HOUSE OF COMMONS

Select Committee on the Armed Forces Bill

Oral evidence: Armed Forces Bill, Session 5, HC 1281

Thursday 18 March 2021

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Watch the meeting

Members present: James Sunderland (Chair); Stuart Anderson; Tonia Antoniazzi; Dan Carden; Miss Sarah Dines; Leo Docherty; Martin Docherty-Hughes; Mrs Sharon Hodgson; Mr Richard Holden; Mr Kevan Jones; Jack Lopresti; Carol Monaghan; Stephen Morgan.

Questions 216-288

Witnesses

I: Air-Vice Marshal (retd) Ray Lock CBE, Chief Executive, Forces in Mind Trust, Professor Catherine Kinane, Medical Director, Combat Stress, and Dr Felix Davies, Operations Director, Combat Stress.

II: David Brewer, Chief Operating Officer, Defence Infrastructure Organisation, and Tim Redfern, Managing Director, Amey Defence Service.

III: Hannah Blythyn MS, Deputy Minister for Housing and Local Government, Welsh Government, and Graeme Dey MSP, Minister for Parliamentary Business and Veterans, Scottish Government.

Examination of Witnesses

Witnesses: Ray Lock, Professor Catherine Kinane and Dr Felix Davies.

Chair: Good afternoon. My name is James Sunderland MP, and it is a great pleasure to welcome all of you to day five of the evidence-gathering sessions for the Select Committee on the Armed Forces Bill. We have three expert witnesses for our first panel this afternoon, and I am going to introduce them in turn. We have Air Vice-Marshal Ray Lock CBE, chief executive of the Forces in Mind Trust; Professor Catherine Kinane, medical director at Combat Stress; and Dr Felix Davies, operations director at Combat Stress. You are very welcome, and thank you for giving us your time today.

We have a list of prescribed questions that members of the Bill Committee are going to ask you, and I come straightaway to Stuart Anderson for the first question.

Q216 **Stuart Anderson:** Thank you, Chair. First, I welcome all the witnesses to the Committee, as the Chair has done. I want to set the scene for the rest of the questions, so how would you characterise the state of healthcare for current service personnel? Air Vice-Marshal, could you start us off on that, please?

Ray Lock: Yes, thank you; and thank you, Chair, for inviting me. The Forces in Mind Trust is lottery funded. We produce independent and credible evidence, which we can lay before people charged with addressing policy, such as your good selves. It is an honour to be able to speak to you today.

If I may, I will first make it clear that we are very interested in the whole armed forces community, not just serving personnel. That would include, of course, their families, former serving personnel and their families as well. It numbers about 6 million people. So if I could make my remarks mainly around former serving personnel, where I am most qualified and most of our work is done, I would describe the provision of healthcare to former serving personnel and their families, particularly in the mental health area, as improving—improving remarkably, I think—thanks to some excellent work by members of the national health services of all four nations.

There are areas where the provision could improve even further, but the recent announcement, particularly of a pathway for veterans' mental health, is one that we very warmly welcome. We would like to see continued delivery around the services, and we are hoping that some of the geographic imbalances can be levelled up, if you like, because what we are seeking is no disadvantage, of course, in relation to health. We do believe that the NHSs have got that message and the Government understand that, so things are heading in the right direction. Veteran

Aware general practice, Veteran Aware hospitals—these are all great initiatives and we're right behind them.

Q217 **Stuart Anderson:** Thank you for that answer; it links into my next question. I am looking at service personnel currently serving and the veterans, so I appreciate the answer there. Professor, do you have anything that you would like to add about the state of healthcare for both veterans and currently serving personnel?

Professor Kinane: Combat Stress focuses on veterans' mental health and their families, so that is where my experience is at the moment. I think that absolutely great progress is being made. NHSE have really gathered some funds together and set up veterans' mental health services, rolling out across England, and it is really great to see that. Our organisation is embedded in some of those services, which is very welcome from our point of view. The NHS is very keen to learn, and there is probably a pool of excellence in our organisation around training NHS personnel to be sensitive to what veterans may have experienced during service and how to gather that information together and sensitively manage it when putting together the treatment plan for the veteran.

I think there is more work for us all to do on families. I think we would probably all agree, across the nation, that that is something we need to press on with. NHS Scotland is maintaining what it is doing, in terms of the provision it is expecting from Combat Stress; and I suppose, in Northern Ireland, we would like to see some funding specifically for Combat Stress to carry on treating veterans with complex mental health problems.

Stuart Anderson: Thank you. I will leave my questioning there for the time being, Chair.

Chair: Thank you very much indeed. Sarah Dines, please.

Q218 **Miss Dines:** Thank you for attending, witnesses. May I ask a general question? Does the NHS sufficiently understand the needs of service personnel, veterans and their families at the moment? What can be done to improve this?

Professor Kinane: I think the NHS is making great strides forward to understand veterans. They are keen to learn from organisations like ours how our specialist understanding of veterans and our military sensitivity can help them. They have asked us to help them with the provision of training to NHS clinicians around military sensitivity.

There is an awful lot to learn. As someone who has only very recently come from the NHS into the charitable sector, it is quite unusual to be thinking about taking a detailed service history, for example, and what that might actually mean. You may know that somebody has served, where they have served and in what branch of the military, but the detail of that really matters to veterans. That is something that could be developed further.

As I have said before, the NHS is eager to learn. There are some good examples emerging of more military sensitivity, particularly for example the GP practice accreditation scheme led by the Royal College of General Practitioners, where we are beginning to see GP practices run registers of veterans, so they know specifically who they have on their books who is a veteran

Dr Davies: I would agree with all those comments. Our research shows that 80% of veterans who come to Combat Stress have previously been in contact with the NHS. What they are often looking for, which they haven't been able to come across until they come to us, is a sense of a wholly veteran-centric organisation. Veterans want to have a veteran-friendly environment and workforce. They want to feel understood and have a sense of their language and culture being fully understood.

We are able to offer that because we are an organisation that is purely about veterans' mental health, but, as Catherine said, we work hand-in-glove with the NHS. We have a number of NHS contracts, so we bring that veteran expertise to the NHS because obviously veteran provision is a part of what the NHS does, whereas it is our exclusive focus.

I echo the point that Catherine has made about provision in Northern Ireland. Northern Ireland is the only nation of the four UK nations that does not have any NHS-provided or commissioned services specifically for veterans. We are conscious that there is a lack of statutory funding for veteran mental health provision in Northern Ireland, and that has an impact on the capacity of provision for veterans there, a number of whom are veterans of Op Banner and are living in the environment where they once served, so there are multiple complications there. Certainly, we would like to see additional capacity in Northern Ireland.

Q219 **Miss Dines:** Air Vice-Marshal Lock, do you have anything further to add?

Ray Lock: I just want to come back to the distinction of families of serving personnel and families of former serving personnel. In both instances, they are quite rightly primarily supported by the NHS. The understanding of serving personnel families' issues is pretty good, but there is a question over whether your typical GP would know whether the family they are seeing is indeed a former serving family. There is more to be done in the identification of the armed forces community as a whole.

Miss Dines: Thank you.

Chair: Thanks, Sarah. Could I bring in Jack Lopresti, please?

Q220 **Jack Lopresti:** Thank you, Chair, and thank you to the panel. My question is to all. When you look at the terms "no disadvantage" and "priority treatment" what does that actually mean in reality today?

Professor Kinane: I will kick off, if that's okay. It means that people will not be disadvantaged by the service they have given the country and that if they need something as a priority because they have served, or even

because they are currently serving, that would be seen as a priority and they will get priority in relation to that.

One example that I heard the widow of a veteran give was that her husband was known to the GP practice—it was known he had PTSD—and therefore once he arrived for his appointment he could go outside and wait, and he would get a text when his appointment was up, and he did not have to stay in the clamour of the waiting room. It is those small things that could disadvantage someone, but where, if it is given priority, the person can access healthcare. That is really important. It is not particularly a Combat Stress example, but it is one that struck home with me.

Of course, the original evidence that gave rise to the Covenant and enabled us to embrace it was about people being disadvantaged because they moved around due to being in service. That seems to me to be important, to ensure people are not disadvantaged by living a particular lifestyle in the service of their country.

Dr Davies: Our experience is that the results of Royal British Legion research over recent years, which has shown that there is a lack of awareness and some confusion about priority treatment for veterans, remain the case to a significant extent. Our impression is that work still needs to be done to promote priority treatment as part of the covenant and also to clarify what this means.

Ray Lock: I would agree with Felix that the definition of priority treatment is very difficult, particularly when you put clinical need as an overriding concern as well. Another area is perhaps not mental health but physiotherapy. A serving person has almost immediate access to physiotherapy at a very high standard because, naturally, the MoD wishes to get them back on to the frontline and delivering operational capability. When you step out of the service into the civilian world, you're faced with a very different environment where access to physiotherapy and the level of success are very different indeed. Part of that, therefore, is the education of serving people, and former serving people as well, as to what they can reasonably expect in terms of priority access and "no disadvantage".

Q221 **Jack Lopresti:** Would you say that the principle of priority treatment is more than just an aim or an aspiration? It is tangible and measurable and, by the sounds of it, has real practical benefits. Would that be a fair assumption?

Professor Kinane: There are some tangible examples, but I do not think it is embedded and well understood broadly yet. That is work in progress.

Jack Lopresti: Anybody else before we move on?

Ray Lock: I would agree with Catherine. Sometimes there is ambiguity—perhaps we may come on to that—around special provision, for example, in the guidance. Sometimes you just have to live with the ambiguity, I

think, but anything you can do to provide greater certainty would be helpful.

Professor Kinane: What really helps the NHS is worked examples of what this means in practice. Although I have heard a few of them, I have not heard enough yet to know that there is a kind of guide for any NHS practitioner about what ways they might approach ensuring that that aspect of the Covenant is living in the experience of the veterans.

I guess we are still looking to see how we are going to be able to measure clinical outcomes specifically for veterans in terms of NHS veterans' mental health services. There is a lot of work going on there. Combat Stress does evaluate all its treatment programmes, so we have a lot of really strong evidence. We have a research department around the programmes we run and how effective they are, so we know that they are successful. We are looking to see the clinical outcomes for the NHS veterans' mental health services in terms of a measurable output.

I think the other thing that I have become a little bit concerned about is suicide, which is always a really big and important indicator in mental health services and in understanding mental health in a community or a sector of a community. It will be good to see the next study of suicide among veterans when that eventually is produced, because the previous study is quite old now, and it did not take into account veterans from Iraq or Afghanistan.

Jack Lopresti: Thank you all.

Chair: Thank you. Before I bring in Stephen Morgan, we have an intervention from Kevan Jones.

Q222 **Mr Jones:** It is on question 2, on one of the issues about the visibility of veterans in the NHS. Back in 2009, it was agreed that we would flag up veterans on NHS patient records; those leaving the services would then be flagged up. Has that actually been done?

Isn't that a problem with a lot of GPs and others; that they have no visibility of who their actual patients are? That was agreed with the MoD and the NHS, on the basis of trying to give some visibility for GPs, in particular, to be able to know that those individuals had served in the armed forces.

Professor Kinane: That was definitely rolled out in the NHS. I cannot say how deeply it was implemented across the whole country; I am not an expert in that particular area. However, there was clearly more to be done, as that Royal College of General Practitioners scheme, around registering or accrediting veteran-friendly practices, is still very much ongoing. I am aware that more practices need to join that scheme, and that that would be a good thing to see.

However, what I am excited about is seeing that that is being discussed—that that's an active discussion—and that progress is being made. I am not sure that when NHS staff are recording the veteran status on

somebody's electronic page of records, they know exactly what to do next with that information, and that is also a work in progress.

Dr Davies: Even where the functionality is present to record veteran status, we know that, to some degree, there is reluctance, in certain circumstances, for veterans to self-identify.

This is particularly the case in Northern Ireland, and I understand that the census, for example, is not capturing the question, in the rest of the UK, as to whether individuals have previously served in the armed forces. We know that, in the prison system, there is also a reluctance of veterans to self-identify as veterans, so these are issues even where we have the functionality to record veteran status. We need to work on trying to support veterans to self-identify.

Q223 **Mr Jones:** I do not disagree with that, and I do take the point about Northern Ireland. However, this was a scheme that was set up so that, when people left the armed forces—this was implemented in 2010, so that's nearly 11 years ago—they would indicate that they were happy to be flagged, and the MoD would then pass that over to the NHS. Has that system actually been implemented?

Ray Lock: I think you are referring to Programme Cortisone, where the seamless transference of medical records from the MoD to the NHS should take place. I am afraid that is not yet delivered, and we would like to see that happen.

Mr Jones: The reason I ask is because it was myself and Mike O'Brien who suggested it in 2009, when I was a Minister, because many GPs, and also individuals in mental health settings, were arguing that they didn't know, when people presented to them, whether they had actually served.

I am a bit shocked that, 11 years later, it has not actually been implemented; that would, at least, give some visibility. I accept the point that's just been made, that veterans who've left years ago might not be on that system, but it was a way of trying to give some visibility to veterans, and also to help GPs and professionals in the NHS at least to have some insight that this person's mental health issues, for example, could be related to service.

Chair: Kevan, thank you. Could I bring in Stephen Morgan, please?

Q224 **Stephen Morgan:** Thank you, Chair. Good afternoon to all our panellists and thank you for giving evidence before the Committee today. I want to follow up on a question that was raised earlier. Do you think that this Bill misses the opportunity to set measurable standards on healthcare and mental healthcare and give real meaning to the words in the covenant?

Ray Lock: It is very difficult to measure standards, there is no question about it. The work we have done at Forces in Mind Trust has shown that it is an incredibly difficult thing to do, and that improving standards is often not actually a function of having those standards. That may seem slightly paradoxical, but actually it is more about the sharing of best practice. I

will not be drawn into saying that this is an opportunity missed. It is a very difficult nut to crack, particularly if you want to present geographic "no disadvantage" as well. I am going to slightly shy away from that, if I may, because you could argue that it is an opportunity missed, but I would argue that it is an incredibly difficult thing to achieve, and that there might be better ways of achieving what you are setting out to do.

Professor Kinane: I am trying to think of some examples from the past where I have seen a Government set a standard and think that that drove improvement. The one that comes to mind most easily is the national suicide prevention framework and that kind of work, where it really did generate suicide prevention strategies in every part of the country. It would be good to see specifics around what is such an important indicator of mental health for veterans. It is the ultimate tragedy, a suicide. I am sure that lots of other standards could be set for things that occur more frequently than suicide, but none the less, that is possibly one.

In our work at Combat Stress, we evaluate what we do on various outcome measures, which are, in part at least, taken up by NHS services, so I imagine that, in terms of demonstrating improvement and recovery and mental health, some measurements could be applied. Whether there would then be a standard that should be achieved, or a measure of improvement expected, I guess it could come from that.

Dr Davies: In addition to what has already been said, I point out that there has been a proliferation of organisations within the third sector over time, and there is a variable degree of robustness of governance arrangements and quality assurance within those organisations. Funding does not always follow to those organisations that have the safest, most effective, most robust arrangements. One initiative that we welcome, which Catherine referred to, is the accreditation scheme for veterans' mental health introduced by the Royal College of Psychiatrists. We would welcome some minimum requirements, such as accreditation for organisations receiving statutory funding, in particular, and funding from the Armed Forces Covenant Trust. That would be a welcome development.

Q225 **Stephen Morgan:** On Second Reading of this Bill, we heard from a number of Members across the House on the postcode lottery in the delivery of public services. Do you feel that this Bill risks reinforcing that postcode lottery on healthcare and mental healthcare for veterans and what they experience?

Ray Lock: I think it is accepted that the phrase "no disadvantage" is not "no disadvantage across the whole country" but "no disadvantage in comparison to the civilian population into which you are settling". I am not sure it is necessarily going to increase the postcode lottery aspects. I think we would all wish to see the same level of performance of the national health services across the United Kingdom. I think that is where our efforts would be targeted.

Professor Kinane: This is quite a difficult one, because the whole NHS does not seem to progress at the same pace uniformly. We seem to get

areas of excellence growing up and areas that are dragging behind, in terms of delivering the expected service at an expected set quality and achieving the targets and so on. I imagine that that will be the case.

We have seen with the roll-out of the NHS veterans' mental health services that some areas have managed to embrace it and get on with it and get their services up and running more quickly, which seems to be part of the readiness of the infrastructure and the organisations in different parts of the country. I suppose, with the integrated care systems coming on board, there is more of an opportunity for Government to expect more standardisation and to achieve set minimums, so I think that could be a driver for good in some of these areas, for veterans as well as for other healthcare systems.

There is a lot of training required for NHS staff in order to be able to achieve those standards, because for most of us, the experience is about the person who actually delivers the care to us at the end of the day, and the rest of the infrastructure is to enable that person to deliver the care to the highest quality standard they can. I think they require a lot of training around military sensitivity in order to provide a really good-quality experience to an expected standard. Some charities, particularly Combat Stress, are a bit of a pool of excellence for being able to help to deliver that training, but in different ways: formal training, but also perhaps working alongside people so they learn how to do it well.

Stephen Morgan: Thank you. Dr Davies, is there anything you wanted to add?

Dr Davies: Briefly, I would agree with all of those comments from Ray and Catherine. This is a challenge, not just for veteran healthcare delivery but, as Catherine said, across the whole of the healthcare system for all areas of need, that there is variation. I would very much welcome the moves to consolidate and collaborate across this sector, across the UK.

We have recently launched the UK veterans' mental health IT project, which is a fantastic concept, to have that interoperability behind information systems across the statutory and non-statutory sector. That will be great in terms of being veteran-centric and sharing of information, so that the veteran pathway can be smooth and the veteran does not have to repeat their story multiple times. The more we can see initiatives such as that, that would be great, and as Catherine said, sharing of best practice and having common assessment approaches and common outcome measures are some of the tangible ways in which we can reduce the variation and increase the best practice roll-out.

Stephen Morgan: Thank you for your responses, and thank you, Chair.

Chair: Thank you very much. We have a much longer session after this with panel 2, so we have some latitude with this one. I am going to take it to a hard stop at 16.15. Can I please ask all Members and witnesses to be quite a bit sharper and shorter on your questions and answers? There is still a lot to get through.

Before I come to Sarah Dines, could I please ask Carol Monaghan to come in?

Q226 **Carol Monaghan:** Thanks very much, Chair. Just a quick question: we are talking about having due regard to the Covenant. Is there a difficulty when we are looking at the provision of, for example, healthcare services, that local authorities could end up marking their own homework, so to speak? How do we ensure that there is oversight, and that having due regard to the covenant actually means that there are better checks and balances?

Ray Lock: The reporting—whatever reporting process there will be—will ensure that should happen. We in the Forces in Mind Trust would welcome the opportunity to present some sort of before-and-after-the-Bill analysis of how all the agencies are performing, so I think you can do that.

Carol Monaghan: Thank you. I do not know if anybody else wants to comment, but I am happy, Chair.

Dr Davies: Nothing to add, thanks.

Chair: Thank you very much. Sarah Dines, please.

Q227 **Miss Dines:** Could I ask the panel of witnesses what they would do as the single best measure to help the mental health of veterans? What is the single most important thing that they would recommend going forward?

Ray Lock: Chair, I would like to go last on that. I would like the professional mental health teams to answer that first.

Professor Kinane: That is a really tricky one. I am never quite sure whether to go down clinical effectiveness, safety measures or patient experience measures when somebody asks me about the single measure, but when it comes down to it, in my heart of hearts, I think it is about the patient experience. If the patient is able to recommend that service—that they got a good service—then they have probably had a clinically effective—[*Inaudible.*]—and they have probably had a safe service. For me, it is about whether that person would recommend that service to others who need the service.

Dr Davies: I would go with integration. We know that the need is significant, and we do not currently have enough resource in place to meet the needs that are out there. We know that the sector is not as efficient as it could be. We have gaps. We have duplication. I would welcome moves towards further integrating some of the initiatives that I have mentioned, such as the UK-wide veteran mental health IT project, because at the moment we have gaps where we need not have gaps, if we were just smarter with how we deployed our limited resources across the sector.

Ray Lock: I would say that we have to reduce the barriers to accessing the services that are there. So many times we see that there are services, but people who need them are not able to access them. Part of it is stigma. Part of it is simply having a lexicon against which you can describe

your own condition and therefore present to your GP, so we need to talk more about it. Of course, the last year has, perversely, helped us to do that, so we would be removing the barriers to access.

Miss Dines: Thank you, that is very helpful.

Q228 **Dan Carden:** I welcome all the panellists and thank them for appearing today. What is their assessment of the number of veterans who suffer with alcohol and substance addiction compared with the civilian population, and how does a substance abuse issue complicate treatment? I will put that to Catherine, Felix and then Ray, if that is okay?

Professor Kinane: Certainly, the level of alcohol abuse among veterans is much higher than it is in the general population. Alcohol does seem to be the substance of choice. That is a barrier to accessing effective psychological treatment. As most of the veterans we see—the vast majority—have post-traumatic stress disorder and mental-disorder-related trauma, the person has to have substance misuse treatment and be dry for a period of time in order to be able to access the psychological techniques and make use of them, to help them to recover.

Alcohol is a big barrier to accessing effective and successful treatment. Alcoholism is clearly a relapsing and remitting condition. Probably everybody in society knows how difficult it is to give up something if you have become dependent on it, and that one does tend to turn back to it in times of stress and difficulty. In our charity, we have substance misuse workers embedded in the teams, and often the initial part of treatment is about stabilisation, and about getting motivated in order to become abstinent so that they can access the more sophisticated and complex PTSD treatment—trauma-informed CBT.

Dr Davies: I would only add the importance for veterans' mental health, and for other mental health patients, of integrating the treatment of the substance misuse with the treatment of the underlying mental health condition. There is very much a two-way interaction between the two elements, so that is what we try to do at Combat Stress, and we recommend that more widely.

Ray Lock: I would always defer to King's College, which holds the definitive statistics on this, but I would just highlight a trial that we ran with Addaction UK, which was a programme that it developed specifically for veterans. It was a very veteran-aware programme, and it was very successful in terms of its outcomes. Then you have establishments such as Tom Harrison House over on the Wirral, which I think is almost unique in the way that it takes people suffering from addiction and mental health issues pretty much at any stage of their journey—right at the beginning of their recovery. I think that is an excellent example that perhaps we would like to see more of across the country.

Professor Kinane: If I could just say one more thing, addiction services are one of the areas that has had a lot of change in how it is commissioned and how it has been provided over the last number of

years. I do not want to say how many, but it is certainly five to 10 years. That will have an impact on the NHS's ability to be successful in working with any group where alcohol is a problem. That includes veterans and service personnel.

Dan Carden: I know that we are pushed for time, Chair, so I will leave it there, but I would say to Ray that Tom Harrison House is in Anfield in my constituency, and it is a wonderful facility. I have visited a number of times, so thanks for giving it a mention.

Q229 **Chair:** Thank you. I will bring in Tonia in a second, but can I personally ask all witnesses this: estimates of how many veterans there are in the UK today range between 2 million and 2.2 million. What percentage of that number seek help?

Ray Lock: Seek help for mental health issues?

Chair: For mental health issues, yes.

Ray Lock: I am sorry, Chair, I simply could not answer that.

Q230 **Chair:** Is it a big number? Is it a small number? Is it 10%?

Ray Lock: The King's data shows that common mental health disorders in the ex-service population are broadly the same as in the civilian population. There are small groups where it is slightly above and small groups where it is slightly below, so broadly the people who suffer are exactly the same—25% of that 2.2 million. How many access mental health services? I am afraid I simply could not answer that.

Chair: Professor?

Professor Kinane: I can't say what exact percentage access it, but I know there is a big delay before they access mental health services. Veterans under 40 are accessing it a bit earlier, perhaps—*[Inaudible.]*—years after leaving the service, but with older veterans it was taking 12 or 13 years before they were accessing services. There is how many access it, but also there is how quickly people access it, and both things are probably equally important. In the general population, the statistics are that one in four people suffers with depression, so we can imagine that with veterans there is still a high level of common mental health disorders; I would imagine it must be 25% to 30%, that kind of level.

Dr Davies: I would just add that there is a circular relationship between help-seeking behaviour and the availability and accessibility of services. To go back to my earlier point about Northern Ireland, there are issues there about availability and accessibility, and we know anecdotally that that has an impact on the degree to which veterans will come forward for help. The more that can be addressed, the more we will get a true picture of the level of need.

Chair: Thank you. I will hand across to Tonia Antoniazzi.

Q231 **Tonia Antoniazzi:** Will the duty to have due regard outlined in the Bill

improve the services offered to veterans? I will aim that question first at Ray.

Ray Lock: I draw parallels with a piece of work we did about five years ago called "Call to Mind", where we analysed all the NHS plans and very few of them mentioned veterans at all. Over a period of years, we have got to the point where we have a much better veterans' mental health system. It sounds trivial, but the very fact that you are forcing people even simply to recognise that there is a group called the armed forces community, and that they need to pay regard to its specific needs, is a huge step forward. I would see that having a very positive impact in years to come.

Tonia Antoniazzi: Does Catherine or Felix want to comment?

Professor Kinane: I agree with Ray that when people focus on something, when the NHS focuses on something, it tends to make a difference, but it is not instant; it is something that grows across a period of time.

Dr Davies: I don't have anything to add, but I agree with what Ray and Catherine have said.

Q232 **Tonia Antoniazzi:** The Government say they have consulted both your organisations about the statutory guidance and their proposals. What do you think should be in it?

Ray Lock: Frankly, there are so many things that could be in the statutory guidance. Of course, we are talking about health a lot, but a lot of the good work of the Armed Forces Bill and the due regard will take place around local authorities, as well. We have done a lot of work on our "Our Community—Our Covenant" report, which shows how local authorities can improve. We have quite a long list; I will not bore the Committee with it now, but we have a basic infrastructure for local authorities and we believe that, if you put that in place, you end up with a very much improved delivery of the covenant. We have quite a number of areas that we believe the Armed Forces Bill also ought to cover. Again, we will submit our evidence post this session, given that we only have a few minutes left.

Tonia Antoniazzi: Thanks, Ray. Catherine or Felix?

Professor Kinane: Nothing to add.

Dr Davies: Nothing to add.

Tonia Antoniazzi: Thank you, Chair.

Chair: On that note, we have five minutes left for two prescribed questions. Sharon Hodgson first, please.

Q233 **Mrs Hodgson:** Good afternoon and thank you for joining us. Hello again to Ray and Felix, and nice to meet you, Catherine. Should other areas of the covenant have been included in the Bill, for example social care? I will

tag on to that: are you concerned that areas excluded from the Bill—if you have areas that you are concerned about—will lead to a two-tier covenant, effectively lowering standards in those areas not covered by the covenant? I will start with Ray, then Catherine and Felix.

Ray Lock: I will answer your second question first. Absolutely, we have concerns that this could result in a two-tier covenant, and those have frequently and very vocally been sent to the Ministry of Defence. I think we are being heard. It is important that we are being listened to.

The areas that we wish to see covered are fairly straightforward: social care, the criminal justice system, welfare and benefits—again, the Forces in Mind Trust has done some excellent work with the DWP on that—and, to throw in a slight wild card, employment. There have been some good initiatives, with a national insurance holiday, the veterans' railcard and public sector interviews, but there is something to be tackled with here around the corporate sector—how do we involve the corporate sector more formally within the structure of the covenant?

Mrs Hodgson: Thank you. Catherine?

Professor Kinane: I have not got anything to add.

Mrs Hodgson: Felix?

Dr Davies: I would refer to the King's conference held this morning. We had our head of research, Professor Murphy, present some research that shows the importance of social factors in recovery from mental health problems, so I would echo what Ray said. Social isolation—social networks are intrinsic, and critical to mental health recovery. At Combat Stress, we are very much in favour of a whole-person approach, and separating out different elements is not as ideal, if you are trying to have a holistic and joined-up approach.

Mrs Hodgson: Excellent. Back to you, Chair. You might just be able to squeeze in the last question.

Chair: Thanks, Sharon. Finally, Kevan Jones, please.

Q234 **Mr Jones:** I think most of my question has been covered in response to Sharon's, but as a catch-all at the end, are there any other issues or points that any of the three witnesses would like to make? I will ask Catherine first.

Professor Kinane: For me, it is the attention to the family. Most veterans live in a family context—not all of them, but many of them—and so, for me, there is something about supporting innovative ways of working with families and perhaps doing that in a way that enables understanding of the disorder and how to manage it for the whole family, almost at the same time, rather than treating veterans individually and then providing some psycho-education to the partners, which is the usual way of doing it in the system. I am in favour of some funding for some innovation in treating veterans in the context of their family and social networks.

Mr Jones: Thank you. Ray?

Ray Lock: Two quick points, with the first one on data and digital. We have spoken about that a lot today. It is important to develop a better strategy, both for the third sector and for the linkage with Government. We have seen some positive moves from the Treasury to support that. We look forward to continuing it.

The second point is about perceptions. We have this perverse outcome that the more we talk about mental health, the more people therefore believe that service in the armed forces is somehow damaging, whereas as we well know, an awful lot of people go through service with their lives utterly transformed in a positive way—

Mr Jones: Yes, I agree.

Ray Lock: We want a Government-led but very collaborative strategy to improve the perception of the armed forces community as a whole with the British public.

Mr Jones: Finally, Felix?

Dr Davies: My vote would go to co-production. We know from our experience at Combat Stress and through research that it is really important for the veteran to feel understood in their experience, their culture, and their language. We know that there are lots of unique elements and characteristics to military service and to being a veteran. I would say that co-production with veterans and, as Catherine has mentioned, their families—ensuring that services are friendly and accessible for veterans and their families—is the way forward. We have lots of good examples around involvement and engagement, but obviously, co-production is much more working hand in glove, in terms of both designing and implementing services.

Mr Jones: Thanks very much. Back to you, Chair.

Chair: Thanks, Kevan. This has been a fascinating session, and I am sure we could have gone on a lot longer, but we will have to stop there—we have overrun as it is. I thank our three guests, Air Vice-Marshal Ray Lock CBE, Professor Catherine Kinane, and Dr Felix Davies. Thank you for your time—we are most grateful.