HOUSE OF COMMONS

Defence Committee

Oral evidence: Armed Forces Covenant in Action? Part 5: Military Casualties, HC 940

Tuesday 21 January 2014

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Written evidence from witnesses:

- Professor Sir Simon Wessely
- Dr Nicola Fear
- Watch the meeting
- Members present:

Mr James Arbuthnot (Chair)
Mr Julian Brazier
Mr James Gray
Mrs Madeleine Moon
Sir Bob Russell
Ms Gisela Stuart
Derek Twigg
John Woodcock

Questions 1 - 89

Examination of Witnesses

Witnesses:, **Professor Sir Simon Wessely**, Director, King's Centre for Military Health Research, and **Dr Nicol Fear**, Director, King's Centre for Military Research, gave evidence.

Q1 Chair: Welcome to the first of our evidence sessions in our second inquiry this Parliament, into the issue of military casualties. Professor Sir Simon Wessely and Dr Nicola Fear, you are both welcome to give evidence to us.

We will be concentrating today on the mental health issues related to military casualties, but we do not want to create the impression that mental health issues necessarily affect members of the armed forces to a

hugely significant degree compared with the population as a whole. Our experience is that most people who serve in the armed forces have a good experience of that service and that they do not have a greater proportion of mental health issues than the population as a whole. Nevertheless, there are some important mental health issues that need to be explored and that we would like to ask you questions about. I put that in by way of preamble in order to set the context of the questions that we will be asking.

If I may begin, how would you describe the mental health of armed forces personnel in general?

Professor Wessely: First of all, to echo what you just said, it is correct that in general, the mental health of the armed forces remains remarkably robust, all things considered in terms of what has been going on in the last 10 years and the nature of the post. It is important that the general public get that fact. This is not a crisis that we are facing, a catastrophic failure in morale or a tidal wave of problems. But, as you also said, we know that there are particular groups who are particularly at risk, and particular problems that are perhaps more prevalent in the armed forces than in the rest of the population. Plus, of course, being in the armed forces does not make you immune from the same problems that afflict all of us.

You are quite right to set this in context. I am a psychiatrist and Nicola is an epidemiologist, so clearly, we concentrate mostly on those who are having difficulties and who have mental health problems, but it is quite right to point out that that is not the universal or indeed the majority experience.

Q2 Chair: I think we would all agree with the Deputy Prime Minister when he says that those who suffer from mental health issues have every bit as much of a right to treatment and dignity as those who suffer from physical health issues.

Professor Wessely: Yes. I have just been elected president of the Royal College of Psychiatrists, so I am absolutely bound to agree with that, to put it mildly.

Q3 Chair: How does the mental health of armed forces personnel differ among those who have deployed to Iraq or Afghanistan, compared with those who have not?

Professor Wessely: In general, we know that deployment per se, the mere act of deploying to Iraq or Afghanistan, does not have a particularly strong effect on mental health. The only area in which you can see a global increase is a small increase in alcohol problems when people return.

Chair: We will come to that.

Professor Wessely: Yes. But there are two groups where you see an increase in general mental health problems, and in post-traumatic stress disorder in particular. One is those in combat arms—the quarter who are in combat roles. There, you see an increase in prevalence—we have done these surveys many times, and there is some noise in the figures, but as a rough rule of thumb—from something like 3% up to around 6% to 7%.

Mr Brazier: Sorry, could you repeat that?

Professor Wessely: Three per cent is the background level of post-traumatic stress disorder in the forces. You need to remember that about half the cases of post-traumatic stress disorder are not actually related to deployment, so there is a background: even if they never went anywhere near Iraq or Afghanistan, there would still be post-traumatic stress disorder from things like assaults, accidents, exercises and so on. However, that rate goes up in those who are exposed to combat. This is not a particularly profound observation; it would be rather odd if that wasn't the case, but it is the case. It goes up to around 6% to 7%.

Mr Brazier: To 67%?

Professor Wessely: No, 6% to 7%. If it were 67%, that would be worthy of note; you are quite right. It is 6% to 7%. I will be more clear.

The second group that we first showed some years ago, and which has not changed, is in the Reserves. Overall, Reserves have a doubling of their rate of PTSD post-deployment, irrespective of the roles that they have. That is a generic effect in Reserves. The thing with the Reserves that is slightly problematic is that, when we follow them up, up to five years post-service, you would have expected that that rate would have gone down, but it hasn't. The difference between deployed and non-deployed remains present, five years post-deployment. Of course, 94% do not have PTSD, but there is a clear deployment effect on Reservists.

Chair: Dr Fear, would you like to add anything to what Professor Wessely has said?

Dr Fear: Simon has talked about the combat personnel and the Reserves. The other area in which we have seen an increase in PTSD is in those individuals whose cumulative length of deployment was 13 or more months in a three-year period.

The armed forces have what they called harmony guidelines, recommending how many times individuals should be deployed and how often. The work that we did back in 2007 showed that if those guidelines were broken, even by one month, there was an increase in the prevalence of PTSD, but again, it was low—at the levels that Simon has already alluded to, of about 6% or 7%.

Chair: I have decided that Gisela Stuart is going to ask the next question, much to her surprise.

Q4 Ms Stuart: Thank you. There are quite fundamentally different approaches with how we deal with mental health—some go more for therapy, others for drugs. I always assumed that the British do it rather well. Nevertheless, I would like to ask you: is there someone else who does it better than we do?

Professor Wessely: Do you mean treatment of mental health in general, or in the forces?

Ms Stuart: In the armed forces.

Professor Wessely: There is no doubt that the US do it more—there is no question about that—in the quantity of mental health support and the range of treatments that they provide, and just the general scale of the entire operation. Do they do it better? There is not much evidence to suggest that, in terms of outcomes. Certainly, their overall outcomes are not as good in various areas, the exception being alcohol, where they are slightly better.

In general, mental health is a difficult area. In the years that I have been involved with the forces, there has certainly been a change in attitude towards mental health problems. There has certainly been a change in provision. You mentioned that the Deputy Prime Minister spoke yesterday about delays in treatment in the population. In general within the forces, that is not a big issue: there is not much delay and they are well provided, particularly with community psychiatric nurses with a range of skills. Psychiatrists are a bit of a problem, as are psychologists, but in terms of access to therapeutic services, you are better off in the forces than if you are not.

Q5 Ms Stuart: The second question is about devolution in the United Kingdom, particularly in relation to the Military Covenant, because things like health are the responsibility of devolved Administrations. Do you have concerns about differences between England, Scotland, Wales and Northern Ireland? If so, how could we address them?

Professor Wessely: You were in Scotland last; you do it.

Dr Fear: I'll leave that one with you, I think.

Ms Stuart: It's that bad, is it?

Professor Wessely: No, it is not that. This is just a general statement, but it is difficult to keep track of what is going on. Remember now you are talking about NHS services. The data are much better for those in the forces, because they are easier to track—we know exactly who they are and where they are, and the Defence Statistics medical branch keeps records reasonably well. That becomes much more problematic when people leave—even knowing who is a veteran is still a problem. As for keeping track of the four Administrations, we don't do that really, and I am not sure whether anyone does.

Q6 Ms Stuart: Is there a difference in the way the Scottish health service, for example, would deal with mental health problems of members of the armed forces, from the way the English service would?

Professor Wessely: I don't think there is. There seems to be a slightly higher profile of veteran's issues in Scotland. That is true, and they have been slightly ahead of the game in trying to organise services, but remember, it is still a devolved responsibility. It is also smaller, which makes it easier as well. I think it is fair to say that they have established—I should declare an interest, in that I am a trustee of the charity Combat Stress—better community links between charities and the NHS in Scotland than is the case at the moment in England. That may be a question of scale, but I think it is true to say that one gets an impression that they are slightly more proactive.

Q7 Chair: You said that outcomes in the United States were not necessarily as good as they were in the United Kingdom. Why is that, do you think?

Professor Wessely: They have a higher prevalence of mental health problems, and the big difference between us and the US is that,

remarkably, those prevalences increase over time. When people come back from deployment, you would expect a lot of them maybe to be going through difficult times, but in general most mental health problems will improve over time; a small number do not, and that is when we get interested in them. In the US, that is not happening. In the US, there is a steady increase over six months, 12 months, 18 months, 24 months post-deployment. It is not even a small increase; in some studies it is a doubling or a trebling of rates of disorder over that time, leaving them at the end of that period with much higher rates than we have. Whatever else that is due to, it is unlikely to be due to what happens in theatre, because we do similar studies to the US in theatre, and I think it is fair to say that the prevalence of mental health problems—give or take—is not dissimilar.

Dr Fear: In theatre, they are very similar.

Professor Wessely: But 12 months, 18 months, 24 months later, it is very dissimilar.

Q8 Chair: We will be asking you later about the research you are doing in the United States. Does that difference in prevalence have anything to do with the length of deployment that US armed forces personnel go through?

Professor Wessely: It certainly could do. As you know, that was a year and then the key thing that was happening was that it was being extended to 15 months, sometimes when people were in theatre. We were able to show that when the UK did that—when it extended the expected time of deployment—there was a significant worsening of mental health and drink problems. That was happening on a much larger scale in the US. There is this kind of violation of expectations about how long you would be out there. Many people do think that that was a big issue. The only way of knowing that for certain would be to randomly allocate people to serving in the US or the UK, or to have a six-month or a one-year service, which obviously is never going to be done.

Q9 Chair: So you are saying that it is not the length of deployment, but the expectation of the length of deployment.

Professor Wessely: There are two things. Certainly, overall length, if you exceed the guidelines that Nicola talked about, is deleterious. However, people mentally decide that they are going for period x, and their families mentally decide that they will be coming back on a particular date. If that was significantly extended, there was quite

substantial worsening of mental health problems, so yes, expectations are definitely vitally important.

Q10 Mrs Moon: What about reintegration when people come back, particularly Reservists, given the problems that they have got in the States, and we also have a smaller problem. Is being able to reintegrate back into civilian life and civilian jobs an issue that is exacerbating the problem? Is that something you have looked at?

Professor Wessely: We have.

Dr Fear: Within the cohort study that we run, we asked our Reservists about how they dealt with reintegration back into civilian life—how they coped with socialising with their civilian friends and their families, but also with reintegrating back into their civilian employment. We found that those Reservists who struggled—who had problems readjusting—were more likely to report mental health problems across the board, particularly PTSD and common mental disorders. So yes, it does have an impact.

Q11 Sir Bob Russell: Can I follow up on that? Are UK Reservists more likely than Regulars to experience mental health problems on return from deployment?

Professor Wessely: Yes.

Q12 Sir Bob Russell: And what are the statistics for that? Is it a small percentage, or doubled?

Professor Wessely: It is both. It is doubled, but it is a small absolute percentage. It goes up from 2% to 3% to about 4% to 6%.

Q13 Sir Bob Russell: Do either of you have a theory? I could guess, but I am going to ask you because you are the professionals. Why is that?

Dr Fear: Again through our cohort study, we looked at levels of cohesion and they are different between Regulars and Reservists. Regulars report higher levels of cohesion and family support.

Sir Bob Russell: And military support?

Dr Fear: And military support, yes. Those factors are lacking among Reservists, so we think that they may be partly responsible for their higher levels of mental health problems.

Q14 Sir Bob Russell: So if you were to make a recommendation to this Committee for us to put to the powers that be, what would that recommendation to assist Reservists be, bearing in mind that the move is towards a greater proportion of Reserve forces in the future?

Professor Wessely: I should say that those differences are correlated with longer-term mental health problems, so the two are associated, but that does not necessarily mean that there is cause and effect; you have to be a bit careful about that. The implications of what we are saying are fairly obvious all round, but these are very difficult things to do in reality. It is not just formal social support that you can deliver. You could deliver increased welfare services and provide more counsellors and more psychologists and all those things, but the evidence shows that just as important—some people think more important—are the informal networks that you cannot create because they come naturally. They are about mates being bonded together.

Sir Bob Russell: The families?

Professor Wessely: Yes, all those things—coming from a military family, living in accommodation and being part of a much tighter community. You cannot legislate for things such as that. It is what we sometimes call a wicked problem: it is easy to see what the problem is but it is not easy to see what the solution is. Just employing more of this, that and the other might not be the solution. It is about creating a sense of cohesion and purpose. Informal support is probably the best barrier against mental illness that we have.

Q15 Mr Brazier: Sorry, Dr Fear said something that I didn't hear properly. She said that they found that the Reservists who were more likely to have mental health problems were in a certain category, and I couldn't quite hear what she said. What were the problems among Reservists in a particular group that made them more likely to have mental health problems?

Dr Fear: It was the Reservists that struggled with reintegration—those that found it difficult to re-establish links with their family and friends, and had problems with employment.

Q16 Mr Brazier: Thank you. At a hearing here six or seven years ago of the all-party group on mental heath, jointly with our little all-party group on Reserves, somebody from King's—I'm not sure which of your colleagues it was—remarked that they had done a study that compared Reservists, who in those days used to go as formed companies and that sort of thing, with those who went as augmentees, and they found a substantial difference. Clearly, that is from several years ago, because apart from field ambulances, nobody has gone recently. Do you know anything about that study, or not?

Professor Wessely: That was our study, yes. What is the latest on that one?

Dr Fear: The latest that we have got on individual augmentees is that there is no difference in their mental health status if we compare them with individuals who deployed as part of a formed unit. There is no difference, whether they are a Regular or a Reserve.

Q17 Mr Brazier: Sorry, turn it the other way round. My question was: is there a difference between Reservists who deploy as augmentees and Reservists who deploy as part of a Reserve formed unit?

Professor Wessely: We'll have to get back to you on that. Neither of us can remember.

Q18 Chair: That would be helpful.

Is there a particular stigma still about seeking help for mental health issues?

Professor Wessely: But of course, yes.

Q19 Chair: And it will be difficult to reduce that.

Professor Wessely: Yes, it will be difficult. Forget about the forces; this is a general comment. There have been some gains made—we've been monitoring this in the forces—and there has been some decrease in the levels of stigma in the last few years, which may have happened naturally in society or it may have been the result of a lot of initiatives, but don't go overboard. It is a small reduction.

The other interesting thing we have found is that stigma is not a fixed commodity that you have, like your height or your weight—well, your weight's not fixed.

Chair: I do hope not.

Professor Wessely: It changes, and one of the interesting things was that stigma levels in theatre, on operations, are much higher than stigma levels at home. It is as though when people are on deployment, they really are very task-orientated, they want to know they can rely on their mates, so it is not the right time to be emoting and talking about your personal problems. Then, when they come back, it drops quite dramatically and it is a good time for talking about these things. So it is important not to see it as an innate quality that people have. In the military context, there are times when you can understand that and you can see why it might be so, so I think we have to have a more nuanced view of stigma. It is not a fixed thing.

Chair: I must say I am thoroughly enjoying this evidence session. It is a fascinating subject.

Q20 John Woodcock: Just to follow on from that, you talk about stigma not being fixed. Obviously, there is a great level still of residual stigma across society as a whole, although hopefully it is coming down. Do you get a sense that there is an increased level within the armed forces?

Professor Wessely: No, I genuinely do not. A piece of evidence for that is if you look at the proportion of people who present with mental health problems, and it is higher than in the general population. It is still a minority, so it is around 40% of those we would like to see present—60% don't—but, as you heard yesterday, in society as a whole it is around 25%, depending on the diagnosis and things like that. Nevertheless, there is nothing to suggest that the forces are worse than the rest of society.

Q21 John Woodcock: If I follow you, how can you have confidence that that is not a case of differing levels of mental health problems rather than willingness to come forward?

Professor Wessely: It is a proportion. Because of the nature of the studies we do, which are population-based, we have a reasonable idea of what the true level of disorder in the community is, just as we do in the general population from large-scale population studies. If you then take the proportion of people that we know, let us say, have depression, and you then see how many have presented, you can see what the proportions are. It is not about absolute numbers; it is about proportions. Obviously, the absolute numbers of the population are of a magnitude not

seen in the military, but as a proportion of those who have disorders who will present, it is a higher proportion in the services—but it is still a minority.

Q22 John Woodcock: I'm sorry, I'm probably being thick, but they may have acquired a greater level of depression from being in the forces, so it may not be the same baseline.

Professor Wessely: Actually, it isn't a greater level of depression. The levels of depression are not higher, but that would not affect what I am saying, which is what is your likelihood of presenting if you have a problem? Your likelihood of presenting with schizophrenia is incredibly low in the forces, because there is not anyone with schizophrenia. If we take things that are in the forces and in the population, you are more likely to seek help. The other factor is that it is easier to get help, but, again, let us keep a sense of proportion: the majority still don't seek help. It is still hard to get help, it is still stigmatised and people feel that they will be treated differently if they get help, so I do not want to paint an overly rosy or optimistic picture.

Q23 Mr Brazier: Just a very quick point. The most interesting statistic you presented out of a lot of interesting statistics was the one at the very beginning when you said that, although there was a difference in level between Regulars and Reservists, the really striking thing was that afterwards the Regulars got better and the Reservists did not. Could that not relate to what you have just said? If you are a Regular and you have a physical problem and you need to see a physio, there is a very good arrangement. We will finally, next year, be introducing a comparable one for Reservists. I imagine the gap is even greater in mental health than it is in physical health, so I think you might have explained your earlier statistic.

Professor Wessely: Well, it could be. It is probably a whole host of things. It is probably due to lower levels of support; it is less support from the employer; Services are much more difficult to access.

Mr Brazier: Much more difficult.

Professor Wessely: Yes, because of the geographical spread. There is probably no single issue, but that is certainly one of them as well, yes.

Chair: Would you like to continue, John?

John Woodcock: I was going to go on to—

Professor Wessely: In fact, just to correct the record—

Dr Fear: In a paper that we recently had published on help-seeking, we asked individuals whether they reported that they felt they had an emotional or stress-related problem and we asked them then, if they endorsed that question, whether or not they sought help. I have just pulled the paper out now and there is no difference in the proportion seeking help between Regulars and Reserves.

Professor Wessely: Bang goes that theory, then.

Dr Fear: Sorry.

Q24 Mr Brazier: But access is very different for all forms of medical service. We are just beginning to sort it a little.

Professor Wessely: It is.

Dr Fear: Yes.

Q25 John Woodcock: Can I ask you about the rate of suicide in the armed forces? What is it at present?

Dr Fear: Statistics are produced annually by Defence Statistics. I have the most recent ones, so I can tell you the correct statistic. These are based on data from 2002 to 2012. If you compare the rate of suicide in the military to the rate of suicide in the general population, you have got a standardised mortality ratio of 22, which means that there are fewer suicides in the military than we would expect in the general population.

Q26 Mr Brazier: Can you expand that? Is that 22% of the civilian average? What is that number?

Dr Fear: A standardised mortality ratio takes into account the differences in the age and gender structure of the two populations. So in this context we have the general population of the UK and the military. So if we take into account the differences in the demographic structure and we look at the rates of suicide after taking those differences into account—it is a statistical technique—we have a standardised mortality ratio of 22. What that means is, if you have a standardised mortality ratio of below 100, there are fewer suicides in the military than we would expect in the general population.

Q27 Mr Brazier: The military are down at 22, so that is a hell of a lot fewer.

Dr Fear: Yes.

Mr Brazier: Thank you.

Q28 Mr Gray: On the statistical question, your explanation puzzles me a bit. As I understand it, you said that you balance it out based on population size, gender and other things, so you can compare the two in an equal manner, but surely that is, by definition, skewing the evidence in the first place. People in the armed forces are predominantly male, young and aggressive, full of adrenaline, full of testosterone and under much greater pressure. Therefore, I should like to know—let us leave aside the statistical balancing out that you described—what percentage of people in the armed forces commit suicide, compared with the percentage in the non-military population. Leaving aside your statistical concerns for one moment, although I can well understand those, what are the raw statistics—the percentage in the armed forces compared with the percentage in the general population?

Dr Fear: I am afraid that I do not know the percentages off the top of my head. This is work done by Defence Statistics. They break those statistics down by gender, by age and by service, so you can look at different groups.

Q29 Mr Gray: It would be interesting to know, because—don't you accept my point that, actually, we are looking at whether or not there is a greater probability among young males who are in combat situations than in the general population?

Dr Fear: If you look at young Army males, there are more suicides in young Army males than we would expect, compared to the equivalent group in the general population. So yes, it is important to look within those specific groups.

Q30 Mr Gray: That is actually a more interesting statistic than the one you gave us.

Professor Wessely: We were just about to elaborate on that.

Mr Gray: I see. I apologise.

Q31 Mrs Moon: I have seen the work of Professor Nav Kapur, from Manchester, which you probably know about. He demonstrated that the largest numbers of suicides were among young people who either failed to complete their initial training or left the Army shortly after completing their initial training. They were the high-risk group, not those who went on to complete and go into combat. Is that correct?

Dr Fear: That is right.

Mrs Moon: That is based on deaths in the overall population. He looked at overall deaths.

Dr Fear: Yes.

Mrs Moon: He correlated that with military statistics and produced that report.

Professor Wessely: It is very important to talk about rates, because if you do not do that, you end up with these non-statistics, such as that more Falklands veterans have taken their own life than were killed in the conflict.

Mrs Moon: It was a *Daily Mail* headline, not a statistic.

Professor Wessely: It certainly was. It was both wrong and meaningless, so it is important to be very boring and dull and talk about rates.

Dr Fear: Thanks!

Q32 John Woodcock: Just for completeness, are there any other particular groups within the forces in which the suicide rate is higher than you would expect for similar groups in civilian life?

Professor Wessely: The problem—not a problem, thank God—is that there are not that many suicides. There aren't enough. There are these young Army men, but in the rest of the forces the numbers are too small to make any real conclusions.

Q33 John Woodcock: Would that hold for the particular issue of people who we know have left the forces and have mental health conditions? How do they fare compared to people with mental health conditions in civilian life? Is that a level of granularity which is really too much?

Professor Wessely: The problem with that is we only know overall lifetime suicide rates beginning with the Gulf War in 1991, because until then, those data were not available and we know there that they are not elevated up until now. They have only just started collecting lifetime data for Iraq and Afghanistan—either this year or next year.

Dr Fear: They are just about to flag them at the health and information centre, so later this year we might know.

Q34 Chair: Why have they only just started?

Professor Wessely: You can't ask me that. I don't know.

Chair: That is a perfectly satisfactory answer.

Q35 Mr Brazier: I am sorry, I am clearly being extremely stupid, but which category is so small that you can't make meaningful statistics out of it?

Professor Wessely: We have had data on in-service suicides for a long time. You cannot look at any particular regiment, or down at that level. You can look at the three services, gender and age group, and you can't do much more. But if you want to ask what happens when people leave and then become veterans, remember, we haven't had a way of tagging veterans at the Office of National Statistics. We did the Gulf because—as you will remember well, Derek—the mortality of Gulf veterans became a big issue and it became imperative to look at their mortality for cancer, neurological diseases and suicide, and it was shown that there was no elevation. But that had not happened for Iraq and Afghanistan until pretty much this year because you have to pay a small amount to register, and that has only just happened.

Q36 Mrs Moon: That was really interesting. I gather that you have looked at research into the mental health services available for deployed individuals. What are your findings?

Professor Wessely: Yes, we have. We have carried out the first surveys: two in Iraq and two in Afghanistan?

Dr Fear: One in Iraq and two in Afghanistan.

Professor Wessely: You keep going, then.

Dr Fear: We have looked at the mental health and well-being of those currently deployed, but we have also done some work looking at data being collected by the field mental health teams. These are the teams that are based within the operational environment. The statistics that have come out from there have shown that most cases that they see can be treated in the operational environment, and that those individuals carry on with their period of deployment and are successful in that period of deployment.

Q37 Mrs Moon: Are you seeing any indication that providing home leave during a period of deployment is a problem?

Professor Wessely: We don't know and we asked about that. It is very popular—whether it does any good or not is a very moot point to which we do not have an answer.

Q38 Mrs Moon: Will you be able to produce any information about the impact on mental health of those who are staying during the final year, during the withdrawal?

Professor Wessely: We are in discussion with the MOD on whether there will be a final round of the study that we have been doing. We do not know if that will happen or not. It is difficult to do. Particularly as we go to the forward checkpoints and the forward bases, it is not an easy thing at all to do, and it is not clear whether that will happen.

Dr Fear: We are about to embark on the third phase of data collection for our longitudinal cohort study. In that, there may well be some individuals who are on their last roulements to Afghanistan—

Professor Wessely: There will be.

Dr Fear: So we may be able to look at their mental health and well-being post-deployment, but not during deployment.

Q39 Mrs Moon: Will you say a little more about the longitudinal study, because it is very important to us?

Mr Gray: What is a longitudinal study?

Dr Fear: It is where you recruit individuals and follow them up at various points over time. The study was established in 2003 at the advent of the war in Iraq. We surveyed about 10,000 individuals—Regulars and Reserves. Half that cohort had been to Iraq and half had not. The study

then had a second phase of data collection, which happened in 2008-09. That followed up all the individuals who had completed phase 1, but we also included two new groups of individuals: a group of individuals who we knew had been deployed to Afghanistan, so we could look particularly at the impact of deployment to Afghanistan, but also a new group of individuals who had recently joined the military. That was so that we could ensure that the results of our study were representative of those who were still serving in the armed forces, because initially with a longitudinal study, unsurprisingly, people get older, and as they get older, they are more likely to have left the military. We do follow people up after they have left so we can look at that transition back into civilian life.

We are just about to embark on the third wave of data collection for that study. Again, we will be following up everybody who took part in phases 1 and 2 and we will also be introducing a new replenishment sample, again to ensure that the results of the survey are representative of the current structure of the armed forces. That data collection is due to start, hopefully, in the next month or so, but there will probably be 18 months of data collection.

Q40 Mrs Moon: Can you see any results of your research in how the mental health services are provided by the MOD? Do you see an on-the-ground change and if so, what have you noticed?

Professor Wessely: Those services are provided for many reasons and very few of them relate to us. Having said that, there has been some impact—I think that is true. We played a quite substantial role, together with the Marines, the Navy and now the Army, in the TRiM programme—the peer support, which is continuing—in developing, extending and evaluating it. We played a role in decompression and the psychological support of decompression. The briefings that people are given before and after they come back have changed as well through research. We have shown the effectiveness of the field mental health teams, which I think has contributed to their continuing. What other areas of mental health are there? I am sure there are others.

Dr Fear: We evaluated the Reserves mental health programme and showed that the individuals who were going through that were having good outcomes, so that was shown to be effective.

Professor Wessely: Probably the biggest single one is the trial of mental health screening that we are currently doing. We previously showed that screening for mental health problems before people deploy was ineffective. It basically doesn't work. It is much more interesting to see whether screening people when they come back, when they may have

developed mental health problems—as opposed to predicting—has more utility. We are in the middle of the first ever such trial in the world, doing post-deployment mental health screening of more than 10,000 people, and that is ongoing. The results of that will definitely have an impact on policy one way or the other.

Q41 Mrs Moon: I thought the Americans did post-deployment screening.

Professor Wessely: Oh yes, but they don't know that it works.

Mrs Moon: Sorry?

Professor Wessely: They certainly do it but they don't know if it works, because they didn't do a trial. Our trial is actually funded by the Americans, not because they love us but because it dawned on them that it was a very silly thing to introduce an incredibly expensive policy that might well do more harm than good without evidence.

Mrs Moon: And not do any analysis?

Professor Wessely: And not do the trial, yes. The US are paying for this trial in the UK because they should have done it in the US. This is all on the record, isn't it?

Q42 Mrs Moon: It is.

Professor Wessely: Oh dear, oh well. Bang goes my visa. Having said that, what I said was absolutely true.

Q43 Mr Brazier: I am finding this absolutely riveting. I don't mean to be stupid, but we are not specialists and are struggling with some of your statistics. This is really interesting. I have three related questions. The first is on pre-screening. I was delighted to hear you make that remark. Some of us have just been down to the Army recruiting centre. Are you aware of just how committed they are, through, in my view, a completely mistaken policy of the service medical services, to pre-screening people mentally before they join the armed forces? One thinks of some great military figures who have allegedly had mental health problems. Were you aware of that? That is the reason they give specifically for having to approach people's GPs, rather than doing a medical themselves.

Professor Wessely: Getting medical information is important—for example, establishing that someone has a history of diabetes or schizophrenia—and in a way, that is screening. I think a particular one they do is on deliberate self-harm, which is a reasonable predictor of subsequent behaviour but is quite low prevalence. I think they do that.

Mr Brazier: Sorry, I didn't hear that.

Professor Wessely: Finding out if someone has a history of deliberate self-harm could be important. It is not that common, but it is important if it is there. I wouldn't call that full screening, would you?

Dr Fear: No.

Professor Wessely: That is getting the full medical records to look at. I am not aware that they do psychological selection.

Mr Brazier: Not psychological. The point is that the largest single delayer for all the people lost in the system is waiting for the records on that. If it is low prevalence, they could—

Chair: It is not simply mental health stuff that they are waiting for.

Q44 Mr Brazier: No. I must go on to the next question. That is the point that they picked out as being what a service doctor cannot do for them.

Professor Wessely: Sure; that is getting the general records for everything, which is sensible.

Q45 Mr Brazier: I have contacts on both sides of the Atlantic on this. Does this study include before and after brain scans?

Professor Wessely: No.

Q46 Mr Brazier: The Americans have started doing some of that because of the connection between brain damage and PTSD. Do you think it should include that?

Professor Wessely: The only way that you would do that at the moment would be as a research tool or research question. There is no evidence at all to suggest that you should do that to improve clinical outcomes—selection or screening. The evidence simply is not there. The Americans are doing it largely because they have paid about £1 billion of

research into this area. That is fine. Even they are not doing that as a routine.

Mr Brazier: I'm sorry, let me rephrase the question.

Professor Wessely: I'm gibbering as well.

Mr Brazier: Let me ask you a different question; we obviously misunderstood each other.

Professor Wessely: No, I could give you a better answer.

Q47 Mr Brazier: I think I mis-stated the question; let me state it again. The team from Oxford that is trying to get this project wants to get brain scans from a sample of people before and afterwards, in order to see whether there is a correlation between those who get mental illness and those who have very small variations in brain patterns. That is what they are looking for. Do you think that would be a worthwhile project?

Professor Wessely: As research, absolutely, but not as routine clinical practice.

Mr Brazier: Well, nobody is suggesting that; of course not.

Professor Wessely: Some have.

Q48 Mr Brazier: Their argument is that if it showed a result, you would be able to say, "We shouldn't just be putting these people with problems down a psychological route; we should be looking at a neurological route." My final question goes back to Madeleine's point on people having R and R in the middle. I did not really understand your answer to that. If you are in favour of decompression before people go home, it would seem very odd to send people home on R and R, as opposed to having local R and R, without decompression. Can you give us a fresh answer?

Professor Wessely: The work we have done on decompression shows that, first of all, people do not like it before they do it, but afterwards, most of them think that it is a pretty good thing. It is a pretty short period of time. It does not prevent post-traumatic stress disorder, but it has a small impact on general mental health. What you have just said is logical—why do they not have it after R and R? I do not really have an answer to that question; it is not really for us. We do not have any evidence as to the effectiveness or ineffectiveness of R and R. The only

thing we do know is that a lot of drink is consumed during R and R. We also know that it is incredibly popular.

Q49 Chair: After the event?

Professor Wessely: Yes.

Q50 Mrs Moon: I want to go back to your research on TRiM. Can you please tell us about your findings?

Professor Wessely: TRiM was brought in because things had previously been done, particularly psychological debriefing, after something bad had happened. That is when trained counsellors arrive and immediately say, "How was it for you? How do you feel?" and so on. We were part of the groups that showed that that not only did not work, but actually did more harm than good—it increased the rate of PTSD. The military stopped that around 2000, I think.

Developing then in the Royal Marines came this idea of peer support: get rid of all the people like me, basically—the mental health professionals—and have it done within the culture by people who know who you are, knew you before and know you afterwards, and can spot in you signs of difficulty, but in a non-professional, non-medical way. That was TRiM, which is support.

We co-operated in a trial of TRiM in the Royal Navy, in which the Navy was randomly allocated—half the ships got TRiM and half did not. It did not show all that much, because that was a year when not a lot went wrong in the Navy, so there was not much trauma to treat. However, it did show that it was very popular and certainly did not make people worse, and it might have had some impact on subsequent disciplinary matters. That has now been rolled out across the forces and is in very common use. It remains popular with both commanders and the forces alike.

It is absolutely clear that TRiM does not prevent PTSD. We hope that it detects better and is part of a general, long-term cultural change over perhaps a generation—a gradual part of improving the acceptance of allowing a psychological role, and the acceptance that it is okay to say why you are having trouble—but it is no more grandiose than that.

Q51 Mrs Moon: TRiM has also proved very popular with police services. Are there any studies looking at the impact on the police service, and any comparative studies between the two?

Professor Wessely: I am not sure about comparative studies. One of our colleagues, Surgeon Captain Greenberg, who was instrumental in developing this, did a study with the Cumbrian police after the shootings they had there. I think that the results were rather similar. It had a lot of face validity—people thought it was good. *[Interruption.]* Suddenly the report has been produced.

Dr Fear: As if by magic.

Professor Wessely: I am sure that that is what it says. If it doesn't, I am not going to tell you. It does say that, does it?

Dr Fear: Yes, it does—it was widely accepted. People used the system and felt it was useful for them and their well-being.

Professor Wessely: Very importantly, TRiM does not prevent PTSD, but equally importantly, unlike some other things that have been done in my profession, it does not create it, either.

Q52 Derek Twigg: On the rates and statistics, in your figures, high profile is given to PTSD, but things such as depression and anxiety form a large part of the overall figure. What is the difference in the figures, in terms of people suffering from PTSD, as opposed to depression or anxiety?

Dr Fear: In our main cohort study, we use a measure of common mental disorder that, as you said, covers a whole variety of conditions. When we look at that wider condition, we find a prevalence of about 20%, compared with 4% for PTSD. We have conducted a clinical interview study, in which we use more diagnostic tools over the telephone, talking to service personnel about their mental health and well-being. We found the level of depression to be about 11%. I am not sure how that compares with the general population.

Professor Wessely: It is not that different.

Dr Fear: We are hoping to repeat that study alongside phase 3 of our cohort study, so we will be interviewing and collecting more detailed clinical information from probably 1,500 to 1,800 service personnel.

Q53 Derek Twigg: I am not sure whether Simon or Nicola will want to answer this question. We have established that there is not going to be a massive spike of people coming out of the armed forces with mental health problems—the term "deluge" has been used—but there will be a point in six, seven, eight or perhaps 10 years' time when more people who have been in the armed forces will present with mental health problems. Do you have any view or research about that which it would be useful to share with the Committee?

Professor Wessely: Yes, I think there are probably two or three things to say on that issue. What we are seeing over time is a small increase in the rates of mental health problems up to five or six years post-deployment—not the large increase that the US has seen, but a small increase. That is composed of two separate things. We know that just under half the cases of PTSD are delayed in onset, so people leave the forces and then quite a proportion of those cases will appear later. That is offset by an almost similar number of people who get better. These are not the same people. A lot of people have problems and get better, but are then replaced by other people who have got worse.

When I say people leave and are well, they are not that well. They have some symptoms and they get worse. Their overall condition deteriorates, and finally they become what we call a case, when they might need treatment. As for people who are absolutely fine and then some years later develop full PTSD, that is relatively unusual. It is not that people are fine and then, on the anniversary of something, that's it. It is that they were not fine, but they have got worse. Maybe they have started drinking more or whatever. There are other people who were not fine and have got better, but are still not completely fine. That is the first thing.

The second thing is that there is no doubt that within the Defence Medical Services and the charity sector, people are presenting earlier than they used to. Combat Stress, for example, used to say that it was 12 to 14 years before people would present. Now that is certainly not the case. Now we know it may be up to two years, so there has been a big drop in the length of time it takes before people will either come and get help or, as happens more often, be told to get help by their spouse or whatever.

As that is the case, you can see that your services will get a lot busier; the numbers coming in, in any calendar period, will be going up. It is easy to assume that is because things are getting worse, but actually it may not mean that at all. It may mean that things are getting better, in the sense that people are presenting earlier. The time at which people present has been brought forward; they are presenting earlier. It might not be a thing that we should be so worried about. It might be a mark of

the fact that some of the stigma campaigns and the outreach programmes are having an effect. We will have to see, and the longitudinal study that we are doing will help to separate out these various themes, but we should not leap to the conclusion that because the defence services are seeing more cases, something has gone wrong in theatre. It might well be that this is something we should be pleased about.

Q54 Derek Twigg: Isn't this one of the difficulties in looking at facts, statistics, rates and so on? How can it be determined whether the mental health issue, whatever that may be—whether it is depression or PTSD—was actually down to the service if it presents two, three, four or five years down the line?

Professor Wessely: It is very difficult. Obviously, it is easy when someone has got a physical injury: you know why that was. But remember, first of all, half the cases are not due to operational service, but due to non-operational issues. We are in the middle of a study now, looking at non-operational stress, and this is to do with work load, redundancy and reducing numbers. There is a lot to suggest that this may be having an impact now. So that is the first thing.

The second thing is that this is why psychiatry is such an interesting subject: because it is complicated. You cannot separate out the type of people who join the Forces and the risks and backgrounds that they bring from what then happens to them. So when I teach medical students, I always say that, almost invariably, things that happen in psychiatry are not due to one thing. They are almost invariably a product of previous history, vulnerability, life experience and subsequent events—psychiatry is for grown-ups, basically.

Q55 Derek Twigg: With the time you have been doing your work, you have a tremendous wealth of experience. Can you tell us about anything in treatment that you feel could be done better in the future? And is there any research that you feel would be really good to do but you have not been able to do because the resources are not there?

Professor Wessely: In terms of research that we have done, the area that most concerns us—you have not covered this, and you may not want to—is not much talked about: it is the issue of violence. We were able to—

Q56 Chair: We will come on to that in a few moments. Have you done much in relation to alcohol?

Professor Wessely: That is the other issue.

Q57 Chair: In our last report we referred to increased alcohol intake and increased risk-taking behaviour. Do you have anything about that?

Dr Fear: We ask, in all our surveys, about alcohol intake. We use standardised measures that we can compare nationally and internationally with other populations. We are seeing that the levels of alcohol misuse are high within the Military and they are higher within particular groups. Young men: we see high levels. We would see them in the general population, but they are still higher within the Military than we would expect. Combat troops: again, that is because they are predominantly young men.

If you compare the data that we have got from the two waves of our cohort study, we have seen that there has been a slight decrease in the prevalence of alcohol misuse between those two time points and we are currently doing some further work to try to look in more detail as to what may explain this change in alcohol misuse between these two points of time in individuals. We know that if you look at the mortality statistics that are published by the Office for National Statistics, they look at alcohol-related mortality and one particular group within the armed forces—I think it is men who are NCOs and Officers—are more likely to die from alcohol-related causes than other occupational groups within the general population. It is an area that we are continuing to look at and trying to delve into to find a bit more detail about what is perhaps associated with change in alcohol consumption and how that is related to other mental health conditions.

Q58 Derek Twigg: That issue of violence clearly comes into it.

Dr Fear: That is right.

Q59 Chair: Other risk-taking behaviour?

Dr Fear: We looked at risky driving. We did that in all phases of our cohort study, so we have looked to see whether people wear seatbelts, whether they speed on the motorway and whether they speed in built-up areas. If I remember correctly, I think about 19% of the armed forces are

what we would define as risky drivers. That is actually pretty equivalent to what we would see in the general population.

Sir Bob Russell: I can vouch for that. The big dread when soldiers return from deployment to Colchester garrison is the first few weeks with them out on the road in their own cars. There is no question about it.

Q60 Mr Gray: But that is not what you were saying; you were saying that they are the same as the population.

Dr Fear: We can't compare exactly like with like, because the general population statistics don't ask exactly the same questions, but if we make broad-brush comparisons they are pretty comparable. We know—again, by using the data that comes from Defence Statistics—that within the armed forces deaths from road traffic accidents or land transport accidents are substantially higher in the Military than in the general population, if you—again—take age and gender into account.

Q61 Mr Gray: And off-roading. A lot of Land Rovers go cross-country, in training. These are not road traffic accidents; these are people turning over Land Rovers, driving over people and that kind of thing.

Q62 Chair: Sir Bob, is there anything you want to ask about alcohol or—?

Q63 Sir Bob Russell: I think you've covered that, Chair. However, coming back to road traffic, that is something that the Ministry of Defence needs to consider as a specific briefing, particularly when young soldiers have returned from combat. That has not been addressed. They come back from deployment in a war zone, they are out on the domestic roads and they have not adjusted.

Professor Wessely: To be fair to the MOD, there is a briefing on driving—

Q64 Sir Bob Russell: It's not working, then.

Professor Wessely: And there's a film and a campaign. There is something that the MOD does, to be fair. I don't know whether it's working or not, but there is something done.

Q65 Sir Bob Russell: It needs to be reinforced, Chair. All I can say is that—

Chair: That is a matter for us in our Report. We can do it.

Q66 Derek Twigg: Can we just come back to the issue of violence? You had some new information, which is obviously concerning, and I would be interested to know what you have that it would be useful for the Committee to know about.

Professor Wessely: Yes, we were able to link all the data that we have on the cohorts—the longitudinal study that has been talked about—with criminal records. It took quite a lot of negotiating, but we managed it. There is an interesting picture. No. 1, those who served in the forces have an overall offending rate that is lower than the general population. When you think about the fact that, as is known, the forces recruit some people from very disadvantaged backgrounds—some of whom already have criminal offences, and they may well have gone on to acquire more—that tends to speak to the idea that, overall, offending goes down when you join the forces.

The exception is violence, and it is clear that that goes up. It is particularly clear that that goes up in the obvious groups—those who have previously offended, etc., with social deprivation and so on—but equally it goes up in those who have been in combat. So, for those in the teeth arms—in the infantry arms—who have been deployed and been in combat, it goes up. Remember that generally in life violent offending goes down. That is a specific deployment effect and it is massively compounded by alcohol and somewhat compounded by PTSD. If you are asking me honestly, I would say that the most significant negative effect of military service is in the rates of violence, but overall rates of offending are lower and overall there are fewer veterans in prison than you would expect from their size in the population. So it is a very specific effect.

Q67 Chair: Can you quantify the extent to which it goes on?

Professor Wessely: Yes I can, but I've forgotten. The figures will appear on the laser display screen any second now, but I have forgotten them. However, the number is not small. We will come back to you in a second.

Chair: You are just about to?

Professor Wessely: I'm just about to.

Dr Fear: 11% is the overall proportion in our cohort who were violent offenders; that is, they had had a violent offence recorded on the criminal record system.

Q69 Chair: It may be that the simplest thing would be this: if you consider this to be the most significant effect of military service, you could write us a very brief letter to pinpoint the statistics that you are referring to and relying on. Would that be possible?

Professor Wessely: Yes.

Chair: Thank you very much.

Q70 Mr Gray: I was very interested to hear what you said about general offending rates being lower in the armed services. This is in contrast to a statistic produced by the Prison Officers Association, if I remember rightly, about a year or two ago. It was pretty anecdotal, and I almost felt it was fairly questionable statistically, but they said that a higher proportion of people in prisons were ex-servicemen and women—well, they were largely men.

Professor Wessely: It is the highest occupational group, but that does not necessarily tell you very much. The best statistic comes from Defence Statistics, which linked with those in prison, so we have two data sets: we know who has been in the forces, and we know who is in prison. That came up with the figure of 3.6%, which I have to put as the right answer. That is the answer done by record linkage, and it is definitive.

Mr Gray: Sorry, 3.6%?

Professor Wessely: It was 3.6% of the prison population. If you just look at the size of the veteran population overall, you will see that is actually lower than you would expect. That comes alongside what I have just said. Overall, being in the forces seems to reduce your risk of offending, even before you take into account social background, but the exception is violent offending.

Q71 Mr Gray: Leaving on one side the POA statistic, which has proven to be not all it might appear, can you point at any answer to the following? Around the same time, someone—I think it was Shelter, but it might have been somebody else—produced statistics showing that a

higher than average proportion of homeless people were ex-Military. Do you happen to know if that is true?

Professor Wessely: We have never done that study, but the best studies that have been done suggest that it is between 2% and 4%. I think a lot of what is talked is a bit similar to what was talked about the Falklands; it is kind of a myth that has got into the population.

Q72 Mr Gray: That is very useful. It is anecdotal but not necessarily true—an urban myth.

Professor Wessely: The best census studies show that.

Chair: I think Hugh Milroy of Veterans Aid has done a lot of research which suggests that it is simply not the case.

Q73 Mrs Moon: The research that you were referring to in relation to violence—was that Professor Neil Greenberg's?

Professor Wessely: It is all of us.

Q74 Mrs Moon: I have seen that one. It might be worthwhile, in the letter, also sending us a copy of that study.

Professor Wessely: He is part of the group.

Q75 Mrs Moon: Good. It is often said that families bear the greatest impact of any problems that a serving member of the armed forces experiences, because they bring it home, and it is in the privacy of the home. What research have you carried out there, and in relation to your violence study, have you looked at domestic violence?

Dr Fear: We have two pieces of work under way at the moment that are looking particularly at families. One is a large study of children of military fathers. We have got over 600 fathers who have been recruited into our study, so we have collected information from them on their health and well-being and on their family structure, their relationship with their partner or ex-partners and children and their view on the social, emotional and behavioural development of their own children.

Through the fathers, we have access to the mother or mothers of their children, and we ask the mother the same questions about their mental health and well-being, their relationship with the father and the

children and their views on the children's development from an emotional and social perspective. For those children who are 11 and older, we have contacted them directly and collected information from them, asking them, "What's it like having a father in the Military—the good things and not-so-good things?" We also ask them the same questions about their own development.

So we have got information from over 600 fathers and over 400 mothers, and information on over 1,000 children and directly from about 170. I am in the process of analysing those data at the moment, so I do not have anything to present to you today, but that should hopefully be in the public domain within the next couple of months, and we can perhaps share some of that offline with you.

Mrs Moon: That would be extremely helpful.

Dr Fear: That is the big study that we are just undertaking. We have also received funding from the MOD to do a study on families of service personnel who are wounded, injured or sick. This is to look specifically at the services that these families have access to, whether the families have found these services useful, what they think the gaps in services are and how those gaps could perhaps be filled. That is a relatively small study. We are hoping to interview about 60 different family members, which could be the spouse, partner, mother or father of the service person. It could be a child, if they are over 16. We have just received ethical approval from MODREC for that study, and we hope to begin data collection in the next month or so. That study is due to report by the end of September. That is another piece of work that we are doing particularly on families. Most of the published research is currently from the US, where, like you said, they have shown that there is an impact of deployment on family members, be that children or spouse.

Chair: We will be finishing this evidence session in about 10 minutes, and I would be grateful if both the questioners and the answerers could bear that in mind.

Q77 Mrs Moon: Domestic violence?

Professor Wessely: It depends. Domestic violence is not coded separately as a criminal offence, so we know about violent offending but we do not know whether it is domestic or not because that is not recorded in criminal records. So, we do not know. Having said that, I would be surprised if that was not the case.

Q78 Mrs Moon: Have you looked at the impact of separated service—say, those on submarines who are away for long periods? Have you looked at the impact of the period of the absence on family life?

Dr Fear: We have not, but within the children's study that I have described to you, we have information on how long individuals were away from their family, be that through a deployment or through operational exercise, so we should be able to get some indication of that.

Q79 Mrs Moon: Have you looked at marital breakdown at all?

Professor Wessely: Yes. We looked at that in those who deployed to Iraq versus those who did not, and we found that the rate of break-up of relationships in the six months after deployment was 7% in both groups, so there was not a specific impact of deployment on that.

Q80 Mrs Moon: Is there a dataset that you would find particularly helpful that is not being collected, and if so, what is it?

Professor Wessely: Yes, there is one. Funny you should ask. It is not so much a dataset. We mentioned that—obviously, lawfully—we have access to criminal records, which have proved incredibly important and never been looked at before, and we have NHS linkages and datasets that we can use. The group that most concerns us is the smaller numbers of people who really just disappear off the radar—the really impossible to trace, reach and so on. The area where we have never made any progress is with DWP. Why that is is a mystery, but of all the Departments that would know about that particular group, it would be DWP. I think that is probably the one dataset we would like to link with, and if we can link with the others, we cannot see any reason why we cannot do that.

Q81 Mrs Moon: What would that dataset give you?

Professor Wessely: First of all, it would tell us where these people are, because DWP would probably know, and it would look at receipt of benefits, employment figures and things like that. We have never had very good data on those areas—no one has got that good data.

Q82 Mrs Moon: So you would know whether they have accessed sickness benefits, unemployment benefits and that sort of thing?

Professor Wessely: Yes, and secondly it would be to trace people, because we trace people and follow them up to see how they have done. We are always conscious of the fact that we may be biasing our results slightly towards better outcomes, because—we are acutely aware of this—the better your outcome, the easier you are to find.

Q83 Chair: Might it be their right not to be found?

Professor Wessely: But of course, but then they can refuse. What we do is to write to people when we find them and say, "Would you like to talk to us?" Invariably, people do like to talk to you; I should say that now. When you can make contact with someone and explain what you are doing, you would be amazed how keen people are to tell you about their lives if you can find them. And they can always say no.

Q84 Sir Bob Russell: Have any of the people you have met been those discharged from Her Majesty's armed forces via the Military Corrective Training Centre—in other words, they have been kicked out rather than left?

Professor Wessely: Yes.

Sir Bob Russell: Does that include some of the people you have met?

Professor Wessely: Yes, we did a study on that. We found that there was a lot of psychiatric morbidity in that group, and a lot of drugs and alcohol. We also found that those people were almost impossible to find. After six months, I think the whole lot had disappeared.

Q85 Sir Bob Russell: That is why I asked the question, following on from your earlier answer.

Professor Wessely: We went to the Royal Military Police and found out that there was a 100% response rate while they were in detention, but it was about 0% once they left.

Q86 Derek Twigg: What about the most severely wounded, in particular those who have lost a limb or limbs or their sight? Is there any particular work that you are doing? I remember reading a paper that suggested that there was so much focus on the recovery from the

physical injuries that not enough had been done in terms of mental health issues. Can you say anything about that?

Professor Wessely: I think that is a very fair point. We are co-operating with a tracking system to look at the mental health needs of those who have been through Birmingham, but we do not know the results of that yet. There is also a bigger study, with which we are also co-operating. We do not have enough of the severely injured—fortunately it is not that common—to make comments directly ourselves, so we are co-operating with Headley Court and a group at Imperial, who are the experts in this area, and we are adding a mental health dimension to what they are doing. I am not sure, however, of the current status of that project. It is an important project, because the study that we have been running for everyone else since 2003 does not have an equivalent for the severely injured. There is a gap, but I believe that there are plans to bridge it and it would be important for it to look at mental health, although it will not, of course, be the main focus.

Q87 Derek Twigg: No. That is part of the issue.

Professor Wessely: We are in touch and have been helping, but it does need to get funded first.

Q88 Chair: We would like to know the answer to that.

Professor Wessely: So would we.

Q89 Chair: This is my final question. You have told us that you do not expect a deluge of PTSD cases at the end of Iraq and/or Afghanistan, but when do you expect the broad picture to be known?

Professor Wessely: I do not expect it at the moment, but predicting the future is inherently dangerous—it is almost as difficult as predicting the past—and much will depend on how we come to see these conflicts and how people see themselves. If you asked me for something that does worry me about the future, it is the public perception—this is where you came in—shown in Lord Ashcroft's study and in the study that we carried out through the British social attitudes survey, that if you have been to Iraq or Afghanistan, the chances are that you will come back physically or mentally injured. The data show that that is not true and that the chances are that you will not, but there is a worry that this could become—*[Interruption.]* That's you, isn't it? There is a worry that this will become self-fulfilling.

I am really worried that the general way of seeing those in the forces is divided between them being either all heroes or all victims, neither of which is true and neither of which is shared by the forces. If that becomes the predominant public discourse around those who served, that would cause me real concerns for the future and would make me worry about my predictions about what mental health will look like. Mental health is not like physical health; it is influenced by many things, including culture.

Chair: May I say that that was one of the most interesting evidence sessions that I have ever been in on? We are all grateful to both of you for a fascinating session.