

Defence Committee

Oral evidence: Armed Forces and Veterans' Mental Health, HC 813

Tuesday 24 April 2018

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

Questions 67-146

Witnesses

[I:](#) Professor Cherie Armour, Associate Dean (Research and Impact), Institute of Mental Health Sciences, Ulster University; Dr Beverly Bergman, Institute of Health and Wellbeing, University of Glasgow; Dr Lucy Abraham, Clinical Psychologist, Veterans First Point Scotland; and Dr Neil Kitchiner, Director & Consultant Clinical Lead, Veterans NHS Wales.

[II:](#) Karen Mead, Head of Psychological Wellbeing, Help for Heroes; Rod Eldridge, Clinical Lead, Walking with the Wounded; and Dr Walter Busuttil, Director of Medical Services, Combat Stress.

Written evidence from witnesses:

[Professor Cherie Armour](#)

[Dr Beverly Bergman](#)

[Dr Lucy Abraham](#)

[Dr Neil Kitchiner](#)

[Karen Mead](#)

[Rod Eldridge](#)

[Dr Walter Busttil](#)

Examination of witnesses

Witnesses: Professor Cherie Armour, Dr Beverly Bergman, Dr Lucy Abraham and Dr Neil Kitchiner.

Q67 **Chair:** Good morning and welcome to the second session in our inquiry on the extent of mental health issues among serving Armed Forces personnel and veterans. We have a particularly highly qualified panel of experts today. As is our usual custom, I will invite each of you to say a few words to introduce yourself and explain what you do.

Professor Armour: I am Professor Cherie Armour from Ulster University. I am the principal investigator on a four-year programme of research called the Northern Ireland veterans' health and wellbeing study. I am currently Director of the Institute of Mental Health Sciences at Ulster University and President of the UK Psychological Trauma Society.

Dr Bergman: I am Dr Beverly Bergman. I am a former Army public health consultant and, prior to that, an Army GP. I now work at the University of Glasgow, where I am the lead researcher on the Scottish veterans health study, which is a study of 57,000 veterans followed up for over 30 years.

Dr Abraham: Hello, I am Dr Lucy Abraham. I am the clinical lead for Veterans First Point in Lothian, and I am speaking on behalf of the Veterans First Point network, with which I have been involved for the past four years, setting up eight services across Scotland.

Dr Kitchiner: Hello, I am Dr Neil Kitchiner, consultant clinical lead and director at Veterans NHS Wales. I am also a veteran of 203 Field Hospital and an honorary research fellow with Cardiff University.

Chair: Obviously, the focus of this panel is very much going to be on the specific aspects of Northern Ireland, Wales and Scotland. Madeleine Moon will start us off.

Q68 **Mrs Moon:** Good morning and thank you all for coming. I would like to start with a fairly general question to give us a feel for what is happening in the devolved Administrations. Can you tell us whether there are any factors that affect the mental health of serving personnel and veterans that are specific to the devolved Administrations? In particular, it would be helpful to know whether there are any groups of serving personnel or veterans who are at a high risk of developing mental health problems, whether there are any particular mental health disorders that are more prevalent in the devolved nations, and whether there are any particular issues with where veterans go to seek help and support. That is a very wide-ranging question, but it will give us a basis from which to start our other questions.

Professor Armour: Northern Ireland experienced a prolonged period of political conflict, which was the largest British Army military operation to



date. It lasted over 30 years. Obviously, a number of unique circumstances come with that for veterans who currently reside in Northern Ireland, relating to concerns over their safety and security. A large proportion of individuals were members of the UDR and Royal Irish Home Service units. Those are essentially people who were working part time as part of the Army and residing in civilian populations. They were working and living in what was essentially their operational theatre, so there are lots of unique concerns there. For veterans, that comes with a consistent and sustained threat perception, and we know that threat impacts on people's psychological wellbeing.

In terms of various groups that might be more susceptible to mental health disorders or concerns, unfortunately we do not have the evidence base for that at the moment. I am leading a large-scale psychological wellbeing survey in Northern Ireland that will eventually be able to answer some of those questions for us, but at the moment we do not have an evidence base upon which we can call for that. We hypothesise that there will be a certain proportion of those individuals who have an increased rate of common mental disorders, such as depression, anxiety and post-traumatic stress disorder.

It is also important to know that the population of Northern Ireland has an increased rate of common mental disorders compared with the populations of England, Scotland and Wales, and populations across the world. The only survey we have that tells us about those rates indicates that post-traumatic stress disorder has been experienced by 8.8% of the population of Northern Ireland, compared with 4.4% of the population of England, so it is exactly double the rate of PTSD in the general population. We know that veterans experience a comparable rate of mental health disorders, so we hypothesise that the rate of mental health disorders in our veteran population may exceed that in the populations of other parts of the United Kingdom.

Where do they go to seek support? We know that safety and security concerns act as a barrier for veterans in Northern Ireland who are trying to seek help for mental health concerns. We also know that there is a different level of provision for veterans in Northern Ireland, compared with other parts of the UK. For example, there are currently no bespoke statutory services for veterans in Northern Ireland, so they have to avail themselves of the support of the voluntary and community sector predominantly. As we move along today's panel, if you want me to elaborate on some of that, I would be very happy to do so.

Q69 Mrs Moon: Very briefly, is there support for families with mental health problems?

Professor Armour: We haven't done that piece of work yet either.

Dr Bergman: Looking at the 57,000 veterans who formed the Scottish veterans health study, in comparison with the general population, generally their mental health reflects that of the wider community—certainly in terms of common mental disorders, such as mood disorders,



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anxiety and, in the older veterans, dementia. Where we see a difference with the veterans is with PTSD, which won't come as a surprise to anyone. There is a complexity within the data for PTSD, which requires quite a lot more research so we can drill down into it.

In terms of specific groups at risk, the two groups that are shown to be at a higher risk than the general population are the older veterans—people born between 1945 and 1954, who served in the 1960s and early 1970s—and early service leavers. Quite surprisingly, the highest risk within the early service leavers was actually in those who did not finish training and had an average length of service of only about six weeks. That possibly reflects pre-service risk factors, which may well have been the same factors that contributed to them not making a success of a military career.

Within Scotland, we are able to look at risks within different areas. There were certainly differences between the urban Central Belt area and the more rural Highlands and Islands areas. In general, it looks as if those who have a health problem tend to gravitate towards the centres of population, where they are more likely to get help. Equally, there is anecdotal evidence—although unfortunately there is no way that this shows up in the research—that there are some veterans who deliberately seek to live in very remote rural areas, well away from the mainstream community. They probably have very high needs indeed, but equally they are the hardest to reach. There is heterogeneity within the Scottish population.

In terms of where they go to seek help, I will defer to my colleague, Dr Lucy Abraham.

Dr Abraham: Interestingly, in Scotland, Lothian was the first service to be created, and we have seen slight regional variations when the other services have been opened across Scotland. Predominantly, we see Army coming forward, which makes sense, because of the natural differences within the military population. With the opening of services in Ayrshire and Arran, we are getting many more Navy personnel coming forward.

The nature of the Veterans First Point model is based on the idea of improving the accessibility, credibility and co-ordination of services. We see any presentation that comes forward. We respond to welfare needs as well as mental health needs. When you look at our clients coming forward, most have issues with relationships and social isolation. Then the predominant mental health issue is depression, and then following on from that we have a high proportion of PTSD. We see any presentation, in terms of mental health issues. Some are very complex needs and some are more straightforward needs.

In terms of deprivation, we have the most deprived sections of the Scottish population coming forward. Homelessness is particularly high among the veterans we see, with 38% of our veterans describing themselves as having been homeless at some point in their life and 1% saying that they are roofless homeless, which, compared with the general statistic in Scotland of 0.05%, is particularly high. There is a kind of ethos



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within the service of getting those basic needs met prior to doing psychological treatments and other interventions.

There are rural differences as well, and we have had to be quite creative. Highland covers a huge geographical area, and as Beverley was saying, some of the complex cases will go there for some sort of respite and tranquillity. It is about being creative in how we reach those individuals. In Lothian we have a homeless hostel for veterans. It is suggested to a lot of those who are homeless to go to Lothian and reside within the hostel, and to have their mental health needs treated. That is interesting because it will skew the demographics in terms of having a large proportion of out-of-area clients residing in a hostel.

Dr Kitchiner: As far as I am aware, the Welsh Government do not have data to answer the questions you have put to the panel—this is based purely on Veterans NHS Wales, which, as you know, is funded by the Welsh Government as a national service, with seven health boards across Wales, and veterans therapists on every health board, who act as the conduit for the assessment and treatment of our Welsh veterans.

Similar to the Scottish summary, we have issues with rurality. In west Wales and Powys, our veterans have to travel some major distances to come to our out-patient clinics, and we do not have in-patient beds at all. We work closely with the charities in Wales. Barnardo's has been funded to run a family veterans service over the past couple of years. It does the bulk of our family work, and we refer to it for that. One of our prisons in south Wales, HMP Parc, has the endeavour unit, which also looks at the integration of families while a veteran is in custody, to try to smooth out family issues such as housing and employment going forward.

On at-risk groups, it has already been said that the earliest service leavers present us with some complex presentations that require a host of multi-disciplinary partners to work with. I think we are quite good at that in Wales—being small, we have a good network with the charity sector services, and it is currently fairly joined up. The people we see most are in the deprived areas, particularly around our major cities of Swansea, Cardiff and Wrexham. They are the people who we probably spend most of our time supporting and treating for a range of problems.

Q70 **Gavin Robinson:** Thank you all for joining us this morning. Will you each outline for your respective parts of this United Kingdom—Northern Ireland, Scotland and Wales—what key services are available, be they statutory or non-statutory, and how that differs from your respective experience and the experience of services offered in England? Has there been a comparative analysis of what you do in your region and the services available in England, or between yourselves? There are a few elements to that. Professor Armour, you have already indicated that there is no statutory provision at all in Northern Ireland, so perhaps we could start with you first.

Professor Armour: As part of the Northern Ireland veterans' health and wellbeing study, our first piece of work was to review the support and



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services available to veterans in Northern Ireland. It was not a comparative piece with other parts of the United Kingdom; it was specific to Northern Ireland. To do that we basically had desk-based research, where we reviewed all the provision out there, and we found that provision to veterans by the statutory sector is the same as that provided to the rest of the population. So veterans can access the national health service and any statutory services in the same way that other members of the population can, but there are no bespoke statutory services provided to veterans in Northern Ireland, and there is certainly no priority treatment given to them either.

Q71 Gavin Robinson: Do you have an explanation as to why that is the case? Is that a failure to implement the covenant in Northern Ireland or is there some other, ancillary reason?

Professor Armour: In Northern Ireland, we have section 75 equality legislation, which says that nobody should be given any preferential treatment based on things such as gender and religion. Occupational status can fall into that as well. Veterans are seen as a particular occupation, perhaps with a predominance of a particular religious affiliation. Many people use that for the non-implementation of the Armed Forces covenant, particularly part 2 of it. That essentially blocks the bespoke statutory services available to veterans in Northern Ireland.

We also reviewed the voluntary and community sector for veteran-specific support, as part of the first work package of our project. We found 19 organisations in total that were formally registered with the Charity Commission. Almost half of those organisations had their headquarters based in GB, with a UK-wide focus of service provision, so they were not specifically focusing on the unique circumstances that perhaps prevail in Northern Ireland. There are lots of issues with funding, voluntary staffing and a rapidly changing demographic.

Just to share some figures that I have noted about that with you, in Northern Ireland there is a total of 4,500 voluntary and community charities, of which only 19 specifically provide services to veterans. If we look at that in terms of a percentage, that is 0.4% of the voluntary community organisations that are providing services specific to veterans. Of the whole sector—that 4,500—6.7% have their headquarters out of the UK. If we look at the veteran-specific ones—the 19—45% have their headquarters outside Northern Ireland and the UK. That is quite a difference and acts as a barrier to some veterans seeking support.

In terms of the provision of those 19 services, our first report concluded that provision for mental health support is woefully under-represented. Lots of things are provided, such as befriending, advocacy, remembrance, welfare, training and respite, but few of those organisations focus on mental health care and support.

Q72 Gavin Robinson: Before you leave that, have you been able to do a comparative analysis, be it evidence-based or anecdotal, between what is provided and how it benefits individuals in Northern Ireland and in



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Scotland, Wales or indeed England?

Professor Armour: We have not yet done that comparative analysis. This is really the first piece of work that focuses on this population in Northern Ireland. One thing that is important to highlight is that some reports are available. For example, I cannot remember the author, but a report was done on the voluntary and community sector across the UK. In that report, they specifically said that they did not come to review services in Northern Ireland because of the difficulties with access and because they really felt it was necessary for people who had knowledge of the local political context to do that piece of work. Northern Ireland is often left out of those national-level comparisons.

Q73 **Gavin Robinson:** That is useful for the Committee to hear. Thank you. Dr Bergman, Dr Abraham, you will know who is best placed to answer the question, so I will leave it to you to give the Scottish answer.

Dr Bergman: I will start off, and then pass over to you, Dr Abraham. In Scotland, we benefit from statutory and charitable services. In terms of statutory services, we have the Veterans First Point network, which Lucy has been talking about, and the NHS, which provides the same service to everybody—the same as in Northern Ireland.

Equally, in Scotland, veterans have a high priority. We have a priority treatment system whereby people can be fast-tracked to their first appointment for a condition that is related to their military service. There is also a very high level of commitment to the armed forces covenant by the Scottish Government, and a commitment that veterans will not suffer any disadvantage because of their military status—their veteran status—or because of anything that has happened to them in service. That extends to a recognition that there may be certain categories of veterans with very complex needs, who will benefit from and be entitled to special services to reach out to them. Veterans First Point is an example of that.

The charitable sector benefits from overarching oversight by Veterans Scotland, which acts as the umbrella organisation representing—and to a certain extent, steering—charitable efforts. We have also got very strong representation from Combat Stress and I understand we will be hearing from them later. We have a Combat Stress in-patient facility in Scotland and we also have organisations such as SSAFA in Glasgow. We have Glasgow Helping Heroes, which is a collaboration between SSAFA and the local authority that, again, reaches out to veterans with a particular emphasis on housing welfare support.

Overall, there is good provision. There is clearly scope for enhanced provision and this is something that Eric Fraser, our veterans commissioner, is continually looking at and bringing to the attention of the Scottish Government and the wider public. However, we do have quite a significant level of commitment.

Q74 **Gavin Robinson:** Dr Abraham, when answering, can you touch on a comparative analysis—whether there has been any comparative analysis of the benefits that are there for Scottish veterans as opposed to English



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or Welsh veterans of the services provided?

Dr Bergman: We are just about to start a follow-on to the Scottish veterans' health study, which will look at whether the covenant initiatives have yet made a discernible difference, and that will be swept up into that fairly lengthy piece of work, which will start later this year.

Professor Armour: Gavin, can I make one point on the statistics? In terms of that comparative piece about the provision in the voluntary and community sector, in England and Wales there are 1,818 charity providers, in Scotland there are 461, and in Northern Ireland there are 19. Of course, there are differences in population size, but just as a very rough comparator, there is a wealth of additional voluntary and community service organisations in England, Wales and Scotland compared with Northern Ireland.

Gavin Robinson: Thank you.

Dr Abraham: I think it has breached the 500 mark for charities in Scotland, and one of the key things, as Beverly said, is Veterans Scotland co-ordinating that. That is crucial. It really pulls everything together.

In terms of mental health provision and services for that, Veterans First Point and Combat Stress are the main providers. We have the in-patient and community services for Combat Stress and the Veterans First Point services. There are also the mainstream services. The Scottish Government mental health division recently funded the Veterans First Point Scotland team 100%. Part of that team's remit is to help skill up and train other mainstream services and providers throughout Scotland on veteran mental health provision. We want clinicians throughout Scotland to feel more able and skilled to respond to those needs, and that will be available for the charitable sector as well, where appropriate.

Services have always been developed in partnership and without that, it would not really be a success. Sometimes, that has been formally. Poppyscotland and Veterans First Point collaborated on the Highlands service. Veterans First Point Lanarkshire integrated joint board, the Lanarkshire Association for Mental Health and the Scottish Association for Mental Health provided those services in Lanarkshire. We have been looking at how the model works with different partnerships as well. We have not got the data on that but we can send it on later. Scotland, being small—like Neil said about Wales—allows that partnership working and the co-ordinating of services.

Dr Kitchiner: The Welsh Government are committed to the armed forces covenant and, following the MOD and Welsh Government-funded pilot 2007 to 2009, and on the back of that two-year pilot, they commissioned Veterans NHS Wales, which covers all seven health boards. Veterans NHS Wales is held up as the go-to first point of contact for veterans with mental health problems and is referred to by statutory service and third sector charities. Uniquely, we have some Welsh-based charities that are not in the other countries, notably Change Step, a peer-mentoring charity that has recently been funded by Help for Heroes to embed peer mentors



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in each of the Veterans NHS Wales outpatient clinics. So we have a dedicated peer mentor, or two, working with the veterans' therapist to do the social interventions that we cannot do as therapists.

There are the usual charities that are not based in Wales but reach into Wales. The Royal British Legion in Wales has a particular influence in as much as it holds regular meetings with all the charities and statutory sectors to co-ordinate the provision for mental health for veterans. That joined-up approach is very helpful. Again, because we are a small country, we can do that fairly easily.

I am sure you will be familiar with the Forces in Mind Trust's "Call to Mind" reports that have been published for a year or two now. They were based on specific data pertinent to each of the devolved countries represented here today.

The Welsh Government have an armed forces expert group that meets every six months, which is attended by statutory organisations and third sector charities. That is headed by one of our Ministers. West Wales Action for Mental Health is very active in Pembrokeshire and co-ordinates lots of activity by statutory and third sector organisations.

We have no Combat Stress in-patient service or building in Wales but, historically, our veterans have gone to Shropshire, to Audley Court for residential care. They can also access Tyrwhitt House in-patient facility. Help for Heroes has become increasingly active in Wales over the last couple of years. We have North Wales and South Wales teams who work very hard with statutory and third sector partners.

The Welsh Government have also encouraged health boards to develop armed forces forums. In each health board there is a regular armed forces forum which is an exec-led NHS board with an armed forces champion. That holds the health boards to account on provision for serving personnel, veterans and families.

The Wales Deanery also has an online resource on veterans' mental health which is aimed at GPs and, latterly, NHS staff. That has been rolled out and is being revised as we speak.

Q75 Martin Docherty-Hughes: Briefly, Gavin's question is about both state and charity-run services. I sometimes have a concern that when we talk about the charity sector, everyone thinks of these large organisations. Dr Abraham you mentioned SAMH—the Scottish Association for Mental Health. There are also the services charities, which I predominately think of as small community-based organisations, for instance, Armed Forces Veterans Dumbarton—which is in my constituency and which I will be visiting on Friday—who seek to reduce social isolation between that 1945 and '84 bit. How important are those small, local, community-based organisations for some of the issues you are facing, as opposed to the big nationals?

Dr Bergman: I think they are vitally important. They provide a service which the statutory sector is not resourced to provide. Provided that they



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are well conceived, well run and perhaps do not pursue, shall we say, non-mainstream agendas, they provide a very valuable service. I am thinking not necessarily of medically focused initiatives, but ones such as Men's Sheds, which can provide tremendous social opportunities and community support for people and thereby, indirectly, create substantial improvement to mental health.

Dr Abraham: Locally, each Veterans First Point links locally with the smaller charities. Within Lothian, I am thinking of a veterans' café, which is hugely supportive in reducing that social isolation. There are lots of links there. Building on what Beverley has just said, it is also about their sustainability and veterans knowing that the service will be there for the next week and the next month. That is key. It is an issue for everybody, but particularly for those smaller charities.

Chair: I am afraid we will have to adopt the principles of Speaker Bercow and go for slightly shorter questions and snappier answers. Not everyone has to answer every question if you are happy with the other answers. It is a problem we always have when we have four panellist speakers; obviously, there is a wealth of information there.

Graham P. Jones: I will just get my advertising plug in for two absolutely wonderful small charities, Veterans Association UK and Veterans in Communities. Thank you, Chair, for that opportunity.

Chair: Well done.

- Q76 **Graham P. Jones:** Do UK-wide statistics on the level of mental health issues in serving personnel and veterans reflect the situation in Wales, Scotland and Northern Ireland? If not, and if there are differences, what are the main reasons for those differences?

Dr Kitchiner: From the data we have collected over the last eight years through Veterans NHS Wales, I would say we probably see more veterans with post-traumatic stress disorder than the King's cohort studies have followed up. That is certainly the bulk of our day-to-day clinical work. I would put a figure of around 65% on our veterans having PTSD and co-morbid problems.

Professor Armour: I want to quickly jump back, because it is an important point to make that those local organisations in Northern Ireland are vitally important, particularly because they depend a lot on informal communication networks and the sharing of information.

- Q77 **Martin Docherty-Hughes:** They are volunteers. They need a lot of money.

Professor Armour: Absolutely. I go back to the sustainability and funding concerns to note that they are vitally important for the way in which veterans in Northern Ireland are supported. Coming back to your question about whether UK statistics reflect those in Northern Ireland, we do not currently have any figures in Northern Ireland. That is the piece of work we are doing at the moment. We are trying to ascertain the rates of



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common mental health disorders, for example through our various psychological wellbeing surveys in Northern Ireland.

One important point to make is that statistics tell you a lot, but the methodology you use to reach those statistics can also be very important. In the previous panel you had our colleagues from King's, who speak about in-service personnel and their cohort studies. Those are in-service personnel, whereas the work we are trying to do in Northern Ireland focuses on veterans specifically. Comparing their results to the results of veterans in Northern Ireland would essentially be comparing apples with oranges. It is very important that you understand the methodology and the target population behind any statistics.

Dr Bergman: The Scottish Veterans Health Study is different again, because that looks at NHS hospital admissions, diagnoses recorded on death certificates and mental health day case admissions. It represents confirmed diagnoses, but it also represents the more severe end of the spectrum. The King's studies have looked at survey data, so they are looking at people who are functioning within the community, not necessarily having presented with a problem, but who score at a predefined level. Again, the reports that are published by the Ministry of Defence on usage of Defence mental health services are based on people who present to what is essentially an out-patient service. That is a different level again. We are comparing very different aspects, and together they all form the big picture.

Q78 Mrs Moon: Dr Kitchiner, can I go back to a statement you made about Combat Stress and in-patient services? My understanding is that the Welsh Government no longer fund those, but if it is felt by a clinician that in-patient care is needed, it is down to the health board to fund it. Are you aware of that, and do you know how many times that has been funded? If not, could you write to us and let us have the figures? My understanding is that it is down to individual health boards to decide whether or not they will fund the six weeks' residential course.

Dr Kitchiner: I have no data today. I am sure that Dr Busuttil will later qualify this, but my understanding is that if Welsh veterans want to access the six-week in-patient programme, we can make a referral to Combat Stress and they will be able to access that. ⁱ

Q79 Mrs Moon: My experience as a local MP is that they cannot because Combat Stress does not have funding from the Welsh Government. The Welsh Government direct them back to the local health board and the health board decides on an individual basis.

Dr Kitchiner: I am aware of the case you refer to but I think that as of 1 April that situation has now changed. Dr Busuttil will certainly clarify that later. My understanding is that as of 1 April that will not be an issue and we can refer to Combat Stress. You are right that the funding has stopped and was diverted from BCU health board into Audley Court. That funding stopped in the past couple of years and has been diverted to peer mentoring and charity support through Change Step.



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Q80 **Mrs Moon:** So those with the most severe levels of PTSD no longer have an option of in-patient support.

Dr Kitchiner: As I said, they can be referred to Combat Stress since 1 April and go for the six-week in-patient programme.

Q81 **Mrs Moon:** Is that funding for a year or is it longer term?

Dr Kitchiner: I do not think there is any caveat to that. Again, if you ask Dr Busuttil in your later session, I am sure that is the case.

Q82 **Mrs Moon:** Thank you. Can I ask again whether there is a different public perception across the devolved Administrations in relation to mental health issues caused by military service? Do you have any figures as to how that compares with the wider UK perspective? Is there a different perspective from the devolved Administrations?

Dr Bergman: In the presentations that I have given to a variety of audiences on mental health, I have found that there is quite an age gradient. Younger people, who are not themselves veterans, tend to have a perception that there is a very widespread problem of mental ill health within the veteran community.

Older people, among whom veterans are much more represented, whether they have served in the armed forces as volunteers or as national servicemen, tend to have a much more balanced view. I do not have data to support that but it certainly comes out quite strongly, because I normally ask my audiences who is a veteran, and then ask a few pointed questions as to perceptions. We do get a much more balanced view from the older audiences.

There is certainly within the community still a widespread view that there is a very high level of mental health problems within the veteran community, not least, I suspect, because the veterans who are most easily identified within the community are those who have difficulties, the ones who sit on the streets begging with a placard. The veterans who are getting on with life, forming the bulk of the working veteran population, just disappear back into the community and are not visible

Professor Armour: Although we do not have any data on that at the moment for Northern Ireland, we have just completed the collection of data from a population representative survey called the Northern Ireland Life and Times Survey.

It is representative because it is able to look at the opinion of the public of the whole of Northern Ireland. We inserted a number of questions into that survey and asked about public opinions broadly and generally, but there are also a few questions in there about mental health. Unfortunately, this panel is happening a month or two early because we literally only got the data last week. We will analyse it in the next few weeks. Unfortunately, I cannot tell you anything about the results at the moment, even if I wanted to, because I do not know, as we have not analysed the data.



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We will be launching that report on 13 June and we will have a very accurate reflection of public opinion of veterans in Northern Ireland and of opinions about mental health. Anecdotally, we believe that there are vast differences between various groups within the population, between older and younger groups, between socioeconomic statuses, between groups based on religion and so on. We have all of that information in our data, so we will be forthcoming with the results. I would be very happy to share that report with the panel when it is ready.

Q83 Mrs Moon: That would be very helpful. Thank you. Again, very quickly, if you could answer this. The devolved Administrations have higher levels of suicide than England, oddly enough. Working along the panel, are you aware of any increased risk of suicide within the devolved Administrations, given those higher levels in the veteran community? If you have those figures, I would be very grateful if you forwarded them to the Committee.

Dr Bergman: We published a paper on suicide within the Scottish Veterans Health Study. Within our population of 57,000 veterans, we found that overall veterans were at no increased risk. What we did show—although the numbers were fairly small, it was statistically significant—was that older veteran women were at increased risk. In the community as a whole, women normally have about one third of the risk of suicide that men have, but among the veteran community, women's risk was much closer to the men's risk. Clearly we had no way of exploring the reasons underlying that. Overall, our figures show that the veterans were not at increased risk. There was a slight but not statistically significant increased risk for the early service leavers. Where there was any increase at all, it tended to be in older veterans, people in their 40s and 50s, which reflected a higher risk in that middle-age group in men in the community as well.

Professor Armour: At population level in Northern Ireland, we know that the rate of suicidal ideation and completed suicide is highest across the United Kingdom. If we think that rates of things such as common mental disorders are comparable between the general population and the veteran population, we could hypothesise that compared with the other nations, rates of suicidal ideation and attempt may be higher in the veteran population, but that is an assumption, because as of yet we do not have the data. However, the psychological wellbeing survey that we are currently administering has a module about suicidal ideation, and those results will be forthcoming. The panel is just a little bit early for me to present facts and figures on an evidence base currently for veterans in Northern Ireland.

There is one thing I do want to make a point of, in terms of the psychological wellbeing survey. Again, in the cohort surveys, King's can say that their results are representative of the population, because they know the total population of the in-service personnel. When we do surveys with veterans that are exactly the same as the King's survey—we even use some of the same measures—we will not be able to say that that is representative of the total population of veterans in Northern Ireland,

because we do not know what that total population is, so we cannot, for example, calculate weights in our data to ensure that our results are representative of the population.

When we do produce these facts and figures, we always have to keep that caveat in mind as well. It will set the context, but it will not be representative of the whole veteran population, because we do not track the veteran population well enough to allow us to do that.

Dr Abraham: The suicide rates as well are linked with engagement, stigma and barriers to accessing services. It is interesting that when veterans presented a few years ago, they would not declare a mental health problem. They would come in talking about welfare concerns, but it would not be until later that they would share their mental health concerns. Now, at point of registration, we see them saying, "I've got some mental health problems." They are much more open about that from the beginning, which means that they are accessing services and getting the help that they need.

- Q84 **Martin Docherty-Hughes:** Let's look at gaps in data and research, if we can. I will try to put in two segments quickly. Currently available in your remit and how it reflects across the whole of the UK, including England, are there any data sets or methods of collection—I include qualitative methods of collection, not just quantitative—in particular nations that you would recommend to others to collect? To what extent do you think that existing data sets in quantitative under or over-report mental health disorders as a result? For example, if they rely on people coming forward to seek help and identify themselves as veterans.

Dr Bergman: In Scotland, we are very fortunate, because the NHS central registry database actually contains the date of joining the armed forces, if people joined, and the date of leaving the armed forces. That information is available with appropriate permission for research purposes. It is not made public or provided to the GP and I think there are some good reasons why it shouldn't be. All GPs when they are registering a new patient in Scotland ask the question, "Are you a veteran and when did you leave?"

- Q85 **Martin Docherty-Hughes:** Does that include Reservists?

Dr Bergman: The question is, "Are you a veteran?", so it is up to individuals whether they identify or not and how they interpret it. Reservists are an issue, because unless they have deployed operationally—even they do not necessarily de-register from the NHS—they will not appear on the NHS central register. As far as the health study was concerned, Reservists could not be included on that. That is one of the major gaps. I would strongly recommend that in the next census there is not only the question, "Are you a veteran?", but also, "Were you a Regular or a Reserve?", and, "How long did you serve for?", because that will help us identify where the risk areas are within the community, these being very much concentrated in those early service leavers. I would also strongly recommend that we move towards routine reporting of veterans'



data, just as we routinely report on the incidence of different conditions within the wider community, always within the constraints of privacy.

Professor Armour: One part of your question was about whether the surveys we are currently implementing are accurate, as they may attract certain respondents. You are correct, in that if we do a survey about psychological wellbeing, it is quite possible and plausible that we will attract help seekers to that survey. This also comes down to the way we recruit to those surveys. If we use the assistance of our service providers, and the service providers push the survey out for completion to help seekers, then we will have a help-seeking population answer that survey. It is the responsibility of the researchers implementing that survey to make sure that we recruit as broadly as possible, and that we do a lot of public engagement in trying to engage with members of the public who are not currently help-seeking. This is a caveat of the interpretation of those surveys' end results.

- Q86 **Martin Docherty-Hughes:** If I could turn to Doctor Kitchiner specifically, does the data collected help address some of the gaps? What are the barriers to collecting further data, again throwing in the issue about the lived experience and the non-qualitative process? If you are looking at a student coming forward and doing a study on the lived experience, for example, of older female veterans as to why there might be higher incidences of suicide, that might also add to the data knowledge.

Dr Abraham: A PhD study was done looking at transition for veterans and what makes a good transition. Again, it is the issue of seeing help seekers rather than those that are very well. It would be useful to do a long-term study to look at those currently serving and following the individuals up in that way, and seeing what factors make a good transition back to civilian life post-military.

Dr Kitchiner: It is a real problem to ask veterans to identify GP practices. As we know, a lot of veterans do not see themselves as veterans; they see themselves in a different form. That is difficult for good data collection. I would endorse the Royal British Legion's "Count them in" survey for their ONS update. That is a good step in the right direction and we should support that. The Anglia Ruskin University hub is being pushed as a resource and depository for research, PhD studies and master's studies. It would be a useful direction to go in if those to be stored and kept for future research opportunities and data.

- Q87 **Martin Docherty-Hughes:** Would you agree that a bit of qualitative research in how we can use the lived experience to improve service delivery is also important?

Dr Kitchiner: I think that, as researchers, we should try to have a mixed methodology.

Martin Docherty-Hughes: Yes, I get concerned that it becomes statistically focused, whereas the lived experience is also important.



Dr Bergman: Research is currently going on at one of the universities looking at why some veterans do well, which is an interesting twist. Most people look at why veterans do badly.

Professor Armour: In Northern Ireland, we produced this report, “Current and Future Needs of Veterans in Northern Ireland”, which is essentially a large-scale qualitative study in which we conducted 13 focus groups with between five and eight participants in each focus group. We also interviewed 20 service providers. We asked them about their current needs, barriers to support, what their needs might be in the future and what the organisational challenges were. We cannot undervalue qualitative research—it is fundamental.

To go back to Neil’s point—that a mixed-methods approach is always the best—that is what we have been doing in Northern Ireland. From that qualitative piece of work, we found that the main themes that were coming through in terms of current needs were mental health needs, accessing mental health services and the stigma that participants felt was associated with disclosures of mental health conditions in military culture. For the future, mental health was again a core need, as was accessing services, and also long-term investment in mental health services and worries about funding. Some of the organisational challenges came to mental health support and delivery, to how we are supporting the mental health of the families of the veterans, and also the interaction between service user and health professional. We learn a lot of information about the context of Northern Ireland from qualitative work, so it is very, very important.

Dr Abraham: There have been some nice qualitative studies done and it is good to have that mix. In Veterans First Point, each area had a focus group as well, to design and respond to local needs. Similarly, it was coming up with themes about accessing services, about having different services co-ordinated and about having a service that understands their needs and the language that is used.

Professor Armour: Our whole programme of research in Northern Ireland is based on a very initial qualitative study we conducted with veterans, asking the basic question, “What is it like to be a veteran in Northern Ireland?” From the results of those initial focus groups, we designed a four-year programme of research around answering those questions. That is a testament to the strength of qualitative work, but qualitative work is never representative of your overall population, so you cannot generalise the findings to the entire population. That is where you supplement with the quantitative work, in exactly the way our studies have been conducted.

Q88 **John Spellar:** I have just an observation: surely there must have been work done, post the second world war, when huge numbers of veterans were sort of dumped back into the community and adjusted?

Dr Bergman: Surprisingly not. In fact, the Scottish veterans study starts with veterans born in 1945, simply because you do not get a good control



group before that. Up to 1960, the vast majority of the male population of that particular age had military service and the only group who did not were those who were either in reserved occupations or were medically unfit, so you do not have a group to compare them against. Post national service, with people who served after 1960, you start to get equivalent groups in the population—of people who served and people who didn't serve—and you can look at their experiences in comparison with one another. Everybody had that shared experience—even the civilian community had experienced bombing, food shortages and the separation of families—so there was really nothing done until the Americans started to look at the Vietnam war veterans and the Australians looked at the Korean war veterans. Also, this was to do with the growth of computing power, because to get the statistics on these big population groups you need some serious calculations, and until we had the computers that were capable of doing that statistical analysis, the sheer workload of working out the maths was prohibitive.

- Q89 John Spellar:** But that would seem to suggest, therefore, that it is not about the military experience that might impact on people's health but about the selection of those who join the services, which would turn down quite a different route of research.

Dr Bergman: It is multifactorial. I do not believe that you can ascribe a mental health outcome to a specific incident in somebody's life. It is the full life course. It is experiences they have had in childhood. It is how much resilience they have—how much innate resilience. It is selection for military service. It is what happens in military life and it is what happens after military life as well, which can include relationships, finances and employment. It is multifactorial. There may be, within that, a specific military stressor or, equally, military life may have provided a stability and a resilience. For the veterans, what characterises them is that, as a veteran, with that one day of service, they are then entitled to a specific level of care and commitment by the community.

- Q90 John Spellar:** I think that may lead to some interesting thoughts. We seem to have a lot of different studies taking place in different areas and some degree of disconnect between those. Are there problems with that and the ability to match data and to draw on the different studies? Are there restrictions about the use of data? There seems to be some indication of that with regard to whether GPs are told whether people have had a certain military service.

Equally, within systems, is the Ministry of Defence system of use and is it restricted, and similarly with the NHS? Are we having a lot of cottage industries going on here, and should we have some degree of industrialisation taking place?

Professor Armour: In the context of Northern Ireland, we are at a very early phase. Prior to us commencing our programme of research, there was no formal academic research happening in the veteran population in Northern Ireland. The reasons for that were because the veterans in Northern Ireland essentially were regarded as a hidden, hard-to-reach



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population, because of the fear of disclosure of your military affiliation and your veteran status.

We commenced this piece of research and were told initially that we would find it very hard to engage with the population, but we have had many successes. We have not really had any difficulties with recruitment, because there is a paradigm shift in terms of the veterans in Northern Ireland wanting their voices to be heard, so they are engaging with us very well.

As a result, several other teams of researchers are now coming in to Northern Ireland and conducting alternative and complementary studies of veterans in Northern Ireland. For example, we have teams coming in from the “Call to Mind” report. We have another team coming in from King’s College, London and a funding application that is under review. So a lot of pieces of work are born from the work that we have done.

We feel that we have opened up the population of Northern Ireland, but it is a very early phase. The ideal situation would be to do a large comparative study of England, Scotland, Wales and Northern Ireland using the same measures, the same methodology, the same questions and interview schedules, because sometimes it is the tiny differences, even in the way that you ask a question or the measure that you use that makes it difficult to compare across the various England, Scotland, Wales and Northern Ireland. We need to get together and we need to standardise the methodology. Neil and I are involved in a larger-scale project where we are doing this on an international level and working with colleagues from Canada, Australia, Wales and Northern Ireland. We are trying to do an internationally comparative study and we need to replicate that for our own home nations.

Dr Bergman: When I first joined the Armed Forces, it was always said that as a member of the Armed Forces you tacitly gave up some of your rights to confidentiality. At that stage, in the 1970s, it was relatively easy to do research. Since then, we have had progressively more stringent levels of protection for personal data. We have had the various Data Protection Acts, we now have GDPR, we have various ethical standards governing research. There is no doubt that it is becoming very challenging to access datasets and particularly to join them up. In an ideal world, it would be wonderful if we could join up the MoD records with the NHS records and social security records and read across the picture. I am afraid I don’t see it happening any time soon.

Dr Abraham: The Wales project and Scotland were part of six pilot sites at the beginning—for that reason, to compare them. But as services developed they took very different paths and it makes it more difficult to compare.

Dr Kitchen: In Wales, we have the National Centre for Mental Health based at Cardiff University, which is a biobank collecting DNA data, which our veterans are encouraged to take part in. That is for all mental health disorders. I think something like that could be very helpful. We are also



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involved with our Dutch colleagues on a novel treatment for PTSD, the only randomised control trial currently under way in the UK.

Q91 **John Spellar:** How do the Dutch get round these problems?

Dr Kitchiner: I don't know.

Q92 **John Spellar:** We know they have a national database because you have to register within three months of moving into a locality. The Dutch have a compatible system in each local authority, so de facto they have a national database that covers all sorts of other areas—car registration and so on. If they can work under GDPR and all these other European regulations, how is it not inhibiting them and it is inhibiting us?

Dr Abraham: That is a very good question.

Q93 **John Spellar:** Well, as you are working with them, could you ask them and do us a note on that?

Dr Kitchiner: I sure will.

John Spellar: Thank you very much.

Dr Bergman: It is a great pity, a great missed opportunity, that the UK Biobank—the major study—did not have a question on military service. We do not know who the veterans were within that enormous dataset.

Q94 **Johnny Mercer:** I just wanted to touch on—you have touched on it briefly—this issue around those who serve and then look back on their time in service and attribute mental disorders to it. Does the military environment help to prevent the development of mental health disorders, or do you think it makes it worse?

Professor Armour: There is no clear answer to that question, because psychological disorders are born from a multitude of factors. Those factors can be things that have happened to an individual during the course of their childhood or things that have happened to them during the course of an occupational role or, for example, from the lack of social support. All these things have a contribution to somebody's risk of subsequent mental health disorders. In the field of psychology and psychological trauma, we will never be able to say that one particular event is the sole cause of one particular mental health outcome, be that military service or an event that happens in childhood. Indeed, two individuals can have the exact same trauma history, but all the surrounding factors, like their social support networks or whether they have managed to maintain an occupational role, can differentiate between their psychological outcomes.

Q95 **Johnny Mercer:** Okay. What do you think, Dr Bergman?

Dr Bergman: Serving in the military theoretically, and practically for many people, is positive towards your mental health, because it provides a stable environment, training, education, a supportive peer group and leadership—all the things that are very mental health-positive. We see from our study, which looked at mental health in relation to length of service, that, in general, the longer you serve, the better your mental



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health. The worst outcomes were in the early service leavers; the best outcomes were in the people with the longest service. People often do run into difficulties when they leave the armed forces, especially if they have had a very disrupted early life. They join the armed forces, they may well serve for a significant length of time, with all the benefits that that brings, and then they leave, and unless they move into an equivalent environment that provides that sort of support, they may find themselves at sea.

Johnny Mercer: Thank you. That is helpful.

Dr Kitchiner: I will just draw on my own experience of deploying on Herrick 19 as part of the field mental health team. When I went to deliver a peripatetic clinic in MOBs and FOBs and in other bases, it was quite striking that the guys who were happy to come forward and talk to the mental health team were guys who had enlisted pre-2006, who had had TRiM embedded into their battalions and had had lots of psycho-education pre and post-deployment. TRiM has been very helpful for help-seeking among certain personnel. It is a real good initiative.

- Q96 **Johnny Mercer:** You have talked a lot about this veteran having one day of service, and about the shorter their service, the increased propensity for a mental health problem. Would any of you support changing that definition of veterans? I would, if it helps.

Dr Abraham: As a service provider, I think that those numbers are relatively few, but they have the largest demand on our service in terms of provision. Particularly for the veteran peer support workers, it is a difficult relationship.

Dr Bergman: I would set the bar at the end of phase 1 training, after the expiry of the "discharge as of right" period and at the point at which you become a trained soldier. Lucy is absolutely right. That group of very early service leavers skews our statistics very, very significantly. The general public see a veteran as a veteran, and tend to think of combat. That group, who are very much at risk, are at risk from their past life, not what has happened to them in their very short period of military service.

Dr Abraham: If you think of those people who choose to engage with a veteran's service when they have only engaged in the military for one day—

- Q97 **Johnny Mercer:** I personally think it's nonsense. It completely skews the figures, and it means that a lot of our resources are going into particular places when they could be better used elsewhere. That is my personal view. On families and partners, do you have anything to say on the effect of the military mental health aspect? Maybe you saw it during your time on Herrick 19a and the effect it had afterwards on people who served and their families.

Dr Kitchiner: It is crucial that veterans' services try to engage with significant others. In Wales, we invite the veteran and their significant other to come to their first appointment, to gather some information from

the informant and also to engage them in the care of their loved one. But we are not funded to look after families, and that is a real missed opportunity.

Dr Abraham: That is something to consider when comparing different areas: who they see and what the referral criteria are. We do have carers groups and we also invite them to the first session—that is good practice—but we do not get that many referrals of family members. They tend to want to go elsewhere.

Professor Armour: We literally just spoke about defining the veteran. There are also difficulties with defining the veteran family. What is a veteran family? Before we can really understand the impact it has on families, we need to know what we mean when we use the terminology of family.

Q98 **Johnny Mercer:** What about you, Bev?

Dr Bergman: I absolutely agree. The difficulty is identifying the veteran family, especially nowadays, when families are perhaps not quite as conventional as they used to be. You may well have a partner who joins the veteran some years after their service, but none the less may experience some of the consequences of their mental health problem. There are some real complexities there that need to be teased out.

Professor Armour: From our qualitative work in Northern Ireland, where we asked our veterans, “What’s it like to be a veteran in Northern Ireland?”, we were often brought back to family and the support system that family provides to the veteran. That is a fundamental piece of work, to understand exactly what it is like to be a family of a veteran and living in Northern Ireland under that social and political context.

Johnny Mercer: Thank you all very much for what you do for service families.

Chair: Thank you very much for coming here today. We will switch over panels as briefly as we can. By all means, if you are interested in staying to observe the second panel, please feel free to do so.

Examination of witnesses

Witnesses: Karen Mead, Rod Eldridge and Dr Walter Busuttil.

Q99 **Chair:** Welcome to our second panel. Numbers are a little bit reduced on the Committee itself because, as you may have seen from the Annunciators, there are a number of urgent statements and other matters coming along. People will be coming and going, but we will stick to the broad guidelines with which you have been issued. Can you kindly do the same and introduce yourselves briefly for the benefit of the record?



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Karen Mead: My name is Karen Mead. I am the clinical lead and the national head of psychology at Help for Heroes.

Rod Eldridge: Rod Eldridge. I am the clinical lead at Walking with the Wounded. I also provide some consultancy advice to Big White Wall. I served in the military for a good while as a nurse consultant, including eight operational tours.

Dr Busuttil: I am Walter Busuttil, I am a consultant psychiatrist. I served in the Air Force for 16 years. I joined as a medical student, I qualified as a general duties medical officer and then I qualified as a psychiatrist. I was involved in the Beirut hostage retrieval and the setting up of the Gulf War rehab services. I left the Air Force 20 years ago. I spent 10 years working with adult survivors of sexual abuse and I have been the medical director at Combat Stress for the last 11 years.

Q100 **Johnny Mercer:** Dr Walter, if I can come to you first, do the MoD and NHS statistics on mental health disorders in serving personnel and veterans reflect what you feel you are seeing on the ground at Combat Stress and more generally across the pitch? Do you think the campaigns and awareness are working? Obviously, you have these competing pressures. What is the picture from where you are sitting?

Dr Busuttil: The Government data and particularly the King's data are epidemiological data, so that is the whole population.

Q101 **Johnny Mercer:** What does that actually mean?

Dr Busuttil: That means that you are serving a population, taking a sample. We see help seekers primarily, so we see the tip of the iceberg: people looking for help who really are in dire straits. We have seen many more coming forward. One year recently, I had a 26% rise in people coming forward, and it's been really year-on-year. When I joined Combat Stress in 2007, there were around 996 new patients coming forward; last year, we had in excess of 2,600, which was an increase of 250 or so over the previous year.

What is interesting is that younger veterans are coming forward more quickly. We have looked at era veterans. On average, for a Falkland veteran or a Gulf war veteran or a Northern Ireland veteran, it is still around 14 years after they leave the military. For Iraq and Afghanistan, it's much lower. It's two years for Afghanistan after they leave the military and it's about three or four years for Iraq veterans. That reflects better knowledge, better education, less stigma, more education in the military and people really wanting to access care and get better. Having said that, 80% of the people we see have tried to get help from somewhere else, usually their GP or the NHS, but for some reason they come to us because they are still not well.

Q102 **Johnny Mercer:** Eighty per cent of people who come to you have already tried the NHS?

Dr Busuttil: Yes, they have tried the NHS or the military mental health, but that's quite a statistic.

Q103 Johnny Mercer: Rod, what's your view?

Rod Eldridge: Some of what Walter said I already agree with. We are a small charity and we have a small mental health programme called Head Start and we are there to complement current provision. We're a military front door, so we're culturally sensitive and we look to help anyone who comes our way in an ethical way, so that the support we provide is likely to have a meaningful outcome. We don't just take on anybody, but I think the figures that we see are not wholly reliable. Somebody mentioned earlier about the qualitative side of it. It is not just facts and figures. There are many reasons why people go to ground, why there is a tip of the iceberg. Much more could be done around the literacy of mental health understanding for those in that need and those who provide that service. For me, those are key areas that would help us get a more accurate figure than those who are maybe not coming forward.

Karen Mead: Obviously, what the panel has already said, I tend to agree with. I am concerned, I guess, at the comparison in existing MoD statistics, particularly around prevalence of PTSD at 0.2%, when you compare that with the international literature. My experience working with the Canadian and Australian armed forces, as well as my work previously involved at Combat Stress and at Help for Heroes, all indicate that the need is higher than that 0.2%.

Q104 Johnny Mercer: Can you just expand on that? When you talk about a prevalence of 0.2%, what does that mean to the layman watching this?

Karen Mead: Essentially, if you do a comparison of existing service personnel and the rates reported between different countries, the UK is reporting that it's 0.2%, Australia is reporting it's 8.7%, Canada's reporting it's approximately 6% and the US is reporting it's 12.6%. That is in the serving population. It is much higher among veterans. That is consistent across international experience.

Johnny Mercer: Currently the MoD have a figure of 0.2% of service personnel with PTSD.

Karen Mead: Yes.

Q105 Johnny Mercer: Have you challenged them on that?

Karen Mead: I have been in post for six months, but I believe our lobbyist Robyn has absolutely challenged them on that.

Q106 Johnny Mercer: Any idea of what the comeback has been? If I was somebody at the MoD and I saw that, it would not take the brains of an Archbishop to work out that something is not going right in terms of recording, or whatever it is.

Karen Mead: Sure, but one of the key things to point out is that the prevalence in the MoD statistics is based on those coming forward and presenting for treatment at DCMH centres. The statistics coming in more broadly—particularly the Canadian and Australian studies—are actually looking at a cross-section of the population. They are not only surveying



those that are coming forward for help, but are also surveying those that are not coming forward for help. The design of those studies is both confidential and anonymous, so there is a strong degree of safety in fully reporting your symptoms because it is not linked to potentially being discharged.

Rod Eldridge: You may know from your own experience that a lot of people keep their stuff together and will appear very well, and they will manage because they worry about the effect on their promotion and their career progression, and how their colleagues will judge them and whether they would be able to deploy. Quite a lot of people will mask their problems until they leave because they want to leave honourably and get it right. After they have left, when you lose those highly protective factors mentioned earlier—you are fed, you have a roof over your head, you have a sense of belonging, a bond and camaraderie—you lose that sense of identity and belonging. It is a kind of grief and adjustment. People will come forward and say, "Hey I am really struggling." That may manifest as PTSD linked to serious or trivial conditions or traumas.

Q107 **Johnny Mercer:** Are there particular risk groups? I remember King's College did a study around looking at prevalence of PTSD, and found a 1% increase for those who had served in combat in comparison to those who had served. I think that was about two years ago. Is there any maturity of that data? Do you have anything to add to that? Are you noticing any specific groups in this around the UK itself, whatever that may be?

Dr Busuttil: For help seekers who are the illest—and usually have a combination of severe PTSD, alcohol problems past and present and depression—combatants are usually the worst ones. Those are the ones that access our most intensive treatment programmes. Combatants account for around 75%, then there are medics, nurses and the people you would expect. I would be surprised if the new King's study—which hopefully will be published very soon—does not show some reflection of that. With particular activity during a deployment comes much more vulnerability. We see the usual people: helicopter technicians who have been to the front line many times, medics who have been there many times. There has been always been a shortage of these trades, but combatants particularly.

Rod Eldridge: From our charity's perspective, we see a degree of complexity, and that has already been alluded to. We do not just look at people from a medical model, we look at the psycho-social aspects. We see people getting caught up in the criminal justice system and see them in police custody suites where we have some resources now to ask the question, "Have you served?" We have staff and employment advisers in military homeless residences, and we are now looking at individual placement support training and staff in certain teams, like the NHS England mental health teams. We see that it is not just the illness side of it; we see that it is about social inclusion and the stabilisation and integration.



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Q108 Johnny Mercer: Do you see a differentiation between the roles that individuals have taken on in their service and what they are representing?

Rod Eldridge: Again, as Walter said, we know from various studies that specific groups such as medics—particularly female medics—and those on reserve service have a healthy worker effect. Those that only serve for a short period of time see that it is not very nice and leave. Some people may serve and do 6, 7 or 8 tours because they are okay with it.

Q109 Johnny Mercer: What about you, Karen?

Karen Mead: Something that has not already been mentioned is the increasing risk of PTSD found internationally, based on frequency of deployments—so, the number of deployments. That is not consistent—I know there has been some disagreement within UK studies—but Canadian, US and Australian studies have recorded that if someone has done three tours or more, they are at an increased risk of PTSD specifically. That is important to think about in terms of directing service provision.

The other risk group is Reserves. Quite a lot of research indicates that Reserves are at increased risk of alcohol abuse. They are also at increased risk of PTSD—in fact, they are twice as likely to get PTSD following a deployment as a Regular is.

On the earlier comments about the degree of combat exposure, that absolutely holds up within my clinical experience, as well as what the literature says, particularly if people are in forward operating bases and things like that.

Something that has not been mentioned is their view around the leadership they experience while in service. Individuals that felt that about their leadership while they were serving or how their transition was managed are at increased risk for mental health disorders. I am getting away from using this kind of diagnostic label, but they are also at increased risk for psychological distress, which is a broader way of looking at people having difficulties with their functioning, because of the change that has taken place, whether through their service or their transition.

Q110 Johnny Mercer: When is this study due out from King's?

Dr Busuttil: It is imminent. Simon Wessely said it was imminent at his last appearance here.

Q111 Mrs Moon: From your experience, how much are we seeing the factors influencing people coming forward and the variation in the mental health problems that they are facing? For example, have you looked at issues relating to poverty, women's service and whether there is a difference between women's experience of serving in the forces as opposed to combat experience, or, thirdly, age of joining and age of experiencing combat? Have those been looked at, and do you have any comments?

Dr Busuttil: To answer all three, we have done a social deprivation study across the UK. All our recent publications are on our website—just click on



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"Research". We found differences in the different countries that form the UK. I think you are more likely to be socially deprived if you live in Scotland, next is Wales, then England and last Northern Ireland.

Equally, with women's service, we tend not to see many women in our clinical services—only 3%, which does not reflect the 9%, 10% or 11% that are now serving in the military. The 3% that we do see come in three categories. The first have childhood trauma and usually have personality issues. The second have been harassed in the military, maybe sexually. The last third are nurses and medics who have been to the frontline. Our service suits these much better. Of course, we try to help the others, but we are not a bespoke service for that kind of category.

As far as age of joining is concerned, we have done a big needs study. We are going to publish about 11 papers this year. One of the papers is going to be about early service leavers. One-fifth of our population are early service leavers. However, they are people who have not joined just for one day; they have probably been deployed once and left before their four-year contract is up. Age of joining is quite important, and we are going to look at that.

We don't know which areas all these early service leavers are from—so, which wars—but obviously that would be very interesting as well.

Q112 Mr Francois: Karen, in terms of prevalence of PTSD, I seem to remember that the King's study had about 5% or so for Regulars and a little higher—6% or 7%—for Reservists. I think that is a bit nearer the international comparisons. The Americans have much higher numbers, often ascribed to the fact that they do longer tours, without necessarily a break in the middle in the way that we do. That is my recollection of it, anyway. You said that 80% of the people who come to see you had already sought help in the NHS.

Dr Busuttil: Yes, or somewhere.

Mr Francois: And clearly that hasn't worked for them, and then they end up coming to you. One area that the Committee would be particularly interested in is: where is the NHS system falling down? Where are the weaknesses, where is it failing these people, and what can be done about it?

Dr Busuttil: We haven't looked at this very carefully—they are mainly clinical audits that we repeat year on year. Primarily, it is about engagement. It is about people understanding what a veteran is, how they tick, and what they are actually describing in terms of their symptoms. So, what we have is a lack of education in relation to general practitioners and mental health workers, including psychiatrists. We also have a lack of clinical services, so that a GP, if he does suss out that this guy is a veteran with possible anxiety, depression or PTSD, will send him to mainstream services primarily—and that is yet another hurdle for the veteran. No matter how much money you invest, even if you invest millions and



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millions, if people fail to engage, you have wasted that money. So I think engagement is the biggest issue.

Then there is treatment completion. People have to stay the course, so your service has to be user-friendly. We have very high completion rates in our biggest six-week residential programme. We had a dropout rate of 4% on average for the seven years that it was running. People were prepared to come in to the programme, and we did a lot of stabilisation. We are very user-friendly. We have a telephone helpline, a triage system, people in the community—so it is very encouraging.

I think that, essentially, the levels of knowledge in trauma, just PTSD in the NHS, are not high. There are not many bespoke traumatic stress services left. There used to be services for refugees, which were quite common; now there aren't so many. So the actual level of training is not high. Rod and I, and representatives from Help for Heroes, have done huge roadshows, along with a general practitioner from the Army, Colonel Julian Woodhouse. We have tried to educate as many GPs as possible, but there are 33,000-plus GPs and we have only managed 6,000 so far. I have run courses for psychiatry as well. So education is really critical. People will say, there are the e-learning bits and bobs for the Royal College of Psychiatrists and the Royal College of General Practitioners—I helped to write the initial drafts and we do a lot of campaigning for that, but usually it is between 3% and 6% of those specialists who read the e-learning and usually they have a connection with the military. So, we are failing somewhere to actually bridge that gap and make it much easier for veterans to access and then complete treatment.

Q113 Mr Francois: I will come to your colleagues in a moment—I do not want to lose your thread. When I served as a Minister in the Department, one of the problems was that we were partly dependent on the NHS. These were “our people”, but they left and became veterans who were reliant on an NHS service. A lot of the anecdotal evidence suggested that once people started to present—maybe there was a trigger event: they had been fine when they left and their exit medical had shown no problems, then their father died suddenly of cancer, for instance, which is a trigger event—it all came out very quickly, and they went downhill very quickly. Part of the problem seemed to be that, even when they were diagnosed, there was a delay in getting them treatment. Is that still the case today, or has it got better?

Dr Busuttil: Yes, in my opinion it is still the case. As medical director I get to see all the more difficult cases. I do tertiary opinions for NHS community mental health services and the letter to me would be: this psychotic, schizoaffective, disordered patient has declared that he is a veteran; maybe some of his symptoms relate to his military service. What you find, when you assess this person, is that he is psychotically depressed, true, but he has rip-roaring PTSD under there. He presents as being very mentally unwell and in need of the care of a CMHT, but all the medication is wrong—they have treated the wrong diagnosis. When you put them on the right track and help them with advice about medication,



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these people get better and eventually, finally, at the end of the journey, they might end up doing some psychotherapy and get very well.

My worry about services as they are planned at this point is that potentially we have very ill people who are not being diagnosed correctly at the front end, who are acutely unwell; then we have very ill people—these are the graduates, of course—who need very intensive therapy once they are stabilised. Those are the most vulnerable in the clinical pathway. We have various tiers of service in the NHS and our health services—very basic intervention and more expert, more intensive intervention—but all tiers need to be funded properly. That would be my view.

There needs to be proper education in medical schools. For example, the Royal College of General Practitioners has introduced a question in its membership exam about veterans and serving personnel's health. That is why we have had so much success in pulling in all these GPs for this education—a day, effectively—because it is part of their exam. The Royal College of Psychiatrists has not done it; we have it asked many times. Samuel Wessely was the president of the college. We still have emails today, in fact, to do yet another thing. There are all the specialties, and veterans have big problems—hearing loss, muscular-skeletal. All the colleges should be made by law to have a similar question in their membership exam, so that everybody will read a small textbook on military life and military veterans. When I was in the Air Force we had lots of hospitals and were very well trained. There was a big cadre of doctors who knew quite a lot about military health. Now there are not many doctors who have trained within the military. There are no real training schemes that rotate just through a military hospital.

Q114 Mr Francois: Thank you. You have given us a specific suggestion there, which might end up in our recommendations. We shall see. Rob, where is the NHS failing?

Rod Eldridge: I think, to set the scene again, these guys are very self-sufficient. It is part of the culture: you cope, you manage. I think that carries over into transition, if you like, where people can end in crisis, where they do not understand what a mental health problem is. They usually wait until they are broken, so they get an ultimatum from a judge, employer or a partner: sort yourself out or else. I think that the speed and quality of that response is really important. Linking in with what Walter said, it is the quality of that first encounter, that first experience. If you have been brave enough to put your head above the parapet and say, "I put my hand up: I give up, I need help" and your first encounter is with somebody who is not trained, who feels de-skilled or does not have the self-esteem and clinical skills to deal with these things, who says, "That is too complex for me. I have not really met that before. That's not within my training, but I know someone who can do it", often you have got to tell that story to yet another person, who may then pass you on to yet another person. What we hear of the veteran's journey is that it is one of being pushed from pillar to post. No wonder that people give up at some point and say, "Look, I have served my country, I have done my best, I deserve better: there is a military covenant", and so on.



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I reiterate that the quality of that first encounter is so important. If we really care about our veterans and want them to get over the threshold of getting quality help, we need to upskill our workforce, make good, reliable assessment and provide good care afterwards, which these people deserve.

Q115 Mr Francois: That first encounter will not always be with a GP, but it will often be with a GP.

Rod Eldridge: Ideally, from the Government's point of view, we would like that, because there is an audit trail of that medical support. I think that is where the charities will work under contact, now that we are working together, for an assured process in which we all work and communicate together, so that the pathway is much clearer and more logical, rather than—as arguably it has been in recent years—being a confusing place for these folk to navigate. Even the staff who work within them struggle to navigate them. I think this is time for a very clear pathway, using the NHS at its root, providing that that is well resourced and well staffed and we have confidence in it. Maybe the charities could step back a little bit if that were the case.

Karen Mead: To go back to your point, the 0.2% that I was talking about was the MOD stat—

Mr Francois: Yes, I am very clear on that.

Karen Mead: Absolutely, a lot of individuals come to us at Help for Heroes who are talking about feeling let down by their first contact with NHS service providers. I very much agree with the comments made by Walter about how many have indicated that they have already tried to get help through mainstream services before they try to access support from the charity sector. That in itself is a bit of a concern, if there is a sense that they have been let down by the statutory providers.

Rod has just talked about the fact that each of our organisations is involved in the contact committee. I think there have been significant inroads in the last six months, particularly being very clear about having a clear pathway so that it is less confusing for veterans when they leave service. Previously, it has been incredibly confusing which organisation provides what. A lot of work is currently being done looking at plain-language information, so that a veteran can go online and go, "Right, this is where I need to go." Most of the time they will be signposted there by an NHS provider initially.

One of the key areas where I think NHS provision is not adequate is the model of care, by which I mean the duration of access to care, particularly for those individuals who have very complex needs. The ISTSS treatment guidelines, which are most commonly considered among clinicians to be a set of guidelines that look at working specifically with complex mental health presentations, talk about more like a two-year model of care. The new emerging complex treatment services that started on 1 April provide an eight-month point of contact for those with complex needs. You do the math—that will potentially not be long enough for those with complex



needs, which is the area where the charity sector quite often steps in to pick things up.

Often we will see individuals coming to us who have a mental health need—87% of the beneficiaries engaged at Help for Heroes have some form of mental health need, but only 40% of those are putting their hands up specifically and asking for help. There are also some gaps there, in that there is a need, but not everybody is directly seeking help. Sometimes they are more comfortable seeking help through engaging in social activities, getting a job, or learning a sport—building their self-confidence or self-esteem. I think it is important to flag to the Committee that not all mental health support has to be hard-hitting clinical psychology/psychiatry. There is really effective intervention and support that can be done through the softer side of things—looking at someone's overall functioning and wellbeing.

Mr Francois: Your organisations are doing God's work as far as I am concerned. You do marvellous work to supplement what the state provides. One of things the Committee really wants to understand is how what the NHS does could be better focused for these people. At the risk of tasking you, perhaps afterwards you could all drop us a brief note with your key suggestions on how the NHS could do this better. I think the Committee would find that extremely helpful.

With that, I am going to dash off to the Chamber, because there is a UQ on Capita and I want to ask the Minister a question. Forgive me if I do the politician's thing of asking you lots of questions and then disappearing, but it is no disrespect. Is that okay?

Chair: Thank you, Mark—well done.

Q116 **Gavin Robinson:** Can I ask you about regional variation? I know you will have heard an awful lot about it in the last session. Obviously, I come from Northern Ireland and have a Northern Ireland-specific focus on these things. I am sure you were, as I was, struck by the comments of Professor Armour about the distinct difference of serving in Northern Ireland and then residing within your field of operation—your operational theatre—and the difficulties when you are conditioned through service to recognise and deal with threat, but then retire to civilian life with exactly the same surroundings.

I would be keen to hear what you have detected through your service users about regional variation in their experience and their diagnosis—whether you have detected a variation in diagnosis according to regions. Also, in terms of access, do you find that there is a regional variation in access of your services? Do you find that those who access your services tend to be located close to where you are located, or do you have an even spread throughout the United Kingdom in the service that you provide?

Rod Eldridge: I am happy to pick up on Northern Ireland. I am acutely aware of that, having served there for a few years myself. As a relatively new charity we have tried to grow in an assured way, with evidence that



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what we do is actually supplementing and supporting, not duplicating and confusing. I think that with Northern Ireland there is that sense around this that the sensitivities and the seriousness of embarking into Northern Ireland without really being assured that what you are doing does not put anyone at risk is really pivotal.

I have spoken with Professor Armour, and we are currently scoping services in Northern Ireland, of which we have heard there isn't a great deal that is statutory. For the UDR and the Royal Irish Rangers and Regiment there is an aftercare service, which we see as our first point of contact because there is funding to support that, and they have the assurance that what is provided is safe and secure. That said, they have limits and they want health-based support. They would have liked it from the statutory provision, but they say that in their experience it isn't very good and they would therefore like us to be involved, hence Walking With the Wounded are currently scoping what provision is going on in Northern Ireland and where we can fit in, again mitigating those risks. We need to be aware that it is not just for the clients who are accessing that help; the therapists themselves are worried about what starting to see veterans means for their own risk.

I know that Help for Heroes reach into Northern Ireland. We have regular weekly conversations on the work that has reached into Northern Ireland and we have taken a number of referrals from Northern Ireland, but we are testing the water, quite literally, to see how that goes, often using Skype therapy with somebody in the UK to reach into Northern Ireland. We do have a few Belfast-based accredited therapists who we see as being sufficiently clinically competent, assured and safe to work with us, but it is early days.

Dr Busuttil: We have published a paper, which you could read if you clicked on to our website. By the way, our research department is linked to King's as well. Compared with the other countries, in Northern Ireland veterans tend to be older, experience less childhood adversity, join the military after the age of 18 and take longer to seek help. In addition, they have higher levels of obesity, sensory problems—sight and hearing—and mobility and physical systematic problems. They are iller from a physical health point of view, but there are no differences found in mental health presentations across the nations. This was a study conducted with 403 veterans.

I spoke to my consultant psychiatrist in Northern Ireland yesterday. At the moment we are desperately looking for a psychologist—we have a vacancy. We have limited funding. It is only 12 months' funding. We are very unlikely to appoint, because nobody is going to take a 12-month post. We do not have enough money to cater for it. We have two community psychiatric nurses, one occupational therapist, one manager, a couple of admin staff and a consultant psychiatrist there two days a week. They are extremely busy. We have a long waiting list for therapy in Northern Ireland if it is going to be done on an out-patient individual basis. People who need residential treatment go to Hollybush House in Scotland



for that. We can talk a little about that later, perhaps, including the Welsh veterans—I think you raised that question before.

At this point we are tending to see younger veterans who have served in Iraq and Afghanistan, which is a movement. When I first joined Combat Stress 11 years ago, it was mainly people who had served in the military because of the Troubles. By and large, we have an indigenous group—people who were born and brought up there. There are others who moved there because they served there and others who moved there because they met their wife-to-be.

Q117 Gavin Robinson: I do not want to frustrate any Welsh connection with Hollybush House, but I know constituents who have been there, and one of the things they will talk about is that isolation from their family and support network when they go. For some, there is a reluctance to go and avail themselves of the service entirely. Is that something you detect in the engagement that you have with individuals who might otherwise avail themselves of the service, had they had that support network with them?

Dr Busuttill: Absolutely. We need a treatment centre in Northern Ireland, but we have never had enough money to set one up. Our programmes are all manualised. They run in our treatment centres. We are increasingly moving them to a community basis as well, which will not necessarily be cheaper than running a treatment centre. Of course, you have to have a gravitas of expertise to deliver these treatments. Treatments for veterans with complicated needs require skill and a multidisciplinary approach—not just one psychologist or one nurse; you need to be a whole team doing it properly. Some people actually like the isolation of being out of Northern Ireland—they feel safer and more able to talk about their very serious problems, and things they have been afraid of do not remain huge mountains for them to climb. Others do want to be treated locally.

We have a project—we have just published two papers—on using a Skype-based intervention with cognitive processing therapy, which is an evidence-based intervention for military and rape victim PTSD. The outcomes are really good, and it actually can work for people who are quite unwell. We were a bit surprised by that. We will be looking at what other services we can deliver for people who cannot travel or who live in places that are far away. Ideally, we need more members of our community team, and it would be nice to be funded properly to deliver a proper service, but we are doing our best.

Karen Mead: Walter made a point regarding whether someone feels comfortable accessing treatment in Northern Ireland. One of the really valuable things Combat Stress is doing is allowing people to have access to treatment in Scotland. They can be sent to the Hollybush centre. Individuals who feel concerned about identifying themselves as a veteran and going for treatment in Northern Ireland can have a certain degree of anonymity. That is one of the key points to consider about Northern Ireland: there needs to be access both internally and externally, and there needs to be some choice around that.



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Internally, there is access. The Help for Heroes Hidden Wounds programme, which offers a mild to moderate level of intervention—we call it step 2—is available for those who served in Northern Ireland, as it is nationally, and can be delivered via phone or Skype. There is some provision through that programme, but I know that Northern Irish veterans consistently report that they are not sure where they can go to get help. They are fearful of identifying themselves as veterans, and we have already had some conversation about the fact that there is no provision for them to have any extra care because they identify as veterans. They get no privilege under section 75 there. There is a lot of work to do in Northern Ireland in particular.

Q118 Gavin Robinson: You are right in saying there are some who want to be treated outside Northern Ireland and have welcomed that. Are requests ever made and satisfied for familial support to travel with individual veterans, so that if a veteran is going to Scotland their support unit can be with them?

Dr Busuttill: Yes, we would accommodate a carer or a spouse—absolutely. We would make it as easy as possible if it were clinically indicated, of course we would, but there is a limit to numbers and what we can do. Ireland actually came top in our social deprivation study, so there has been a lot of investment in libraries, education and GP surgeries, but mental health is not good enough, really.

Q119 Gavin Robinson: On access, when you look at the prevalence surveys that tell you the number of individual veterans affected by mental health issues, do you find a disparity between those accessing your service in a given location and what that figure should be given the number of people affected by mental health issues?

Karen Mead: Regional variation is a good question. Our Hidden Wounds service in particular tends to map to the areas we would expect—the areas of largest veteran concentration. In my experience, they appear to be somewhat consistent.

There are particular areas where we are consistently aware that there are gaps in access or problems with access. That is part of the strategic grant funding that we have provided, which Neil Kitchiner referred to. It was identified that the wait times in Wales in particular were enormous—they were very, very high; I have had some reports of veterans in Wales recording that they have had 18 months on wait lists—so we funded three additional band 7 therapists. Help for Heroes has actually subsidised the NHS service provision to try to meet that need in Wales.

Pennine was another area that was identified specifically as having high wait times. With the addition of two therapy posts that we have appointed, the wait time has gone from 25 weeks to 13 weeks, which is still outside of the IAPT model of service delivery—it is still quite a lengthy wait. The south-west of England is another area where we have identified that the wait times are quite high, but there are more areas. Someone on the previous panel mentioned that the Scottish highlands is a particularly



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hard-to-reach area. The best way to reach people there is through digital platforms, phones, Skype and that sort of thing. Those are the specific areas we have identified as having significant need because of wait time.

Rod Eldridge: As I have already alluded to, we do not have that much going on in Northern Ireland, but when we do get a referral, they will be seen within 10 days of getting their consent and verification of service. They will get access to an accredited therapist who is skilled and assured to provide that service. That is what we provide nationally.

Q120 **Gavin Robinson:** Do you have other areas within the United Kingdom where you feel you could have a stronger presence? You cite Northern Ireland, but are there other regions within the United Kingdom where you feel your presence could be stronger?

Rod Eldridge: Sure. We always see that the NHS has priorities because of all the governance issues that we have mentioned. We want to work alongside the NHS, not be seen as working alone. We only supplement those areas where there are long wait times. You are asking about regional variations, but where we have got what are called transition, intervention and liaison teams and a good working relationship—it is contracted in one case—they are finding our swift help or offer of assistance useful. Often going from 12 to 18 sessions means we can start to go a little bit further than just wellbeing and mild or moderate things. That seems to be helping. That may answer one of the questions about how we can help the NHS. We can give you a note on that to elaborate.

Dr Busuttill: We are very, very busy. We get between 1,200 and 1,400 phone calls a month on our helpline. We will have two helplines. The new military helpline was extremely busy to start with, but I think that has petered out a little. I think the need is everywhere. We have had to close a residential treatment centre in the midlands—Audley Court. That closed as a residential centre. We have got a small community hub there, and we are going to develop more community services and maybe expand it if we get enough funding. Our funding stream from NHS England will stop in a few weeks' time. We will now have to raise 80% of our funding, which is quite a lot for a relatively small charity. We were concerned that maybe we would not be able to do all our outreach for the midlands, but maybe we will. For people who need residential treatment, we will do our very best to keep them funded through charity. Scotland is now the only Government that will fund us for residential and some community treatment. A contract for £1.4 million has just been renegotiated and extended for three years.

So far as your question is concerned, Mrs Moon, if a country decides not to pay us for our service, we will do our very best to fund that veteran through charity. That is what we have tried to do all along. I was not aware that there was a real mechanism to make Wales pay. I have never heard of Wales paying for a six-week programme.

Mrs Moon: There is not a mechanism. It does not work. It is only there in theory.



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Dr Busuttil: Yes. In the past we have taken all comers. With the English contract, there has been a lot of pressure on numbers. We have had to prioritise English and then Scottish veterans to ensure we have the numbers to keep the contract. Then it is all comers from Northern Ireland and Wales.

When I applied for national specialised commissioning, it was for this very small group of less than 500 veterans a year. Roughly 300 veterans a year need intensive residential help. I devised a rehab programme. It was borrowed from my Air Force programme by the Australians. It was embellished and worked on, and I then reimported that programme with a very good evidence base. Essentially, I asked for funding for 224 veterans from NHS England for national specialised commissioning. I applied in 2008 and got the money in 2011. Scotland also wanted to commission 32 places. I reckoned there were 32 Northern Irish veterans and 32 Welsh veterans who needed this every year.

Without funding, we are relying on charity. The need is still there. We are going to make it a point to do our best to continue to provide the same level of service on charitable money, with one treatment centre closed, as far as beds are concerned. So we're going down from 87 beds to 57 beds; we have done that already. And we will migrate some other programmes to the community and do our best to deliver them there. But it would be good to have a whole funding strategy.

With our six-week programme, if you look at the effect size—that is the level of improvement, both from a symptom reduction point of view and from a functional, relationship and outlook-on-life point of view—the outcomes are better than equivalent programmes in the US. We have very high completion rates, as I explained. The US has very low completion rates; 46% don't complete in the US. We are at least as high as Australia, which really is at the cutting edge; we're probably just better than the Australians.

We share our datasets with the US, Canada and Australia. We know that our veterans are very similar to theirs, needing this. So there is world evidence in the literature as to the level of need, and if we don't have this properly in place then we are letting our veterans down.

Q121 **Mrs Moon:** There was a suggestion that the Welsh Government are now funding residential, from April of this year. Are you aware of that?

Dr Busuttil: I am not aware of that. Maybe I am the wrong director to know about that.

Q122 **Mrs Moon:** Perhaps we need to clarify that.

Dr Busuttil: Yes. It would be great if you could. Thank you.

Q123 **Chair:** We have about five topics left. Are all three of you still okay for time? We will try not to spread it out longer than we can.

To what extent do the public think that there are more mental health disorders caused by military service than there really are, and what are



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the reasons for the public thinking that?

Rod Eldridge: We heard from the previous panellists today, and before, that the public are, quite rightly, very anxious about the wellbeing of the citizens that do our country's bidding in active foreign policy. I think they are concerned that we send our folk away to do these things—boys go away and come back men, and so on—and that there is not enough provision, or the correct provision, for people in service and outside of service. I think that distortion is there because people really feel a need—our folk who appear to be affected are not getting that help.

The media, as we know, and other methods of putting this thing across kind of distort the real facts, and I think the public are fed a line that actually military service is, in fact, bad for you.

Q124 **Chair:** How big is the degree of distortion, do you think?

Rod Eldridge: A recent straw poll was really high—in the 90s, actually—on the idea that anyone who deploys will come back with a physical or psychological injury, which is far from the truth. We know the vast majority serve well, thoroughly enjoy it and have a life-enhancing experience, which they bring back to civvy street.

Q125 **Chair:** Are you all agreed on a rough overall figure for the extent of significant mental health injury to veterans?

Rod Eldridge: One other bit I would add is this business about PTSD. We have all mentioned here that there are a whole raft of psychological disorders relating to military service, and not to military service, and prior to service. I think it has become an acceptable term that is a badge of honour. For men—looking at the masculinity aspect of this—it is more acceptable to talk about PTSD than it is to talk about depression, anxiety, hysteria and so on and so forth.

I put in our submission that I think it is useful, because it gets people coming forward and recognising it; equally, we get a number of people not coming forward, because they feel they do not have PTSD and they do not have the badge of honour. It is not directly related to my operational service, because we know that 50% of PTSD does not occur on operations. So, actually, it may be a barrier to people coming forward, because they feel they do not deserve it because they have not deployed. I think that very careful use of the term PTSD by those who are qualified to make that diagnosis should be used.

Dr Busuttil: We are kind of the wrong people to ask, because we deal with this every single day. Look—92% of our veterans at combat stress or seeking help have served on at least two operations. Our rates of PTSD are very high—82%. We seem to attract—

Q126 **Chair:** That is 82% of the people who come to you?

Dr Busuttil: Yes, the people who come to us.

Q127 **Chair:** Just to be clear, we are saying that the public are over-estimating



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the degree of mental health injury that service personnel present with.

Dr Busuttil: Yes.

Q128 **Chair:** In that case, can the three of you give any sort of figure that you would all agree on that would be a truer reflection of the risk of acquiring a mental health injury in the armed forces?

Karen Mead: I can comment on the international rates. In Australia, of those who have been discharged from the armed forces, within five years, 46% have met criteria for a diagnosable mental health disorder.

Q129 **Chair:** Sorry, did you say 46% of those discharged?

Karen Mead: Yes, 46.4% of those that have been discharged from the Australian Defence Force. That comes from a March 2018 transitional study. Using a structured clinical interviewing measure—that is quite a robust tool—46.4% met criteria for a diagnosable mental health condition. For the Canadians, when they use a similar design, it is approximately 30% of their current serving members. When we look at the statistics specifically from the Help for Heroes Hidden Wounds service, around 40% are specifically asking for some form of support.

Q130 **Chair:** You used the word “discharged”. Is that people who left before they had finished their period of service, or just people who had left in the normal course of events?

Karen Mead: No; that is my Australian coming through. I worked with the Australian Defence Force. They have left, for whatever reason. They have not necessarily transitioned out for medical reasons. It may be that they have just completed their period of service and have decided to leave.

Q131 **Chair:** Sorry if I am coming at this from a layman’s point of view, but to be clear: looking at the United Kingdom armed forces, do we have a rough idea, for those people who have been serving in the last 20 years or so for a significant period of time, what the percentage odds are that they will have acquired a mental health injury?

Rod Eldridge: There was a paper called “Counting the Costs”, which was from Help the Heroes working with the King’s College London. The bulk of that said how difficult it is to co-ordinate all of the figures and different reporting methods to come up with a figure. I would be happier if you looked at the actual paper, but I think from something like 800-odd Regulars and maybe then 200,000 Reservists, they looked at about 61,000—including Reserves, maybe getting up to 65,000—people who were likely to suffer with a psychological condition.

Q132 **Chair:** Give me a percentage, please. A rough percentage.

Karen Mead: My maths isn’t up to it. I can confirm it was 61,000 with a projected need over the next 20 years, of those who were deployed to Iraq and Afghanistan.

Dr Busuttil: Of 250,000, or something like that.

Q133 **Chair:** So we are talking about something between a quarter and a third. Am I right?

Karen Mead: That, to me, would be consistent with what we are seeing internationally.

Dr Busuttil: My view would be that we should wait for the King's study, because it really was a long time ago—2010—that they reported on data collected in 2008 and 2009. That showed a 4% baseline, or 6.9% if you were a combatant—this is for PTSD. It was 5% if you were a Reservist. There were very high rates of alcohol—14%. Other studies show that 20% had common mental disorders. Really, what we are seeing in the veterans' arena is going to be very different now, because many, many more people have come forward. When I first started at Combat Stress, it was rare to see an Afghanistan or Iraq veteran. It was maybe three or four a week. Now it is everybody, or most of them. They have superseded the Northern Ireland conflict veterans. Those are still coming forward, but they are No. 2 in our "Top of the Pops", then it is the first Gulf War and then the Falklands.

Q134 **Chair:** This is quite a dramatic figure. You are saying, basically, that anybody who signs up to the armed forces, especially if they are likely to undertake operational deployments, has a one-in-four or one-in-three chance of getting a significant mental health injury. Is that what we are expecting to find?

Dr Busuttil: I think that that is what we can expect.

Q135 **Chair:** Can I take you back to what my colleague, John Spellar said about the second world war? There, we had an entire nation under arms. Are we saying that, of all the people who fought through all that—sometimes away for years on end—and came back and got on with rebuilding Britain after the war, a quarter to a third of them suffered significant mental injury?

Dr Busuttil: It is possible. What happened after the second world war was that everybody here in Britain and in other countries understood what the war was about, so there was a lot of support. People had to rebuild the country; they had to have families, get jobs and rebuild their houses. Many of the second world war veterans presented when they retired—when they were not solving problems, working hard and ignoring their emotions. When they retired, they had a lot of time to reflect.

That is where delayed-onset PTSD came for the second world war veterans. Some of them had died off anyway, so I do not think we ever saw the real percentage. There were very small pockets of treatment for them, too. Assessment was not very sophisticated, so I am sure there was a lot of pathology of second world war veterans, but a lot of it was hidden.

Once I saw a 93-year-old tail-end Charlie from a Lancaster bomber presenting for the very first time to Combat Stress—this was about eight years ago. The next guy was 19; he had just left the military on medical discharge and had served in Afghanistan. The older gentleman's wife had



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died and he totally fell apart. In his history, he had been ill for many years—she had contained it for him and understood what it was like. The young chap was more likely to want to get help and the first thing he did when he left the military was to come.

I think attitudes have changed—stiff upper lip and all that. We are relying on old epidemiological data, from 2008, 2009 and 2010, to plan services now. This paper will be published fairly soon and we need to look at what it shows.

Q136 Chair: We are saying that the incidence of mental injury as a result of service is actually quite high—of the order of one in four to one in three—but that the public perception of this is much higher still.

Dr Busuttil: Much higher, yes.

Q137 Chair: How do you balance the need to increase mental health awareness with correcting the public perception that most, if not all, veterans have some mental health issues of a significant nature?

Rod Eldridge: One of the questions mentioned earlier was that we do not seem to mention the positive aspects of military service. Again, there are all those protective factors. We recruit from some of the socially deprived areas, particularly into the infantry, with poor literacy and numeracy skills. We give them an opportunity in life to see the world, to gain skills and training and that sense of belonging. Some of these folk come from very difficult backgrounds—broken homes—so the bonds and attachments are pretty central to how to navigate life. That is somewhat held in the military. When you leave, that is lost.

Q138 Chair: But despite all that, we still see this very high incidence of mental health problems.

Rod Eldridge: Yes, but the key caveat is that—back to what Dr Armour mentioned—you cannot extrapolate what is directly attributable to or aggravated by military service and what is not. It is not black and white like that. It is very difficult. It is not all attributable to military service and it is not all PTSD. There is a range of disorders. Some of them are quickly resolved, and some are not.

Q139 Karen Mead: There is a very strong emphasis on PTSD in the public's mind. When we did the survey of MPs, very similarly, the expectation of rates of PTSD was much higher than the reality. That is quite consistent. How do we tackle that problem? Part of it is raising awareness of the common mental health disorders. Stop speaking about diagnosis as being the only indicator of mental health need, because it is much broader than that. There is a huge number of individuals who have been impacted by their military service. They do not have PTSD or depression, but they are impacted in their quality of life, the quality of their relationships, how much they drink and their ability to go to work every day.

Speaking more broadly about need, expanding that definition, creates a bit more awareness and wiggle room in thinking that people with mental health needs or psychological distress aren't all needing an inpatient



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admission—they aren't all acutely unwell. In fact, huge numbers of our armed forces personnel and veterans are massively equipped to be cutting edge and have huge amounts of responsibility. They are a huge force for good in our community. A lot of our media campaigning and awareness is about saying that these are the skills veterans have. They may also sometimes struggle with anger issues, they may have a bit more to drink than perhaps they should, or they may not always have good sleep. They may go through periods of time where, around an anniversary date, they struggle with sleep and have some trauma symptoms, but other than that they are actually functioning very well.

Rod Eldridge: I think again that is an area of neglect. We don't talk about the resilience and actually post-traumatic growth, where you can have a negative experience, but actually that is life-enhancing, because you can view things in a different way, where you see the world differently and behave differently.

Q140 **Chair:** Before I hand back to Madeleine for the next question, can I just ask: do you think that the NHS on the one hand and the MOD on the other are statistically in tune with the sort of broad figures and analysis that you have just been giving us, or are they under or over-reporting?

Dr Busuttil: I still say, let's wait for the next point. That is going to be fairly interesting, because there is a very long time gap and a lot has happened. The war in Afghanistan really heated up after data was collected. I think that is really critical. I don't think the NHS or the MOD see the figures as we do, but we don't know exactly what those figures are going to be.

Rod Eldridge: I would just add that the MOD is back to that idea of non-reporting, because we are self-sufficient. We don't report sick, because there can be negative connotations about being seen as weak, etc. and you don't want to affect your career. I think that may well affect the figures. Also, some people are so over-identified with the military. They want to see a military service with a military front door. Hence, charities and specific veteran services are preferred over others. That may affect reporting as well.

Chair: No pressure on Madeleine here, but we want to finish no later than 2 pm, so Madeline, if you can canter into a finishing line, that would be great.

Q141 **Mrs Moon:** I don't think that is my responsibility, it is you three. I was very taken with a comment made in the previous panel about the different outcomes of research in terms of methodology, the phrasing of the questions and interpretation. From each of you in turn can I ask the following two questions? One, is it actually your job to be doing some of this research and collecting the figures? Two, should there be a commonly agreed methodology—forgive me, I am probably using all the wrong terms and my son, who is an academic will slam me for this—across the devolved Administrations and across the charities? Should there be an agreed data set, way of collecting and interpreting data, and



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questions asked? Because it seems to me that we are getting mixed messages. Should it be your job and do we need to finally get to a point where there is an agreed methodology, information collection point and interpretation of the data?

Rod Eldridge: It's everyone's job. Anyone who has contact with veterans has something to add to the body of knowledge that would help us understand the issues. The answer quickly is yes, we should. It would be an ideal world if we could all agree a standard set of valid and reliable measures to use across the piece, so that if you are doing any meta-analysis or data-analysis it is all the same. That would be great. Our role, certainly within charities, is to contribute, as we do with a number of research projects. Evaluating any intervention is vital, because you must see that what you do is ethical and is making a difference. You just don't do something because it looks good and because we think it is going to be beneficial. Unless you know that for a fact and can prove it, from a governance point of view it is pretty weak.

Karen Mead: I agree with Rod. Absolutely, it is our responsibility. I think it is everybody's responsibly—whoever has that contact with veterans and has their trust. I think we each feed into a wider body of knowledge. It is the responsibility of all of us. In terms of the commonality of methodology, assessment and that sort of thing—once again, I am speaking about the contact group—Rod, myself and the clinical lead from Combat Stress are all working on a common assessment tool. Ideally, that will mean that at the actual point of contact—asking for help—we will be collecting a common dataset. Obviously, we then need to think about data sharing and the new challenges that are there.

The charities and those involved in contact are working towards a common assessment tool for data capture, which will also mean that veterans' experience is consistent. We are moving that way. When you start talking academically about how things should be analysed and what measures are used, it becomes a trickier animal. There are always going to be specific questions that need to be asked, and in any dataset there will be holes. We have to balance what questions we ask and what information we capture with the burden of having to provide that information. That is often what we experience in our clinical work. If you give someone a thick set of questionnaires, they don't complete them, so we need to be quite selective.

Can it be achieved? I think it can be. I say that because there has been some degree of collaboration and consistent methodology utilised between countries. As I mentioned before, Australian and Canadian cohort studies are using similar data capture methodologies now so the results can be compared between countries more effectively. If two countries can do it, I hope the devolved Administrations will also be able to do it. I don't think it will be straightforward, but we can work towards that.

Dr Busuttil: At the moment, we have eight collaborations going on: Napier University, Edinburgh; Ulster University with Cherie; Oxford; Anglia Ruskin; King's; the University of Melbourne—the Phoenix centre is their



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national trauma centre, with veterans as well—Kent University with Harvard for brain injury and post-traumatic stress; McMaster University in London, Ontario in Canada.

We do a lot of data sharing. The main data sharing we are doing at the moment is about needs. Who are these veteran help seekers? What is wrong with them? What are their needs? Then there are treatment outcomes. We are pooling data, and we will be publishing papers on this quite soon. As Karen mentioned, we are very keen to have a common dataset across everybody involved in the UK, including the NHS. All of this needs thought, skill and sometimes funding. It is really important that it is well supported, too.

Q142 Mrs Moon: Can I very quickly ask, are we missing a trick with women veterans? It seems to me that every one of you has referred to guys. Over and over again, I keep hearing that word. Are we missing a bespoke service that is made for women veterans?

Dr Busuttil: I think we are missing something for women; I agree with you. Women in theory go sick earlier. I don't quite know exactly what the rates of women consulting while still in the military are. If they are not—a lot of their behaviours become like those of men—then they are not accessing my service as much as I would like to see them access it.

The other group is officers. We are seeing quite senior officers now with moral injury. That is not necessarily about mental illness. It could be with PTSD as well. We are very worried about officers, women and early service leavers. We have got early service leavers we are going to analyse. We were very surprised when we looked at the data with the early service leavers. On women, we have not seen an increase, certainly since I joined Combat Stress, and we had nothing really apart from respite care before. It has remained 3%, but with officers and early service leavers it has gone up. Women are not coming to us as much as we want them to.

Q143 Mrs Moon: Historically, the women I have spoken to have all said they do not access services because of the dominance of men within the service.

Dr Busuttil: Yes, absolutely.

Q144 Mrs Moon: And much of the distress they are experiencing has been about men.

Dr Busuttil: Can I add something about female partners and spouses? We have done studies on that. Many are too anxious to go and seek help. They are too shy, they are too busy with children and they are really left out. We are looking at doing something for partners, and we have two studies going on to see what the intervention might be. We will publish that soon too.

Rod Eldridge: We see a fair number of women coming forward for our services. We are sensitive to the reasons why they may do that, and certainly would seek a therapist conducive to their needs, whether that is gender or therapeutic approach. Again we are in our early days, but the number of ladies we see is representative of the people who seek help.



Karen Mead: In the current serving MOD stats comparison, women are 6.3% and males are 2.8% on mental health issues. We know that women tend to come forward for help more quickly than males do. Having facilitated the group treatment programmes, which I believe you might be referring to in terms of women's reluctance, I worked in the group treatment programmes in Australia that the Combat Stress model was based on for about 10 years. We had that issue of what to do with women veterans as well. It became somewhat of a conundrum, to be completely honest.

We offered specialist women programmes, but because the number of women coming forward for support was relatively low, we were finding it was almost a disadvantage for the women who were waiting to go on a women-specific programme, so the wait times were blowing up astronomically, because there were not enough coming forward. Whenever we gave women the option to engage in a group programme, all bar two, in the 10 years I was working, agreed to be part of a male group.

The areas where, clinically, we experienced women not wanting to be part of a group treatment programme were generally when they had experienced some form of sexual violence. It makes sense that normally we would then offer individual therapy to women who perhaps do not want to sit in a room of men. There is the challenge of offering women-specific programmes and acknowledging that that may in some ways disadvantage women, because the numbers simply aren't there. I think the access for individual treatment for women is a bit of a gap. I believe they should have the option to be able to access care individually, if they cannot get a group programme within a reasonable timeframe.

Q145 **Chair:** Before anyone else comes in, can I just ask you to add one more consideration, which is the mental health impact on families? We heard before about families and their role in supporting the returning veterans of world war two. Could you just say something about that? I think for anything further, we will have to write to you, because we have had a marathon session, and a very informative one.

Karen Mead: In January, we completed a YouGov survey on families. This has been a particular area of focus for my service over the past few months, so I am happy to speak about families. We identified that one in four family members said that they felt there was some form of mental health issue for them, as a result of their partner's service. That is quite a significant figure who are flagging that their own mental health has suffered as a result of being part of an armed forces family.

Of most concern were the numbers that identified that, if they were experiencing a mental health issue, they wouldn't ask for help. The reasons why they wouldn't ask for help that we identified were primarily around feeling like they didn't deserve it and they needed to be the strong ones to hold the family unit together. We can understand why they may feel that way when that is what their function has been if their armed forces partner has been on deployment—the family member, the wife, has had to hold it together. So they are generally quite reluctant to seek help.

Only 6% of those surveyed identified that they would go to a mental health professional, so many of them are not comfortable going to seek mental health support.

Families are a massive area of need. Our Hidden Wounds service provides step 2 care to the family members, not only of those who are veterans but of those who are currently serving. I believe that that is one of the few services that actually looks at families specifically. Because I am aware of the huge need in the area, and that there are not that many services out there, that is a big push strategically for our service at the moment.

Rod Eldridge: I work for Big White Wall on a part-time basis. Help for Heroes funding provides two partners and families from the age of the 16 onwards access to a 24/7 support line, which is moderated and monitored, for advice. There are then what we call Wall Guides, these folk who will take people through specific mental health programmes at need. So that is available, it is anonymous and highly effective. That is one service that is available, and actually available to people in the military as well.

In terms of our own charity, we support families, mainly those caught up in the criminal justice system, the partners of those who are maybe turning up in police custody suites. Rather than being given a custodial sentence, they are being diverted. Our support workers in what is called Project Nova will support the families in that setting. In terms of our other employment, because we are mainly about employment through Walking With the Wounded, we indirectly support the family by getting the individual who is unemployed or not suitably employed into sustainable, good-quality and appropriate employment, because that is good for the whole family.

Q146 **Chair:** A final word from Dr Walter.

Dr Busuttil: Very, very briefly, our study 2006 into partners and spouses of the illest veterans we treat—rates of depression, 39%; anxiety, 37%; PTSD by emotional contamination, 17%; alcohol disorder, 45%, in contrast to the population surveys of common mental illness, 20%; PTSD 3%; hazardous drinking, 16%. Many don't seek help—only 47% sought help. The illest were the ones who were not employed, who lived with the veteran partners and, interestingly, who were ex-military themselves. The ones who tended to have more alcohol problems were the ones with children, so that is even worse for the children. There is a huge need. We are working with the University of Michigan to look at an intervention for these families specifically. I think that trials are now finished, so we are writing up and will publish. But there is a huge need to manage this kind of level of illness, I'm afraid.

Chair: We will finish on that clarion call. Thank you all very much indeed. It is welcome expertise that you have brought to our hearing today and we are extremely grateful. The session is concluded.



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ⁱ The witness later provided clarification in supplementary written evidence ([VMH0043](#))