

Defence Committee

Oral evidence: Mental Health and the Armed Forces, Part 2: The Provision of Care, HC 1481

Tuesday 11 September 2018

Ordered by the House of Commons to be published on 11 September 2018.

[Watch the meeting](#)

Members present: Dr Julian Lewis (Chair); Martin Docherty-Hughes; Mr Mark Francois; Graham P. Jones; Johnny Mercer; John Spellar.

Questions 1-66

Witnesses

I: Professor Alan Finnegan, Professor of Nursing and Military Mental Health, University of Chester, Dr Jon Bashford, Director, Community Innovations Enterprise, and Matthew Green, journalist and author.

Written evidence from witnesses:

[Northumbria and Chester Universities](#)

Examination of witnesses

Witnesses: Professor Alan Finnegan, Dr Jon Bashford and Matthew Green.

Q1 Chair: Good morning and welcome to the first session of our inquiry into the provision of mental health care to serving Armed Forces personnel, and to veterans and their families across the UK. We previously had a part 1 of this inquiry, which was to do with the extent of mental health issues. Now we are looking at the extent of the ability to provide care to deal with them. I would be grateful if our three witnesses would introduce themselves very briefly for the record.

Dr Bashford: Hi, I am Dr Jon Bashford. I am a registered mental nurse by background, and I was responsible for the *Call to Mind* series on mental health needs provision and assessment of needs for the UK.

Professor Finnegan: I am Alan Finnegan. I have been in the health services for 40 years—nine years in the NHS, and the next 28 years in the British Army, where I served as a department lead in a department of community mental health as a nurse consultant in military mental health and the MoD's specialist nurse adviser in mental health.

I spent time at the Royal Centre for Defence Medicine during the peak of activities in Afghanistan and Iraq—2007 to 2010—where I was commanding officer, 2IC for a period of time, and the senior nurse. I undertook the first large study into depression in the British Armed Forces, where I was evaluating the MoD's in-patient register. I then left the MoD at the end of 2015 as professor of nursing. I am now professor of nursing and military mental health at the University of Chester. I am also a director of their veterans centre.

Matthew Green: I'm Matthew Green, and I am a journalist. I spent 14 years overseas as a correspondent with Reuters and the *Financial Times*, reporting from Iraq. I was embedded with US Marines during the invasion. I spent time with American forces in Afghanistan. Five years ago, I came back to the UK to write my book "Aftershock", which documents the struggles of ex-forces and their families coping with psychological injury. I travelled all over the country for two years meeting many families and hearing about their experiences. I hope that I can bring a flavour of what I heard to you today, because there are thousands of people out there as we speak who need help and are not getting it. I hope we can do something to fix that.

Chair: The purpose of this is to get those pieces of information and interpretations of them out there before the public. This is the opportunity to do so.

Q2 John Spellar: I am going to ask a scene-setting general question: is the Government's current provision of mental health care to serving



HOUSE OF COMMONS

personnel sufficient, and is treatment effective?

Professor Finnegan: With serving personnel you need a service where the clinicians have experience of the military and of dealing with military mental health. You need clinicians who provide a peripatetic service. What I mean by that is that they do not wait for patients to come to a centre, but they go to barracks and to regiments and provide psychological education, liaise with the chain of command and provide treatment or support to the personnel when they are there.

The other aspect of effective treatment has to be in relation to access. You need performance indicators on whether people in the Armed Forces can access support quickly. The MoD's performance indicators used to be a bed in four hours, a consultant-led appointment in one day or a routine assessment within 28 days. That is gold-standard. That is good. If those elements are in place for Regulars then the service is good.

Dr Bashford: Thinking particularly about veterans, you have to unpick a bit what we mean by Government. We looked at this across the UK as a whole, and I think it is reasonable to say that in local areas the provision is variable. There are some excellent mainstream NHS services out there, but it is not consistent, and it comes down to two main factors. One is the need for informed local assessments of need; there are data gaps particularly in service utilisation, so we are still very reliant on national surveys and national pieces of research to identify need. The other factor is the need to link up national and local strategies more strongly. There is a need for a higher-level strategy focus on the specific mental health issues for veterans, and implications will come out of that for transition, but for that then to be firmly linked with local area commissioning and procurement.

Q3 **John Spellar:** You say that there are variations; are there any particular centres of excellence that you could identify?

Dr Bashford: The pieces of work that I was involved in go back to 2015, and things have changed a lot since the start of that work. I think NHS England in particular has a clear focus on this area and has been developing some new and innovative services through the Transition, Intervention and Liaison Service and complex treatment services. They have six pathfinders now, looking at mental health needs in the criminal justice context. There is some excellent provision in Wales with Veterans NHS Wales, which is commissioned for the whole of Wales, though I think there are complicating factors of rurality and reach. The leadership provided by the Scottish Veterans Commissioner has also made a difference. There are some particular issues with Northern Ireland, where we do not have statutory provision at the moment.

Matthew Green: On the question of provision for serving personnel, this Committee heard earlier in the year from Lieutenant General Bricknell, who said, "At the moment, we are not fully manned for our mental health workforce". I speak to people in and around the military and I hear what that means in practice; it means very long waiting times—so long, in fact,



HOUSE OF COMMONS

that I know of welfare officers who are recommending that serving personnel go outside the military to seek treatment, because they just cannot get it in any kind of reasonable timeframe from the DCMH network.

In one example, a senior officer saw 12 different clinicians within the military system and then self-funded his own private care. That is a very recent example. It touches on this problem that, because of the lack of staffing and indeed the lack of experience of many of the staff, you end up with people with very serious, complex presentations, whether PTSD or other psychological injuries, seeing lots of different staff. In another case, a serviceman with PTSD saw 11 different clinicians in 18 months; you can imagine what it is like having to tell your story 11 different times.

Q4 Johnny Mercer: Sorry, what year was that?

Matthew Green: That was within the last couple of years. This is very recent. The obvious problems are lack of capacity, long waiting times and the triage system. Yes, if you are actively suicidal, you will go to the front of the queue, but if you are not, you could have a very long wait indeed. We talked momentarily about the rates of presentation. I interviewed Surgeon Captain John Sharpley, who is the chief defence psychiatric adviser—he is quoted in my book. He says he is only seeing 10% of serving personnel who have mental health problems; the rest are not coming forward. There is obviously a big question to be asked about whether serving personnel are getting the care they need.

Q5 Chair: You said certain people go to the front of the queue. What about people who suffer a mental health crisis? Would they qualify most of the time to go to the front of the queue?

Matthew Green: Yes. My understanding is that, in essence, a triage system is used, so yes, if somebody is in an active crisis, they will. But there is still enormous variation in the quality of care they can expect. I suppose my intent is to reflect to you the message that is coming to me via email and phone calls from people who are very much on the frontline of this: that the system is not coping. That is why we are seeing more and more personnel essentially slipping under the wire to pursue treatment independently.

Dr Bashford: Outside the military, there is a real problem with crisis provision and the need for veterans to be specifically referenced in crisis concordats. I have spoken to a lot of family members, and they tell common tales of people presenting at A&E, being arrested by the police and circulating through our blue light services, with very little effective intervention to stop that cycle—and it escalates. In the worst cases, it ends up with someone going to prison. Families particularly feel that there is a lack of co-ordination of response and a lack of understanding of specific needs.

Q6 Martin Docherty-Hughes: Is that across the NHS structures of the UK in general or in specific pockets? Is it worse in some places than in others?



HOUSE OF COMMONS

Dr Bashford: You will find some local areas where they have a better psychiatric liaison service or a better approach to integration, and some areas may have thought particularly about veterans as a sub-group. But generally, I have heard the same story up and down the country, particularly from family members—that they have experienced their partners or children going through this cycle of crisis and it has not been stopped in its tracks.

Professor Finnegan: Matthew makes very good points. The important aspect here is that the MoD should be providing good metrics in relation to exactly what is happening. They should be saying how many people attend DCMHs, how long they are waiting for, what type of conditions they have and how many people they see. I did that when I was in the Armed Forces and I can say with confidence that we also went out to service users, and 94% of soldiers were satisfied with the mental health support they received. We were able to say that over 95% of people got a bed inside four hours. That was fact. Those were the issues.

There were always people who slipped through the net. We used to have senior military officers who would not go to a DCMH—they distrusted them because of the impact they may have on their career. We had people deploying on operational tours who were on anti-depressants and we did not know anything about it because of these issues. There have always been those cases, and they are really important, but the fact is that unless you collect the correct metrics, you will always have these versions of, "This is what's happening."

Q7 **Chair:** Let's just get this clear. Are you saying the system for collecting the metrics is reasonably good within the services while people are serving but no good after they have left, or are you saying it is not good enough within the services either?

Professor Finnegan: Well, I have been gone for two and a half years, so I can make reference to how it was in the past but I am unsure whether that data is still being collected. It is certainly not reflected in defence statistics in relation to their mental health support. Those elements of really vital data we would like to see are not there. The veteran community is a different scenario altogether. We did a survey last year and only 8% of veterans are correctly registered with a GP practice. If you try to work out what veterans' mental health conditions are using GP coding systems, only 8% are correctly registered. To bring that to light, the study was of 40,000 patients, and we correlated one person with a drink problem with a veteran. If we look at families and carers, that data is even worse.

Dr Bashford: There are still some problems with passing information across those systems, as well, and ensuring an appropriate handover from the MoD to the community where it is known. Reservists are another group I would highlight as falling through some of those gaps in information.

Q8 **Mr Francois:** What is a DCMH? Is it just an out-patient facility or does it



HOUSE OF COMMONS

have in-patients as well? Does it have in-patients and secure accommodation if that is required too? Can you give us some idea of the scale and the range of a DCMH?

Professor Finnegan: The DCMH is in between the two really. There are 15 in the UK. They receive referrals from the primary healthcare GPs. Quite often they will be co-located. There will be a multi-professional staff—consultant-led—with uniformed community mental health nurses who provide the operational support, so when we deploy they will deploy with the troops. There will be civilian nurses there, and if there is a shortfall in the military cadre, they will be replaced by civilians. They can access things like social workers and psychologists as required. If there is a complex mental health issue going on, or if someone is at risk of self-harm, they can call on the NHS, which has a contract with the MoD to provide a service through a number of hospitals around the UK.

Q9 **Mr Francois:** Are they located on military bases, or are they co-located with NHS hospitals?

Professor Finnegan: Traditionally they are on military bases. They are meant to be co-located with the populations at risk, so you will find them in Aldershot, Colchester and Catterick.

Q10 **Mr Francois:** But they do not have an in-patient facility.

Professor Finnegan: No.

Matthew Green: It is important to understand the context of the military mental health service. Primarily, it is occupational health. You will hear from the military that there are twice as many clinicians or mental health staff per capita for the serving population as for the civilian population, but the reason for that is that, obviously, in a military environment, there need to be staff available to assess people who may be having difficulties and see whether they are fit for duty. That is the core job.

There is clinical work that is also done, but so often, what happens is—this is a classic example—that someone is having problems and they do not want to go forward themselves because, in reality, in those military bases, there is no real confidentiality. It may exist in theory, but in practice, everyone knows where you are going and everyone is talking to everyone else. In some cases, that can be good, because if your mental health nurse has a quiet word with your commander, maybe there is a way of managing the case in a good way, but because of the very high level of stigma, of course, often problems get to such a pass that it will be an NCO or an officer who will more or less send somebody to the DCMH.

The chances are that they may be medically downgraded—if you are infantry, that means that your weapon, effectively, is taken away—and often sent home. You will have patients languishing, effectively, for months and often feeling like they are getting very little follow-up, and essentially in the hands of their family to look after.

I am not out to knock the DCMH system for the sake of it—I have examples in the book of some really successful treatments; they do



HOUSE OF COMMONS

sometimes get it right—but a lot of the time, they just do not have the capacity to provide the care to get people better. The personnel will go down the medical discharge route and then be in the hands of the NHS. It is very important for the Committee to appreciate the limitations of what the DCMH system is designed to do, and what it is capable of doing.

Chair: Hold that thought, because later on, we will come to the vexed question of priority for service personnel in the NHS, so we will come back to that.

- Q11 **John Spellar:** Can I take us to the point where service personnel are leaving the service and transitioning back into civilian life? Do you think the current systems are effective in helping either to prevent or detect mental ill health at the point of leaving and to convey that information to the appropriate bodies?

Dr Bashford: I think they have been improving, but there is still a lot more to be done. As Matthew referred to, on the issue of identifying the problem before someone leaves and being able to appropriately risk-assess and pass that information on to the outside systems, there is still a real reluctance by people to be identified as having a mental health problem, particularly due to stigma. As Alan said, low numbers of people register with a GP. There are still some inherent system problems that we need a real integrated approach to address. There is a lot more to be done to get that as a smooth and co-ordinated process. It is when someone is in real crisis that that becomes critical.

- Q12 **John Spellar:** So do you think that might prevent people from accessing that service, because they think they will get a clean break into civilian life and do not want to carry that with them?

Dr Bashford: Yes, and they are still sometimes ill prepared to access help in the community. There is a very complex array of possible provision and people are not necessarily good at navigating it.

- Q13 **John Spellar:** What help is or is not given by the military and other services to effectively give them a route map of how they can access those services?

Dr Bashford: I think it is variable. You might have some really good people involved who know the people and the systems and make extra effort. Certainly, I have spoken to veterans who described having someone come out and visit them a few weeks later to say, "Are you okay?" They say, "Yes, I'm fine," but they are not.

- Q14 **John Spellar:** Has there been any work done on whether transitioning into work straight away helps to ameliorate or suppress symptoms? One of the ways of dealing with mental health problems is early access to work and seamless transition from an ordered way of life into a semi-ordered way of life.

Dr Bashford: I think Forces in Mind Trust has looked and is looking at that. We know that mental health is better if you are housed, have employment and have a supportive family. Those are often the key issues



HOUSE OF COMMONS

at transition—being suitably housed, finding employment and having support to manage those processes. If those things go well, your mental health is likely to be better. If they are problematic, they will have a profound impact on mental health.

Professor Finnegan: The primary causes of mental health in the Armed Forces are situational stresses. For the early service leaver, their situational stress can be leaving the Armed Forces—they want to leave and they are restricted from leaving because PPR takes too long. Those who are a little older may be going through a number of situational stresses—relationship, family and occupational issues, such as being promoted too quickly. You have a third group in the Armed Forces—

John Spellar: Being promoted too slowly is sometimes stressful.

Professor Finnegan: Too quickly can be as stressful. The point I am making is that those situational stresses will make people feel ill and they will have an impact on their mental health. One of the big issues we have from veterans is being a heterogeneous population. We try to characterise someone who has one day's service and is 18 and put them into the same pot as someone who has done 30 years or is 90. That can be unhelpful. In the transition element it can be unhelpful, too. If someone has done two or three weeks, their transition back home should be fairly seamless. If you have done 25 years, it is not just you who is transitioning but your wife and your children. All of a sudden you are going back into a city where you don't know anyone and you may or may not have a job. You add those situational stresses, and there you will find your mental health issues. If you can provide support in relation to a job, that takes one of those stresses away. That will de facto help that individual in their transition.

One other point to make about that is more anecdotal, but I have come across it enough times: if you know you're leaving—I knew about three years in advance what day I was leaving the Armed Forces—you can prepare. I was able to get my ducks in a row. But someone who is suddenly injured will have to leave suddenly, and that is much more of a stress and much more management is needed, because that individual is looking many years out, in relation to their military career, and all of a sudden has to take stock. That is more challenging.

Matthew Green: I know that the question of the handover from the MoD to the NHS is an issue that has been talked about and has been identified as a pressure point. Not enough ex-forces are registering with their GP, who obviously should be the first point of contact for them to enter the mental health care system as a civilian. I wonder whether it might be possible to link some kind of final leaving payment to registering with a GP. There may be administration involved, but that seems to be a huge gap. We are throwing a lot of information at ex-forces as they transition and, if they think they are okay, going to their local doctor's surgery is often the last thing on their to-do list. But if a payment was involved, that might dramatically increase the rates of registration and help us to move towards a more coherent service.



- Q15 Martin Docherty-Hughes:** Let me take that a bit further. Is there effective continuity of care if a service leaver under MoD mental health care is transferred to the NHS? "NHS" is a generic term, because as a Scottish constituency MP, I'm not only talking about the NHS—it is an integrated process in Scotland, a full health and social care partnership arrangement, so primary care does not just fall under NHS provision but is part of health and social care provision. I am wondering whether you will say a bit more about that process of continuity and how it is different—is it effective or not?

That silence will be a no.

Professor Finnegan: In the UK in the last 18 months, they have brought in a Transition, Intervention and Liaison Service—TILS—which is to engage with DCMHs. If someone has a mental health condition, they should have a referral to the NHS. The TILS will to a large degree provide almost a support work service—it will look at some of the situational stresses that you have and try to earmark local support if need be, but if there is a complex mental health issue then there are also complex mental health services.

TILS is a fairly new initiative—traditionally, the emphasis was on the individual to register with a GP. In Colchester there is a Veterans and Reserves Mental Health Programme for operationally attributable mental health issues. If you feel unwell after a number of years, you go to your GP and it is thought that your mental health condition is attributable to your service career, you can go back to a DCMH to be assessed and then signposted to the most appropriate care.

I am not the best person to answer on Scotland, Wales and Northern Ireland; my colleague Matt Kiernan should have been here. Professor Kiernan has done a lot of work in relation to this, but unfortunately illness has prevented him from being here. There is more data out there.

Dr Bashford: I think the England example of the TILS is quite unique, but you have Veterans First Point in Scotland and, as you alluded to, there is a much more integrated system of social care than we have in England, so some factors make that better. But there are also problems in terms of the capacity and reach. In more vulnerable areas there is less likelihood of adequate local provision, and people have to travel more. Families are still consistently left out of the picture, although they can be an absolutely core element of support, but that element is not always attended to. We have not thought enough yet about the needs and provision of women in that context.

- Q16 Martin Docherty-Hughes:** You have answered the second half of my question within that. I have read the March report from the DCMH covering Scotland specifically—just because my constituency is there. Some of the report is appalling. It says, "our service's response to people's needs: inadequate"—this could be anywhere across the UK. It says "Our service is well led: inadequate." The evidence speaks for itself. Do you think therefore that the DCMH process, whatever part of the UK it



HOUSE OF COMMONS

is in, is having a detrimental impact on the NHS and health and social care providers, because they are having to deal with its inadequacy? The DCMH process is profoundly not serving armed services personnel, and those providers are therefore having basically to pick up an area in which they do not really deliver a service.

Matthew Green: I would say absolutely, that is what is happening. The DCMH can offer some care for some serving personnel, and it can be really transformational. I have seen examples of great care, but they are very few and far between. For serving personnel who are medically discharged due to some form of psychological injury, yes of course, they will then go to the NHS and social care system, which is in most cases woefully poorly prepared to help them.

I am glad that you are dwelling on this point about the transition between the military mental health care service and the NHS, because in all the most tragic cases that I have reported on or come across—for example the young Scottish soldier from the Black Watch who took his own life a few years ago, very shortly after leaving the Army after a tour of Afghanistan—there were question marks about the communication between social services and the military.

Equally, in one of the most high-profile cases from a few years ago, a Grenadier Guardsman was involved in a horrendous insider attack in Afghanistan, where several of his colleagues were killed in front of him. He himself received multiple gunshot wounds and, unsurprisingly, had a very severe case of post-traumatic stress disorder. He came back, was treated in a DCMH, and at one point was referred for an anger management course, which I can assure you is not going to make a dent in symptoms of that degree. He was medically discharged, and some time later he was up before a judge, accused over the death of his own seven month-old daughter, which he had caused during a fit of rage linked to his PTSD. The review of that case, which is on the public record, found that the lack of co-ordination between the DCMH and the civilian staff was one of the glaring gaps. That is an extreme example, but exactly the kind of failing that needs to be tied up.

Q17 Johnny Mercer: Everyone knows my views on this stuff, but you have got some seriously committed and clever people in that Department, for example Helen Helliwell and Tobias Elwood. This was the situation that drove me into Parliament three or four years ago. One of first things you said there was “a year ago”—someone has had to explain this story 11 times. Why is this still happening? Why is it beyond the wit of man to get this right? I fail to see that it is that difficult. Is it an issue of competence? You are the expert: why is it still happening?

Matthew Green: Only a few days ago I was having this very conversation with a former military colleague who works in this field, and he came to the point of staffing. So many mental health staff have left: a training programme of military nurses who have come on for maybe three years, got their qualifications and experience, and left again. There is a lack of personnel available.



Q18 Johnny Mercer: Why have they left?

Matthew Green: I don't know why they have left, but they have left. There are some great people in the system. My frustration is that I have travelled all over the UK and met brilliant individuals in the MoD, in the military, in the NHS and in charities as well, who all want to get it right, but the sheer scale of demand means that the system just is not fit for purpose as it stands, as far as I can see.

At the weekend I listened to all of the previous panellists speaking and there were lots of good initiatives coming on stream, but the reality is that they are way behind the curve in actually delivering the help that people need. It is partly an issue of resources and expertise, but also of acknowledging where this problem came from.

Of course, there are the Falklands veterans, the Northern Ireland veterans and the Bosnia veterans. They all need help as well, but think about how these campaigns unfolded. We went into Iraq in 2003 and came out in 2006, just as Afghanistan was starting to peak in terms of operational intensity. In all my research, I never heard anyone having a conversation about what we were going to do to prepare for the influx of psychiatric casualties and psychological injury ahead of time.

It was actually Combat Stress, the charity, that had to start banging the table in about 2007 when Walter Busuttil took over as clinical director and saying, "We're going to need to get some resources in place." The impetus for trying to build the system was actually coming from a charity, so it is not surprising in a sense that we are now desperately struggling to play catch-up to patch together a system that can work.

Q19 Johnny Mercer: I am afraid, in a way, that I do not buy this issue of resources. If you look at the veterans care sector, it is swimming with money. This needs organisation and leadership. Why is that still not there?

Matthew Green: I agree with you, Johnny. On the point about resources, I was thinking more generally about having enough qualified, expert staff in place in the DCMH system. In terms of the money flooding into this problem, you are absolutely right. It is a case of making sure it gets spent properly. That is why if I were in a position of authority on this topic, I would choose a veterans commissioner—some kind of veterans tsar—to pull this sector together, look at all the insanity that is taking place at the moment, and try to create a rational, coherent system. That is what I hear from a lot of my friends in the military, and I think it is a great idea.

Johnny Mercer: If only someone had gone to see the Prime Minister twice to say that—oh, I have.

Dr Bashford: We are siloed from the top, right down from departmental level, and there are iron curtains between those boundaries that prevent joint working. Yes, we need to have that specific, central leadership, but there is no point to that if it is not then linked to what is happening locally. We have an increasingly devolved and fractured system of health and



HOUSE OF COMMONS

social care, even where it is integrated. It has been integrated in Northern Ireland since 1973, but on the ground, it is still not necessarily working. You are right: it is not just about resources. It is a cultural and a leadership issue in terms of having a real commitment to breaking those boundaries.

- Q20 **Chair:** Can I just check a point before we go back to Martin? Are there great differences between problems while people are serving, which you have just been describing, and problems that have to be attended to after they have left? Johnny's point appears to be that you need to have strong central leadership and anticipation of the increase in demand for services when you know people are going to go into action or are going to get involved in campaigns, but your point, Jon, seemed to be more about the failure afterwards in wider society, presumably when the people, even while they are serving, are then sent home and have to rely on the NHS.

Dr Bashford: Yes. My experience is in the outside bit, mainly, and that is what I have looked at: what happens to people when they come out of those systems? You need that integrated thinking earlier on; you can't just have those walls in between. It is about linking what is happening in terms of local commissioning, procurement, provision and knowledge with national strategy.

- Q21 **Martin Docherty-Hughes:** As regards linking up some of those things in terms of national strategy, we have had Ministers in front of us, and even the Secretary of State. We have discussed the Veterans Board, for example, and I get concerned, as I know some other Members do—those from Wales and also those from Northern Ireland—that there is no ministerial or senior service representation from the devolved Administrations on that board. That is taking it right from the top, asking how we bring about that engagement in terms of the post-DCMH system, but it also goes back to the DCMH impact locally, because we do not have that leadership in terms of veteran support from all the Administrations.

Again, I am reading the report from this year about a base 10 miles from my constituency. It asks, "Are services well-led?" and it says, "Insufficient staff of the right experience and a lack of leadership hampered the team's ability to meet performance targets at Faslane. The management structure was not being adhered to at Faslane so that leadership roles were unclear. Morale was poor at Faslane and some staff were displaying destructive interpersonal relationships within the management and staff team. This was undermining performance and was not managed at any level." That goes beyond the pale in terms of trying to deliver mental health services for those already in active duty, and when they then transition to local healthcare.

It will be utterly irrelevant how good or bad the local service is, because the service for the DCMH in my local area is utterly, woefully inadequate. Leadership, from my perspective, therefore needs to change. How do we change that leadership of these services for service personnel across the UK before they come into the NHS structure?



Professor Finnegan: The first element would be to resolve the staffing issues and to ensure that the skill mix inside the departments is correct. I would urgently commission some independent research into why it is happening in the DCMHs. If the staff were giving you these comments in an isolated area, or if this is across all 15 DCMHs, then you would have a picture that would identify the issues, but the staff would probably also be able to give you what they believed to be the solutions.

We have done that in the past. I did a study a number of years ago looking at depression in the Armed Forces. I interviewed 19 members of DCMHs. Between them they had nearly 400 years of experience and had been on three or four operational tours each. They gave us some of the comments Matthew was mentioning earlier about the senior command not going into DCMHs. These were issues that were recognised inside the departments.

If you commission the right research and identify it, it will not give you an immediate solution. Some form of survey could be rolled out fairly quickly, which could give you some form of solution or identify some of the problems. I think it needs leadership and some form of proper, informed metrics and research to give you that response.

Dr Bashford: We know how to turn failing services around. We have done that in many examples across the NHS, education and all kinds of different systems. We can do it. It can only be a lack of will if it is not happening.

Matthew Green: I would like to make an observation on that very point. There are some officers out there who are excellent at standing up in front of their battalion and talking about their own mental health problems. That is what really changes the culture. I was visiting the Parachute Regiment last year. They had invited a theatre company called Theater of War, which is from the US. They have performed at hundreds of US military bases. They do a scene from Sophocles' "Ajax" which examines what happens when a mighty warrior becomes unglued, essentially. At the end of the performance the CO stood up in front of his entire staff and NCOs and said, "Guess what? I had real anger problems when I came back from Afghanistan." You could see the room relax—it's okay to talk about this stuff.

That was a great example of leadership at the battalion level. Imagine if you could have that leadership from the very top. We know that everybody is absolutely capable of having some form of psychological injury in whatever form it comes. When that is okay all the way through the system, and when you have senior leaders who are still in their careers coming forward and talking about what has happened to them—they got treatment, they came back, and it didn't derail their career—that will be worth so much more than any number of laudable poster campaigns that the MoD has run. That is good, but I think that really shifting the culture is the core of driving fundamental change in this area.

Q22 **Mr Francois:** But Matthew, on exactly that point you have the TRiM programme, which was developed in 3 Commando Brigade. It was



HOUSE OF COMMONS

exactly this kind of stuff: your buddies absolve you, because part of it is that everyone is frightened of being seen to let their mates down on operations. Part of TRiM is that your friends say, "It's all right, Bill, if you're having a tough time. Let's get you some help." It was so successful in the brigade that they exported it across the rest of the Armed Forces. The information I have is that, although that is not the silver bullet answer, TRiM has made the situation a lot better than it was a few years ago. Does that gel with what you have found?

Matthew Green: Yes, I hear very positive things about TRiM. As you say, it has been rolled out across the whole military. If you speak to frontline infantry, they often do not have a problem talking to each other about these kinds of things. There is no shame attached at that level. The issues are about career, the hierarchy and the fear that when you are back out of the theatre, if you come forward, your career will be derailed, especially as the Armed Forces shrink and the opportunities are fewer. That still has not changed enough. The DNA around this issue still has to shift further.

Q23 Mr Francois: I appreciate the scale of the problem. A lot of what you are saying rings true, but if for a moment you decide that the glass is half full rather than half empty, on the positive side—this is not to make excuses, but to look at the glass being half full—the whole attitude to mental health and stigma has definitely changed in the past few years.

The work that the princes have done has been fantastic in removing stigma, and that has had a knock-on effect in the military. My perception is that it is now possible to talk about this issue in a way that, even five years ago, it was not. Even within families, many families had one member—"Auntie So-and-so has always been a bit odd"—and you had a bad problem that nobody wanted to acknowledge. I think that really has changed in the past few years, so there are some pluses here as well.

You talked about the difficulty of manning DCMHs with competent and qualified staff. I am not decrying that—I think that is true—but in the NHS, the mental health trusts have exactly the same problem, and it is not always just a matter of resource; it is a lot to do with the stress of working in those areas. As you say, the people come in, get their qualification, and then they are off to Australia, Israel, or wherever it may be.

Again, to be fair to the DCMHs, it is not that they are doing something abysmally and the NHS has cracked it. The NHS has almost exactly the same problem; in fact, in some cases, it is worse. Overlaid on that, the military has a general issue with retention at the moment—although, in fairness, so does the NHS. I am not asking you to resile from what you have said, but I am just asking you to acknowledge that while the situation is not perfect, it is probably a lot better than it was five or 10 years ago.

Matthew Green: It is improving, but it needs to improve faster.

Mr Francois: Well, Johnny is our in-house ninja on this one.

Johnny Mercer: We are now meeting one in four, and we are just



HOUSE OF COMMONS

crossing over to meeting one in three, so you are right, but that is still a huge unmet need. I'm sorry to cut across you.

Chair: That is all right. That is why we are doing this inquiry.

- Q24 **Martin Docherty-Hughes:** Just before I move on to the next question, Chair, I take the points that Mark has made, but I have that report from the Care Quality Commission in front of me. We talked about leadership. Technically, the leadership goes direct to the Surgeon-General and to the two other individual medical directors of the British Armed Forces, so that leadership has to come from them. Is that leadership vocal? Is it out there in terms of mental health provision and the DCMH structure? That will be a no.

Professor Finnegan: To a degree. I wouldn't leave the leadership just to the Surgeon-General. Accepting leadership in relation to your area of operations is embedded in military training from day 1; it is about the fundamentals of understanding a mission, understanding a vision and implementing them locally. The Surgeon-General would certainly be part of that, but at a local level, if the scene you are describing is across all of the DCMHs, that is absolutely a matter for the Surgeon-General. If it is one or two departments, then maybe they need to start benchmarking, looking at how some departments are working well and how others are not working as well, and maybe learn lessons from each other.

- Q25 **Mr Francois:** Just on that, we rate trusts in the NHS, don't we? We have star ratings and suchlike. Should we have the same for DCMHs?

Professor Finnegan: We used to do it. When we had an ISP—an independent service provider—providing hospital care for a while, we looked at all the DCMHs and they all provided us with the same type of metrics. We were able to turn around to one DCMH and say, "Why are you admitting x amount of patients, and why is another DCMH admitting half the amount of patients? You have still got the same populations at risk." To tell you the truth, we were not saying that one was doing good and one was doing bad; we were just making sure that those figures were aware across the piece, and then using that as a medium to discuss these issues along with appropriate metrics to say, "This is what we are meeting."

The other metric I would bring into that perspective was asking service personnel if they were happy with their support, and 94% were. You really have to look at the 6% who were not—that is really important as well—but it is using that information. It can be done.

- Q26 **Chair:** This seems to be a fairly constant theme coming back to us: if you do not quantify what is going on, you cannot set policy correctly. Do you all agree with that?

Dr Bashford: You have got to have the right information and not be trying to extrapolate that from national research and survey data.

- Q27 **Mr Francois:** On that point, Ofsted inspects schools. The CQC now inspects hospitals, and it inspects mental health trusts. Should the CQC be allowed to inspect DCMHs? Ofsted inspects youth training



HOUSE OF COMMONS

establishments in the Armed Forces, doesn't it? So why shouldn't the CQC inspect DCMHs?

Professor Finnegan: There is no reason why they can't. The CQC did inspections of Camp Bastion hospital—they have been invited into the DMS before.

I think Matthew made a really good point in relation to occupational mental health: it is different in the military. If you look at defence statistics, they will tell you that the number of admissions in the last 10 years has gone up from 5,000 to 6,000, but it does not say how often or how many times those people were seen. That is key information. If you have the right people who understand the military structures—that is the first point in relation to what makes it effective—and can engage with the chain of command, provide leadership and resolve some of those stresses, you may see people on only one or two occasions. So you see people who have got a much lower threshold than those who may have received support within the NHS.

Q28 **Mr Francois:** Very quickly, I am advised that the CQC have just begun inspecting DCMHs. Presumably you support that.

Professor Finnegan: Yes.

Chair: Martin, will you move on to the next topic, please?

Q29 **Martin Docherty-Hughes:** Should veterans be treated for mental health issues in a different way from the general population? If so, why?

Dr Bashford: That is a really complex question. I tend to think yes, but not for everything and not in every situation. We need to recognise the specific needs around veterans' healthcare and mental health care, and subgroups within that—I think again about women, Reservists and different categories. There is a need for provision that is sensitive and appropriate to the experiences people have, whether that is simply understanding military culture or having trauma-informed specific assessments and interventions that can work with a population who have particular needs.

We are never going to have sufficient specialist provision for that always to be the answer, and I do not think it should be. To me, it is about getting the right balance. There is no one single service that can provide all the answers, so we need to find the right balance between levels of specialist provision—probably at a sub-regional level—the right partnership working arrangements and being able to ensure that people have smooth, seamless movement between those and local services. I would add into that mix the Armed Forces charitable sector. Some of the best examples that I have seen have been where you have got those three elements working together.

Professor Finnegan: I generally like to look at veterans being integrated back into their communities, so if there are services which can reach out and provide support, with veterans respected as part of that group but integrated into it, that is quite beneficial. On some of the services we have



HOUSE OF COMMONS

locally in the north-west, we have a veterans' hub at Everton football club and the very proactive Warrington Wolves, who I have worked with— Rugby league tends to be very supportive anyway. They are shifting the paradigm away from GP practices. They engage with the local population, many of whom would traditionally avoid going to GP practices. They go along and capture them, and once they are in those environments they become much more receptive to advice. If you can signpost them from those areas, it is all well and good.

Some veterans would like to be in veterans' services. It goes back to this heterogeneous population. A lot of veterans do not want to and are quite happy, when they leave the Armed Forces, to just go off. The difficulty is in bringing 2.6 million people in there together, but generally, from a personal perspective, I do like this type of collaboration; they respect veterans for what they are and bring them in to the local community.

Matthew Green: I agree with what Alan said. The point that is really important to bear in mind on this question, and which came through in a lot of the interviews I did, is that a lot of ex-forces who have suffered some form of psychological injury during service are very reluctant to unburden themselves with civilian staff, because they are concerned about harming them with what they are telling them. I have seen this.

Take a veteran special forces soldier, who may have called in airstrikes that have killed dozens of people, and been involved in serious combat operations. If you sit someone like him down in front of a fresh-faced 24-year-old psychology graduate, you are probably not going to get very far. That is not to say—this is an important point—that civilians cannot treat veterans. In fact, I think it is the other way round. Some of the best examples of ex-forces who made really quite substantial recoveries, often after very long journeys, alighted just upon the right NHS psychologist or psychiatrist, who really took them in hand and got them over the line to a more stable position.

Mr Francois: Someone who gets it.

Matthew Green: Yes, it is someone who gets it. That can be a veteran, but it does not have to be. There is sometimes a danger— particularly for some of the charities, although they are well-intentioned—in saying that “veterans need to treat veterans.” Yes, there can be value in that, but we should not perpetuate the myth that only veterans can treat veterans, because I think that does a disservice to some really excellent civilian clinicians.

There is another point that is really worth emphasising, and it circles back to the debate in previous sessions of this Committee about the media narrative and the reality. The reality is that there are ex-forces—we do not know exactly how many, but significant numbers—who have really severe, complex presentations of post-traumatic stress disorder, often combined with alcohol misuse, which is an extremely toxic and dangerous combination. That is the gap in services. That is where there is literally nowhere for them to go. They cannot go to Combat Stress if they are not



HOUSE OF COMMONS

stabilised sufficiently. They will end up bouncing into an NHS secure or emergency psychiatric ward and then bouncing back to their family again. We really have a gap in the infrastructure for taking hold of those very severe and complex presentations, and giving them the care that they need to really recover. That can take six months of in-patient care, or even a year. It is not something you can necessarily do in six weeks.

I would urge the Committee to really consider the question of how to cater for that extremely vulnerable population who, at the moment, are really falling through the net.

- Q30 **Martin Docherty-Hughes:** I think that you have answered my second question which was going to be "Are there any particular groups of service personnel that need specialist treatment or support for their mental health issues?" Clearly there are. Would you like to expand on that?

Dr Bashford: On the point about professionals and whether the professional who is treating someone is also a veteran, I think we have to think about peers. A lot of mental health treatment is not one-on-one, but in groups. I have certainly spoken to veterans who, as has been described, not only have complex psychological problems but use alcohol and drugs. A lot of those treatments would be in a group setting. People do not feel safe to work at that therapeutic level with civilians. They do not feel they will be understood and they are not particularly confident in the process. We have to recognise some of those elements and have informed therapeutic options for people.

Professor Finnegan: Can I identify a particular group? We have to remember that 50% of veterans are over 75 years of age and 65% are over 65. It is that elderly veteran group who may have dementia, which is something we very rarely talk about as a mental health condition but is impacting on veterans. Men in this country die younger than women by an average of about four or five years. We have families—wives of servicemen—who could be socially isolated and on their own. Their husbands could have spent years inside the Armed Forces. They don't tend to be the focus of many of these conversations, which tend to lend themselves more to a younger population. If we want to represent the veteran population as a whole, we cannot move away from those statistics: more than 50% are over 75 years of age.

- Q31 **Graham P. Jones:** A particularly interesting point you make is that most veterans are over 75. I am concerned about civil litigation, so I will ask about that. That just arrives on an old soldier, who thinks that he has done his time and is managing his life beyond the Armed Forces into retirement. Suddenly, this is thrust upon them. What is being done for those veterans who now potentially face civil litigation, like we have seen in Northern Ireland? That must be causing an enormous amount of stress for these individuals. We know about the civil side of it and we are dealing with that, but what about the mental health side?



HOUSE OF COMMONS

Professor Finnegan: It would be extensive if you felt that you would be prosecuted. That level of mental health stress would be extensive, and they would need support.

- Q32 **Graham P. Jones:** The question that follows from that is: what support is being given, and what policies are being put in place to try to help these individuals in this set of circumstances?

Professor Finnegan: I am not overly aware of any particular services. They are beholden—I think they see their support coming from champions who are championing their cause. I suspect most of them—this is anecdotal—wouldn't go anywhere near the NHS and they suffer their stress at home.

- Q33 **Graham P. Jones:** I was about to make that point. In summary, these particular individuals, who may face the threat of a civil court case, are suffering in silence. Is that where we are with the individuals who are potentially facing, or fear that they may face, civil litigation? They are suffering in silence—I think that's pretty shameful.

Professor Finnegan: That would be my opinion.

Matthew Green: May I just make a very brief contribution on this question of the populations that are neglected? I think it is worth dwelling for a few seconds on this. I think of a classic example during my research visiting Leamington Spa—this is a case study in what goes wrong. A veteran called Dave Salt had done almost 20 years in the Army—Bosnia, Northern Ireland, Iraq and Afghanistan. He served with distinction and had come out with a very severe case of post-traumatic stress, self-medicating with a bottle of vodka. He was well known to the police and paramedics because he had immersive flashbacks on the high street and in the supermarket. He had been treated by the MoD—the DCMHs—and by the NHS, and he had been through Combat Stress as well. Two years after I met him, he was found dead in his flat at the age of 45—he died from liver failure. There was no pathway that was capable of grabbing hold of him and giving him the help he needed.

I have seen others who have been lucky: a charity has found them and got them into the right bit of the NHS by hook or by crook or by some act of almost divine intervention, and they have done really well. It is possible to help people such as Dave with the right care.

- Q34 **Chair:** And is there an answer to this? For example, isn't there something like the Veterans' Gateway as a one-stop shop? Is there something that can be done so that the first thing that occurs to someone who feels in a downward spiral is, "I must ring this number"?

Matthew Green: That exists, but the problem is that the missing piece of the puzzle is some form of national trauma centre, where perhaps trauma survivors who are civilians, as well as ex-forces, could be treated with trauma-specific services and have some kind of wrap-around care capable of handling this kind of complexity. That is the gap. There are lots of



HOUSE OF COMMONS

helplines and phone numbers, but it is about having the right care for somebody who has got that particular presentation.

Dr Bashford: Trauma-informed work is something that we need not simply for the military and veterans community but across blue-light services and following major incidents, whether that is a severe climatic incident or a terrorist incident. There is learning coming out of the Manchester bombing at the moment in the Kerslake report. Across the board, in primary, secondary and emergency services, we need to have more trauma-informed staff. We can work in this way. A national centre may help to develop expertise and focus, but that will not meet everybody's need across the country, so we have got to work with the existing generic professional groups to skill and upgrade them in these areas. That will benefit the military populations and veterans, but it will also have broader benefit to society as a whole.

Q35 **Chair:** Alan, what is your view on a trauma centre and what is the answer to the issue of the isolated veteran, who has nowhere to turn?

Professor Finnegan: I can see some merit in the trauma centre. The difficulty would be that you may isolate the person away from his friends and family. The whole idea of the TILS is to try and provide some form of local support. With the isolated veteran, we can make more use of our veteran communities. Most cities now have breakfast clubs and hubs where veterans get together every couple of weeks. They are not talking about PTSD; they are talking about the football, and they can talk in a manner and a language where they feel they can speak freely.

We are trying to embrace those types of local hubs, which do not always get a good press and are sometimes seen as doing more harm than good. They are not advocating a form of treatment; they are there just to support veterans. We should really look at why certain veterans go to them and why they would rather go to a local hub than phone the Veterans' Gateway or go to one of the larger charities. It does attract a lot of people, and when it comes to social isolation it is a jigsaw that we need to put lots of pieces into to make it work. Local trauma support is something that would keep you close to your relatives, although I can see some benefits in a national centre.

Mr Francois: Matthew, when this session has finished I am going to give you 20 quid—or whatever it is—for a copy of your book.

Matthew Green: You can have this one for free.

Graham P. Jones: I need two signed copies—can you add that?

Mr Francois: No, he offered it to me first. You get your own.

Graham P. Jones: I'll have two and three then.

Q36 **Mr Francois:** From my experience, Matthew, everything you are telling us chimes true—as indeed does what your colleagues have said. Five years ago I was the Veterans Minister at the MoD. I looked at physical



HOUSE OF COMMONS

rehabilitation in quite a lot of detail and I looked at what you might call mental rehabilitation. I came to the view that in terms of physical rehabilitation, for guys who had lost limbs, say, we were doing quite well, if I am honest. We got access to Regenum prosthetic, the world-standard prosthetic that the Americans gave their people but originally we didn't give ours; we managed to do something about that. We had Headley Court and plans for the Defence National Rehabilitation Centre, which has now opened in the midlands. I went to see it under construction—it is sometimes called New Headley Court. That provision is genuinely world-class, I think. We can look the Americans, or anyone else, in the eye and say “We are as good as any of you at doing this.” What people can do with prosthetics is utterly humbling.

On the mental health side, I always had the view that we still had a long way to go. We were not as good, although we had made some progress. I am instinctively attracted to your idea about having some form of DNRC for the worst cases of PTSD, schizophrenia or whatever. You could send people who had served in the forces—people from DCMH who were serving and Regulars—to an absolutely specialist facility where they focused specifically on that kind of problem. Whether you could relocate it or co-locate it with the DNRC or you would want a separate facility I do not know, but I am attracted to your idea and I would say maybe the Committee should look carefully at it.

One of the things about the DNRC is that the NHS has learned a lot from the military side about prosthetics for civilian use as well, so there has been a great deal of beneficial read-across, and I believe there could be beneficial read-across into the NHS mental health trusts. That is an exciting idea. You have talked a lot about people who left with PTSD, but let me posit you a slightly different scenario: someone leaves after, say, 12 years' service in which they did one tour of Iraq and two tours of Afghanistan. When they leave, they have their exit medical and they are perfectly fine—their colleagues have not reported any problems, their CO's report is glowing—but they were on the frontline and they saw some gruesome stuff. They go into civilian life, they transition successfully and get a job; 80% of service leavers get a job within six months, because they are very employable. A few years later, say five years on, their father is suddenly diagnosed with terminal pancreatic cancer and has a few weeks left to live. It is a bolt from the blue. That is a trigger event, and then it all comes out. You are nodding at me, for the record. It all comes out, and when it does it comes out very quickly. This guy starts getting very angry, he starts yelling at his wife and screaming at his kids, he starts underperforming at work and he hits the bottle. Eventually, although his wife loves him, she leaves him because of the kids. She cannot deal with it any more, and he goes into a rapid downward spiral and ends up in a one-bedroom flat somewhere, trying to blot it out with alcohol. That can all happen in literally a couple of months. Does that ring true?

Dr Bashford: Yes.

Matthew Green: Yes.



- Q37 Mr Francois:** We are talking about veterans; the problem, I think, is that when these people present, the NHS is not getting to them in sufficient time to intervene and interrupt the spiral. We only end up getting to them when they are in a one-bedroom flat and their family ties, which we all know are so important, have broken down. Very often, how long it takes to get that person into treatment depends on their individual local mental health trust and, often, on whether the leadership of that trust has any sympathy for veterans. It could be that a senior consultant used to be an MoD doctor and therefore they get it and that guy gets treated a bit more quickly. Does that picture ring true?

Matthew Green: Yes.

Professor Finnegan: Yes.

Dr Bashford: Yes, and even when people get into a treatment pathway, what I have often come across is that they fall out of that pathway fairly quickly. We do not seem able to hold people well, even when we pick them up.

Mr Francois: Okay. That brings us on to the debate about priority.

Chair: Actually, Mark, we have priority coming up next.

Mr Francois: I have question 6, on whether veterans receive care fast enough when they need it.

Chair: Yes, but question 7 is specifically on priority, so I suggest that we pause you for a moment if we may, because Johnny has to leave us at 1 pm. Can we get Johnny in with questions 7 and 8, and we will come straight back to you?

Mr Francois: That's fine; Johnny and I have pretty similar views on this.

- Q38 Johnny Mercer:** What you have mentioned today is extremely disappointing and distressing, particularly for the veterans community. People such as Mark worked in the MoD; I am of the view that the MoD is pedalling as hard as it can with some of this stuff, but I will tell you now that I have been to see two Prime Ministers on exactly the things that you have asked for. I have seen their Parliamentary Private Secretaries, their political private secretaries and their chiefs of staff and talked about this stuff, and ultimately none of them get it. You talk about leadership; that is where this comes from. It is not for the MoD to talk about health and the benefits of a job in a veteran's recovery. It is about leadership and culture. I am sorry to report that No. 10, at the moment—well, I wouldn't say that they don't care, because they care about veterans, but they don't care enough. That is why we are where we are.

In your view, do veterans get priority across the UK? I am not one of those who thinks that a veteran who turns up should always get priority; the NHS is there to make sure that people receive healthcare at the point of need. However, we have seen all these headlines over the summer about veteran suicides. What is your view on that? Should we gather data



HOUSE OF COMMONS

on the number of veterans committing suicide?

Dr Bashford: Absolutely.

Matthew Green: Yes, I think so. This is something I have written about and looked at as a journalist. It is actually a very difficult subject to report on, because the Government do not have a central database or keep track of veteran suicides. It is down to individual coroners across the country. To get a reliable picture is actually an enormous amount of work. Various veterans groups online come up with different figures from the data they have gathered, but the fact is that nobody actually knows for certain how many veteran suicides happen. A lot of the studies routinely quoted by the MoD were done years ago—way before operations in Afghanistan started to intensify in 2006—so there is a real knowledge gap on that very question.

Q39 **Johnny Mercer:** I'm sorry to rush you a bit, but we need to be a bit clearer. The data on this is not hard to understand. If you are going to dictate Government policy, you need the data to go off. That is day one, week one. If we could take that away from this, that would be helpful.

You have answered a couple of my questions, including about how the current provision of mental health care compares with that for the general population—waiting times are broadly similar and so on—but the specific question we wanted to ask is how that compares within the four regions.

Professor Finnegan: Can I just go back very quickly to metrics? In primary healthcare there is a system called Read coding. Fundamentally, everyone in this room has a Read code. You can go into a medical practice and it will say whether you are male or female, what medication you are on, whether you are asthmatic or diabetic and so on. There is a Read code pertaining to being a veteran.

Having done a Read code search, we can say that only 8% of veterans are correctly registered. We did a six-week pilot study last year and increased that figure by more than 200%. We did a campaign inside surgeries, just using zap stands and getting the reception staff to be engaged. We went out to where veterans go, such as the local football club, the local sports club and into pubs, and we advertised there, and it went up by 200%.

One of the biggest issues is veterans not knowing that they are veterans. They do not correlate one day's service with meaning that they are now entitled to priority care. That came as a surprise, and we heard that from the staff. However, there was a spectrum. Some veterans didn't want to be registered as veterans and some were quite happy where they were. However, only being able to identify 8% of veterans inside a general practice raises a problem in relation to any metrics that follow from that.

Q40 **Johnny Mercer:** One of the best recommendations came from one of my colleagues here and was about going through the career transition partnership. It was that their payment should be made on the basis of their registering with a GP. I went to see the Prime Minister in 2015 and



HOUSE OF COMMONS

said that, and it still hasn't happened. That gets to the nub of the problem. This entire veterans piece is all about leadership and pulling it together as a whole-systems approach.

Finally, before I hand you back to Mark—this is slightly left-field—what did you think of the TV programme “Bodyguard”, Matthew?

Matthew Green: I have to admit that I haven't seen it. I'm sorry to disappoint you. I've heard it is very good, but I have not seen it.

Johnny Mercer: It is about an Afghan veteran who keeps thinking that he wants to kill the Home Secretary. I suggest that you watch it and write to me. It is not good.

Chair: We won't draw any conclusions about any Afghan veterans who may be serving on the Committee.

Johnny Mercer: Sajid and I are firm friends.

- Q41 **Chair:** Can I just check one point that arose in part one of our inquiry? There is no real convergence between the idea of veterans receiving priority treatment and the NHS ethos that everybody gets treatment according to their need as they present it. Does the concept of veterans getting priority mean anything at all in the context of the NHS, or would it simply be more relevant to talk about those service personnel who have had to go home, who are still waiting to serve and to go back, needing that extra priority because they are in the Armed Forces and their career may depend on their quick return?

Dr Bashford: I think there is confusion about the notion of priority under the Covenant, particularly among professionals in the NHS. They may not understand it at all, or it may get confused. It is always related to clinical need, and that is sometimes not fully appreciated.

- Q42 **Chair:** Can I just ask about one point? It is usually phrased as “veterans should not be disadvantaged by their service.” Arguably, because veterans' service has put them at greater risk of psychological damage, for example, that means they should get treatment earlier than they otherwise would. If it does not mean that, what does it mean?

Dr Bashford: It should still be on the basis of clinical need, but as with many of the issues we have been discussing, that clinical need is often poorly identified and poorly diagnosed, and not always understood, which has an impact. If people are not identifying who the veteran is in the first place, that is going to have an impact.

- Q43 **Chair:** I understand that, but I still want to persevere with this, because I am completely stymied by it. If everything depends purely on clinical need, what added value does the concept of there being some sort of priority for veterans give us in the context of treatment by the NHS? Can anyone throw any light on this?

Dr Bashford: In England, particularly, it has informed a lot of the development of services that has gone on. There is quite a drive towards that, which comes from the notion that this is a significant group that



HOUSE OF COMMONS

requires a priority focus. In Northern Ireland, they have sort of missed the point and stumbled over their equality legislation in how to interpret "priority". They have almost taken it as a legal basis that you cannot prioritise, because that would contravene the equality policy.

I don't think that is the right interpretation, but at local levels, you will find huge variance in this, because it comes down to how it is understood within the local context and who is actually making sense of it, in terms of what influences service provision. That is your identification of need and your commissioning plan for service provision, and that needs to specifically encompass veterans.

Q44 **Chair:** Any other views on this?

Professor Finnegan: I believe that if you are a serviceman and you have a mental health problem that is attributable to your service career, you should get priority treatment.

Q45 **Chair:** Even if, arguably, somebody else is just as ill?

Professor Finnegan: Yes.

Chair: Okay. That is at least consistent and clear.

Matthew Green: If I were a clinician and I had one unit of trauma care, and I had one patient who was a veteran of Afghanistan with multiple traumas and another who was maybe a survivor of horrific childhood sexual abuse, who would I prioritise? I don't know. I can't tell you that I am always going to prioritise the veteran in that case. It seems to me like a word has been thrown into the mix here that does not actually mean anything, or means different things to different people.

Chair: That is exactly what we are trying to establish.

Matthew Green: I think I agree with you.

I want to say one final thing, before Johnny goes, on a small practical point that is relevant here. Part of the feedback I get from families, especially those who have relatives with very acute presentations who end up admitted to psychiatric wards, is, "Please roll out more training in restraint techniques that do not involve basically slamming someone on to the ground and piling on top of them." There are ways you can restrain people in those kinds of conditions that are far gentler and equally effective. Rolling that training out is a very small thing that could be done, which would make a lot of these families' lives a little easier.

Q46 **Mr Francois:** Following on directly from the Chair's question, the Armed Forces Act 2011 enshrined the two key principles of the Armed Forces Covenant in law. The first was the principle of no disadvantage as a result of service in the provision of goods and services, and the second was the principle of special treatment where appropriate for those who have given the most, such as the injured or bereaved. That is the law. I would argue that if you have PTSD as a result of service in Afghanistan, that is an injury that you have incurred in the service of the Queen, and the nation



HOUSE OF COMMONS

therefore owes you a debt. I would therefore argue that there should be at least some priority at the margin for veterans with mental health issues.

Matthew, you have raised another emotive example, and I get that, but it seems at the moment that it is a complete lottery. It all depends on the individual policies of whichever of the country's mental health trusts you are under, and often whether senior people within that trust have any kind of experience with, and/or empathy for, the military. It is very much a lottery dependent on those factors. Is that a fair summation of the situation?

Dr Bashford: The understanding of the clinician making the assessment, and how they interpret the late-onset symptoms, complicate it as well. People trip over the argument of "Is it attributable?" and that becomes the focus, rather than meeting the needs. It concerns me that people get into arguments about the cause, rather than confronting what is in front of them.

- Q47 **Mr Francois:** You see, we have a problem, because we have had evidence from Ministers. We have had the Veterans Minister sitting next to the NHS Minister with responsibility for mental health, and when you ask the Veterans Minister, he says, "Yes, under the Covenant, veterans should get priority." When you ask the NHS Minister for mental health—who is a friend of mine, by the way; they both are—she says, "Actually, no. We have to do it on the basis of clinical need." There is clearly a philosophical difference, which leads to two questions: what is the point of the Armed Forces Covenant, and why did Parliament pass this Act in 2011 if the NHS does not take any notice of it?

Matthew Green: That is a very frequent comment among families I speak to who rail against the Armed Forces Covenant, precisely because they run into these barriers and feel that the Covenant has not made any practical difference to them. I do not know what the answer is, in terms of giving priority or not, but it has crystallised a lot of the resentment or sense of betrayal that a lot of these families feel.

- Q48 **Mr Francois:** Is there any way, Jon, that the NHS could try to standardise—at least to some minimum standard—the priority that it gives to veterans, so that we do not have this total postcode lottery between the trusts?

Dr Bashford: I think you can standardise it in terms of the balance of provision. We only have specialist veterans' mental health provision because of the Covenant; that would not happen without it. That is a form of prioritisation above other groups, and it is important. This is a capacity issue. We need to encompass and embrace that properly at local commissioning and planning levels, and decide how this fits within the mix of local service provision.

- Q49 **Mr Francois:** And you are talking about clinical commissioning groups.

Dr Bashford: Yes, or possibly at the level of strategic partnerships, which is a slightly higher level than local commissioning groups.



HOUSE OF COMMONS

Q50 Chair: Is the current Government mental health care provision for families of serving personnel and veterans sufficient? What should be different about this provision, compared with the general population—we have touched on some of that—and how does provision vary between the four nations? I think you said earlier that you are not regional experts, but if you could give me anything out of that triple-headed question, I would be grateful.

Dr Bashford: I think it is really poor; families get a raw deal across the board. I have spoken to a lot of families across the four nations, and they feel ignored and left out. Families are, on one hand, a prime support, and we should be embracing that and supporting them to give help. They also have their own problems and mental health needs, and they struggle to get appropriate access. We have talked about the issues with read codes and GPs identifying veterans. They are even poorer at identifying the families of veterans. The main element of provision that exists is in the voluntary sector. There are groups, such as Parents4Parents in Yorkshire, that provide a really comprehensive support service to the family members of both the serving and veteran populations. In terms of a comparison with the general population, I do not think the NHS is very good at doing that for anybody, but it becomes particularly acute with veterans when the family members are such a key support. We should be doing everything we can at earlier points to keep those families intact.

There are issues within that around children, with the risk and concern that —especially if there is a lot of trauma, domestic violence and aggression within the household—the kids are suffering. You are passing on the impacts of trauma across generations.

Q51 Chair: Any further comments?

Professor Finnegan: For Regular Armed Forces personnel, the care for families is particularly challenging. The Regulars are seen under the Defence Medical Services and the families are seen by the NHS. If you want to provide some form of couples' therapy or they are having relationship issues, it can be very difficult, and that is a challenge.

I endorse what Jon said: care for families in the veteran community is poor. For many old soldiers who volunteered to join the Armed Forces, the family take a particular burden. When the serviceman is away, the family can be isolated and get poor support. The longer the service, the more challenges there are for the family, but that is not really recognised.

Matthew Green: I thought Mark Francois painted a very accurate picture of so many of the cases in which a veteran starts to struggle, and the family bear the first impact of that. I 100% endorse what Dr Jon Bashford was saying about how trauma is transmitted right back from Iraq and Afghanistan to our homes, and particularly to spouses and children. Just before I came here today, I received an email from a mother whose husband had served 18 years in the Army—in Afghanistan and so on—and took his own life three years ago. He was on a five-month waiting list for PTSD treatment on the NHS and just could not hang on any longer.



HOUSE OF COMMONS

Q52 **Chair:** I am sorry—I just want to come in there. We said earlier that when there were crises, people went to the front of the queue. Evidently, that did not happen in this case.

Matthew Green: I hope that my earlier comment was phrased precisely enough. The theory is that you would be triaged in the DCMH, but whether there is a service there is another question. It is obviously the same outside the forces as well.

Q53 **Chair:** But something obviously failed in that part of the NHS for that veteran.

Matthew Green: Yes. This is a classic story that I have come across so many times. The point that I wanted to bring to your attention is that she says, "My son, 11 years old, is now suicidal and self-harms and wants to die and be with Daddy." That is an absolutely classic picture of what is taking place in so many of these households. Mark pointed out that the dilemma for wives—of course there are men who are married to veterans, but mostly it is women—is: "Do I stay and try to hold things together and essentially keep my guy alive? Or do I leave for the sake of the children?" It is an agonising dilemma, and so many families up and down the country are facing it.

One thing that was suggested to me by a support group called Combat PTSD Angels was training for carers. Essentially, overnight, those women and their families are becoming 24/7 mental health nurses. Is there some way they could be given at least some guidance in best practice? I think that would be a fairly easy, low-cost measure that might actually help some of these families.

Q54 **Chair:** Here is an idea. Imagine a situation where you have got a veteran, who was perhaps being cared for quite well while he was serving but who has now gone and that care has ceased. I think it ceases after quite a short period of time. Is it six months?

Witnesses: Yes.

Q55 **Chair:** Could there not be some system whereby if a family member triggered the Armed Forces machinery, they could communicate with the NHS about the particular circumstances affecting this person, as a direct result of his or her military service? That would be one way of making it a question not so much of priority, but of not being disadvantaged by your military service.

Dr Bashford: That would be an idea. We still trip over confidentiality and professionals not talking to family members because they believe it would compromise the confidentiality of the individual person, or not always listening to them.

Q56 **Chair:** Couldn't part of the leaving package be—just as we were talking about having to sign up to a GP before you get your payoff—having to nominate someone to be able to speak on your behalf, under these circumstances?



HOUSE OF COMMONS

Dr Bashford: It could, but I don't think we have the culture outside ready to accept that basis very well and to work with it. We then have the issue that there might not be any problems apparent at that time, and they might come later. The other thing is that we looked at a range of very complex cases where there are not just mental health problems but criminal justice involvement. One of the consistent characteristics in those complex cases was family members repeatedly raising concerns and not being listened to.

Q57 Graham P. Jones: Do you think that Armed Forces charities fill the gaps in Government provision? How effective are they in doing that? Is there duplication of effort? Do we have regional variations provided by various charities? Specifically, do they do enough to support service families with regard to mental health?

Dr Bashford: I think they do a terrific job, on the whole. There are many excellent examples of the military charities providing brilliant services. To some degree, yes, they are plugging gaps. Some of that might be appropriate; some of it might be due to the systems not being adequate enough, and we don't give enough support to those charities to enable them to deal with that level of demand.

I know from cuts in local authority services that, across the board, charities have absorbed additional referrals—cases—sometimes with more complexity than they were designed to deal with, as a result of other system problems. That is equally true of the military charities.

At the same time, I would say that we have a huge amount of Armed Forces charities, some of which are not very good and some of which are not providing evidence-based treatments. There is a lack of co-ordination, and it is complex and difficult for veterans, family members and professionals to know what is good, and how you determine that in terms of local provision. Where money is directed in support of that sector is not always thought through on the basis of effectiveness.

As I previously said, what works best is where we have integrated provision—the statutory and voluntary sectors together. Having them work separately is not good; it needs to be part of joint provision. Project Nova, working with the liaison and diversion services, is part of an integrated package and is excellent. It is worth pointing out that in Northern Ireland, of course, you are totally reliant on the voluntary sector because they don't have statutory specific veterans' provision in Northern Ireland. The voluntary sector there is absolutely vital.

Professor Finnegan: I would agree on integrated care. Feeding back into the last question, if we have GPs and primary health care staff who really understand the veteran communities and what pathways are available to them, that should work pretty well.

We have said that, quite often, these mental health issues are due to situational stresses, and that is where the charity sector can help. If there is a lot going on in your life, a mental health charity and the third sector



can provide support. For example, if I am just about to lose my house but the RBL are going to pay my rent for a month, that is probably going to have a good effect on me. They can provide that sort of provision, which is very important.

I also know that the charity sector is supporting some of the initiatives I mentioned earlier. It is supporting the Everton football club hub, which attracts people in—people who would not normally go to a GP practice.

The other area where they are covering the gap to a certain degree is in care homes. We keep on talking about the elderly in relation to dementia. The RBL now have six care homes, which provide a good service. There are, of course, limitations because of where they are based and capacity, but together it works best with an integrated care pathway. Anything that removes some of those stresses is likely to improve the mental health of the individual.

Matthew Green: I would pick up on a lot of what Jon said just now. He is right about the need for integration. There is an enormous number of charities out there, as you know. It has been extraordinary how the landscape has evolved since the Afghanistan campaign. Take Help for Heroes: it was only founded in 2007, and now it is pulling in almost £40 million a year. That is an enormous amount of money going to the rehabilitation of ex-forces through a charity. Combat Stress has a smaller budget and is dealing with cases of post-traumatic stress and other mental health problems that the system cannot cope with.

The issue with so much charitable provision is that, as Jon and Alan pointed out, essentially those who have not had the help they need from the system end up going to charities, which may, in some cases, be the least qualified to deal with them. There is some great work being done out there, but there is also some not-so-great work.

I think it is also important to complete the picture of the gap in the system. Combat Stress is obviously the big charity for veterans' mental health, and it receives Government funding. If you get referred there and are admitted to the programme, you get perhaps six weeks of residential therapy and care, and then you leave. If that hasn't worked, where do you go? That is when some of these cases end up bouncing back into the psychiatric care system or elsewhere. A lot of money being spent and a lot of charities proliferating has not actually provided the final piece of the puzzle that we need to save some of the people that I have been talking about throughout this session.

- Q58 **Graham P. Jones:** Those are very interesting answers. I have some concerns. The Veterans' Gateway is to be applauded. I have a fantastic British Legion in Haslingden that has just restarted, but there seems to be a disconnect between that charity and, for example, the Veterans' Gateway, and people accessing it or going through it—that being a local gateway. Veterans in Communities is in Haslingden in my constituency; down in Accrington, they don't even know it exists. It is in a different borough, but the same constituency.



HOUSE OF COMMONS

I was going to ask a question about Veterans' Gateway, but I want to tie that in to the point that you have all made: some of these charities are quite poor. How does the national Veterans' Gateway work with the local gateways, and what are we doing with some of the poorer charities and the notion that we are somehow going to integrate—coming back full circle to the Veterans' Gateway—these charities in a meaningful way for our veterans who are looking to access services? There is a circular picture that comes back round on itself. What would you like to say about the poor charities, the Veterans' Gateway and help for some of the good local charities?

Dr Bashford: I welcome the Veterans' Gateway. Consistently, in our reports, one of the common issues across the nations was the need for better information—trying to do that and co-ordinate in that way and put it into an easy, approachable one-stop thing to keep. As you highlight, we also see the need for that to then link into the local system. We would like some kind of national template for what good is, and how we encompass such a range of different levels of provision, which might go from a befriending service to a therapeutic intervention. There is such a huge range out there. I think Cobseo and others should come together with some of the statutory national leads to work out some form of regulation. I do not think it would help to have anything too heavy. We don't want to bring a burdensome level of regulation and administration to a sector that does not have sufficient capacity, but we need something whereby individuals can easily identify what good looks like.

Professor Finnegan: The Veterans' Gateway is a good idea. However, how many veterans are aware of it is questionable. I think that, if you google the Veterans' Gateway, it comes up about halfway down the page. There is also Veterans UK, and Combat Stress has a 24-hour helpline. It is about understanding whether veterans are aware of that. I am not convinced that they are.

If the poorer charities advocate some form of intervention—as in some form psychotherapy or what have you—but they are poor charities. We don't understand why many veterans decide to go to those local groups. They are aware of the Royal British Legion, Help for Heroes, Combat Stress or others but they decide to go to these smaller groups. We are still not too sure why they do that.

Matthew Green: I think that it's because they cannot get the help that they need from these groups. I know so many ex-forces who have knocked on the doors of those bigger organisations and have not received the support that they need. I agree that it is a dilemma, because I know some excellent charities that have no endorsement from anybody but that do great work. I have also heard of others in small towns that have so much money flowing through the door and it suddenly goes missing, and all kinds of problems result from that. It is a very mixed picture, which is why that is such a difficult question. I do not have the answer right now.

One point worth adding on the charitable sector is the almost total lack—apart from one example I know of—of charities dealing with veterans'



HOUSE OF COMMONS

alcohol problems. The Committee has heard in previous sessions that that is one of the most prevalent problems. Tom Harrison House in Liverpool is the only charity that I came across offering residential rehab care for ex-forces, and that only opened in 2014. There is a remarkable gap. There is no rehab for heroes. That may say something about attitudes towards ex-forces, but it is a gap in the system.

Mr Francois: You have Veterans Aid in the east end—Hugh Milroy and all of that.

Matthew Green: Okay. It's a big landscape, but I think it is an underserved population.

Dr Bashford: Forces in Mind Trust is currently mapping some of the voluntary sector provision in a mental health context. I think that evidence will be interesting.

Chair: I had an email from Dr Hugh Milroy only yesterday about how this great new building has been opened for precisely these sorts of circumstances, by the Mayor of London no less. Let's hope that that meets with the success that it deserves.

- Q59 **Graham P. Jones:** I have a great local charity—Veterans in Communities, again in Haslingden—that does great work and is valued considerably in the veteran community. However, they are not easy to find on the Veterans' Gateway, for example.

You talk about poor charities. Many of them will be seeking grant funding from the national lottery or whoever, or will pass round the bucket at local fundraising campaigns. Should there be some form of accreditation or quality assurance on the services those charities provide, or even on the charities themselves, in order that we can move towards some form of voluntary integrated system? I appreciate that it won't be fully integrated. However, that knowledge, and investment in those that are doing well, would surely be helpful.

Dr Bashford: I think we should. If you look at the alcohol and drugs sector generally—not just for veterans—most of it is provided by the voluntary sector. It is subject to regulation and it is governed by clear standards. What is brilliant about the voluntary sector is that those charities are started by committed individuals who understand and perceive a gap and do something about it. You don't want an overly burdensome system that stops that creativity and immediacy. Getting that right is tricky.

- Q60 **Graham P. Jones:** Should they be accredited? Should there be a quality assurance, and should they be on the Veterans' Gateway when they achieve that? Should that be on the Veterans' Gateway, and should there be a better system?

Dr Bashford: I think the Veterans' Gateway should only be recommending services when they are confident that they are good. We need a system to do that, and it should come from some form of accreditation. I think LIBOR funds—public funds—should be given to



HOUSE OF COMMONS

services that have a clear evidence base and fit some national criteria. It is harder to say what things the Big Lottery Fund should fund and to legislate for that, and what individuals want to give as donations. It is harder to manage that system, but there are some areas where we can clearly do something.

- Q61 **Graham P. Jones:** Some form of quality assurance or accreditation would be very beneficial.

Professor Finnegan: Cobseo, the confederation of service charities, has a governance structure relating to that. This feeds into what Matthew said. Even when people are informed about these charities, they still choose to go to other ones, and we don't know why. Matthew's point—they may just feel let down by others—is a good one. We don't know why. There are other groups out there that provide the sort of recreation—getting service personnel together—that they like doing. I did a study a couple of years ago about a group of veterans who went and did archaeology together. I wouldn't say that it got rid of any form of mental health condition, but it got them working together in a group with comrades they enjoyed being with. That is something that could be a pathway. If you could get into those types of activities and signpost those who need support into mental health services, that would work as well.

- Q62 **Graham P. Jones:** How is this integrated?

Professor Finnegan: When we talk about mental health treatment, it tends to be cognitive behavioural therapies and NICE therapies, and it is just not that straightforward. What you really want is something that will help help-seeking. Help-seeking in the Armed Forces community, and young men in particular, is poor. If you have some form of perhaps charity-led activity that gets people to come together and then signposts them into a form of therapy—they have got examples in America, and we have got examples in the UK—that would form some sort of integrated pathway.

- Q63 **Mr Francois:** I think there are something like in excess of 2,000 military-related charities in the United Kingdom. In my experience, they vary greatly because of their history, how they were founded, and their aims and objectives. They all want to help and do good, but they want to do it in their own way. Trying to co-ordinate the activities of those different charities can often be quite difficult. For instance, a few years ago, Help for Heroes and the Royal British Legion famously had a very poor relationship—it is a lot better now—and that can translate down to a much lower level.

In this space, clearly Combat Stress are the market leader. I have been to Tyrwhitt House, and I remember speaking to a sergeant major there. I said, "What are you doing here, sergeant major?" He said, "Well, I did nine tours of Op Banner in Northern Ireland, sir," and I said, "Right, well, I think that answers the question."

As you say, Matthew, they have capacity issues. Help for Heroes, for instance, have invested a great deal of the money they have raised—I am



HOUSE OF COMMONS

a great Help for Heroes fan—in physical rehabilitation centres like Tedworth House and Chavasse House in Colchester, which I know quite well. Is there spare capacity in those centres that could be used for mental rehabilitation? There is a lot of evidence to suggest that veterans do well when they are in the company of other veterans—that whole team spirit. They recover together.

I wonder, just off the top of my head, whether Help for Heroes have a lot of spare capacity that could be put to good use. I just wonder whether you think any of those ideas has any merit, or whether you have got any suggestions. The Charity Commission is ultimately responsible for the governance of charities, and Cobseo have a mental health cluster of charities that work in that space. I wonder whether you have got any ideas about how this can be more joined up.

Dr Bashford: Interestingly, it is not always appreciated that the voluntary sector have resources, so they can bring in funding that the statutory sector cannot access to enhance local service provision and do more. We still have a problem that, generally, the NHS does not work well with others. That goes back to some of the leadership and cultural questions. You have got to show how good partnership working can mean something and make a difference.

We need to stop treating the voluntary sector as a poor relation and give it the credit and its due for what it does provide, and provides very well, as an integral part of the whole pathway, especially in terms of a lot of those wrap-around support areas such as housing support, practical advice, befriending and access—people will often go first to a voluntary sector agency. They feel more trust. We know that the voluntary sector does that better, so let's capitalise on that and make it formally part of the system. We can do some things in terms of national regulation, but locally it still comes back to commissioning plans locally embracing the sector, and supporting people to form proper partnerships. We do have good examples. We need more of it.

Matthew Green: I think it is a brilliant idea to use one of those potentially underutilised centres that have been built by Help for Heroes to house the national trauma centre. That would solve two problems in one go.

Q64 **Mr Francois:** Well, Bryn Parry no longer runs Help for Heroes, but having got to know him a little bit, I would be interested to know what his view on that would be.

As you said, Dr Jon, the voluntary sector brings in additional resources because however much the state spends, there is always an extra pound that the voluntary sector can bring. In the case of the DNRC, that was really the brainchild of the late Duke of Westminster, who put up a lot of the money and seed capital to get the thing rolling. Then he knew a few people. In total, I think it cost about £300 million or thereabouts. They raised the money almost entirely privately. That was the late Duke's bequest to the nation, if you like. I wonder whether it would be possible to have the voluntary sector and/or benefactors come up maybe with the



HOUSE OF COMMONS

funding for a national centre for mental health. The more I think about it, the more I think that might be an idea. It would be interesting to talk to Help for Heroes to see if they were up for it.

I wonder if you have any other ideas to finish. There are lots of small charities that have often been formed by the loved ones of someone who has been killed on operations. To give one example, there was a guy called Aaron Lewis who was a commando gunner killed on operations in Afghanistan by a stray round. It was an absolute freak occurrence. His parents, Barry and Helen Lewis, formed a wonderful small charity called the Aaron Lewis Foundation, which has raised tens of thousands of pounds for veterans and good causes. That is one of the ways, positively, that they have dealt with their grief, but they would probably admit that doing mental health work is not really their *métier*.

I wonder whether there are any final thoughts on how the charitable sector could assist in this endeavour, or have we covered it?

Dr Bashford: As you have described.

Q65 **Chair:** We are almost on exactly two hours. Thank you all for your endurance. Before we draw stumps, is there anything that any of you would like to say in conclusion?

Dr Bashford: We haven't spoken a lot about veterans in the criminal justice system. I would just like to ask the Committee to keep that on its radar. They are a small group but they have significant issues.

Professor Finnegan: We haven't spoken as much as I would have wanted to about education for GPs and nurses. We have spoken about how veterans will turn around and say, "You don't understand what I've been through." There seems to be acceptance from healthcare practitioners not to engage. You don't need to be an asthmatic to treat someone with asthma, you don't need to be a diabetic to treat someone with diabetes, and you don't need to be a veteran to support veterans.

We are leading on an initiative in Chester that is looking at undergraduate training—getting our future workforce to have a common level of training so that, when they qualify, if someone turns around and says, "You don't understand," they will hopefully feel empowered to say, "Maybe I didn't serve, but I've had some training. Let's talk about it." That is a key aspect of how we prepare for our veterans of the future.

Matthew Green: In previous sessions there has been a lot of mention of the way the media cover this topic—not always positively. I hope that we can play a constructive role by highlighting some of the cases where things have gone wrong, and some of the best practice and initiatives out there that are doing some great work. Particularly, on a subject that we didn't get to, when it comes to which therapies are used there is some incredibly exciting innovation taking place in this field. That is the subject for another whole Committee. It is offering real hope. I think that is my real message.

Q66 **Chair:** May I ask which therapy you have in mind?

Matthew Green: You're getting me on to my favourite subject.

Chair: Just the title will do.

Matthew Green: I would look at the comprehensive resource model—that is the technical term—but, more broadly, at therapies that work through the body up as much as the mind down, because trauma symptoms live on in those deeper parts of the brain that do not always understand reasoning and cajoling. That is why the evidence base for CBT is actually a lot thinner than a lot of people realise.

There are so many people out there who want to get this right, and to prevent some of the awful cases that we have been hearing about. I feel personally honoured to have been invited, and I wish you all the best in pressing this agenda forward and saving lives.

Chair: Can I thank all three of you? It has been an outstandingly informative session, and you can see from the interest of members of the Committee throughout the two-hour session how seriously we take the problem. If there are any afterthoughts, as opposed to aftershocks, that occur to you that you wish to submit in the form of written evidence, we are always open to written evidence from experts and the wider public—details are on the website.

With that, thank you all very much indeed.