

Defence Committee

Oral evidence: Armed Forces and veterans' mental health, HC 813

Tuesday 27 March 2018

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Members present: Dr Julian Lewis (Chair); Leo Docherty; Martin Docherty-Hughes; Mr Mark Francois; Mrs Madeleine Moon; Gavin Robinson; Ruth Smeeth; John Spellar; Phil Wilson.

Questions 1-66

Witnesses

I: Professor Nicola Fear, Director, the King's Centre for Military Health Research, King's College London; Matt Fossey, Director, Veterans and Families Institute, Anglia Ruskin University; Professor Susan Klein, Professor of Health and Social Care, Veterans and Families Institute, Anglia Ruskin University; and Sir Simon Wessely, Director, the King's Centre for Military Health Research, King's College London.

Written evidence from witnesses:

[Matt Fossey and Professor Susan Klein](#)

Examination of witnesses

Witnesses: Professor Nicola Fear, Matt Fossey, Professor Susan Klein, and Sir Simon Wessely.

Q1 Chair: Good morning, and welcome to this session of the House of Commons Defence Committee, dealing with Armed Forces and veterans' mental health. We have four distinguished panellists today, and I should be grateful if each of them would introduce himself or herself with a few words of explanation about their current post and qualifications.

Professor Fear: I am Nicola Fear. I am a professor of epidemiology at the Academic Department of Military Mental Health and co-director of the King's Centre for Military Health Research. Both units are based at King's College London.

Sir Simon Wessely: I am Simon Wessely. I am the other co-director and I am a Regius professor of psychiatry at King's.

Professor Klein: I am Susan Klein. I am a professor of health and social care at Anglia Ruskin University, and I serve as an adviser to the Veterans and Families Institute, of which Matt is the director.

Matt Fossey: I am Matt Fossey. I am the director of the Veterans and Families Institute at Anglia Ruskin University. We host the Forces in Mind Trust's research centre.

Sir Simon Wessely: I should also say I am a trustee of Combat Stress.

Chair: Thank you very much indeed.

Q2 John Spellar: What do you think are the main reasons for the reported rise in mental health disorders in both serving personnel and veterans? In other words, can we determine whether there has been an actual rise in mental health disorders, rather than more people seeking help or the welcome public focus because of better reporting?

Professor Fear: Within our studies, we have seen an increase in the prevalence of PTSD reported by our service personnel and among our veterans. That is a population-based sample. So yes, we are seeing an increase.

Q3 John Spellar: Of what sort of order?

Professor Fear: With PTSD, when we first conducted our cohort study back in 2003-04, we found a prevalence of PTSD of 4%. We follow the same people up and add new individuals to that cohort. In our latest phase, for which the data was collected in 2014-15, we find a prevalence of 6% overall. There are differences when we break that sample down and look at what individuals did while they were deployed and whether or not they are still serving in the military; we see differences by that. That is the only mental health disorder where we have seen an increase over time. Common mental disorders for our regular serving personnel have

remained at approximately 20% across all phases of our cohort, and alcohol misuse has decreased across the different phases.

Sir Simon Wessely: The reason we see the differences in, for example, MoD data is that there is no question at all that there has been a large rise in help-seeking. Certainly, until this year we had seen no change at all in the true rates of disorder, suggesting that a greater proportion of people are presenting. You mentioned veterans; we also know that people when they leave are presenting earlier than they would have done a decade or two before. You can see how that would create greater pressures and an increase in that kind of administrative statistic, but the underlying rate was remaining the same. That suggests there has been a positive change in willingness to seek help, probably linked to a small decrease in stigma that we have also seen in the past couple of decades as we have been doing these studies.

- Q4 **John Spellar:** Should we conclude from that that there has been an increase in mental health disorders, or that we are seeing a very welcome greater degree of reporting and awareness?

Sir Simon Wessely: It is a bit of both. The biggest change is in help-seeking, awareness and stigma, but there has been a true increase in PTSD. That is not huge, and it is nothing like what has been seen in the US, for example, but equally there has also been a drop in alcohol disorders, which have been going down. The true rate has been going down.

Professor Klein: There is also the influence of a societal and cultural acceptance, to a certain extent, of PTSD and how it is presented. Certainly, within the media there tends to be a focus on post-traumatic stress disorder to the exclusion of other disorders, despite the fact that the evidence suggests it is not the main mental health issue affecting military serving and ex-service personnel.

We did a study on personnel with severe combat-related injuries who were first-time admissions to the defence medical rehabilitation centre at Headley Court. There are certainly differences in terms of the numbers who are reporting symptoms for post-traumatic stress disorder. For that cohort—this is based on people with very severe complex trauma injuries—the prevalence rate for reported PTSD was in the region of 11.8%, which in some respects is actually surprisingly low, when you consider the severity of the injury and that a number of them were amputees.

- Q5 **Chair:** You said that PTSD, which we hear so much about, is not the main one. Could you perhaps list two or three that you would regard as being more prominent?

Professor Klein: As Nicola mentioned, common mental disorders and alcohol abuse—although, as Simon said, that rate is dropping. The media would have you suggest that PTSD seems to be the main issue of concern, but that is not the case.

Matt Fossey: Adjustment disorders.

Professor Klein: Yes, adjustment disorders. Certainly, that is also true in civilian traumas.

Q6 **Chair:** Sorry, can you explain adjustment disorders? Remember you are dealing with laypeople here.

Sir Simon Wessely: It is a short-term, fairly intense emotional reaction. It falls short of PTSD in timing, but it is more than just a normal change. It is on the spectrum of normality, but it is at the end where you are starting to get concerned and pathological. By definition, it should be short term and should resolve fairly easily.

Matt Fossey: The point I was going to raise was about help-seeking behaviour and how that has probably changed over the last few years, particularly in terms of broader societal changes. We have had a number of large, national campaigns looking at trying to reduce stigma and discrimination around mental health conditions. As society changes, so do the armed forces, even though we may be slightly slower behind. I certainly think they have an impact and an effect more broadly.

Q7 **Mrs Moon:** I want to ask you some questions about how many women are coming forward, because I am deeply concerned that we are missing an issue. I have been talking to a number of serving and veteran women about their willingness to come forward, and basically, they are not willing to come forward because all the groups being run are dominated by men. They do not want to engage with groups that are largely men.

One of them said to me, "I joined the Royal Navy" in the early 1990s "as one of the first sea-goers, and before there was any kind of effective diversity and inclusion training. The idea of going to a veterans' support group is not something that would appeal to me, mainly because of my experiences of working with Servicemen of a certain vintage. I would assume I would be in the minority as a woman...I would never have approached a veterans' organisation for support, even when...at a low ebb...There are Service charities that can provide support for women, but little that really addresses social isolation and mental health in particular." They mention Salute Her, which seems to be the only one that is dealing with it.

Is there a problem of a lack of support for women with mental health and post-traumatic stress disorder in the serving and veterans community, because of the focus on male veterans and serving personnel? Is that something you have looked at at all?

Professor Fear: Our cohort study of about 9,000 personnel is predominantly men, but about 10% of those are women, so we have about 1,000 women. We asked them exactly the same questions as we asked the male service members and veterans. Data from our phase 3, which is the most recent data, shows that there is no difference between men and women in the prevalence of PTSD or common mental disorders. We find that men are more likely to misuse alcohol compared with women, which is what we would see in the general population. When we look at



help-seeking behaviours, women are more likely to seek help, which again reflects what we would see in the general population. Perhaps some of the details, and the particular reasons why people are seeking help—men versus women—is something we could consider in our cohort.

We do not find any difference in rates of leaving between men and women, but the reasons for leaving do differ. Women are more likely to leave for health problems and pregnancy, and we also find in our data that women report lower levels of job control and unit cohesion compared with men. There are a number of issues where men and women are very similar, but there are also some differences between those two groups that may influence who is going forward to seek help.

- Q8 **Mrs Moon:** What about in the veteran community? Certainly, information that has been brought back to me suggests that women with mental health problems and post-traumatic stress disorder in the veteran community are not going to the established groups. That is largely because they would be unhappy dealing with their problems, which are sometimes associated with their service, and with male colleagues. Is that something that you have any insight into?

Professor Fear: We could probably look at that with the data we have collected, because we ask men and women who say that they have a problem about their help-seeking pathways, and who they have sought help from. We have not looked at that by gender, but it is clearly something that we would be able to do.

- Q9 **Mrs Moon:** Mr Fossey, you looked as if you were building up to say something.

Matt Fossey: I often look like that. I was just thinking that, as far as I am aware, I cannot think of any research that has been done in the veteran community on help-seeking behaviour, particularly for mental health needs. I think that would be a really useful and needed piece of research. If you will allow us, I am very happy to have a look at the literature and see whether there is anything out there, and we will certainly provide you with that information.

Mrs Moon: Thank you. Salute Her seems to be the only organisation I have come across that specifically provides support for women. It would appear that for some women, issues of their engagement with men during their service mean that they do not want, when they have mental health problems, to engage with the services that are there. We are missing a group that needs that help and support.

- Q10 **Chair:** Earlier you were talking about common mental health disorders among serving personnel, and whether they have increased or not. I do not think we covered the veteran community for that. Can you just run over that again with regard to veterans?

Sir Simon Wessely: We know from the cohort study that rates of disorder in veterans are higher compared with those still serving. They were not originally, but now they are. There are two explanations for that. One thing we know is true is that the longer people serve, the lower their



rates of disorder. That is not because serving is particularly good for their mental health; it just means that those who have poor mental health are more likely to leave. The longer someone goes on serving, they become increasingly self-selected—well, not self-selected, but a selected group. The general media perception is that the longer someone serves the more likely they are to be damaged, but it is entirely the other way round. You then see an increase in veterans, and we know that because we can see that they were more unwell—unwell isn't quite the right word, but they had higher rates of mental health problems when they were in service, so that is predicting leaving.

You also have the stresses of transition and leaving, and the losing of that social network. For that one, we showed that the best way to leave that has the least impact on mental health is done by those who leave the military with good social networks. They leave, and then they establish new equally good social networks—they do the best. Those who do worst are the ones who leave and lose their social networks and do not replace them with anything. The ones in between are those who leave and keep their social networks. They are halfway, and you will probably guess the particular problem that they continue with, which is alcohol misuse. You could probably have worked that all out for yourself, but at least we did some nice research to prove that it was true.

Q11 Phil Wilson: Simon, you mentioned that PTSD in the UK is not as high as it is in the US. Why is that?

Sir Simon Wessely: First of all, PTSD rates in the population in the US are higher anyway. Obviously, that is all due to the nature of the President they have. You are recording this, aren't you? So strike that one from the record.

Chair: Fortunately that is not included in our terms of reference.

Sir Simon Wessely: What a relief. Good. Okay. So it is higher in the US anyway. Second—this is a big bone of contention as to why that's happening. To put it at its simplest, when people are in service, and we do studies with our American colleagues, we don't find big differences in the rates of PTSD, and when we do they are partly explained by the things you'd expect them to be explained by. The US uses many more reservists than we do, who have higher rates. At the beginning of the war in Iraq, they had higher casualty rates, which are very related to PTSD, but that has not been the case since 2005-06. They have a much longer deployment and you do not need to do research to know that the longer you are in a hostile environment, the more likely things will go wrong. So there is that. And they were younger—considerably younger—in 2003 than the UK forces: 70% of the UK forces had been previously deployed; it was 10% for the US. So that meant they had less experience. All of those you can adjust for, and they also—

Professor Fear: We have more officers.

Sir Simon Wessely: We have more officers—that's right. So, all of those things you can adjust for and when you adjust for them, you make the



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rates fairly similar, and the big one was tour length. So that is okay. But when you leave service, we have just said that basically, over a 10-year period, we have had a small increase of PTSD. In the US, they have had a very big increase, and for once, the words “tidal wave”, “tsunami”, or “epidemic” are probably correct. If we look at studies that use the same measures as we do, their rate may be 7% when they return from deployment, which is not desperately dissimilar to us; six months later, 14%; two years later, 28% or 32%. Those are really big figures.

There, we part company as to why that might be. The US say it is delayed onset, which is certainly right for some, but why would it be delayed in the US and not so much in the UK? We do see delayed onset, but nothing like the rate they do. We cannot prove this, but we think it is to do with the access to health services that you get when you leave. In the US now, you have five years of free healthcare; it used to be two, but it has gone up to five. That only takes you to your early thirties and after that, unless you have a service-related disability, if you are poor or from an ethnic minority and you didn’t serve 25 years, you have a struggle to get healthcare. And that goes down like a ton of sick when we do this over there and say that it might be about inequalities in healthcare provision.

- Q12 **John Spellar:** Does that also reflect differences between small-town America—in other words, the areas that are suffering economic decline, the collapse of social structures and the opioid epidemic, especially as those are often the areas from which the military are drawn and particularly the army?

Sir Simon Wessely: I had not thought about that, John. I went to school in Texas and I know it quite well, actually. We do know that the socioeconomic distribution that the US Army recruits from is very similar to ours; the ethnic distribution isn’t, but the socioeconomic distribution is quite similar. And the rates of pre-service adversity—childhood abuse and things like that—are quite similar. I don’t know the answer to the question you are asking specifically. I presume the US knows. Do you know?

Professor Fear: No.

Sir Simon Wessely: We don’t know. We know who to ask.

- Q13 **Mrs Moon:** If you ask, would you send us whatever you find?

Sir Simon Wessely: If they will tell us.

- Q14 **Martin Docherty-Hughes:** Simon and Nicola, did operations in Afghanistan and in Iraq increase mental health disorders in serving personnel and veterans?

Sir Simon Wessely: Overall, if you look at the whole deployment, the answer is no. That’s compared to people who didn’t deploy to Iraq and Afghanistan. That’s not saying there were no mental health problems; there obviously were. The rate was 4%, which we quoted. However, when you break it down and look at different sub-groups, not surprisingly you find the rate for those who are in combat increased—7%, 8%, 9%,



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depending on how you look at it. It would be kind of odd if that wasn't the case, to be honest with you.

I have already mentioned reservists, who we have shown all throughout the life of these cohorts have always had an increased rate compared to regulars. So there are groups that are more likely to develop disorder, but if you look at the whole force together, then you don't find it.

Remember, that is not comparing with people who haven't deployed, because there isn't really a control group left in the armed forces, and the people who don't deploy at all are themselves somewhat unusual and more likely to have health problems. So compared to everything else that they were doing, there wasn't a specific Iraq or Afghanistan effect, but there has been in combat and in reservists. I think there are other groups as well, but I just can't put my finger on what they are.

Professor Fear: We did a piece of work to try to unpick whether it is deployment or other factors. As Simon said, it wasn't deployment per se, but if you were deployed in a combat role, you had an increased risk of PTSD, as did reservists, and also those who had an adverse childhood and had a pre-existing vulnerability. We also found that if you had had an accident, not while you were deployed, but during your military career, that was associated with the development of PTSD. That reflects again what we would see in general society.

- Q15 **Martin Docherty-Hughes:** Taking those underlying conditions a wee bit further—I invite the rest of the panel to come in—you have been talking about things around alcohol. I imagine there are other addictive substances that people would have problems with, and other addictive personality traits. You talked about relationship difficulties. I can imagine risk-taking behaviour, and I am thinking of underlying conditions such as ADHD. I am just wondering where these types of underlying conditions come into it.

Sir Simon Wessely: First of all, on substance misuse other than alcohol, we don't have data, so we don't measure that. The reason is that when we try to measure it, we get considerable hostility and resistance. People are very unwilling to tell us that, whereas they are very happy to talk about alcohol. We discovered years ago that it just buggered everything up if we asked about things like that. So we don't do that. Matt and co. will have more to say on that. We have certainly looked at risk-taking behaviours that are increased as a result of deployment. That has got better recently, probably because of the things they have been doing, but it certainly does go up. The one thing we have not mentioned but should is that the strongest impact of combat—very specific to that—is on increased rates of violent behaviour. That is probably the biggest single change that deployment in a combat role does.

- Q16 **Martin Docherty-Hughes:** Is that in full service or in reservists?

Sir Simon Wessely: It's in anyone who has had a combat role. We link with the criminal justice system, so we know their criminal records before and after they serve. Overall, they are less likely to have a criminal record,



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and that is before you factor in social disadvantage. Given that the military do recruit people with increased social disadvantage, it is a very surprising finding. That goes to the general view that for many people, military service has had a positive effect on their life chances and trajectory, but there is never such a thing as a free lunch, and the one exception to that is a clear increase in violent offending. That is mediated by alcohol and PTSD, but it is directly linked to combat exposure.

- Q17 **Chair:** If that does happen to someone, does it tend to happen pretty quickly after their service, or is that also something that can be delayed and emerge only in later life?

Sir Simon Wessely: In the few studies that have compared total population sample with military sample, such as the psychiatric morbidity survey, the only thing that is increased over a lifetime is violent behaviour.

Matt Fossey: I was going to make a comment about drugs, if that is okay. On people being discharged from the military for abuse of substances, the data is kept by the MOD and made public. That is through a survey of the early service leaver cohort—of people who are discharged. That is readily available. Unfortunately, I do not have that to hand. Certainly among the ESLs, a significant number are mandatorily discharged for abusing substances.

Sir Simon Wessely: Forces in Mind has funded a study looking at those, but it is not our study.

Matt Fossey: The Forces in Mind Trust has funded that. In terms of other risk-taking behaviour, there have been other studies conducted by colleagues in Wales looking at gambling addiction in the veteran community. They have found rates that are certainly higher than you would expect in the civilian population. Again, they have been funded by FiMT to undertake a further piece of research in that area.

- Q18 **Leo Docherty:** Sir Simon, going back to the impact of operations on rates of PTSD, why does the MOD report the much lower rate of 0.2%, compared to your cohort of 4%?

Sir Simon Wessely: We know that. The only access to data MOD have comes through their medical services, so they are reporting the number presenting and getting a diagnosis of PTSD. We know what the true rates are, and the reason we emphasise this is the fact that for a decade we had shown steady rates of PTSD, but the MOD were showing steadily increasing rates on their statistics. That does not mean that the statistics are wrong; it means that we are measuring different things.

So long as the overall rate remains stable but the rate of people coming forward is going up, that is a good thing. That implies that more people who have PTSD are presenting and being diagnosed. That is why those two things are different: they are measuring really different things. They are not contradictory in any way; they are measuring something different.

- Q19 **Leo Docherty:** Okay. In terms of the specific impact of operations, has a



particular group showed itself to be more susceptible than any other?

Sir Simon Wessely: We have mentioned reserves, and obviously there are those in combat, and those who have had previous adverse childhood experiences—it is mainly the things you would expect. One thing we have also shown, not surprisingly, is that certain Marines and Paras have slightly lower rates than others, probably due to cohesion, training and so on. Then there are other groups that surprisingly do not have different rates: IED operators seem to be much the same, medics have slightly higher rates—that has dropped recently—but these are all quite small variations; they are not big changes.

Q20 **Leo Docherty:** Has the prevalence of mild traumatic brain injuries had any effect?

Sir Simon Wessely: Okay, that is another thing where—I am not going to be allowed back into America after this—we have very different experiences from the US. The only studies on MTBI, as it is called, in the UK have shown that our rates are much lower than the US's at about 4% to 6%; the American rates are from 12% to 22%. That is not because the Americans do not wear their helmets and we do, so it is something else.

On the actual rates, Lieutenant Colonel Jones, one of our group, did a study in Afghanistan, going out to the places where you get these things, concussions, to forward bases and checkpoints—including on foot, actually; he is a brave man—and the rate there of actual concussion, exposure to these things, was about 4%, so not that common, and about one in four of those went on to develop what we would call a concussion. So it is not that common, and three quarters of those got better. It is there, but it is not the biggest problem that we have. Plus, it is massively linked with PTSD, and it is very, very difficult to separate out the contribution of mild head injury from the psychological trauma that goes with it.

That, by the way, has been the case since the First World War. If you know your history, you will know that shellshock originated as an MTBI—they did not call it that, but that is what they thought it was—and gradually as the war continued, they brought in psychological concepts as well. We are going through the same process now.

Q21 **Gavin Robinson:** Sir Simon, you mentioned the lifetime study, which took violent behaviour out as something that is quite different; it is the only one where there is a difference among the military cohort. I want to ask about using comparators between the civilian population and the military population on mental health issues. Is it a useful comparison to pit those engaged in military activity with those who are not? Do we have a sense of the totality of the difference in figures?

Sir Simon Wessely: The answer to your question is: it is not very useful, but everyone always asks these questions; therefore, you have to do it a bit. But you are quite right: it would work in places like Israel where you have a full-conscript national service military, and we have done that for the national service period, but obviously now they are very, very



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different, so any comparisons with civilians have to be taken with a very, very, very big dose of salt, because they are fitter—the main determinants of mental health are physical illness, and that is much less likely. You know all the differences. So any comparisons—we have done them—are massively caveated.

Professor Fear: I take Simon's point that they are not very useful, but in a sense they are useful to help set the context. When someone says, "PTSD 6%", we do not know whether that is good or bad. Should it be 66% or 0.6%? It is helpful because it helps to set the scene, but I agree that there are lots of caveats when you do those comparisons. Yes, we do them, but to the best of our ability we try to ensure that we are comparing like with like, where we can.

- Q22 **Gavin Robinson:** Sure. So what about specific comparators—looking for individuals who are engaged in the emergency services and people who are open to and in contact with traumatic events outside the military sphere? Is that more useful, and are those studies available?

Professor Fear: It would be great if they were. The military is one step ahead by having this large-cohort study. We know lots about these individuals over a long period of time. Not many other occupational groups have the beauty of that data available. We have been able to make comparisons with general population surveys. Those generally collect information on occupation, but if it is a general population survey, you have everybody from someone who is unemployed or unable to work because of illness through to bank managers, shop assistants and emergency service workers. If we are looking at an occupational group, we try to limit the comparison group to individuals who are in employment, so that we know that we are comparing like with like that way.

It is very hard to get a large cohort of either emergency service workers or others exposed to traumatic events. There are colleagues who have done a study with the police. We have approval to access some of their data where there are comparable measures, so hopefully in the future we will be able to answer that question more directly.

- Q23 **Gavin Robinson:** So that is something you believe that we could benefit from doing in a much more focused way?

Professor Fear: I think it would be interesting to see. Obviously there are still differences. We still won't be totally comparing like with like, but it will help to unpick the puzzle.

- Q24 **Mr Francois:** If PTSD in the military is 4% to 6%, broadly, and slightly higher for reservists, do you have any kind of global figure for the general population?

Professor Fear: Yes.

Sir Simon Wessely: Yes. It's about the same. It differs a bit, but not dramatically. Some estimates are slightly lower, and some estimates are slightly higher—it depends on how and where you measure it—but it is not dramatically different.



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Professor Klein: It would be great to be able to do a comparative study where you have an occupational group that is exposed to traumatic events on a routine basis. As far as I am aware, that has not been done as yet. In the Aberdeen Centre for Trauma Research, we did a lot of projects involving the police and the ambulance service. Obviously, the type of exposure to trauma is different to that of the military, in the sense that ambulance personnel deal with what we call critical incidents on a daily basis. There is evidence to suggest that the way in which people cope with these types of daily, or consecutive, traumas may be slightly different. For some, it may be a protective factor, in the sense that the more exposure they have, the easier it becomes to manage. For others, that is not the case.

The crucial question, and what we have yet to ascertain, is that if two individuals are exposed to the same event, why is it that one individual may go on to develop a post-traumatic stress condition or a problem with their mental health, whereas the other person manages to cope, in whatever fashion?

The other thing that is particularly important is that we tend to get distracted to a certain degree by the idea of a diagnosis. There is this issue of a disability paradox. In other words, you can have an individual who meets the diagnostic criteria based on the symptoms they are reporting—that could be a threshold or a cut-off score of one point, which pushes them into being regarded as having, for example, post-traumatic stress disorder—who can function reasonably well. On the other hand, you can have an individual who wouldn't fulfil those criteria yet does not function at all well.

There are a lot of grey areas here that we need to really explore, and we need to look underneath the numbers, in a sense, to see what it is that actually enables people to cope. It is obviously a very complex picture, as you all know; that goes without saying.

Very quickly, the interesting finding in the Headley Court study was that we make an assumption that it is the combat-related trauma that may be most distressing for those individuals. We sought to ask the sample to identify all the traumas they had experienced, and to say, of those traumas, which one was most distressing to them. We considered not just military or combat-related trauma, but those in civilian life, too. Interestingly, a number of them reported that they had already been exposed to civilian-type trauma, and for many, that was the one they found the most distressing. We sometimes put the focus very much on military experience and the combat-related trauma, but that may not actually be the underlying issue.

Matt Fossey: I was going to mention the disability paradox. It is also really important, as Susan said, to consider people's through-life experiences, how many pre-service experiences impact on their mental health during service and thereafter, and whether traumas within military service can be exacerbated by their pre-service experiences. We don't really know enough about the whole-life journey.



Sir Simon Wessely: We should make clear that 50% of the PTSD that arises during military service is not through deployment; 50% is road traffic accidents and assaults, and 50% is deployment. There are one or two things that we can say are more likely to cause disorder. For example, there is the nature of the exposure. We have errors of omission and commission. One reason why friendly fire is so psychologically damaging is because it shouldn't happen; it is a kind of violation of the rules of the game. That is associated with a lot of anger, and you get more PTSD. There is a difference between being shot by the Taliban and being shot by our own side. One is much more psychologically damaging than the other.

The second scenario is when you let the side down. If you feel—rightly or wrongly—that you have done something wrong, you then get emotions such as shame and guilt. Those are also much more likely to lead to psychiatric disorder. For someone in the services, the kind of things that would upset civilians like us are not the same as those that will cause psychiatric disorder in the military. That is another reason why comparing the outcome of military trauma with civilian trauma—such as people who are commuting on a train when something terrible happens; they don't know each other and there is no meaning to it and so on—is very dangerous.

Q25 **Chair:** Can I just take you back to something you said before? You said that people who stay in service longer are actually less likely to suffer psychological illnesses, merely because if they were more likely to, they would probably have left earlier. Does that carry forward into a comparison between countries that have all-volunteer armed forces and countries that have national service?

I am thinking that people who are likely to find Army life unpleasant and stressful in a volunteer service are not likely to join. However, in a country with national service, they could be drafted. You would therefore expect to find much higher rates of psychological problems in countries where people are required to join, whereas in a country with all volunteer forces they would have just said that service life was not for them. Is there any evidence to support that view?

Sir Simon Wessely: Julian, that is very difficult. When people make comparisons in the UK—for example, with the first and second world wars—again, we say that both the nature of the war and the nature of the people fighting it were different. That is another reason why we counsel against drawing on statistics from those conflicts.

The second thing you need in order to answer that question is a country that does these kinds of studies. The only one I know of is Israel. Of course, Israel is also different in so many ways that I think it would be hard to make those comparisons.

It sounds intuitively obvious—and I suspect it is probably correct—but I think it is quite difficult to prove. I do not think there is any NATO nation



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now that does that—apart from Turkey, I suppose, but the others do not do these kinds of studies.

Q26 **Chair:** Okay. Madeleine you wanted to come back.

Mrs Moon: Has anyone looked at whether training TRiM advisers within units is making any difference in catching people early? I know it has also been used in the emergency services.

Sir Simon Wessely: Yes, and you have got Mr TRiM sitting behind you, which is a slight problem.

Yes, we did a trial of TRiM in the Royal Navy, which certainly showed that it did not have the adverse effects that its predecessors, such as psychological debriefing, had. Unfortunately, we chose a very quiet year for the Navy and not much happened. It was quite difficult to get a sufficient number of cases to know whether TRiM had had an impact. It did not have a negative impact, but taken overall, we think we can say that TRiM has helped help seeking. It has not reduced PTSD—it was never intended to prevent PTSD; it is not that kind of intervention—but it has had a moderately positive effect on help seeking and sickness absence, I think.

Professor Fear: Sickness absence in a non-military study.

Sir Simon Wessely: I am looking for any help—good, Mr TRiM is nodding, so that is true. And it is popular: it has been accepted as part of the culture in the armed forces. But does it prevent PTSD? Absolutely no way.

Matt Fossey: I suppose part of the effect is raising awareness of mental health problems.

Sir Simon Wessely: Yes. It probably increases the rate of help seeking, which is what it is supposed to do, which is good.

Q27 **Mrs Moon:** I saw some interesting stuff in relation to TRiM and rape as well.

Sir Simon Wessely: Okay. I did not know that.

Q28 **Ruth Smeeth:** You have already answered my first question, which was about service leavers being at greater risk of mental health problems. Why are those enlisted before the age of 18 more at risk?

Sir Simon Wessely: We are not aware that there is strong evidence showing that they are. We had a partial look at that, which we shared with the people who are interested in this. The partial look did not actually show that they were at greater risk—surprisingly, because you can think of all the reasons why they might be.

We now have the data on age of enlistment, which we have not had before, so we will have a proper look. Remember, by the way, that even though people join at 16, they cannot deploy until they are 18.



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The other problem with the stats—just to be the boring boffin on this—is, for example, that the data shows that the younger you join, the more likely you are to become a casualty compared with those that join later. You have to take account of the years at risk. What is the chap called? David Gee?

Professor Fear: David Gee.

Sir Simon Wessely: He has written a good report on that—for ForcesWatch, I think.

Professor Fear: Yes.

Sir Simon Wessely: He points out that there are some statistical problems that you have to solve before you can draw the conclusion that if you join earlier, it is more dangerous for you. You have to adjust for the fact that if you join earlier, you are likely to spend more years deploying.

So we will know more about that, when we get round to it, because we do now have the age of enlistment. I should also say that the Scottish data—fortunately, they have very good data on this; they are much better at record linkage than we are—definitely does not show that.

Q29 **Ruth Smeeth:** Excellent. Are any groups considered to be more at risk? What about women?

Sir Simon Wessely: I think the ones we have talked about certainly are. The other thing about the younger ones is they are more likely to leave early and that increases the risk. I do not think it is the act of leaving that does that, but there are reasons—my colleagues have already mentioned those—why we all agree that those who leave early are more vulnerable to every single outcome going. Is that the result of their service? For some of them it will not be because they will not have deployed.

Matt Fossey: We are talking about transition and people leaving the military, and we still do not really know enough about those experiences and what a successful transition looks like versus a non-successful transition. How do we measure that? How do we understand how we can improve those types of experience? What are the sorts of metrics we should be applying at the latter end? At the moment, the MOD are quite blunt in how they measure what a successful transition looks like. It is quite binary: are you in employment or aren't you is what they consider. The quality of employment, for instance, is not something they necessarily consider. Therefore, it is a challenge to understand these other determinants of people's wellbeing, which are obviously important markers for people's mental health. We do not really know enough about those in the context of people's military service but also, importantly, in that transition phase and in how people get on thereafter and cope in civilian life.

Q30 **Mrs Moon:** Have you seen the study by Professor Nav Kapur from Manchester? He has looked at the rates, in particular in relation to suicide, where there was an issue with early leavers, but often associated



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with life experience before joining the military. How much do early life experiences roll across as well into general mental health problems? Could you say a bit more about that?

Professor Fear: All our research shows that early life experiences are one of the key factors for the development of all adverse outcomes: whether or not you have a mental problem, whether you do well when you make your transition, whether you get a job, whether you are in a relationship and so on. With regards to suicide, Nav Kapur looked particularly at veterans and he was able to show that, in general, rates of suicide in the veteran community were comparable to rates we would expect in the general UK population. However, there was that increase: the rates were higher in those young service leavers, who were predominantly young Army males, which in the past has reflected what we see in the military, the serving community. I know that the latest suicide report was published this morning, and I am sure it will be interesting to see what they have found this year. I think that early childhood experiences are crucial and have a huge impact on all outcomes.

Professor Klein: I think that is true if you look at general population studies of trauma as well. One of the key predictor factors is early adverse experiences, and one of the most important factors in protective terms is having support. That is true whether you are within an organisation or as an individual.

Sir Simon Wessely: Again, overall, for those serving, the suicide rate is lower than it is in the population. That is because one of the predictors of suicide is, of course, unemployment and by definition those people have a job. The group that is more at risk is very specifically the young Army but overall the rate is lower. You would not think so from some of the coverage, but it is.

Mrs Moon: Indeed.

Q31 **Ruth Smeeth:** Moving on to the data, are there regional variations, probably more for veterans but for serving personnel and veterans?

Sir Simon Wessely: I do not know. There is a specific study from Northern Ireland that I know Forces in Mind has funded, which will definitely be very helpful on this.

Professor Fear: Then there is Beverly Bergman's work from Scotland. Within our cohort, because we have a nationally representative sample it is difficult to dig down into the different regions. People cover the whole of the UK and then move around, so where do you attribute them to?

Sir Simon Wessely: They are a mobile population but they can settle and there are certain parts of the country that have a lot more of them, but that may not be where they are from. It is very difficult to do. We never got their previous postcode, did we?

Professor Fear: No. If you could track people from the minute they joined the military and get their postcode so you could then understand



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the area in which they lived prior to joining, and then when they leave get their new postcode, that would be absolutely fascinating.

Professor Klein: There have been some studies done in Wales as well, haven't there? Jon Bisson—has he not reported on veterans?

Sir Simon Wessely: He used our data.

Professor Klein: Was that based on your cohort?

Sir Simon Wessely: Yes, we shared the Welsh bit with him.

Q32 **Ruth Smeeth:** I think one of the interesting things is transition, at this point. If you are returning to a non-military town afterwards, the transition could potentially become a bigger challenge. I think that is why the regional variation could be interesting.

Sir Simon Wessely: Certainly, we think that reservists, who do not have greater rates of problems in theatre, have greater rates when they come back and that those are still visible five years later, in contrast to the regulars, because it is harder to adjust as a reservist. That is a larger version of the point you are making. I think you are probably right. It is certainly what we think is going on with reservists—it is about post deployment.

Matt Fossey: I think it is also quite important to note, when you are thinking about the military population and transition, that the military are a very heterogeneous population, so they will be very different. You cannot say that transition could be a challenge for people living in this area or moving to this town, because for every single person there is going to be a different experience. As I was trying to say earlier on, we need to try to understand a little bit more about some of the challenges.

Q33 **Ruth Smeeth:** I am chair of the covenant group in this place, so that is why I am interested. I represent Stoke on Trent, and know that what we provide would be very different from Stafford, for example, because of the very nature of it. It is that aspect for me.

Matt Fossey: The Government are funding some work that we are collectively doing at the moment—looking at trying to understand and collect data on the services that you are funding, to try to have a better picture of the outcomes and the wellbeing for service personnel who have left and who are now using Government-funded services. We are working hard at the moment, trying to build the outcome framework for the covenant, to begin gathering the data. It is something we will be looking at in the next five to 10 years, probably. It is quite exciting stuff when we actually manage to get the data together.

Ruth Smeeth: Thank you.

Q34 **Chair:** Gavin, you want to come in, and then Mark.

Gavin Robinson: Thanks, Chair. On the point that Ruth was raising, it is important to know not only the regional variation of rates but also the level of service, given the devolved nature of our health services. One of



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the particular issues that arises in Northern Ireland, particularly with veterans—whether they served in Northern Ireland or have simply relocated to Northern Ireland—is that they do not want to be publicly identified as a veteran. Therefore that precludes their access to services. From what you have said thus far, I guess that you cannot speak to that in a professional capacity with regards to having carried out a study—but if there is a study available, can you share it with our clerks?

Professor Fear: Cherie Armour, based in Northern Ireland, is doing a study funded by Forces in Mind Trust. I am one of the collaborators with her on that project. She has mapped out service provision within Northern Ireland from the statutory sector but also the charitable sector, and I believe that that report is available, so I am sure we can share that with you. She is also doing a piece of work that is a survey of the veteran community. Obviously, people have to self-identify to take part and then they are asked a whole range of questions about their health and wellbeing, their military experiences, their transition experiences. They are also asked about whether they would value having a veteran-specific service in Northern Ireland. Again, I know she has got some preliminary findings on that, which I am sure she would be willing to share with the Committee.

Sir Simon Wessely: When we did our main study, getting the material to people in Northern Ireland was extremely problematic. We did it but we had to go through a lot of hurdles—I shall put it that way.

Matt Fossey: Another piece of work is just starting at Queen's University in Belfast, looking at adverse transition experiences, I believe—again, funded by Forces in Mind.

Sir Simon Wessely: Very popular, aren't they?

Matt Fossey: A very popular way of funding things.

Q35 **Mr Francois:** What is the public perception of mental health issues caused by military service?

Sir Simon Wessely: I suppose that can be answered within the social attitude. I think you half know the answer to that, but it is distorted—there is no question about that: it is distorted from the facts. There has been our study with the British social attitudes survey, and Lord Ashcroft has funded two big surveys now, through MORI, I think.

Professor Fear: And MORI has done one.

Sir Simon Wessely: And MORI has done one of its own. All of them show that most people believe that most people who served in Iraq and Afghanistan have come back physically, emotionally or psychologically damaged. That is the general view of most people—that they think most people are damaged. The facts are that most people are not damaged. Indeed, a study we have got coming out shows that many of those who have returned give very positive accounts of their deployment. Many of them say, "As a result of my deployment I can handle stress better".



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Small numbers say that it has been terrible, and one understands that. When people are asked to estimate the prevalence of, for example, PTSD, they are tenfold wrong. The distorted effect of seeing military service as a toxic occupation as opposed to a professional one that brings its own unique hazards is the single most worrying factor for the future. Most veterans say, "I am glad I joined. It was a good time." A small number—a minority—come back damaged and folks like us and you are here to try and help them. The public have a clearly distorted view, and so do the US public if that is any consolation.

Matt Fossey: I think that is driven by a media narrative.

Sir Simon Wessely: Possibly.

Matt Fossey: On the back of a genesis of an idea that we discussed a couple of years ago, we have been looking at media concepts of veterans, particularly around the hero/non-hero discord. We are finishing off a paper led by my colleague Nick Caddick at the university, and we hope to have something relatively soon. It is a big piece of work looking at media narratives over significant periods of time during the Afghan conflict, and it is starting to show some interesting themes. We will circulate that.

Sir Simon Wessely: It goes beyond that. We did an analysis of the very powerful TV programme "Warriors". We knew lots about them, and had done a before-and-after study. The final conclusion of that powerful drama was completely at odds with what had actually happened, and we knew the true mental health rates. It gave an accurate picture of the campaign, but a completely inaccurate picture of the aftermath.

Matt Fossey: Yes.

Professor Klein: One of the things we found from the British social attitudes survey was that the British public's perception of the actual mission also coloured their perception of how they valued UK armed forces, and the impact on health and wellbeing. In terms of being able to estimate military fatalities, for example, they were more likely to overestimate the number of fatalities if they had a negative perception of the mission itself.

Sir Simon Wessely: One other interesting thing to come out of that was when we asked people to define what a veteran is. The correct UK definition was chosen by 2%. We gave them a choice of options: 2% got it right, and 98% got it wrong. The commonest view was that a veteran is someone who has left service, and the second commonest was that a veteran is someone who has been deployed.

Professor Fear: Deployed overseas.

Sir Simon Wessely: The number of people who said that a veteran is someone who has one day of service including training was 2%.

Q36 **Mr Francois:** What more could be done to change these perceptions?



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Sir Simon Wessely: I do not know. It is like being King Canute, to an extent. It worries me a lot. Many of us try but there is a dichotomy in which everyone is either a hero—which we know is not true; some are and get medals but most are professionals—or a victim, which is equally untrue, because some are but most are not. That is a very dichotomous view.

Professor Klein: Or a villain.

Sir Simon Wessely: Yes, some of them are villains but most are not. There is a lack of a narrative of the realities of military service. We have to keep plodding away.

Q37 **Mr Francois:** Do you think those perceptions have any effect on the mental health of our personnel?

Sir Simon Wessely: I think they do. Or at least if they do not, then ultimately they will. The example we look towards is the US, which does now have a distorted view of their veterans, and that has been unhelpful. Many Americans agree that that has been the case, but there are other drivers behind that in the US that fortunately we do not have, including the need for healthcare.

Q38 **Mr Francois:** Why might serving personnel be reluctant to come forward and present when they have a mental health issue?

Sir Simon Wessely: You are making an assumption that is not actually valid. We know that that has changed quite substantially. The majority of those who we know have mental health problems—it is only a small majority; I would be making the figure up if I gave you one—has definitely been going up.

Professor Fear: We did a survey: as part of our cohort study, we asked individuals who recognised that they had a mental health problem about their help-seeking, and only 7% had sought no help whatsoever. A proportion had sought informal help or support—talking to friends or family—and then you had those who had gone on to seek more formal healthcare. Only 7% had done absolutely nothing. That is quite reassuring.

Matt Fossey: Someone mentioned the Defence Medical Services prevalence figures. People do not necessarily need to go to the Defence Medical Services to seek help. They could go to see their GP, a private psychiatrist or someone outside the chain of command. That is potentially another reason why those figures are out of kilter.

Sir Simon Wessely: As you would imagine, the first thing that most people do is turn to family, friends and so on—it is slightly different from civilian populations, but nevertheless they do—and people like me and health professionals are much lower down the list, as indeed we should be.

Q39 **Mr Francois:** How about the charities? Where do they fit into that list?

Sir Simon Wessely: In the social attitudes survey, we asked about knowledge of charities. As you would imagine, two charities completely



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dominated: Help for Heroes and the British Legion. That survey is a random sample of the population, and we got a module in. Everyone else basically did not register. This was 2011—or was it 2012?

Professor Klein: Yes, 2011. Well, the questions were asked in 2011.

Sir Simon Wessely: It may have changed since then, but the public's knowledge was of two. I cannot remember what came next. I think it was Erskine Hospital or something, but it was very low.

Q40 **Mr Francois:** What you are telling us is that the vast majority of serving personnel who have a mental health issue do something about it.

Sir Simon Wessely: Well, they do, but not involving formal services. About half of those who know they have a mental health problem—I should also say it is lower for alcohol: a minority of those who have alcohol problems will seek help—

Professor Fear: Sorry to interrupt, but there is also recognition. I just told you about data that showed 7% had not sought any help. Those are individuals who recognise that they have a problem. There is also a proportion of individuals out there who do not recognise that they have a problem. For them, their symptoms and experiences are kind of normal, or they have not got to a level where they feel they need to seek help. There is a proportion out there who do have significant problems but have not recognised in themselves that something is not right and they need to seek help.

Q41 **Mr Francois:** Is there anything more we can do to encourage people to come forward that we are not doing already?

Professor Klein: Linking back into the stigma thing and the barriers to help-seeking, the latest FIMT report that you guys did, which was in relation to stigma, found that it was not stigma per se that was the issue. The main problem was not knowing where to go for help, or encountering difficulties getting help.

Sir Simon Wessely: That was the practical problem. The single main reason why people didn't was that they thought they should be able to manage it themselves. Stigma was fourth in the list. By the way, it is the same in student populations. Direct stigma—"People will be ashamed of me," or whatever—was lower down the list, but the biggest thing was, "I should be able to manage it myself." There was also the difficulty of getting help and not having a high opinion of the services that were being provided, which was one of the reasons why screening failed.

Q42 **Chair:** Before I bring in Madeleine, may I ask this? It was said—it became almost a byword—that many people who came back from the previous global conflicts in which Britain was involved, such as the Second World War and even the First World War, never wanted to talk about them, even with their own families. Is this a phenomenon that you recognise in the present day?



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Professor Klein: I can answer that in part, certainly from the Headley Court study, because we looked at not just the military personnel but also the impact on their partners. One of the common things that was reported was a reluctance to actually talk about their experiences. That proved to be, certainly for the partners themselves, quite a difficult thing to do, because they felt that because they were not privy to what had gone on it could not help them to really understand what those experiences were; therefore they didn't really know what they could do in order to help. I think there is certainly a huge amount that needs to be done in terms of assisting partners and spouses and family to help with not just, obviously, their partner, but also how they can best help themselves; because it is bound to have an impact.

Matt Fossey: We have just completed a piece of work as well, looking at the impact of traumatic limb loss on families, working with Blesma. Similarly, we have found some of the challenges around people actually coping with the limb loss—whereas the veteran themselves may be coping okay, the families are not coping at all well; and because our lens tends to be on the veteran themselves we are not actually seeing the broader impact of—in this case it is not a mental health problem, but it may well have a comorbidity with a mental illness as well. There are certainly those types of challenges that, again, we are starting to understand, but we don't really know enough about to be able to come up with some solutions.

Sir Simon Wessely: I am remembering now, in the study, that there were almost equal numbers who said "I would only talk to my colleagues, my mates; I would never share with my family," but there were others, an equal number, who said, "Well, I wouldn't talk to my mates, but I would share it with my family." The figure went right down—the only thing they were all sure about: only 2% would share it with a psychiatrist and only 6% with the chain of command, and only about 7% or 8% with padres. So family and friends were way above that. These were just normal people. They were just returning—the whole cohort returning; but, again, informal social support was rated much higher than formal support.

Q43 **Chair:** Was there a difference between how people who were continuing to serve responded, and people who were veterans?

Sir Simon Wessely: No, they were all just back from deployment, so they were all still serving.

Q44 **Chair:** Right, but have you found in other studies that veterans show a different pattern of who they will share it with?

Sir Simon Wessely: Oh, God, we know don't we? We have looked at that, and I cannot remember the results.

Professor Fear: I can't remember.

Chair: Drop us a line. We are going to have to speed up a little bit. We are making very good progress, but with four people it means that we have to move on a little more quickly.



- Q45 Mrs Moon:** Two quick questions—if you cannot answer them, if you could send us anything that you have got: the Navy Families Federation evidence suggests that there is an unrecognised number of people being treated in primary care. Do you have any evidence on that? Also, a feeling that domestic abuse is playing a larger part in mental health problems within—I was going to say the military family, but that does not quite fit: have you seen anything that looks at the issues in relation to domestic abuse?

Sir Simon Wessely: We have done a bigger study on military families, certainly, in this country. On domestic abuse we have a big thing we are running now, with Deirdre MacManus, based on—the problem with the criminal records study I told you is, as you know, domestic abuse is not recorded, so we know ABHs but we don't know who the victims were; so we now have a big thing which is coming towards its end, that is looking specifically at that. I imagine we will find it has increased—just guessing, but I think we will.

Professor Fear: We are looking at the prevalence of victimisation and perpetration within the military community and also those that are veterans; and then we can look at the risk factors that are associated with those behaviours, but Deirdre is also doing a qualitative piece of work where we are interviewing individuals who are either victims or perpetrators to understand a little bit more from their side—what they feel, how their military and deployment experiences may be associated with their domestic violence behaviours. That is work in progress and hopefully we will have that in the near future.

- Q46 Mrs Moon:** What does “near future” mean? That is one of the words they use here. It drives us crazy.

Professor Fear: We have been encouraged by the number of people who have come forward to take part in the interviews. We thought that we might struggle to recruit people, but that has actually been much easier than we anticipated.

- Q47 Mrs Moon:** Six months?

Sir Simon Wessely: Shall we say in the life of this Parliament? Does that help?

Gavin Robinson: That's less than six months.

Sir Simon Wessely: We don't know, I'm sorry. We will let you know.

Matt Fossey: You asked a question about primary care as well. I think one of the challenges is recording veteran or veteran family status in primary care settings. There are read codes that are set up, but people do not necessarily complete them, so I think the data is pretty incomplete. In the intermediate bit between primary care and specialist services are things like IAPT—the Improving Access to Psychological Therapies programme—which does record veteran and veteran family status, but again I believe that there are some holes in the data. I know that you are doing some analysis on that.



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Sir Simon Wessely: We know that about 25,000 veterans have been treated by IAPTs. I am sure that it will not be long before they tell us how well that has worked. That data is around. We also know that most of the current generation report that they have told their GP that they have served, so we can establish that.

Matt Fossey: Whether it is recorded or not—

Sir Simon Wessely: Yes, I think it is variable, isn't it? There are also people who do not want their GP to know that they are in the military, as is their right. It is not uniformly one-way traffic, and not just in Ireland.

Q48 **Phil Wilson:** Do you think that Government statistics under-represent mental health disorders in serving personnel? Do you think for example that PTSD is under-reported? Don't people have to self-refer for these issues? Is it therefore under-recorded?

Sir Simon Wessely: It depends on what you are talking about. Certainly in studies that use standardised interviews, and so on, which we do, I would say that it is reasonably accurate. It is as accurate as you can get in our profession, because we do not have biomarkers or blood tests.

Professor Fear: We do not ask people, "Do you have PTSD?" We have a whole set of questions and validated algorithms. You can then work out whether or not someone is likely to have PTSD based on that. We have also done a study where we have given them a very structured clinical interview. We find very similar measures from doing a clinical interview and with a questionnaire. As Simon says, I am confident that it is pretty accurate.

Q49 **Phil Wilson:** So you think it is pretty accurate.

Sir Simon Wessely: I think it is reasonably accurate, yes.

Q50 **Phil Wilson:** Are there any gaps in the data? For example, Lariam is neurotoxic, which could cause mental problems, and so on. Do you take that into consideration?

Sir Simon Wessely: The nature of psychiatric diagnosis is that it is not etiological. You diagnose someone as having depression and then look at what the causes might be. We do not have a diagnosis of neurotoxic depression; we have a diagnosis of depression, and then we look to see whether it could be due to, for example, thyroid problems, marital problems, early life, and so on. Unlike in other bits of medicine, our diagnoses are descriptive, and then you go deep down to find out what the causes might be. Usually you find a multitude of causes.

On the Lariam question, we have data on anti-malarials, but we do not have data on specific ones, so it is difficult for us to address that. The best data comes from the Cochrane review. To summarise quite a complex piece of work, the first thing is that Lariam is a very good anti-malarial, and malaria kills. Secondly, it is a safe-ish drug. It does have an increased



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rate of adverse symptoms compared with some of the others. You are more likely to have bad dreams, depression, and so on. I think most people who have taken it will probably remember that. It is higher than other anti-malarials.

On the other hand, other drugs have different side-effects that Lariam is better on. I think it is a bit of an open verdict on that. We have not been able to look at what the long-term outcomes are, and nor has the Cochrane review. For that, we would need to link our data with some of the data on prescribing. The MOD are changing to a new system, called cortisone. I have this wonderful fantasy that the maritime version will be called hydrocortisone. That is just a medical joke, but I would really like it if it were. That may help in further record linkage.

- Q51 **Chair:** Are there serious limitations on the main ways in which mental health in serving personnel and veterans is recorded and the data assessed? Would it be better to conduct more research using anonymous conditions?

Sir Simon Wessely: I do not know about that. I was not quite sure where you were going.

Professor Fear: The beauty of a cohort study is that you can follow people up. If you use an anonymous data collection tool, you cannot follow people up, so you cannot look at how things change over time or what happened to them when they were in service and how that is then associated with what has happened to them after service.

- Q52 **Chair:** And you do not think people would be more forthcoming with the promise of anonymity?

Professor Fear: We have done a piece of work in which we administered two identical surveys—in one we got people to give their names and in the other we said, “Don’t tell us your name, we don’t need to know who you are”. We analysed the results and we found slightly higher rates of PTSD and common mental disorders where people remained anonymous. But I would say that the value of being able to follow people up over time outweighs that of anonymous data collection.

- Q53 **Chair:** Apart from the point about anonymity, are there any serious methodological limitations on the way in which the mental health of serving personnel and veterans is recorded and assessed?

Sir Simon Wessely: I think you have to look at it in the round. It depends on the data source. Obviously, if you are using medical records, that is a very good thing for who is presenting, but it is not very good for looking at population levels. For that, you have to look at big population studies, such as the adult psychiatric morbidity survey—there are others as well, but that is the best one.

There is not a single answer to that question, Julian. It depends what you want to get out of the data.

- Q54 **Chair:** On the whole, are you reasonably confident that the conclusions



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that you have come to and some of which you have shared with us today reflect reality?

Sir Simon Wessely: Yes, I am reasonably confident that they reasonably reflect reality.

Professor Fear: The two caveats to that are that, first, our cohort was selected from individuals who were serving when we were in Iraq and Afghanistan. It is a relatively young cohort. Older veterans are individuals who served and left pre-2003. Our cohort does not tell us anything about those individuals, so we are dependent on, as Simon said, the adult psychiatric morbidity survey or seeking help from statistics.

The other thing is that our cohort was selected from individuals who joined the trained strength and were deployable, so they had to be over the age of 18 and to have gone through basic training. So we do not know anything about the younger age of that spectrum—individuals at the point that they were recruited into the military. We are missing that part of the picture. I would say that they were the ones—

Matt Fossey: What we are seeing are the most potentially vulnerable people as well. We are talking about early service leavers. The vast majority of them actually leave during basic training and take discharge as of right. They are leaving 20 to 40-odd days into their basic training. I think that is the policy at the moment. They would not be picked up, so we really know little about them other than—

Sir Simon Wessely: There are two things that you can probably help with as well. We have recently been able to link with DWP data, again funded by their wonderful friends. That is really powerful data and it has never been looked at before. We are the first non-Government department to have access to that data. That obviously is very good for those who are much more difficult to reach, because the one thing they will be doing is claiming benefits. It is still not perfect, because we were not able to get the records of the group that never joined our study, but we have the records for anyone who ever did. It shows a much better picture on employment than you might have got from other sources.

The second thing is what is going to happen in the future. All the studies we have done start with the deployment. They started with Gulf 1—that is how we got in—then Operation Telic, and then Operation Herrick—big deployments that go on for a long time. You know better than me, but I am told that that may not be the picture for some years to come. For that, we need to have a different approach, which starts at the recruit for everybody and follows up one large group of people—not linked to a deployment. Then you could take out different bits of possible legacy issues. That would need a new start for the future. If we were going to do that again, next time we would start with a big recruits cohort—almost like a birth cohort that we would use in general studies—and stick with that. That would be much better for the changing nature of military operations.

Q55 **Chair:** Are there any priority areas for improving our knowledge?



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Sir Simon Wessely: If I were to ask for one, it would be that one. The second bit would also be—because of the change in data protection, which is causing trouble for various sources—to do it and to get consent to follow up and link for the future. When people are asked, they are often quite happy to consent, but when they have left the services you cannot bloody find them and you cannot get the consent to find them, because you do not know where they are—you get trapped in a terrible Catch-22 situation. If we had an adult approach to getting the correct permissions at the start, everything would be easier and cheaper.

Q56 **Chair:** Does screening personnel have a role to play? If so, should it be pre-service, during service, after service or some combination?

Sir Simon Wessely: You know what I am going to say. It is a very good question. Every NATO nation bar us does it. We are the only one that have tested it. We did the only ever randomised control trial of post-deployment screening. We randomised 10,000 people coming back from Herrick. When you do research like that, you want a definitive answer—you either want it to work or not work—and you do not want an answer that says, “More research needed.” It unequivocally did not work.

Q57 **Chair:** What did it consist of?

Sir Simon Wessely: It was what we would do if we were doing it for real. We do not have the resources to interview everyone coming back—10,000 people—we do not have a sufficient number of mental health professionals, so it was a computer-generated questionnaire using mental health screening, followed by randomisations of different types of referral. As I say, no matter what we did with it—no matter how much we tormented the poor old data—we could not find a positive effect of screening on either help seeking or outcomes.

We have previously shown that pre-deployment screening also does not work and, indeed, has adverse effects on the forces. We are not in a position to recommend mental health screening at the moment and we think the money should be spent elsewhere, for example, on improving the quality of services—a lot of people did not do it because they did not think the services were good enough. You would need stigma-reducing exercises and all sorts of things before you would get a positive result on screening.

Q58 **Chair:** Why did pre-deployment screening have an adverse effect? What sort of adverse effect?

Sir Simon Wessely: In 2003, just before Telic, we were lucky enough that we had done a big study on British Forces Germany and mental health. We held that data to ourselves. The data that would have been used was in fact a study of screening. Afterwards, when they came back and we knew who had had problems, we looked to see whether we could have predicted those problems beforehand—because that is the whole point of pre-deployment screening—and the answer was, yes, we could. It was not random. But for every person we correctly identified pre-, who came back with problems, we got five wrong. You would never, ever be



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able to run a screening programme if you got five wrong—five careers ruined; five people who would be wrongly told not to deploy—for one who had been correctly told not to deploy. You could never do that. That is the same result they got in 1944 in the American study, bizarrely. It has not changed.

Chair: Very good.

- Q59 **Phil Wilson:** How far can you say that the mental health issues that servicemen, servicewomen and veterans might have are not related to their military experience?

Sir Simon Wessely: I will start on that one. You cannot, in any given person. As I say, one of the reasons why psychiatry is so interesting and the rest of medicine less so is that you never have a single cause for the things we do—it is an interaction between the person you recruit, the things that happen to them when they are in theatre, and also when they come back—the things that happen post deployment. It is very difficult to be absolutely certain that what happened to them is solely and only the result of their military deployment. But you can say it contributed.

- Q60 **Phil Wilson:** What other causes do you think might contribute? Can I give you an example that I have just been reading about? Walking With The Wounded has said in a written response that recruits from the north-east and north-west, where there might be poor educational attainment, poor attachment and bonds to family and so on, might have emotional problems when they are in the military, which has led on occasion to early discharge and also mental health difficulties. Are those the kinds of circumstances that you would consider?

Professor Klein: There is certainly evidence to back up the fact that those who have a lower educational status, are male, in a younger age group, and of lower rank, which is probably associated with a lower educational status, are the ones who are likely to encounter more difficulties. By virtue of their socio-economic status they tend to come from more deprived areas. This goes back to what I was saying previously. What we do not know is the individual differences; the way people cope with things is very much on an individual level. Certainly, for example—I keep going back to the Headley Court Trust study—a lot of it comes down to the subjective interpretation and meaning of the injury in terms of how they coped. There are so many complexities here in terms of trying to understand. I do not think you can necessarily pin it to one particular thing. What we really need to do now is start to look and try to understand more in depth what enables people.

- Q61 **Phil Wilson:** So if you come across a service man or woman who has got issues, will you look at how much it is down to their military experience and what else it could be, so that would be part of a consultation?

Professor Klein: Yes, but, from what Simon was saying, having a birth cohort study where you could follow these people through, you can actually see how over the course of time exposure to certain things may change their trajectory in terms of those who go on to develop mental



health issues and those who may not. That is where we lack the real understanding. You have the advance study, the 20-year follow-up.

Professor Fear: The advance study is a study of battle casualties from Afghanistan. We are identifying and recruiting 600 battle casualties and 600 individuals who were deployed at the same time to the same place, did the same role, the same age, all male. We are recruiting 600 of those so we can collect some baseline information and then follow them up at various points. The idea is that we follow them up over a 20-year period. Then we can understand about how ageing, how being a battle casualty, how long your military service, and whether you stay in or leave service impacts on a whole range of outcomes. The study was set up to look very much at physical health outcomes, but Simon and I are involved in that study and we were able to encourage them to include measures of mental health and wellbeing and measures about family support, so we can see how all of these different factors interplay on a range of outcomes.

Sir Simon Wessely: I doubt I will be involved for 20 years, Nicola. Nice thought.

Q62 **Chair:** You keep referring to the fact that different people in the same circumstances react very differently. This is almost going back to the idea of nature versus nurture. To what extent in the end is it the fact that people have very different personalities, different characters, different resilience and strengths and weaknesses? Put those very different people in the same stressful circumstances and you are pretty much bound to get very different outcomes, aren't you?

Sir Simon Wessely: Yes, you are. The practical implication of what you are talking about comes back to the issue of when people join. Remember, they join at 16 or 18—relatively young. One of the reasons why a prediction at that stage is poor is because many of the things that create personality and character, if you wish to use a Victorian term, are still to happen, and many of those things will be related to what happens to them in the forces. I still think one of the best things we have ever done was the criminal records study to show that, for the majority, it had a positive effect on them, but for a minority it did not, and the difficulties of predicting that in advance. Then, remember, if you were to remove at recruitment everyone who had a risk factor for mental health, I think in the Army you might have four people left, because they are very broad.

The pre-deployment study we did before Telic showed very clearly that, although these things are important, they cannot give the precision that you need for an individual to say, "You can join up, but you can't; you can deploy, but you can't". They are not that good. It may be that, in 20 years' time, we will have better markers for these things, but until we do, to screen people out for anything other than the most overt things like bipolar, schizophrenia and so on, or having one eye—well, actually, not even that. We can screen people out for the easily measurable things, but things that apply to mental health are fraught with danger and you are likely to do more harm than good.



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Matt Fossey: You were talking interestingly about a recruit cohort, and we are currently working with the MOD and thinking about what types of metrics we can use, and the wellbeing measures that look at the social determinants of not just mental health but physical health as well. You could be measuring things during people's careers, and getting a more rounded view of what is going on with individuals. Obviously, we are at the early stages, but there seems to be a bit of a sea change in the MOD in thinking about the wellbeing of service personnel.

Sir Simon Wessely: The other good news—I think Tobias Ellwood mentioned and confirmed this—is finally getting a question into the census. That is really good. Brilliant.

Q63 **Chair:** Do you have any security concerns about having a question in the census that identifies where veterans live?

Sir Simon Wessely: So long as it is handled properly—no. Well, some, but one has to assume that the census data are treated well, which I think they are. Certainly you can't identify individuals. They will not give you data that lead you to be able to identify individuals. They just won't.

Chair: Let's hope their cyber-security is up to the mark.

Sir Simon Wessely: Yes—that is well beyond what we can cover. It is a good point; I do not know about that.

Chair: We have a couple of questions from Mark, and then to conclude I will invite each of you to make any final observations you wish to make.

Q64 **Mr Francois:** Chairman, both of my questions have been answered in the course of the hearing, so I will end with one final one. You have given us very conclusive evidence today that the lazy media journalism view that our people come out mad, bad or sad is nonsense. I think that is reassuring to the Committee. If there is one thing that we could change in the whole arena of serving personnel and the mental health of veterans, what should it be?

Sir Simon Wessely: Something we have not already mentioned?

Mr Francois: Yes, or one specific way that we could improve things that we are not doing at the moment.

Sir Simon Wessely: I still think we haven't totally mastered the interaction with the NHS when people leave. I know you and others have tried, but I still see far too many people for whom that interaction has not worked very well. People in charities and general practice and so on find it incredibly difficult to get a good, clear and concise summary. The medical records are enormous, and a concise summary is not transmitted anything like as often as it should be.

Matt Fossey: I am not sure if this is within the terms of reference of this Committee, but we should also think about and understand fully the impact on families. That is something that we have not yet properly addressed. I know you have done some work on it, but a lot more work needs to be done.



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Professor Fear: My point would be about families. You talked about public perceptions and the impact that those have on service personnel and veterans, but how does it affect a family if their loved one is portrayed as sad and mad and bad? How does that impact on your spouse and partner, and also on your children?

Professor Klein: I wonder whether more needs to be done—perhaps this is a rather naive suggestion—in working with the media and how they go about portraying things. For example, Lord Ashcroft mentioned in his report the necessity of working with the media rather than treating them as if they do not have anything to offer. You have done studies on the media portrayal from the service personnel perspective and how it impacts on them. Is that something that could be looked at—changing the way the media portray things?

Mr Francois: Hopefully, our Committee report can go some small way towards doing that.

Q65 **Chair:** Why does the prospect of a leopard without any spots suddenly flit into one's mind? Any final observations that you would like to make for us to take away?

Sir Simon Wessely: I suppose if there were one it would be following up on Chilcot. We have made major strides since Gulf 1. You will remember all that. We were in an information void and then an awful lot of stuff filled that void that was unhelpful and inaccurate. The investment that we put in has been worth while in giving at least reasonably accurate data. We don't make policy. We just give what we hope is reasonably accurate data to assist policy. I think that has been generally positive. There is a need to refine that for the next round of what the military are going to be like for the next decade.

Q66 **Chair:** Any other observations?

Professor Fear: Just to bang the drum again for families. As has been mentioned, we ran a large cohort study of military families from King's. Yes, there are some adverse consequences on those families but there are also some positive things that we can learn from, and that may be helpful for other families going forward. I would like to wave the flag for families, so that they are not forgotten.

Matt Fossey: Of course, I would like to bang the drum for families but also bang a big drum for understanding more about wellbeing and how that impacts on individuals' and families' mental health. How can we gather more data and understand more about that?

Professor Klein: There is one area that came out of a Scottish Government scoping review that we were commissioned to do on the impact on serving personnel and their families. We often look at things from the perspective of the veteran or service personnel and integration back into civvy street. We don't necessarily look at the alternative view of civilians and how they view that integration.



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A very interesting comment from a civilian came out of the consultation process, who remarked that, although we talk about stigma for military personnel, sometimes civilians feel that they are not being treated fairly and are at a disadvantage. The example was given in relation to prosthetics. Amputees in the NHS do not receive the same standard of prosthetics, for example, as an amputee who had been through the Defence Medical Rehabilitation Centre with £70,000-worth of C-legs. I am perhaps thinking about it in a more societal way and, again, maybe that is very much out of the box. A point came up in submitted evidence or written testimony about integration and not differentiation.

Chair: That is a very good note on which to finish. Thank you all very much for sharing your time and expertise with the Committee.