the diagnosis and treatment of two separate things. Am I right in thinking that Professor Simon is saying that they are too linked to be dealt with separately?

Professor Fear: Yes. There is an overlap between mTBI and PTSD, and some of the symptoms are the same as well, so it is difficult to untangle. I probably wouldn't want to say more than that. As I said, I am not a clinician. That is my understanding from the reading I have done in that area.

Q126 **Sarah Atherton:** So there's not one type of scanner that will diagnose one and one type of scanner that will diagnose another?

Professor Fear: Not that I am aware of. I don't think there is a scanner that would diagnose PTSD, but Simon is the person that would answer that for you. I understand that there is this scanner called MEG—it has a very long name—that the Americans are using, and I think there is some commitment within Defence to see if they can get some work under way

to look at funding one of those scanners. I think that would go part way to addressing those issues.

Q127 **Chair:** On Sarah's question, can you be affected by traumatic brain injury through an explosion where you can stand up afterwards but not actually be physically scarred on the outside? Is it the shockwave itself that can cause an impact on the brain?

Professor Fear: That is my understanding, but you are getting to the edges of my understanding now.

Q128 **Chair:** The concern we have, though, is that many military personnel could experience that—walking away and not feeling that they need any treatment. That is where they need to put their hands up, or somebody seeing them must make sure that they report in to be checked. Otherwise, there could be longer term consequences. Is that correct?

Professor Fear: The way we have collected information on that within our cohort is that we have asked about those events—so, "Have you had any of those events where you have been exposed to a blast?", etc. We've then asked those follow-up questions, such as, "If yes, have you had any of these symptoms?" That is how we have looked at it. I know that there are colleagues at the centre for blast injury studies at Imperial who have done modelling on how those blast waves have an impact on the brain.

Q129 **Chair:** Thank you. The final question is on the Armed Forces Covenant, and the principle of priority in supporting our veterans. Do you feel that it is working, or does it need more attention—more vigour?

Professor Fear: Again, I think it is unfortunate that Simon left at this point, because I think he has some thoughts on where it's working and where it's not working. Again, I don't want to paraphrase Simon, but my thoughts are that care should be prioritised by the clinical need, and I think that if the clinical need is the same for a veteran and a civilian, then yes, the principles of the Armed Forces Covenant should apply. However, I think Simon would say that it should be based on clinical need as the premise.

Q130 **Mr Francois:** Professor, Cobseo surveyed all their members in both May and October of 2020, to see what the effect of the pandemic was not just on their fundraising, but on the demand for services. They found that, among all their members, on average, requests for mental health-related assistance had increased by 74%—a massive increase in requests for help.

One of the things that this Committee has been told by charities and veterans is that while the NHS has come up with these highly-specialised services, which we all welcome, they unfortunately just do not have the capacity to deal with the level of demand that they are experiencing. That has been exacerbated by the sorts of figures that I have just given.

The NHS is doing great work, but it is being swamped by the degree of demand it is being asked to deal with. Hence, perhaps, the Committee's frustration that at the DNRC, you have a £300 million facility that is

massively underused. We would like to see more made of it.

Professor Wessely was saying that, where you have this overlap between the psychological and the neurological, it might make sense to do some specialist work there at the DNRC, particularly in relation to mTBI. Does that make sense?

Professor Fear: Yes, it does. There is more and more work being done in the general population, looking at comorbidity between a physical and a mental health condition, to treat both at the same time, rather than focusing one and then the other. I think that that could be the case with Stanford Hall. If we have individuals there for a physical health condition, then what can we do to support their mental health and wellbeing at the same time?

Q131 **Mr Francois:** You may know already, but the original concept of the late Duke of Westminster, who came up with the idea for Stanford Hall and began the fundraising may years ago, was of a facility that would look after both the physical and mental health needs of veterans. When he had the dream, if I can put it like that, that was what he had in mind.

Many of us feel that there could be at least some applicability, in terms of mental health provision, by this incredible facility, which is not virtually empty but is certainly underutilised. That is why we are making a bit of a point about it this afternoon. It seems that you, as the experts, are saying that it could at least be something worth exploring—I don't want to put words in your mouth, but that seems to be what you and Simon are suggesting.

Professor Fear: Exploring it from a physical and mental health comorbidity perspective, all the research to date shows that it is better to treat a mental health condition locally. Stanford Hall is in Loughborough, Leicestershire, and that is not going to be local to a lot of individuals. We have moved away from that kind of residential care for mental health problems, into a community setting.

Q132 **Mr Francois:** We know that, but the problem is that the local services cannot cope with the level of demand. We have heard lots of very unfortunate stories where people are diagnosed as needing help and are then referred for treatment, but in some cases they are waiting for up to a year to get into a treatment programme and, unfortunately, in some of those cases—the worst cases—they take their own life while they are waiting. The theory is great, but the capacity isn't there to execute the theory. What advice would you give us?

Professor Fear: That is a really challenging question. There is discussion to be had with our NHS colleagues who were on the previous panel. It is not an answer, but we have seen that there are challenges for mental health provision across the board, not just for the veteran and Armed Forces community. This is something that we as a nation need to think about how we deal with. This is a conversation to be had with clinicians and with the NHS. I am afraid there is probably not much more that I can comment on on this topic.

Mr Francois: Okay, thank you very much.

Chair: It is an interesting point, though. In any hospital, they can't offer all the services from A to Z, and therefore we end up specialising across the country, whether that be pre-natal services or cancer services and so forth. The public anticipate and recognise that you may need to go further for that specific treatment. What we see at Stanford Hall is an incredible capability—a campus environment, which the military actually enjoy. Veterans quite like going back there. There is a sense of arrival and a sense of purpose that you are doing something there, with incredible facilities. The point has been made that it is underutilised. Let's get our vets in as best we can.

Thank you very much indeed. You are the sole survivor of the seven people in all who came today. We very much appreciate your time this afternoon, Professor Nicola. Thank you to Sir Simon, Colonel David Richmond, Kate Davies, and Ministers Nadine Dorries and Johnny Mercer for their time this afternoon. That brings to a conclusion the Defence Committee's study on mental health and our follow-up in connection with veterans.