

Defence Committee

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

Tuesday 13 November 2018

Ordered by the House of Commons to be published on 13 November 2018.

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

Questions 67-212

Witnesses

I: Charlie Wallace, Scottish Veterans Commissioner, Mark Birkill, Therapist, Veterans NHS Wales, Dr Oscar Daly, Psychiatrist, Combat Stress Northern Ireland, and Dr Bethany Waterhouse-Bradley, Lecturer in Health and Social Care Policy, Ulster University.

II: Dr Jonathan Leach, Honorary Secretary, Royal College of General Practitioners, Dr Deirdre MacManus, Royal College of Psychiatrists, and Dr Michael Grey, Reader in Rehabilitation Neuroscience, University of East Anglia.

Written evidence from witnesses:

[Mark Birkill](#)

[Dr Bethany Waterhouse-Bradley](#)

[Dr Deirdre MacManus](#)

Examination of witnesses

Witnesses: Charlie Wallace, Mark Birkill, Dr Oscar Daly and Dr Bethany Waterhouse-Bradley.

Chair: Good afternoon and welcome to this second part of our two-part investigation into mental health and the Armed Forces. This second part is about the provision of care. We have a panel of four this afternoon in the first half of the proceedings. Could you say a word or two about yourselves by way of introduction?

Mark Birkill: I am Mark Birkill. I am a veterans' therapist with Veterans NHS Wales. I have been in post since the service started six or seven years ago.

Charlie Wallace: My name is Charlie Wallace. I am the newly appointed veterans commissioner for Scotland. I have been in post for precisely 17 days and therefore have a wealth of knowledge that I am looking forward to sharing with the Committee.

Dr Waterhouse-Bradley: I am Bethany Waterhouse-Bradley. I am a lecturer in health and social care policy at Ulster University. I am also the project co-ordinator for the Northern Ireland veterans' study.

Dr Daly: I am Oscar Daly. For the last four years, I have been a psychiatrist with Combat Stress in Northern Ireland. Previously I was a psychiatrist in the NHS for 30 years.

Chair: Thank you. An excellent geographical spread. Ruth will start us off.

Q66 **Ruth Smeeth:** Good afternoon. Do you believe that veterans understand what mental health care provision they are entitled to?

Dr Waterhouse-Bradley: The veterans that we spoke to in the second part of the veterans study did seem quite confused, generally speaking, about what they were entitled to in terms of mental health services, and particularly what they could access that was specialist to veterans in Northern Ireland. There was quite a broad mix of awareness of entitlements. Veterans who were involved in the troubles, who were in home service, had some awareness of specialist services—the Aftercare Service, for example, that is set up specifically for that cohort—but people outside of that were much more general and felt like going to their GP would be their main port of call.

Charlie Wallace: From a Scotland perspective, the understanding of the mental health services that are available is pretty good, but it could always be better.

Q67 **Ruth Smeeth:** Do you think veterans understand what specifically would be different in terms of your nations versus what they might consider to be general NHS provision?

Charlie Wallace: I wonder how many of those veterans understand the difference between NHS England, NHS Northern Ireland or Wales or



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Scotland. To them it is just the NHS. What they see is the NHS in their particular area that they come from. I don't think they differentiate.

Dr Waterhouse-Bradley: I would say that a lot of the veterans I have spoken to would have maybe even overestimated how much more veterans living in other parts of the UK would have access to, in terms of specialist mental health services.

Mark Birkill: My sense is it is a generational thing, so the younger guys coming out of the forces now have a better understanding and are perhaps more aware of mental health than the guys in their 50s and 60s.

- Q68 **Martin Docherty-Hughes:** Charlie, congratulations on your appointment. It is good to see you here. I just wonder, in terms of the expectation of care, what do you see as being your role as the Scottish veterans commissioner, and do you think the approach could be rolled out across the other nations of the UK, to help with these boundary issues, in which we could be better co-ordinated?

Charlie Wallace: I think my role is very much to look at the statutory and moral component of the Scottish Government and how it is approaching care for veterans, and helping veterans reassimilate into society. Can it be covered across the rest of the UK? Of course it could be. I sense that I have an advantage that we work in a country that is pretty tight. There are not that many people in it, relative to the United Kingdom as a whole. The community is much more stable, perhaps, and therefore it is easier to bring that together than it might be, for instance, in just England; but, of course, there is an opportunity—and the role brings that opportunity—to hold the Scottish Government to account, in my case, to make sure it is doing what is its statutory responsibility and, more importantly, focusing on the moral responsibility. That is the area for debate—what we mean by that.

- Q69 **Gavin Robinson:** Good afternoon. Bethany, you mentioned veterans often overestimating the level of care that is available to colleagues in different parts of the United Kingdom. Is that a Northern Ireland phenomenon, where we believe care is different, and it does not similarly occur in Wales, England and Scotland—where there is a sort of “the grass is greener on the other side of the fence” scenario? Is it born out of a dissatisfaction with the care they receive, or do you have other suggestions as to why there is that view? Obviously, the Armed Forces cross our geographical and jurisdictional divides within the United Kingdom. From listening to you, I wonder if you have a sense that relationships are therefore built up with service personnel who may have come from another constituent part of the UK, so they obviously talk and share information. Is it not born out of the experience of their friends and colleagues who may have similar circumstances of mental health difficulty but are living in other parts of the United Kingdom?

Dr Waterhouse-Bradley: That did not necessarily come across, but I think that might have been because a large part of our cohort were home service veterans—so veterans that would have served specifically in



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Northern Ireland, and maybe did not have as much exposure. We had a lot less who had served in other spheres. I think a lot of it is related to the Armed Forces covenant, and an awareness that there is no overt, formal implementation of the Armed Forces covenant—so there is an assumption that if the Armed Forces covenant was in Northern Ireland, that would give them access to things that they cannot access. I think a lot of the time an overestimation of priority treatment is related to an assumption that the covenant really significantly disadvantages them.

Q70 Gavin Robinson: Dr Daly, do you have any contribution to add to that, or do you see any cross-fertilisation of the information shared among comrades?

Dr Daly: Obviously there is a bit with social media, as it is now, but, as Bethany says, probably about 50% of the people we see now in Combat Stress would probably be ex-UDR or RIR. We are increasingly seeing veterans from Afghanistan and Iraq. While I think non-implementation of the covenant probably is the main impetus for veterans feeling like that, I think it probably, whether known to them or not, reflects the fact that in Northern Ireland less resource is given to psychiatric services compared with England, Scotland and Wales. I think at the moment it is 6% now, whereas I think it is about 10% in the rest of the UK. I suppose that is reflected, too, in how they perceive things. We do not have access to psychological therapies the way the rest of the UK has. We have no IAPT, for example. We do not have TILS, which has been developed recently. So our veterans, even if they do come into the service, are at a distinct disadvantage.

Q71 Gavin Robinson: Yet it was suggested that we overestimate the care provided in other areas. So you would say that there is actually a genuine distinction between the levels of care available in Northern Ireland as opposed to other constituent parts of the United Kingdom.

Dr Daly: Yes, I think there is, but whether veterans know that or not, I am not sure.

Dr Waterhouse-Bradley: To clarify, I think there is a genuine difference in what they have available, but they maybe overestimate what the entitlement is in other places.

Q72 John Spellar: We are clearly moving seamlessly from the subjective impressions into the objective analysis, so the question whether the provision of mental healthcare to veterans in your nations is sufficient probably applies more to the other two witnesses. And do you know whether the treatment provided is effective? Also, to all of you, where gaps appear, are charities effectively filling those gaps?

Mark Birkill: I have lost the first question.

John Spellar: The first question is: within Wales, for example, is the current provision of mental healthcare to veterans sufficient, and what assessment have you made as to whether the treatment is effective? Then, where there are deficiencies and gaps, are the charities filling



them?

Mark Birkill: In terms of the level of provision, across the health boards in Wales there is a waiting list from no weeks in some health boards to 18 weeks in others, and one health board—mine, I’m afraid—has a waiting time of 49 weeks. There are issues in terms of the geographical area that we cover in reality and where we hold clinics, but I suppose we could always do with more people doing my role, if I am honest.

In terms of filling the gaps, the Welsh Government have a referral protocol where they suggest that people come through Veterans NHS Wales first and, if the veterans don’t get better or prefer a different service, it is suggested that they go elsewhere—usually Combat Stress. There is a problem sometimes with some charities, in that they fill the gap in terms of psychological treatment but they are perhaps not filling it with evidence-based therapies. That is something to be mindful of.

Charlie Wallace: From my perspective as the new Scottish veterans commissioner, I cannot bring you any statistical facts, but my perception is that the provision of mental healthcare is okay and the understanding of mental health issues is growing. I am not so sure, and I would like to find out whether the provision of mental healthcare is matching the increased understanding of mental health issues. I think there is a place for the charities in that. The charities, specifically the likes of Combat Stress, play an important part in helping us to understand the mental health issues that our ex-service people, and service people, are facing. Hopefully, the two of those can work together to make sure that there is better understanding of what provision we should be providing and, of course, that we are providing it.

Q73 **John Spellar:** What about the role of charities in Northern Ireland? We have already dealt with the other part.

Dr Daly: In Northern Ireland, despite our history, very few statutory services have been set up to treat trauma, apart from after the Omagh bomb and two services in Belfast, no services in the statutory services were dedicated to trauma. Most of the charities are based in England—their headquarters are in England—but do reach to Northern Ireland. Combat Stress has a very small community-based service, with residential care available in Scotland for those who need it, but we don’t have enough resource to meet the need.

Dr Waterhouse-Bradley: To emphasise that point, Combat Stress is the only voluntary sector organisation specifically set up to deal with mental health issues in Northern Ireland. Forty-five per cent. of charities have headquarters based in England, as opposed to 6% in the charity sector as a whole, and there are only between 19 and 21 organisations—depending on how you define them—set up for veterans in Northern Ireland, as opposed to close to 600 in Scotland and 1,800 in England and Wales, so there is quite a deficit.

Mark Birkill: It has just occurred to me that some of the waiting lists in some health board areas were higher, but we have had money from Help



for Heroes to employ additional veterans' therapists for three years. That is probably a way in which the charity sector can assist us.

- Q74 **John Spellar:** Given the services that you do have, is it your experience that GPs and other NHS practitioners are actually aware of the services available to veterans? Also, I presume—or certainly hope—you make some comparisons between each other and try and plagiarise good ideas from each other. What sort of good practices would you wish to take from some of the other nations in order to improve that in your own?

Charlie Wallace: From a Scotland perspective, the awareness of the practitioners to the service community writ large—that is still serving and the veterans' community—tends to be based geographically: where the serving community has traditionally been and where people tend to retire. Therefore, it is not even across the whole of Scotland. There are areas, I think, in Scotland, which I am looking forward to exploring to confirm whether I have got this right, where there is a level of ignorance in the general practitioner worlds about veterans and the needs of veterans. That is easily countered in some areas where there is absolutely a very clear understanding and very clear support, and more importantly there is a very good understanding of the charitable sector and support that they can get from that. If I can replicate that across the whole of Scotland, so that retiring service person wherever they go in Scotland can be sure to pick up support, that would be a result for me.

- Q75 **Mr Francois:** Mr Birkill, you said that in your health board there is a waiting list of 49 weeks. Which is your health board?

Mark Birkill: Betsi Cadwaladr in north Wales.

- Q76 **Mr Francois:** North Wales—okay. Forty-nine weeks wait for what?

Mark Birkill: For psychological therapy to start. We will have assessed people. Talking of good practice, we have borrowed from the Scottish model and now have peer mentors that are attached to us. They can provide support emotionally, socially and practically, while the person is on the waiting list. Yes, it is 49 weeks. We have had a Help for Heroes-funded veterans' therapist in place for six months. Hopefully that will begin to take that waiting list down. We are also piloting a telephone therapy symptom management-type intervention for people on our waiting list.

- Q77 **Mr Francois:** But if you have a veteran who has got serious psychological issues in your health board area, they have to wait virtually a year in order to get actual psychological help?

Mark Birkill: That is for the longest wait. It is not like that across the whole of north Wales.

Mr Francois: No, but in your health board area it is a nearly a year.

Mark Birkill: In the area that I cover within north Wales and for people who cannot travel to clinics outside their home town, then yes, but it is, in fairness, for a smallish number.



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Mr Francois: One of the things we are looking at is regional variations. I don't mean to be rude, but I don't think we have heard of anything that bad anywhere else in the United Kingdom. I am personally quite amazed by that.

Ruth Smeeth: I think there might be another response, so there might be something—

Q78 **Mr Francois:** Really? Okay, well we will come to that later. Does that include veterans who are suffering from psychosis?

Mark Birkill: We would not see people who are suffering from psychosis. We see people who have a serious related mental health problem. If it is a psychosis then they would go through the normal NHS secondary care system. If somebody has PTSD and they present risks to themselves or others and have difficulty functioning, they would be referred on to the community mental health team anyway for support.

Q79 **Mr Francois:** Sorry to dwell on this, but it is quite important. Just so we can get our heads around it, why in your particular health board area is it nearly a year?

Mark Birkill: We offer people the option of travelling to clinics across north Wales. It seems to me that we have a cohort of six or seven individuals who aren't able to travel beyond the closest clinic.

Q80 **Chair:** Can I just ask about that point? I thought some therapies such as IAPT can be delivered over the telephone. Is that not right?

Mark Birkill: That is possible. I know Combat Stress have trialled some cognitive therapy over the telephone and I believe they have good results. For a certain group of people, face to face is necessary, for those who perhaps have the most intractable difficulties. They often tend to be the ones who don't have access to transport or who can't travel.

Q81 **Chair:** Do you do anything over the telephone for less serious cases?

Mark Birkill: I know a colleague in west Wales does because of the sheer distances she has to travel. I will do telephone assessments. I have done; I have treated somebody with insomnia, post his PTSD but who had outstanding insomnia. That is fairly easily done via Skype or telephone. For complex PTSD problems, that face-to-face moment is so important.

Q82 **Mr Francois:** Did we say that there was another example comparable to a year elsewhere? Did someone say that?

Dr Daly: In the NHS in Northern Ireland, if you are looking for psychological treatment for an individual with PTSD or other conditions, the waiting lists vary within trusts but it can be up to close to a year. For acute problems, the individual will be seen much more quickly, within hours if need be—so that is someone who is suicidal or developing a psychosis. But for somebody who has been assessed with PTSD, for example, and is deemed suitable for a psychological treatment, the wait can be considerable, both in the NHS and in the charitable sector.



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Q83 **Mr Francois:** Why a year? Is that just pure lack of resources?

Dr Daly: Yes.

Q84 **Mr Francois:** Let us imagine that we have a Corporal Tommy Atkins who has fought in Afghanistan. He has come back and, maybe after he has left the Army, he has a trigger event such as a family bereavement or something like that, and he starts to suffer clear symptoms of post-traumatic stress disorder. It will take him a year to get any help?

Dr Daly: To get him the most appropriate help, yes. He would be seen, assessed and deemed suitable for treatment, so he would go on a waiting list. He might then get some support during that period, but it wouldn't be active treatment.

Q85 **Mr Francois:** But what about the Armed Forces covenant?

Dr Daly: The Armed Forces covenant does not apply in Northern Ireland.

Q86 **Mr Francois:** It does in certain communities, because certain councils are more likely to have signed it.

Dr Waterhouse-Bradley: But local councils do not have responsibility for the administration of health care. Even though the council has signed up, that is a good relations policy more than anything else. They do not have a remit for health care, so they can't make decisions about health care.

Mr Francois: I defer to Gavin on the Northern Ireland specifics, but I am disturbed that it can be up to a year.

Q87 **Gavin Robinson:** To clarify, I have shared with the Committee correspondence from the then Health Minister, Sinn Féin's Michelle O'Neill in 2016, which explicitly used the phraseology that Dr Daly used, which is that the military covenant does not apply here. It was factually incorrect but she was giving a policy direction through her Department to the trusts. I raise this every time we do the covenant and reports. That means that the way in which our trusts have to respond to the needs of veterans is below the radar and unsatisfactory.

Dr Daly: The veteran will join the waiting list, along with other people who need treatment for PTSD. The need is dictated on clinical priority.

Q88 **Ruth Smeeth:** Can I just clarify what you are saying? If a woman has been raped, is she also going to have to wait nearly a year if she has got a form of PTSD? Are we saying that the normal waiting time is up to 52 weeks?

Dr Daly: It can be, yes.

Q89 **Ruth Smeeth:** So it doesn't really matter, regardless, unless there is an immediate break when they will get fast-tracked. Broadly speaking, the longest waiting time is up to a year.

Dr Daly: It can be, yes.

Q90 **Mr Francois:** Does that not strike you as unacceptable?



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Dr Oscar Daly: It does, absolutely.

Q91 **Mr Francois:** So what would you do about it, if you had a wand to wave?

Dr Daly: I would get more resource in.

Q92 **Johnny Mercer:** On resource, we have to be honest in this sector about veterans' care resource. An eye-watering amount of money has been put into the sector over the past 10 years—£970 million of LIBOR funding, notwithstanding the £300 million on reserve. I am afraid, for the individual soldier, complaining about resources is just not good enough anymore. I accept that you are dealing with what you are given as well, but it is a total cop-out in the veterans care industry to say that there is no resource in the industry anymore. There are not many parts of Government that have seen more money go into them.

Has it been done in a co-ordinated way, which could have achieved significant strategic outcomes? No, it has not—I accept that. But there is money available, so we have to ask the question why it is not getting through. There are people in this country who give millions. The great British public have given millions of pounds, yet you are coming before us today—and I totally understand why; this is not about you as an individual—and saying that there is no resource. I am thinking to myself, "What the hell is going on?"

Dr Daly: There is inadequate resource in psychiatric services in Northern Ireland. I assume the same applies in England, Wales and Scotland. There is never enough resource, but—

Q93 **Johnny Mercer:** Where is that disconnect? Where is it falling down between the money being given by the Government and the great British public and the service being delivered to the veteran who has fought for his country?

Dr Daly: I am not the person to ask. The people who run the Department of Health in Northern Ireland are the people to ask.

Q94 **Mr Francois:** Before the Executive collapsed, which political party in Northern Ireland was in charge of health?

Dr Daly: I believe it was Sinn Féin.

Q95 **Mr Francois:** Well, they should bloody answer then.

Dr Waterhouse-Bradley: When money comes through, there is no ability to provide a statutory service specifically to veterans, which would contravene section 75 of the Northern Ireland Act. If that money is coming through statutory services, it cannot go specifically to veterans. If it is coming through the charitable sector, there are all kinds of tricky things that make it—

Q96 **Johnny Mercer:** I totally get that, but my point is that there are the people who work in the sector, like you fine individuals here today, and us, who are pouring the money in the top, if you like, or making sure that as much goes into the top of the system. There are many brilliant people



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like you working in and around the system, but then we see the guys at the bottom of the system. What is coming out of that process is still not good enough. If we ask you what the problem is, it is not really good enough just to say, "I don't know." You must have some sort of opinion on where that money goes.

Dr Waterhouse-Bradley: I do know. It cannot go through specialist services in the statutory sector in Northern Ireland because they are not allowed to deliver them.

Q97 **Johnny Mercer:** So why are the charities not doing it, if they have been awarded £970 million from the Government? Why are the charities not providing a service that means that guys in Northern Ireland can access psychological therapies before a year is out?

Dr Waterhouse-Bradley: Because there is only one organisation providing psychological therapies to veterans in Northern Ireland.

Q98 **Johnny Mercer:** Are you saying that Combat Stress does not have enough money?

Dr Daly: At Combat Stress in Northern Ireland the services consist of myself two days a week as a consultant psychiatrist, one therapist, one community psychiatric nurse and one occupational therapist. That is the clinical staff we have for community work. We have access to residential treatment in Scotland for a limited number of veterans, but that is the resource we have for however many thousands of veterans living in Northern Ireland.

Q99 **Chair:** I do not quite get this. I understand the point that Johnny is making: that if a lot of money is collected specifically to help veterans, there may be problems channelling that money through the national health service specifically for veterans, because the national health service will not discriminate between veterans and non-veterans. But when there is a separate organisation, such as Combat Stress, which is specific to veterans and which does supply services, how come that money—or some significant part of it—is not being channelled through that route, to provide services specifically for veterans? In other words, why are there not more people like you, Oscar, and instead of two days a week, why is it not more?

Dr Daly: Again, it comes back to resource. I am not sure what Combat Stress' budget is, but it is in the region of £20 million for the whole UK.

Q100 **Chair:** So you are saying that people are giving many millions and that it appears to be funnelled towards the NHS, which cannot then deliver it specifically to veterans, as opposed to being funnelled towards charities that perhaps could deliver services specific to veterans. Does that not seem a little illogical, or am I misreading the situation?

Dr Waterhouse-Bradley: There is a difficulty in Northern Ireland, because of the way the money is administered through the covenant fund to the charitable sector. There are a lot of technical things about that, about eligibility for funding and the way that they apply for funding, which



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mean that the smaller community organisations that are delivering are not eligible or do not have the resources even to apply for the covenant fund, so the covenant fund tends to come through the larger, UK-wide charities. In our research on the services that were available, one of our key recommendations was that they need to review the way they administer funding to the charitable sector in Northern Ireland, so that local organisations are able to deliver services.

Q101 Johnny Mercer: Do you see how the great British public and the Government, who give all this money, will look at organisations such as Combat Stress and think, “We really care about these soldiers. We are giving loads of money, running marathons, having cake days and doing all these fundraising events in the UK, and essentially what we are being told is that you cannot administrate it all enough, and consequently people are not being looked after”? I don’t mean you as individuals, but as an establishment. If you can’t administrate it well enough to ensure that the care actually gets to the individuals, do you think that is acceptable to the British public?

Dr Daly: If that were the case, it would not be, but I am not sure that is the case. I cannot speak exactly for Combat Stress and the administration of the organisation, but I do not think it is as inefficient as you are suggesting. But I don’t know.

Chair: We will be having Combat Stress here in a couple of weeks’ time, when we will be able to pursue this further with them.

Q102 Martin Docherty-Hughes: I certainly could come in on the LIBOR situation, but I think that we are well versed on how we have approached that with the Minister of Defence. I will just step back to ask Charlie about vizzying out through the NHS structure in Scotland, which you have said you will be undertaking. I would be delighted if you come along to West Dunbartonshire. One of the issues I get concerned about when we are discussing the structures across the constituent nations—I know that Madeleine is not here today—is that in Scotland we have, as you rightly said, a more homogenous approach. We have 32 local authorities, but healthcare is not just provided by the NHS. Is your intention to visit, for example, the 32 community planning partnerships? For me, that would be a more co-ordinated approach, where you would see both primary care and social care through the healthcare partnerships. For me, that would be the best way of doing that, because you would be joining up local government, health, the third sector and the private sector.

Charlie Wallace: The simple answer to your question is yes. You have to look at this from a holistic perspective. It is a complex area that requires a number of people to play a part in bringing forward some successful outcomes. Absolutely, I would wish to ensure that I am involved with all those who are playing a part in the whole of the welfare service combining together, to produce some of the results that we need.

Martin Docherty-Hughes: Could that also include the new social security department, which is the part that has been devolved to the Scottish



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Parliament? You might also want to meet with them to discuss common issues.

Charlie Wallace: I wish to ensure that everyone who has an opportunity to improve the life of our veterans community is engaged by me, and that I ensure that the Scottish Government understand that and take on their responsibilities appropriately.

Q103 **Chair:** One theme that has come through repeatedly, including in the first part of our inquiry, which was to do with the extent of mental health problems among veterans, is this paradox about the covenant saying that veterans should receive some form of priority care and the fact that the NHS cannot discriminate between people presenting, whether they are veterans or not, with certain symptoms. Do you feel that, in the light of that paradox, probably the only way in which any form of specialist or priority care can be given to veterans is through veteran-specific units supplying services only to veterans?

For example, we recently had the launch of an appeal for a unit called the Veterans' Orthopaedic Service in Oswestry in Shropshire, which specialises in caring for veterans who have suffered traumatic injuries. Are we basically saying that if this pledge of priority care for veterans is ever going to be applied through the NHS—that unit is set up within the NHS—it will be through specific veteran-oriented units and not through any sort of general NHS service?

Charlie Wallace: You raise a paradox that is a difficult nut for us to crack. On the one hand, we wish our veteran community to be properly embedded within the society from which it comes and to be part of that society. However, we must never forget that they have decided to step up to the plate and do something that not everybody in the country is prepared to do. Perhaps the question should look at whether it is right for the NHS to discriminate or, indeed, to prioritise. Maybe people who are prepared to step up for the defence of their country should be prioritised.

Q104 **Chair:** But it is evident that they are not prepared to do that, and that it seems to run counter to the ethos of the NHS. A very strong case can be made for that being the correct situation. My question is whether the only way out of this clash of priorities is that there should perhaps be more centres within the NHS such as the one in Oswestry that is specifically designed for veterans. Veterans will therefore get a sort of priority by the function that the centre performs.

Charlie Wallace: By having a separate institution delivering a service specifically for veterans, you will inevitably achieve that aim. However, there is the danger that you separate the veteran from society. From my position, it is one of those areas that I would wish to try to explore, as the commissioner, to see how we might be able to address the balance of this. If we get that balance wrong, I suspect that we may end up doing too much harm in the longer term, so I am concerned about it.

I sense that there is a bit of a view of following a similar sort of model that might occur in America. The scale of what they do there is such that they



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can afford to do that, whereas our scale is considerably smaller. My instinct tells me that it is better for veterans to be properly integrated into society.

Q105 **Chair:** Even if there are these long delays?

Charlie Wallace: That is the dilemma.

Q106 **Chair:** There is another reason for slight concern about veteran-specific treatment being unavailable. Last weekend was obviously a special Armistice Day commemoration. I spoke to a veteran in my constituency with long service in combined operations who was very frank about the fact that, after long service, he suffered a severe breakdown. He was full of praise for the support that he received for a limited period after he had to leave the military, but he then explained that, when he was slotted into local NHS therapists, the therapists themselves were finding it difficult to cope with the traumatic experiences that he had witnessed and was relating to them. I come back to the question: to what extent do we need veteran-specific care for veterans who have been through things that the rest of society cannot normally conceive of experiencing?

Charlie Wallace: The challenge you have if you decide to go for some veteran-specific care is that it will almost inevitably happen in only one part of the United Kingdom, which means that you will need to take some of those veterans away from their home in order to receive that treatment. That is a dilemma. I am not a professional practitioner but I think we will need to explore that question if we are going to work out the right balance between that centralised and specific care and trying to keep the individual in his or her local community.

Q107 **Chair:** This chap was quite certain that the two weeks—I think it was residential with Combat Stress—had saved his life. He was in no doubt about that and that it had worked. I think we need to bear that in mind. Before I pass over to Mark, would you say that the Official Secrets Act or classified special forces work prevent some veterans from feeling that they can talk about their experiences? If so, and if they are taking their oath of secrecy so seriously even where they are ill, who do they turn to for help? Can anyone explain, if you are an ex-special forces person and you need therapy, who could you go to?

Mark Birkill: I see people who are ex-special forces. I would like to jump in on your last point as well. It is not a picture that rings true for me and it is not something I see with my colleagues across Wales—that they cannot handle this military trauma. Sometimes, if you identify more closely with somebody, maybe because you are a fellow veteran or have experienced certain things, that can have a bigger emotional impact. It is certainly not something I recognise. On the special forces issue, I have seen people who are special forces. They may tell me that there are certain bits of information they cannot give me, but that does not interfere with the nature of the therapy.

Q108 **Chair:** So the things that are disturbing them would not necessarily be the secret things—those are just incidental?



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Mark Birkill: They may be secret in terms of names and locations and dates and times, but they do not need to give me that.

Q109 **Mr Francois:** The Committee has an issue, because as I think you indicated, Mr Wallace, veterans are people who have volunteered—since we do not have conscription—to do something that most people in the general population do not want to do. They have volunteered, if necessary, in extremis, to die for their country. I think most of us feel that means they deserve some priority. Mr Wallace, you said there is a dilemma about taking them away from their local community for specialised treatment when you want them to be part of the community, and I understand that, but if remaining in the community because that sounds nice means you have to wait a year to get helped, I would rather take them out of the community and help them. Wouldn't you?

Charlie Wallace: Of course.

Q110 **Mr Francois:** The Committee is finding that, because the service across the NHS is patchy at best, it is something of a postcode lottery. A lot depends on where you live and the attitude of the mental health trust in your area. Some prioritise veterans and some do not. Some have ex-services people on their staff, maybe a senior consultant, and are therefore sympathetic and some do not. There is no real gold standard of treatment for these people, unless you are very lucky and you happen to live in a particular area where your mental health trust is very hot on it. I think that is part of the difficulty we have. We think these people deserve better than that.

Charlie Wallace: What you highlight is one of the challenges that we have and that I am beginning to notice in Scotland; it is about understanding. Do the welfare service and the practitioners within it and in the health service understand? The question I may have for the Scottish Government is what they are going to do about ensuring that their practitioners do understand. If you can inform and put some resource into informing them, maybe we might get over the postcode lottery, as you describe it, of attitudes of individual practitioners in their desire to try to help that veteran.

Q111 **Mr Francois:** Let me make a comparison. In terms of physical rehabilitation, I would argue that we are now world class. I think we can look the Americans in the eye. Veterans who have lost limbs in Afghanistan or Iraq get a Genium, which is the world standard prosthetic. They have a specialist centre at Headley Court and the DNRC at Stanford Hall, where they can be sent for rehabilitation and the fitting of limbs, and then they have a regional centre—a Murrison centre, as they are known—back in the region they live in, where they can continue to get care and maintenance. Every so often the limbs have to be readjusted and re-measured. That is a world-class service. In terms of mental health, we are nowhere near that.

Mark Birkill: Can I speak in defence of Veterans NHS Wales? We have got hung up on this 49 weeks figure a little bit. The waiting times of nought weeks to 18 weeks across the seven health board areas of Wales—it is a



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veteran-specific service, and therefore it is a priority service; there is one conurbation area in north-east Wales that has a particular problem, and it does not operate in a vacuum. Some of that is to do with relationships with the mental health service. You cannot necessarily refer people on quickly, so therefore you have to hold people, which clogs up the waiting times. I would take issue that, if you want a Welsh perspective, there is a bespoke priority treatment service for mental health out there.

Q112 Mr Francois: Yet you told us that unless they live in your health board, it is 49 weeks.

Mark Birkill: That is a small area of north-east Wales.

Q113 Mr Francois: Well, all right—the point I am making, and the comparison I am attempting to make, is that if it is physical rehabilitation, you have got a world-class system for that. You have got Help for Heroes and their rehabilitation centres to back all that up. If it is mental health rehabilitation, we are not world class. We are nowhere near it. So why don't we copy the physical model and have some residential centres like Stanford Hall where can send people that have mental issues for residential treatment and actually give them a bespoke service, funded by the NHS, that is world class? Why are we doing it through this kind of patchy local model that is a complete lottery?

Mark Birkill: I cannot quote the evidence, but my understanding is the evidence does not support the residential model for psychological therapy.

Q114 Mr Francois: Well, we just heard an example of someone that would have died if they had not gone to a residential centre.

Mark Birkill: There will always be certain people who have certain experiences, and certain thoughts about the care they have had.

Q115 Mr Francois: Yes, but what I am saying is your theory about doing it all in the community is actually not necessarily working for these people, because if it were, why are we having this inquiry?

Mark Birkill: I think that residential treatment comes into its own for those veterans who do not get better in a community service, or maybe have an attitude to NHS or civilian services that perhaps would not allow them to make best use of those services. For that cohort, and I also think maybe for people with a drinking issue, as well, so that they can detoxify, residential treatment is perhaps the—

Q116 Mr Francois: Forgive me, but I am thinking about the customer, and I am wondering whether your argument is better for the customer, or just more convenient for the provider.

Mark Birkill: No, for the customer.

Q117 Mr Francois: I am unconvinced.

Dr Daly: Combat Stress has a residential programme and the evidence is very strong that that does help people with PTSD. One of the difficulties with the decentralised model is that six weeks—and our residential



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treatment is only six weeks—will not cure someone. These conditions essentially cannot be cured. So in addition to whatever residential treatment you might need for a small number of people, you still do need significant community services as well.

Q118 Mr Francois: I am not decrying that. What I am saying is that if you have got someone who is waiting 49 weeks to be helped, could we not at least send them off to a residential centre for six weeks, in order to get them some treatment quickly, rather than leave them living at home for 49 weeks, but say “We feel good about this because we are not prioritising anybody”?

Dr Daly: For some individuals, yes, but not for all who are waiting for—

Q119 Mr Francois: What I am saying is, wouldn’t it help to have a national centre where people in real need of help go, rather than having to wait a year, and where it is clinically appropriate? I think if I stopped 100 people in Rayleigh High Street and said “We’re going to have a mental health equivalent of Headley Court,” they would say, “That’s a good idea.”

Dr Daly: It is certainly worth considering, but a unit like that would be very resource-intensive, and you do have to weigh up how many people you would help with that resource versus how many people you would help in the community with the same resource.

Q120 Mr Francois: Excuse me. Some of these people have had their legs blown off in the service of their country. I am very prepared to be resource-intensive with those people, okay?

Dr Daly: Well, if there is more resource, that is great, yes.

Q121 Chair: Bethany, can I ask you this, as you’ve been a little bit quiet recently? You said earlier that there were difficulties, in that the Armed Forces covenant is not really seen to apply in Northern Ireland. If there were not necessarily just one national centre but a small number of national residential centres specifically for veterans, wouldn’t this be one way around the problem? Referrals could be made from Northern Ireland to such centres, specifically for veterans.

Dr Waterhouse-Bradley: Yes, in theory, this does allow a means of circumventing some of the legal restrictions—absolutely. We did a piece of work where we specifically asked veterans and service providers in Northern Ireland how they felt about having a veterans centre. It wasn’t a residential mental health unit the way people envisioned it. We asked them to tell us what it was. And this builds on a point that I think is missing from this conversation a little bit and that we found was quite important in the ongoing preventive work of social camaraderie and social interventions for this community. We found that, repeatedly, veterans wished that they had a place where they could go and be with other veterans. There were definitely ones who didn’t want that, who wanted to move on with their lives and be separate, but the majority of people we spoke to did want a veterans-specific centre, where a range of support services was available.



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Q122 **Chair:** If your findings are in documentary form—

Dr Waterhouse-Bradley: Yes, we have a full report.

Q123 **Chair:** Could you please supply that to this Committee?

Dr Waterhouse-Bradley: Yes.

Q124 **Chair:** Just so that people know, I should point out that the Division bell will probably go in a few minutes' time. Although we are coming towards the end of our questions for this panel, I suspect that we won't get through all of them before the bell goes, so there will be a 15-minute break at that point. Will all of you be okay just to finish off after that 15-minute break?

Witnesses indicated assent.

Chair: Thank you. We must now move on. Martin, I believe that you have a tail-end question arising out of that discussion, and then we have other questions to proceed with.

Q125 **Martin Docherty-Hughes:** Yes, this is just on the back of the discussion that has been had. I think it is very important that we have an evidence-based approach. I get very concerned—with all due respect to everyone around the table—about the need to have a fully comprehensive evidence-based approach in terms of any healthcare provision, regardless of whose citizens we are talking about. We want it to be the best.

I am mindful of the Danish model—the Danes' veterans policy. I am mindful also that Denmark is a country in which they don't have an issue about trying to get people into the forces; they have an issue about trying to get them out of the forces—no one wants to retire. The fourth of their five pillars says: "Support for the wounded must be a coordinated and integrated effort that focuses on the needs and resources of the individual veteran." The fifth pillar talks about that being a "shared responsibility".

I am talking about having an evidence-based approach to the vast majority of services that veterans require. Again, I can speak only as a Scottish constituency Member; Scotland has the Health and Social Care Partnership approach. We do this by—I hate to use this imagery—hammering home the point that that co-ordinated, integrated approach actually brings results. Nations like Denmark show that. I get worried about the lack of talk about a fuller evidence-based approach. That also challenges other Governments across the UK. It's about finding resources that fit that model. Would you agree or disagree?

Charlie Wallace: I would agree. It is important also to understand that dealing with the issues that our veterans communities face, be it physical or mental issues, produces a set of challenges that must incorporate everybody playing their part in bringing a sensible conclusion. It may be easier to deal with somebody who has a physical injury. It's more challenging to deal with somebody who has a mental health issue or injury, depending on how you wish to define it. I suspect that one of the reasons why we're having quite a debate at the moment about the mental



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health side is that it is so nefarious. I am no expert, but to me it is about trying to make sure that you produce a solution for every single individual with a mental health need. That is the challenge that we have to face and it's one that I think plays a part in how you have described the collective responsibility of every element to make sure that an individual is looked after. That requires understanding.

Q126 Martin Docherty-Hughes: Yes. I am mindful, just before we might go to a vote, that when we have discussed this issue, whether in all-party parliamentary groups or around this table, it has been clear that the vast majority of mental health services can be delivered in the community—I know that some people might not like that word—and that that is the best place in which to provide them, but that it also means that the targeted approach from those integrated services needs to step up to the plate.

Dr Waterhouse-Bradley: From the evidence, we would certainly agree, as a research team, that an evidence-based approach is the best way to go. In Northern Ireland we have an extraordinarily big problem with actually compiling that evidence. We have spent two years, using advanced modelling, trying to get just an estimate of the number of veterans living in Northern Ireland. We have met block after block after block in even getting access to the information we need to do that modelling. We wrote to every Department within the Assembly and asked if they or any of their outreach bodies that deliver services on their behalf collect data on veterans of armed service. None of them did. So, at this stage we cannot even figure out a way to get that evidence base, making that a huge issue for Northern Ireland.

Q127 Gavin Robinson: Just to connect the dots, is that research the same research that we will have heard from Dr Cherie Armour?

Dr Waterhouse-Bradley: Yes.

Q128 Martin Docherty-Hughes: Is priority treatment being implemented effectively in your nation? If not, why not?

Dr Waterhouse-Bradley: It is not.

Q129 Martin Docherty-Hughes: Charlie, do you want to add anything?

Charlie Wallace: No.

Q130 Martin Docherty-Hughes: Does the provision of bespoke services, such as the new NHS England services, act as an effective alternative to priority treatment? I think you will probably start saying something about evidence-based approaches on top of that.

Charlie Wallace: Yes, exactly. It has got to be evidence based.

Q131 Leo Docherty: Just widening out the lens a bit, what mental health care is currently available to families and carers? What more could be done? Let's start with Scotland.



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Charlie Wallace: At the moment I do not think much attention has been placed on the families of service people or ex-service people. That is certainly one area that I am interested in investigating. The support mechanism that is in place is loose, I suspect. It is certainly something that we have got to focus on.

Mark Birkill: In my opinion it is the missing component. Families where there is a wife—usually a wife—or a girlfriend keeping the situation together are the ones where you really do get some good outcomes. The more support we can give them— We did, in north Wales, have a group—a service—going, which was covenant-funded, but like all of these things there is a year or two years of funding and then it is pulled. If I had one wish it would be that charities get proper funding for a really sustainable amount of time to support families.

Dr Daly: Agreed. With any psychiatric illness it is not just the individual but the whole family who are affected. The family can be the most powerful help in helping the individual, particularly after intensive treatment. It is something that certainly should be resourced.

Q132 **Leo Docherty:** Are there any particular charitable bodies that are doing family-specific work to the best of your knowledge?

Dr Daly: Not to my knowledge in Northern Ireland anyway.

Dr Waterhouse-Bradley: There is an inclusiveness in terms of membership, where families are described as being members of RBL or Blesma, for example, where they see family members as their clients as well, but not in terms of psychological support. The veterans that we spoke to would have said that, in the absence of feeling like they can trust service providers, they rely incredibly heavily on their families. That bore out in any conversations that we had with family members.

Chair: It looks like we may have escaped a vote, so let's move to the final questions from Gavin.

Gavin Robinson: This is when the Division bells go.

Chair: Maybe. We will wait and see. We live in hope.

Q133 **Gavin Robinson:** We have a sense from some of the questions thus far about your relationship that you see co-operation between central Government, local government and, in the case of Northern Ireland, regional government, as local government has no role, and the charitable sector. This is a general question to all three constituent parts. Is there a good level of co-operation? Do you find it a useful relationship that you have across these various strands? Or could there be significant improvement to iron out any issues?

Mark Birkill: I think that we have developed it over the last 6, 7 or 8 years. We have a monthly meeting with six charities in north Wales, one being Combat Stress, and we try to work together. We have peer mentors employed by a Welsh charity called CAIS. They are employed to directly



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work with and support our clients. It is an evolving situation that, to be honest, has a good level of mutual support.

Charlie Wallace: In Scotland there is a very good partnership that has been brought together between all these constituent parts. The key to that is understanding and knowledge. That is the effort that has been made by all of those constituent parts in order to ensure that they remain together, understand each other and, therefore, help each other. There is no significant improvement, but there is certainly always room for improvement based on that business knowledge.

Gavin Robinson: I referred earlier to some of the Northern Ireland issues. When we have an assessment of the annual covenant implementation report, we often have Ministers from central Government say, "It is great that we now have 11 champions appointed in our 11 councils," and we have to continually remind people that our local councils do not give the service delivery, when we are thinking about housing, education needs or healthcare. Do you think it is a slightly different reflection on the co-operation between central Government, regional government and the charitable sector in Northern Ireland, as opposed to colleagues from Scotland and Wales?

Dr Daly: In the health sector there is the Armed Forces liaison forum, which is overseen by the Department of Health, where representatives of each of the health trusts meet on a quarterly basis with the different charities and members from the MoD. That is quite a useful forum for keeping relationships going and for liaising. As in most cases, there is a lot of individual liaison and informal liaison, more particularly applying to individual patients. Again, that is very important and useful.

Dr Waterhouse-Bradley: I agree with that. The Armed Forces liaison forum is largely set up for serving personnel, but they have done a really good job of being inclusive of veterans issues where they can. The new Veterans' Support Office will hopefully start to bridge some of the gaps that are there.

One thing we would emphasise over and over again—this is not isolated to the veterans sector at all—is the idea that when something is rolled out across the rest of the UK and then rolled out in Northern Ireland in the same way, it is often really problematic, because it is reliant so heavily on local government and when you slide things into local government in Northern Ireland it just does not work. Even the Veterans' Support Office right now is not set up to be linked into the health trusts and jobcentres.

Q134 **Gavin Robinson:** Dr Daly, we have heard evidence that talks about the compounded nature of the difficulties for veterans in Northern Ireland, because they live within what was their theatre of conflict and that has associated difficulties for individuals. Combat Stress' residential provision system—this is the counter-argument—is in Scotland. There are those who say, "Why can't we have service provision in Northern Ireland?" Could you reflect on whether it is beneficial to lift people out of the Northern Ireland context and have care far away from home, or there is a



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danger in having folks so removed from their support network that it proves problematic being in Scotland, when they would rather have care at home?

Dr Daly: The answer is yes, yes.

Gavin Robinson: Paradoxically it is both.

Dr Daly: It is both. It is very beneficial for the individual to be taken away from an area where he or she has great difficulty relaxing, because, as you said, they are living in their previous theatre of operation, living side-by-side with people who previously were foes, and perhaps still are. Perception is very important for individuals. It is very helpful to move them out of that area. It would be difficult to have meaningful treatment in the situation where you are still feeling under threat. For that type of intense residential treatment, it is probably necessary to move them out of Northern Ireland. But when they come back, they come back into the same area. They need a lot of support to prevent them from losing the gains that they made when they were away.

Q135 **Gavin Robinson:** Is that support there? Do you provide it as a separate strand?

Dr Daly: We try to provide a limited amount, but that is all we can do.

Q136 **Gavin Robinson:** Starting with Northern Ireland, and then we can work back to Wales, can you give a reflection on what you feel about the continuity of care provision for folks, if they are receiving care in the MoD and then move out into civilian life? Is there a good level of continuity of care? Are there deficiencies in that process? Do people lie on the bench for a while until they are picked up by the charitable sector?

Dr Daly: Continuity of care is critical, and it depends, for individual soldiers. From my four and a half years in Combat Stress, I think the liaison has improved. I have had two referrals from the MoD in the last month. There are still many individuals I see after a few years who had difficulties when serving. It might be that the individual was offered a transfer—a liaison, if you like—and declined it. Many of these people just want to get out and get away from the Armed Forces, even though that is to their detriment. It is improving, but I think a lot more can still be done, definitely.

Charlie Wallace: Fifteen days in, I cannot really answer that question.

Gavin Robinson: I thought it was 17. You have dropped two.

Charlie Wallace: I have dropped two because it was getting quite tiring.

Gavin Robinson: It has been a regressive process.

Johnny Mercer: Do you actually work there?

Charlie Wallace: Occasionally. Very much part time.

Q137 **Gavin Robinson:** If there is an answer from Scotland and you have



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particular reflections, perhaps you can write to the Committee.

Charlie Wallace: If I can find some evidence that would be of benefit to the Committee, I absolutely will.

Mark Birkill: My understanding is pretty straightforward. The defence community mental health team in St Athan in south Wales has a clinical psychologist who sits on our national steering board. Routinely, four months before medical discharge, people will be referred to us. Obviously, there is an issue if you have a longer waiting time, in terms of treatment, but that is only one area of Wales. How we work is a peer mentor goes out and assesses somebody, provides them with practical support and helps them with any transitional issues.

Dr Daly: Can I just say that I was speaking as a member of Combat Stress? I think there is very little liaison between the MoD and the NHS in Northern Ireland for service personnel who are leaving the service.

Q138 **Gavin Robinson:** Is there a centre being established, or does one currently exist within Thiepval, to cater for those who are leaving?

Dr Daly: There is still the DCMH facility.

Q139 **Gavin Robinson:** Does that buck the trend? Is there better co-ordination between the NHS and the military, or not? Is that in-service provision?

Dr Daly: That is in-service provision.

Q140 **Gavin Robinson:** Okay. And you do not believe that there is a good relationship between it and the NHS foundation trusts?

Dr Daly: Not to my knowledge.

Q141 **Chair:** Before I thank you all formally, is there any last point that any of you, or each of you, would like to make to the Committee? Mark?

Mark Birkill: No, thank you.

Charlie Wallace: As I come into this job and look at the veterans world in which I am going to be involved in Scotland, I think we have got to ask ourselves some big questions about how we provide the right sort of care for the veterans community. On the one hand, we must make sure we do not separate it out from society. We must keep them as part of society. We must also remember that a vast majority of veterans go into the community very successfully, and bring some particular skills that are of a real benefit to the community. We must not forget that, as we deal with the small minority who have particular issues.

I reiterate the difference between what I see as being physical issues and mental issues. Dealing with those two things is a challenge. I think that the way to do that is through knowledge and information, and making sure people understand.

Q142 **Chair:** Bethany, as a researcher?

Dr Waterhouse-Bradley: I would really call for a strategy to get more of an evidence base, even though it will be hard and even though it is sensitive. We really need a political push behind collecting an evidence base in Northern Ireland that we can use effectively.

Dr Daly: While things have not been great yet, there has been the development of a regional trauma network in Northern Ireland as part of the Stormont House agreement four years ago. A couple of years ago, the Health Minister, Simon Hamilton, committed money to the service. Unfortunately, because of the situation with the Government now, very little has happened yet. But, with a fair wind, that service hopefully will develop and it is going to be statutory, community and voluntary working together. That should help all people who have been traumatised, including veterans.

Chair: Thank you all very much indeed and we will now move to the second panel.

Examination of witnesses

Witnesses: Dr Jonathan Leach, Dr Deirdre MacManus and Dr Michael Grey.

Q143 **Chair:** Welcome to the second panel. As is our usual practice, I will ask each of the new panellists to say a word or two about themselves, starting with you, Deirdre.

Dr MacManus: I am Dr Deirdre MacManus. I am here representing the Royal College of Psychiatrists. I am a clinical academic. In my clinical work, I am the lead psychiatrist for one of the NHS veteran mental health transition, intervention and liaison services. I am also a consultant forensic psychiatrist within a prison in London, and I am a senior clinical lecturer at King's. Most of my academic research has focused on military health and behaviour over the last 10 years.

Chair: That should be very valuable—thank you.

Dr Leach: I am Dr Jonathan Leach. I am a general practitioner. I currently work clinically in Worcestershire. I am here on behalf of the Royal College of General Practitioners as their joint honorary secretary, but I have an additional role as chair of the NHS England Armed Forces clinical reference group. With your permission, Chair, if the topic of conversation veers more into NHS England territory than Royal College of GPs territory, I will try to make that clear. As you will be aware, I served for 25 years in the Army around the world—I am ex-military.

Chair: We will watch your quick changing of hats as you go along.

Dr Leach: Watch my hats, yes.

Dr Grey: I am Michael Grey. I am a reader in rehabilitation neuroscience at the University of East Anglia. I specialise in rehabilitation following



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acquired brain injury. Prior to becoming an academic, I was in the Canadian forces. I now work with football managers. I am here today at the behest of Blind Veterans UK, specifically to talk about mild traumatic brain injuries and their relation to mental health.

Chair: For the benefit of colleagues and listeners, I should explain that it was very kind of you to accept quite a last-minute invitation, which arose out of the fact that Blind Veterans UK came to see me and had some very interesting observations to make on the specific subject of mild traumatic brain injury. I appreciate that you may not be chipping in on all the other questions, but we do have one, which I am keeping for myself, specially tailored to your expertise.

Q144 **Graham P. Jones:** It is probably best to ask this to Dr Leach. How well are GPs and psychiatrists trained to help veterans and their families who come for help?

Dr Leach: I will cover the GP bit, and I will defer to Deirdre to comment on psychiatry. The Royal College of GPs has recognised that a huge amount of learning needs to be done in this area, so military veterans are now in the curriculum for general practitioners nationally—right across the United Kingdom. That happened four years ago. That will be a slow burn, but that will probably make the biggest step change. That means military veterans' health is part of the curriculum for every single doctor who qualifies as a general practitioner.

To give you an example, I was at the John Radcliffe Hospital in Oxford about two months ago. Just as young doctors who specialise in general practice have to know about high blood pressure and diabetes, they also have to know about military veterans' health. I had 25 young GPs, and we spent two and a half hours talking about military veterans' health. That is absolutely brilliant, because that is replicated across the United Kingdom.

That is a slow burn, but the college has done lots of other things, recognising the fact—let me put my NHS England hat on for a second; I will try to slip between the two—that, if I can put it this way, feedback from patients has sometimes been adverse. I am not ducking that. We as the royal college have accepted that. We have done a lot of work to try to educate people and raise the profile of military veterans' health. In combination with NHS England, we are rolling out a system of veterans accredited practices. We piloted that in the west midlands—I have 94 in the west midlands, with another 47 coming online—and there is agreement that that will roll out across England over the next period. That will raise the profile and the understanding within general practice.

Q145 **Graham P. Jones:** How are we encouraging GPs to check and record whether patients are veterans or families of veterans?

Dr Leach: Various things. The first thing is that there is a change to the registration form. It is quite archaic—it is called the GMS1. That will now mean that if you have a service record, that is now clear. As part of our veterans accreditation process, it is one of the criteria that when



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somebody turns up you ask them whether they are a veteran, and secondly that you code it.

In the longer term though, and this is all quite manual, the biggest difference would be having access to the records. I saw somebody who wanted to join the services last week, and there was a particular problem. He registered with our surgery because he wanted to see me, and I took him through. I was then able to go right the way back through his medical record. I could see which hospital he had been to, which GPs had seen him, his blood results and everything.

The big step change will occur as and when the MoD GP computer system, which is called DMICP, can actually talk to the NHS computer systems, which at the moment it cannot. That may be something that we will come back to in terms of Project Cortisone. That will probably be the biggest step change. Just as I can see NHS records for my NHS patients, I will be able to see all the way back—there may be some security caveats, which again we will come back to—and see who they have seen, what they have said, and things like that.

Q146 Graham P. Jones: With or without that system, will GPs be able to see, or will they understand, the services to which they can refer veterans? Is there training and communication with GPs about available services? Some of this, of course, will be highly localised. It cannot be distributed nationally. There will be localised services. How will GPs know, with or without this system?

Dr Leach: For England, there is one system. For mental health we have the transition, intervention and liaison service, of which Deirdre is the clinical lead in London, as an example. There is one system. In NHS England we have put out material. We have put everything on what is called NHS Choices. Then, as part of the overall education of the workforce, because it is much broader than GPs, we are guiding people to these resources, as well as the veterans and charities—I can come back to the data on that if you wish—so that we use one resource and people can go to one place.

That is all wrapped up both in the material that NHS England puts out and the material that the Royal College of GPs puts out. For example, I did a screencast, which is potentially available to all GPs, of an educational resource. It is called "Five Minutes to Change Your Practice". It is quite simple, but the key message is about how you look after your veterans, what the key issues are, and how you look after the families. That has gone national.

Q147 Graham P. Jones: May I say, Dr Leach, that that all sounds to me a bit too persuasive? I would draw your attention to the fact that I have military charities, as you mentioned charities, or those who are providing services—they do not have to have charitable status—which veterans would benefit from.

The service need not necessarily be associated with veterans. Mine do not seem to be included in some of these databases, so I would challenge



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you to explain how some of these charities or local provisions, which can be as helpful to people because they are local, are engaged in your system. A simple question: will my GP find all the charities or services in my area listed on your system?

Dr Leach: They would be guided to what is called the gateway. That is the organisation that has been set up—

Q148 **Graham P. Jones:** That was not my question. My question was, “Can my GP see the services?”

Dr Leach: If they go through the gateway. There are 3,000-odd military charities. It is impossible for a GP to know all of them, but we have guided them, first, that charities can provide very constructive help. We have made that clear. In the material, we list all the major ones, but if they want further information they would go through the gateway. That is on the material that we have put out.

Q149 **Graham P. Jones:** So, every service in my area, for simplicity, is on the gateway.

Dr Leach: If it is on the gateway. It is not for me to say whether or not they are on the gateway.

Q150 **Graham P. Jones:** And if it is not on the gateway, then it is not a service accessible for GPs, and they won’t know about it.

Dr Leach: It would not be accessible, probably, for most people, because that is one of the major ways that the whole system—not just the NHS, but the charitable sector—are saying how they can help veterans themselves.

Q151 **Graham P. Jones:** The integrity of the gateway is dependent on the information that is put on it.

Dr Leach: That’s correct; it is a database.

Q152 **Graham P. Jones:** And, of course, it may not include all the services available to veterans.

Dr Leach: I am not here to answer on the gateway.

Q153 **Graham P. Jones:** It all sounded a bit too persuasive. I just want to be clear that not every service is on the gateway.

Dr Leach: I think that is fair. What I am trying to show you, though, is the fact that, both as the Royal College of GPs and as NHS England, we have made huge efforts, both with the veteran community and the charitable areas, as well as GPs and the wider NHS, so that we highlight the services that are available. That is the point I am trying to make.

Chair: Thank you. Anybody else what to comment? Deirdre?

Dr MacManus: Would you like the perspective from the Royal College of Psychiatrists?

Q154 **Chair:** Yes, please.

Dr MacManus: The first question was whether psychiatrists have the skills to deal with veterans and their families. The first point in this is that psychiatrists are trained to deal with individuals with a broad spectrum of mental health problems and from a broad spectrum of backgrounds.

Do they have the specific understanding of veterans' mental health problems and the experiences that they have had? I suppose that is very dependent on their day-to-day clinical experience, but the Royal College would recognise that there is a lot of training that needs to be done there. Similar to the Royal College of GPs, we have online training modules. There is one about service personnel and their needs and one specifically for veterans. We are also providing information on the services that are available for veterans.

What the Royal College of Psychiatrists has also been doing is trying to improve recruitment of trainee doctors into psychiatry, but into psychiatry within the Armed Forces as well. They have been doing work with the defence medical services. They have created a promotional video for trainee doctors to watch and hopefully attract them into that as well.

We have a Royal College psychiatry lead for the Armed Forces and veterans. He is sitting over there—Professor Neil Greenberg. He provides advice on the mental health problems that veterans might experience and what the Royal College can do.

We are providing continued professional development days. There is one planned for next year and we have had some already; they are generally very well attended. That is what we are doing to try to address the training need among psychiatrists. I can't remember what the second question was.

Q155 **Graham P. Jones:** One of the questions I am asking is about the specific services in a locality and the awareness; we talked about the gateway. In the case of psychiatry, it is not just the consequences that the veterans might have to contend with but what their families might have to contend with, and the impact that would have for the nuclei of people living together: spouse, partner, children and so on. As a psychiatrist, what measures do you take not just to reach out to the veteran but to the nuclei surrounding that veteran in daily life?

Dr MacManus: As was identified in discussions with the previous panel, identification and provision of care for families of veterans is a gap. Certainly, as the lead psychiatrist for one of the TIL services, it is something that we have really identified. Given the resources that we have, although we provide carers' assessments and assessment of family need, we are not currently in a position to provide that. We are currently bidding for further funding to develop services for that, but it is a definite gap.

If family members have specific mental health problems of their own, they will be signposted into generic mental health services. Of course, they



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then fall foul of the waiting times that we know exist within those services. But if there are specific mental health or social welfare problems related to the veteran's mental health that are having an impact on the families, we would like to be able to provide more support to them for that.

Q156 Chair: Would anyone like to comment on the phenomenon that we often hear about veterans having to repeat their story multiple times to different practitioners?

Dr MacManus: I hear that all the time. It is something that the TIL service is trying to overcome. We want to be the first port of call for that first assessment. Veterans can self-refer or be referred by their GP, by charities or by other NHS services, and if they have that full, comprehensive assessment it should reduce their having to tell their whole story over and over again if they are referred to other services. But currently, I do see veterans who have been to many other services before they make it to us, and they are tired of telling their story over and over again.

Q157 Chair: Presumably, this is because their story is not recorded on their medical records with the same degree of detail that perhaps somebody with a physical problem would have their story recorded. Or is it about the same for both?

Dr MacManus: I don't know whether I agree with that. If people have a mental health problem, the detail of their story is recorded in much greater depth. It just depends who they have seen, whether there are data-sharing agreements in place and whether the veteran comes with evidence of previous reports. It does happen; if someone sees Combat Stress we will always contact them and contact all the previous services to try to get their previous assessments. Sometimes that does not cover the information we need—it just depends—but where data-sharing can happen, it does.

Dr Leach: I agree with everything that Deirdre said. In the design of both the TILS and the complex treatment service, which of course are run together in England, it was made explicit in the specification that that first assessment by the TILS would then go on to the complex treatment service, which would reduce the number of times—so yes, you would need to update and you would need to connect and have an understanding, but you would not necessarily need to go through everything. In the design of those two services that are linked, the fact that that was a common refrain from patients is the reason why that was put in the specification.

Q158 Johnny Mercer: This problem of telling your story multiple times has been around for years or decades, but particularly of late, since 2006, 2007 and 2008, it has been identified as a significant problem. Why have groups such as yourselves or others not sat down and come up with a common needs assessment that can be done at the point of entry into the veterans' care system? You then get all the details you want, you enter into a data-sharing agreement and this guy can stop telling his story repeatedly—people such as Dan Collins, who ended up taking his



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own life for a number of reasons, one of which was that he was sick of telling his own story. Why do you think that has not happened?

Dr MacManus: That is what we have now. When someone comes to our service, we will get them to sign consent—

Q159 **Johnny Mercer:** So there is now a common needs assessment for entrance into veterans' care?

Dr MacManus: When they come to TILS, they will sign consent that we can contact the previous services that they have been in contact with and get all their previous assessments.

Q160 **Johnny Mercer:** Are you looking to reach that out? A lot of veterans, with the greatest will in the world, will not know what TILS is. They will think of Combat Stress or Hidden Wounds at Help for Heroes. Have you reached out to them and said, "Right. We need to come up with a common needs assessment that stops these guys going through this process."? I am not very clever; if I can think of that, surely someone in your organisation has come up with this before.

Dr MacManus: The difficulty is also that if someone has been before, it depends what the assessment was for at Help for Heroes or Combat Stress. It may have been a while ago. They will need to go through a further assessment. But if I see someone who has previously been assessed, say at Combat Stress, I do not need to go through everything that they have told before. I can refer to that report. I can say, "I see from your history this, this and this," and I will only focus on the additional information I need.

Q161 **Johnny Mercer:** Is that two-way? If someone comes to you—

Dr MacManus: They can access our reports, absolutely, if the patient consents.

Q162 **Johnny Mercer:** —and says he's been at Combat Stress, you can read it, and the other way around as well. Is that happening across the sector, or is that just within small groups?

Dr MacManus: It should happen across all the TILS.

Q163 **Johnny Mercer:** Is it happening across all the TILS?

Dr Leach: As I said, there are two things. Within the NHS services, that is built in; that is the first bit. Also, the TILS is not just about the NHS. Deirdre will have the detail, but here in London, for example, STOLL, which is one of the homeless charities, is part of that service. In the design of the TILS, we were looking much, much broader: first in terms of the determinants of health, and secondly, "Look, actually, here is somebody who has this type of problem. As doctors, it may not be directly clinical, but it is of real importance to that individual." We can do that.

Let's say, for example, that person is then seen by Combat Stress somewhere else. It is not an automatic data share, but if there were a request from Dr Walter Busuttil or somebody like that who is the medical



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director—"Please could I have the details?"—then, yes, of course we do. That is routine across the NHS. Where it is for the benefit of the patient, letters, emails and the like would be routinely shared, and that is the same right across the NHS. It is not specific to this.

Q164 Johnny Mercer: How does someone running a Hidden Wounds programme in Plymouth access that common needs assessment? Say they have been through TILS, and three or four years down the line they return to a normal job—plumbing in Wales or whatever it is—and then start to think, "Actually, I should really go for another course of CBT now." Their nearest provider is Combat Stress, Hidden Wounds, or whatever.

Bearing in mind the individuals we are dealing with, when they go to that organisation, how is something triggered to say, "This guy has been in the system before; this is what happened to him, and these were his needs" so we do not need to retell the story again and again? He flashes up, and his details are there, and we can just crack on with it.

Dr MacManus: It would be dependent on that service requesting the details from us. We do not share electronic data systems, but it is very easy to do that, and we get individuals who have repeat periods of care. We might request the information from Combat Stress, or vice versa.

Q165 Johnny Mercer: Do you know if they actually do that? Have you heard of Combat Stress or Help for Heroes reaching out to organisations like yours and asking for details of treatment?

Dr MacManus: Combat Stress, yes.

Johnny Mercer: Help for Heroes?

Dr MacManus: It normally works the other way: they come to us from Help for Heroes. The other TILS have models of shared working with the third sector organisations within their area, and we hold joint clinical meetings, so that there is sharing of information if the veteran has consented to that.

Q166 Johnny Mercer: Dr MacManus, what is your organisation doing to help get its members to understand the specifics of this sort of military treatment pathway? If people are coming in who are veterans or whatever, what are you doing to instil in your members the idea that they can go back to Combat Stress, or another TIL service, and find out what these people have been through?

Dr MacManus: At the moment, that is communicated through the online training modules and the CPD days that we are offering. That is probably about it at the moment. These services have only been in existence for the past 18 months, so there is a much clearer pathway now, and raising the profile of those pathways into care is a piece of work that needs to be focused on, especially among all of the psychiatric workforce.

Q167 Johnny Mercer: What about your organisation, Dr Leach?



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Dr Leach: I will respond on behalf of NHS England; I will put that hat on. I have two strategic aims. The first bit, on one side, is those bits that NHS England is responsible for, where we have specific money—things like the TILS, the combat treatment service, and the Murrison centres for those who have unfortunately lost limbs—and the aim is to make those better.

The other strategic aim is to make the NHS generally better and more responsive. That would include things like the general education of the NHS, such as through the Military Veteran Aware Accreditation. It also includes, as was announced last week, the Veterans Covenant Hospital Alliance and things like that. There is that piece: how we can make the NHS generally more responsive to the needs of the military community.

For example, the Royal Colleges talk about this and obviously we share lots of information. If you take the clinical reference group, which I have the privilege of chairing, that is joint: we have psychiatrists on it; we have psychologists on it; and we have GPs, like myself, on it. We have military and NHS, all sitting around in one room and discussing how we can improve the care for veterans. That's what the clinical reference group does.

Q168 **Johnny Mercer:** Fantastic! And did I hear you say there were 85 veteran-friendly GP surgeries at the moment?

Dr Leach: I have 94 in the west midlands; I have another 47 coming online now and that is from the federation in Birmingham. It is now in the Wessex region—so these are the Royal College of GPs. So that is Hampshire, Wiltshire and Dorset. And then there is agreement between the Royal College of GPs and NHS England that this will then be rolled out across England.

Then, there is the wider aspect, for example in Scotland and Wales. The Royal College of GPs—i.e. me—has had conversations with the chairs of the Welsh, Northern Irish and Scottish Colleges of GPs about how a similar arrangement could be established in devolved nations, accepting the sensitivities, as we have already heard, about Northern Ireland.

Johnny Mercer: Great. Well done.

Dr Leach: So that will be rolling out. England has funding, and there is agreement between the Royal College of GPs and NHS England, and it is the Royal College of GPs that will be the delivery arm.

The final bit of the model is that practices must have a clinical lead. I will just give you an example. About a month ago, one of my colleagues said, "Jonathan, can you come and help me?" It was actually an ex-Royal Marine having a significant problem and my colleague said, "I don't know what to do. Where do I send him?"

What I was able to do, as the clinical lead for military and veterans' health in my practice, was to say, "Look, actually, yes, the alcohol we need to deal with. Send him to the TILS." And that's what we did. And that gentleman now—his blood levels, after the alcohol, are now back to



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normal. And we talked about families. His was quite a common story: his partner was saying, "Sort it or I'm leaving". That's quite a common story. And actually things are now much better.

Q169 Johnny Mercer: So have the days now gone where an individual, when he or she leaves service, will be given a folder with all their medical notes and told to find themselves a GP?

Dr Leach: What happens is that they are given a summary. They will have had their pre-release medical about two months out. There is a summary. They register with the GP and the traditional way is that the GP can then request the notes, which come in paper form. In England we are looking for a stop-gap, which is essentially that we will get the notes in PDF format, so at least we get them in an electronic form. As I said earlier, the key thing that I need access to is the notes generally. I get an electronic copy of the notes, showing everything they were ever treated for—

Q170 Johnny Mercer: What is there that makes the individual sign up with a GP?

Dr Leach: We can't force anybody to do that. They are given strong advice. If they have been under the wounded, injured and sick service, for example, or under military psychiatrists, there is a really strong push to get them to register with a GP. But at the end of the day I can't force it. Actually, if you are coming out of the services and you don't know where you are going to be living—you don't know where your job is—it is actually quite difficult. But the MoD makes that strong recommendation and we would support that.

Q171 Johnny Mercer: Obviously, you go for your career transition partnership meeting. You turn up and get your enhanced learning credits, for learning how to write a CV of whatever. Is there no way of establishing the fact that if they want some more enhanced learning credits they must register with a GP, and a conversation must take place between the military officer and the GP before they get them, so that there is some link there?

Dr Leach: Yes. As I say, there is a strong push now. I think that the more that could be done, the better.

Q172 Johnny Mercer: What is the argument against mandating it?

Dr Leach: That is a question that you would have to pose to the MoD, but I think the difficulty would be that not everybody would know where they are going to live.

Johnny Mercer: Well, of course; that is the same for everybody.

Dr Leach: Yes, but if you are going to be in Bromsgrove—I will use that as an example, because that is where I work clinically—then yes, in theory that could be—

Q173 Johnny Mercer: Why can't one of the tick release things be: "Right, you register with your GP and you have a handover, and then you will get



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your money so you can go off and do your plumbing,” or whatever it is?

Dr Leach: There is no particular reason why it could not.

Q174 **Chair:** May I ask about a small matter that we discussed briefly with the previous panel? Do any of your members feel restricted by the Official Secrets Act in talking to veterans about their experiences? If so, what alternatives can GPs and psychiatrists offer to veterans who feel that what they did was so hush-hush that they cannot confide in you?

Dr Leach: I think this is more about the support and education of the veteran, rather than of the doctor, the nurse, the psychiatrist or whoever. We deal with confidential matters all the time, in every single surgery and every single clinic. Our regulator, the General Medical Council—

Q175 **Chair:** May I cut across you for a second? I am not putting in doubt your ability to handle confidential information, but the fact is that these veterans, who have been in the special forces, take their oath of secrecy very seriously. The simple fact that you deal with confidential matters all the time will not convince them that they can divulge things to you. Is there any mechanism to make it clear to them that they can safely divulge what might be relevant to their treatment?

Dr Leach: I beg your pardon.

Chair: No problem—I don’t think I put the question as clearly as I could have done.

Dr Leach: I think there is a lot to be said for helping with education before people leave. I agree with the previous panel that, in the main, most people do not have something that is secret. In general terms, it is not about the clinical stuff such as whether someone has had a knee operation, but about where it happened and the timing of it. A piece of work to educate people both generally and specifically about the sorts of things that would be of concern—

Q176 **Chair:** Coming back to Johnny’s prescription for what should be done before people leave the grip of the MoD, is there some instruction or guidance that the MoD could give? Could it say, “Look, as long as you keep specific details to yourself, there is no reason why you cannot discuss with your practitioners what happened to you on sensitive operations,” before they have to make their own decisions about matters that they have had it drummed into them never to reveal?

Dr Leach: I am conscious that I am in the public domain, but if it helps, let me put it this way: NHS England is in consultation and in conversation with representatives of that group about trying to educate and make that clear.

Chair: Okay. That is as far as we can take it.

Dr MacManus: May I add to that? I think there is a small group of people for whom it would be difficult to engage in therapeutic treatment without divulging some of the details of their sensitive roles. The Royal College of



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Psychiatrists would certainly be keen to recommend that there should be a small pool of professionals with the appropriate security clearance to deal with those individuals. They could be from uniformed services, but also perhaps from other roles.

Johnny Mercer: I believe there is already, is there not? If you have a mental health problem at Thames House or within UKSF Group, there is a specific pool of individuals you can access.

Chair: It might be worth seeing whether that can be joined up for the wider special forces community.

Johnny Mercer: Joined-up thinking—a rare thing.

Q177 **Chair:** Indeed. That is very helpful.

Michael, at last it is your moment to enlighten us. As I said in my introduction, you are here today mainly because Blind Veterans UK came to see me about a number of issues, in particular the new campaign on the misdiagnosis as PTSD of what in reality is often the effect of repeated, cumulative mild traumatic brain injury, on which you are an expert. They impressed on me the fact that if this misdiagnosis occurs, people who are actually suffering severely from mild repeated traumatic brain injury, but who are misdiagnosed as having PTSD, will be getting the wrong treatment entirely. Can you begin by explaining the challenges of distinguishing between those two very different conditions, given the similarities in some of the symptoms, and then give more detail about the work you are trying to do?

Dr Grey: I should preface this by reminding the Committee that I know you have heard evidence from Professor Sir Simon Wessely that mild traumatic brain injuries were the signature injuries in our forces, the Canadian force and the British forces in recent conflicts. A significant number of our veterans have these mild traumatic brain injuries. I will move to this document, which you will have seen recently—it was released in October and all MPs will have received a copy. This was put together by another charity I work with, UKABIF—the United Kingdom Acquired Brain Injury Forum. It is all about traumatic brain injuries.

On one of the pages of the document there is a nice big coloured diagram outlining the signs and symptoms that are common for traumatic brain injury. If you were to put that next to the signs and symptoms for some of the mental health issues that we have been discussing, such as PTSD, you will see that they are virtually identical. It is a big challenge for the medical practitioner to dissociate the two, especially if they do not have access to the prior medical records. If they do not know that the service person has had a traumatic brain injury in their past, and if the service person has not actually told them, they may treat for PTSD, which is a common thing to do, when in fact they should potentially be doing something different. The primary treatment with PTSD, as you are all aware, is cognitive behaviour therapy, and that does not necessarily work with people who have sustained mild traumatic brain injuries.



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Q178 Chair: If someone was unfortunately misdiagnosed as having PTSD, and given what would be appropriate therapy for that, and the mild traumatic brain injury was left untreated, what would the consequences be for that person?

Dr Grey: Very simply, they will not get the efficacy of treatment that they otherwise would.

Chair: Progressive sight loss?

Dr Grey: Absolutely. If the treatment is not working, the effect will be much worse.

Q179 Chair: Can you explain to us in some detail mild traumatic brain injury? What actually happens? What sorts of results does it tend to lead to and how does the cumulative effect take hold of people?

Dr Grey: A good way to explain this is to look at sport, and we see this a lot in the news. A big part of this document from UKABIF was about sport. There we have the phenomenon of chronic traumatic encephalopathy, which we have heard about with American footballers and now with rugby players here in the UK. We see progressive behavioural changes, primarily depression, which spirals and unfortunately, in the worst cases, leads to suicide. There are behavioural problems. There are particular problems with dealing with one's family and community. We had a very good debate in the previous session about whether we should have a national centre to which people should be sent or if this should be dealt with in the community. In cases like these, being part of that community is very important—being connected to one's family and getting help with one's family is very important.

Chair: But being surrounded by other veterans is important and that might work better in the residential setting, might it not?

Dr Grey: Absolutely. I think there is an area for both. My recommendation would be to have a centre. I think that is actually a brilliant idea, but there need to be regional support networks as well. I think that one national centre is not necessarily the answer.

Q180 Chair: What would help practitioners correctly diagnose a veteran's condition? I am going to ask you all this, but we will you first, Michael. Assuming that someone presents with all these terrible symptoms of depression, and of course the immediate reaction, particularly since PTSD has become such a vogue term—I hate to use the expression "vogue" but you know I mean it without disrespect—how would you be advising general practitioners to be on the lookout to avoid this particularly dangerous form of misdiagnosis?

Dr Grey: One of the big things that we need to start looking at is serial testing of the brain. For example, every year I have an eye test—in other cases it is every two years. I think we should be doing a brain fitness test at the same time. It would be very simple to do, and by serially testing these people—either each year or every two years—we can actually start



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to see trends. We can start to see somebody declining in their mental health before it becomes very serious.

Q181 Chair: You said it was very simple to do. What is the technique? Is it a scan?

Dr Grey: No, there are no scans at the moment. People are working on this, but at the moment there are no scans that will detect this, so typically it is done through a series of neuro-psychology tests. There needs to be more research in this area, to be fair, but these are relatively well known tests. I could see this easily being rolled out into GP surgeries, for annual testing.

Q182 Chair: Deirdre, would you like to comment on what you have heard?

Dr MacManus: Any specific aspect of it?

Chair: Yes, namely how the people in your cohort could most successfully be educated to avoid this potential misdirection of diagnosis.

Dr MacManus: I would suggest that there is a greater problem with missing the diagnosis in someone who has co-morbid TBI, rather than necessarily misdiagnosing with PTSD.

Q183 Chair: Can you explain that term, please—co-morbid?

Dr MacManus: Co-morbid means co-occurring. If someone is presenting with severe PTSD symptoms—nightmares, flashbacks, hyper-arousal, these sorts of symptoms—they do need to be treated for that, but what can be missed is the underlying additional diagnosis of mild traumatic brain injury, which can present with mental health symptoms of poor concentration, depressed mood, anxiety and so on. Psychiatrists, in order to pick up on this, have got to be alert to it and aware of the possibility, when taking an individual's history, that they might have recurrent traumatic head injuries—asking about what was happening at the time: did they lose consciousness and did they have any amnesia or loss of memory? That would alert them to the fact that there might be something else going on. I think there is a piece of work—the Royal College of Psychiatrists provides online modules for all sorts of disorders. I do not know what the uptake is for the online module for traumatic brain injury, but that is something that could be promoted.

Of course, you then have the problem, if you make the diagnosis, of what to do. Currently, I would be referring them. We have a good neurology service in London and can refer them for a neuro-psychological assessment. But if they fall beneath the threshold for that service taking them on, that is another gap in service provision for appropriate care for those individuals—that is probably moving on to another question. There are adaptations that need to be made to their treatment, as Michael says.

Q184 Chair: Before I bring Jonathan in, I know a young sergeant—a medic—who served in both Afghanistan and Iraq, and he survived being blown up in an armoured vehicle, apparently without a scratch. The vehicle was wrecked, and the crew saved, thanks to good equipment design.



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Presumably the fact that he is now having certain symptoms ought automatically to lead him down being tested for something like this, should it not? Yet until Blind Veterans UK came in and told me about this and I told his family, I do not think it would have occurred to him. What can we do about that? Jonathan, so you have any ideas?

Dr Leach: I think the first thing as a general practitioner is that you need to think about it. As Deirdre said, you will see something of a constellation of symptoms, and some of it is about taking a good history. As Deirdre described, if I saw somebody with head injuries—and I have—we would tend to refer for neuro-cognitive assessment. We have a centre in Birmingham.

By chance, the Royal College of GPs is just about to publish an education module that is done in conjunction with the head injury charity Headway—I had the privilege of doing the voice-over. We have done this jointly, and we will be incorporating the military and some of the hormone changes that also occur.

In terms of rolling out screening, I think that everybody would say that we would want to see the evidence base for whether or not that is an appropriate way of doing it. That is how we would do any sort of screening. It is not specific to this. That would need to be seen in the context, obviously, of the other priorities that we have as GPs.

Chair: That was very useful.

Q185 **Gavin Robinson:** Good afternoon to all three of you. With respect, these questions are about GPs and psychiatrists, so I hope I am not setting you aside, Dr Grey. May I ask both of you about the clarity that practitioners have around implementing priority treatment, and the challenges faced in pursuing that policy?

Dr Leach: If we look at the wording of the Armed Forces covenant, it says that you get priority access for things that are attributable, but around other patient need. I have not got it immediately in front of me. The main issue, however, is not being disadvantaged.

I think there is a lot of confusion around this. First, there is a perception that it is a priority for everything. If, for example, I saw a patient who needed a gall bladder operation, I would struggle to see how that would be attributable to service. I think it is fair to say that it is not clear, for us as clinicians as well as for the system and the service. There are some areas—we have described some of the areas around mental health—where you would still be alongside other patients with similar clinical need. It is not as if you would go immediately to the front of the queue. You are judged according to your needs.

If we take this in a physical sense, let's say somebody had a very badly injured knee. You could attribute it, and the GP would be recommended to put it on the referral letter that this was following an injury going across Barossa, or wherever it was that they happened to be. That would then be prioritised by the hospital alongside other people. It is quite a messy



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answer for what is sometimes not a completely transparent system. That is the straight answer.

Q186 Gavin Robinson: Feel free to answer this, Deirdre, or to complete the answer to the question that you were initially posed. Does that mean that this is really about managing expectations? Maybe expectations have been unfairly raised around the military covenant, and therefore the difficulty clinicians have particularly is about trying to reappraise people of what the covenant actually says and does.

Dr MacManus: Yes, but actually I think that expectations of priority care among veterans are quite variable. Some do not know about priority care at all, and some expect to have priority care for every health need they have. Yes, I think there is something about raising awareness of what they are actually entitled to, but that is difficult at the moment because it has been so difficult to implement priority care.

Within TILS, when we refer veterans to other services, as it may be easier for them to access a trauma service in their own locality rather than coming to us, we will make the service aware that a veteran should receive priority care if their trauma is military-related. I would say that we rarely get that actioned. When you discuss it with the clinician, they would be saying, "Well, it's subject to clinical need, and I have victims of sexual abuse, institutional abuse and torture. How do I prioritise their need?" I think there is great confusion over the definition of priority care.

Q187 Gavin Robinson: Will the royal colleges be engaging around the veterans strategy to try to inject a level of clarity or guidelines associated with this that might make it easier?

Dr MacManus: The royal college's line would be that it is not their responsibility to define it but they would be very happy to comment on any new guidelines and help with the implementation if that is made clearer.

Q188 Gavin Robinson: Is that the same?

Dr Leach: Yes, from the Royal College of GPs it is the same.

Q189 Gavin Robinson: I don't want to deprive you of any opportunity, Dr Grey, so do you have reflections on any of that?

Dr Grey: No, I think I am all right.

Q190 Gavin Robinson: Jonathan, you mentioned earlier the joint reference group. I guess the purpose of that, as you outlined, was to get a level of consistency across the four regions. Is that right or wrong?

Dr Leach: No, that is not correct. It is an NHS England clinical reference group that advises NHS England on the NHS care of current serving personnel, their families—the Families Federations are strongly represented—and veterans. In that regard, we have for example the chief executive of Help for Heroes and the Defence Medical Welfare Services, plus patient representatives. Patients are an integral part; they provide us

with feedback and ensure that we keep grounded. It is an England clinical reference group that guides NHS England.

- Q191 Gavin Robinson:** You talked about the transferability of that model to the other areas and different discussions, but how do you as a royal college, or indeed the Royal College of Psychiatrists, ensure consistency of care across the four nations? Do you challenge? Do you say, "Here's our experience in England—what's happening in Northern Ireland?"

Dr Leach: What I just described is me wearing my NHS England hat. For example, I am conscious that I have the new Scottish Veterans Commissioner behind me; his predecessor Eric and I used to meet regularly. There have been similar conversations. I have had conversations with Northern Ireland Government officials. From a clinical perspective, often the problems are the same and the solutions are very similar, even if the structures are different. I don't think there is any monopoly on ideas. From an NHS England perspective, we would be keen to work with—and we do work with—the devolved nations on how we can improve the services. From the perspective of the Royal College of GPs, yes, we want to ensure that if there is learning from one particular part of the United Kingdom, it is brought across into others. In that respect, it is the same.

- Q192 Gavin Robinson:** Do you have experience of that? Could you give us examples of where you have said, "I have learned this with my NHS England hat on," but you have disseminated it through the royal college?

Dr Leach: Not particularly through the royal college, but I went to the Veterans First Point conference in Scotland, for example. That is their delivery. I spent a lot of time talking to people about how that had been delivered, what was different and what was the same. I think that cross-pollination is really helpful, even if the context of how the services are delivered—basically the funding streams—is different. The needs of the patients are pretty much the same.

Dr MacManus: I would take a little bit of a step back from that as well. We do not have any official comparisons of veteran outcomes across or between the regions yet. That would be a very helpful piece of work on which to base decisions about which areas are doing better and what aspects of the care that is delivered are working best.

- Q193 Gavin Robinson:** That could probably form a consideration for us as a recommendation coming out of this inquiry, so thank you for that. How do we assist those in rural or remote areas? We know GPs are great for house calls, much more than others. Is there a particular concern about people who may be in the Outer Hebrides or beyond the M1 in Belfast? I jest, before I get criticised, but do you as royal colleges have an interest in that?

Dr MacManus: First, access to mental healthcare for people living in remote areas crosses boundaries between mental health disorders and populations. It is not specific to veterans. The TIL services make every effort to provide mental health access and care to veterans in remote



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areas. Home visits may be done through an assertive outreach approach, but telemedicine or telecommunications, such as telephone or Skype therapies, are also used. Of course, as was discussed in the previous panel, that is not suitable for every individual, but the Royal College of Psychiatrists certainly promotes new digital ways of improving communication with remote areas.

Q194 **Gavin Robinson:** How do you overcome the difficulties associated with remote living, such as not having access to high-speed broadband, which means that keeping a connection on Skype is impossible?

Dr MacManus: Absolutely. I am reviewing a gentleman by telephone at the moment, and he doesn't have the facilities to do Skype interaction. It's not ideal.

Q195 **Gavin Robinson:** That might be the best level of care he can get, but it's far from ideal. Would you agree with that?

Dr MacManus: Absolutely.

Dr Leach: In terms of College GPs, we have a remote and rural group. It is much wider than mental health, and it is wider than veterans. It tries to make sure there is equitable service for people. I am now resident in Worcestershire, and out on the border of Herefordshire and Wales, you can be an hour from your district general hospital and an hour and a half from your big hospital—for example, in Birmingham. This is not just an issue in the devolved nations; it is also an issue in England. We do have that.

I accept the challenge of broadband that Deirdre described. There is good evidence about it now. Perhaps it should not be used at the initial consultation, because you need many more of the non-verbals. You need to be able to sit down with somebody and look them in the eye. Once somebody is more stable, that can be delivered, as Deirdre said. That was in the specification, both for the complex treatment service and the TIL. That is an option, but the patient must be happy for that to happen, and it must be therapeutically appropriate. It has to be both.

Q196 **Gavin Robinson:** I was just thinking, in remote circumstances many folks rely on publicly provided internet—for example, in a library. I was thinking about the inappropriate nature of sharing consultations and receiving treatment in that context. Has that been factored in?

Dr Leach: Yes. For confidentiality, you need to be in the right place without distractions. You might be able to do that in the library, but it might be in a private room. The TIL has what we describe as pop-up clinics. We don't want therapists spending all day driving down the motorway. Pop-up clinics are in the design, and they often use the offices of people like the Royal British Legion. What you need is a suitable private office where you are not going to be disturbed. You don't need much technology. You can provide a pop-up clinic. There is one in Birmingham, but it doesn't matter where it is. It is a pop-up clinic away from the usual



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base. We do encourage that. For example, it might mean that people can meet where there are transport links.

Dr MacManus: I did not want to create the impression that, for the gentleman I was reviewing by telephone, that was the only interaction he was getting. We have a satellite clinic not far from his home. Resource-wise, he won't be seen by the clinicians as often, and we have only one psychiatrist, so I do his psychiatric reviews by telephone. We don't have anyone who is being reviewed only by telephone.

Chair: We are in the home straight. Just two more question groups, from Johnny and Graham respectively. Johnny first.

Q197 **Johnny Mercer:** I think you have answered a few of these already. The main point I want to labour is, what are we going to do about the challenge of those who practise psychiatric or psychological therapies that have no basis in evidence, no evidence-based care and no formalised complaints structure within the organisation? How are we going to protect very vulnerable people from those who are, however well meaning, not helping our veterans? It is very difficult for those of us outside your specialisms to do that. How do you do it? Do you kitemark it? Do you regulate at point of entry? What would you do?

Dr Leach: We can talk about England. The first thing is that if it is a proper organisation, it should be registered with the Care Quality Commission, and that is the same whether they are a charitable provider or a statutory provider.

Q198 **Johnny Mercer:** I get what they should be doing, but when you have a charity group create something like PTSD Resolution, for example, or a group similar to that, which is very well intentioned but ultimately does not have any evidential basis to bid for money, raise money and have access to veterans, what do we do about that?

Dr Leach: I will give you two examples. I am conscious that Professor Greenberg is to my left and I will bring him in on this. The view from us as the NHS would be that there needs to be proper informed consent. The NHS would generally use therapies that were guided by august organisations, such as the National Institute for Health and Care Excellence. If you were going outside of that, which we can do, there needs to be a proper process in terms of explaining to the person that you want to try X, which people can understand, and a process that will make sure that you don't have harm. What Cobseo, the confederation of charities, has done is put in an accreditation process. It is low level, but I think it is a start.

Your point is well made. It would be unfair for me to say which organisation, but—if I may bring you in, Neil?—Professor Greenberg and I did write to an organisation a couple of years ago. Actually, it is completely outside my responsibility, but, as a doctor and somebody who has a moral responsibility, we wrote independently, together, to an organisation saying, "Look, you are not practising what we would describe as reasonable, evidence-based medicine." That is fine, but you need to



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make sure. I have no authority, the NHS has no authority, but we have a moral duty.

Q199 Johnny Mercer: With the greatest will in the world, moral duty does not guide policy when we are talking about access to vulnerable people. What is within the art of the possible to legislate, which is what we do in this place? Ultimately, we have people who are vulnerable—they may not like that description, but they are vulnerable—looking for access to treatment. What is there that the state, which has a duty to them, can put in place to make sure that they will go to an organisation that practises evidence-based care and that has qualified staff, and where they have a reasonable chance of achieving a better outcome than when they started? What can the state do?

Dr Leach: Actually, I would put it into the remit of the Care Quality Commission and that is a conversation that I have—

Q200 Johnny Mercer: Why is that not happening now?

Dr Leach: Because it is outwith the responsibility of the Care Quality Commission. That could be put in. I have had that conversation.

Q201 Johnny Mercer: Why is it not within the gift of the Care Quality Commission?

Dr Leach: Because it is not included within the Health and Social Care Act 2012. That is the technical answer.¹

Q202 Johnny Mercer: Right. And are there moves afoot to change the legislation?

Dr Leach: I can't answer that question. I don't believe there are, but that is—

Q203 Johnny Mercer: Would you support that?

Dr Leach: Yes, I would.

Q204 Johnny Mercer: So why don't we do it?

Dr Leach: We are here in the Houses of Parliament!

Johnny Mercer: Another gold standard recommendation from Johnny Mercer.

Chair: I feel a recommendation coming on.

Johnny Mercer: That's three you have had today for the price of one session.

¹ Clarification from witness: [Care Quality Commission \(Registration\) Regulations 2009](#)

[The Care Quality Commission \(Registration\) and \(Additional Functions\) and Health and Social Care Act 2008 \(Regulated Activities\) \(Amendment\) Regulations 2012](#)

[The Care Quality Commission \(Registration and Membership\) \(Amendment\) Regulations 2012](#)

Dr Leach: It is fair to say that, wearing my NHS England hat, I have had the conversation with the Care Quality Commission about exactly that point.

Q205 **Johnny Mercer:** Well, let's do it.

Dr Leach: Neil is nodding in agreement, because we have discussed this. You can use therapies that are outside NICE. We do that. We prescribe off-licence all the time, but it is the process by which you do that. If I am prescribing a medication, I have to make it clear. I have to make sure that it is in the notes, that there is proper consent and, particularly in this area, that there is a mechanism to make sure that people do not come to harm. That is the point I have made to the Care Quality Commission on a number of occasions, but it is outwith the Health and Social Care Act 2012.²

Chair: Very clear—thank you.

Q206 **Graham P. Jones:** How does the current provision of mental healthcare to veterans compare with that to the general population?

Dr MacManus: The first thing to say is that it is quite hard to establish the burden of unmet mental healthcare need within veterans, but there is research emerging from King's that tells us that the prevalence of common mental disorder is higher in veterans than in the general population. Some qualitative research does tell us that there are still veterans who are reporting that they are not having their needs met appropriately at the time they need it, but as we have heard from this panel, services are certainly improving.

When I think about the services that veterans can now access in the NHS and how that compares with mental health services for individuals who have not served in the military, and I look at waiting times, we have targets in the TIL service that individuals should be offered an appointment within 14 days, and that they should then be offered treatment within a further 14 days. I think Jonathan has the data.

Dr Leach: If I may, Chair, this is the data from April 2017 to September 2018. The average for an assessment is 22 days—this is across England—and the average to be seen for treatment is 46 days. That is still higher than our KPIs, but—well, I will let Deirdre finish.

Dr MacManus: Actually, if you compare that with other mental health services, IAPT services have a target of about six weeks for individuals to be seen and in my experience it is not very common for that to be met. The only other mental health service I know that has a standard of two weeks is early intervention in psychosis. They do quite well at meeting their 14-day target, at 76%, but across other services there are long waiting lists.

Q207 **Chair:** But this is all subject to what we heard from the first panel: if

² Ibid



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someone is in crisis, it is quick.

Dr MacManus: Yes.

Q208 **Chair:** Yet we see report after report of ex-service suicides. Presumably that is not because the person could not receive a quick service but because they did not seek to receive a quick service. Would you say that? Has any research been done on the circumstances of what was offered to people who took their own lives?

Dr MacManus: Probably the best study to refer to is a little bit dated. It was done in 2009. Nav Kapur, who is a professor at Manchester, carried out that study. Overall, the suicide rate in the veteran population is no higher than in the general population, but in men under 24 it is two to three times higher. They are the population group who are least likely to be in contact with mental health services prior to their act of suicide.

Q209 **Chair:** So you would say that the data shows, in so far as we know, that it is not a problem of somebody taking their own life because they sought emergency help and did not get it in time?

Dr MacManus: At a population level, you could say that that is the group most at risk, but obviously there will be individual variation case by case.

Q210 **Chair:** We see these figures, and there have been reports in the papers in the last few days about some hundreds of service veterans who have taken their lives in the last few years. Is any work being done to investigate what contact, if any, they had with the health services before this happened?

Dr Leach: There are various things, Chair. First, from an NHS perspective, virtually all of these we would say were preventable, and every one is a tragedy. That needs to be said. If we look at the context, they are all very complex circumstances that may relate to service and often involve difficulties in finance, housing, relationships or substance misuse. For a complex problem, you have to have a complex solution. I will do the general and then come to the specific.

The general point is that the NHS has a no-suicide policy, and the NHS generally is working hard to address that. In terms of the veterans, we have specific work going on in various parts of the country to look at how we can specifically support veterans communities, for example in Kent, where we are working very hard with the rest of NHS England regarding that.

In terms of research, there are two elements. First, as you will have heard previously, there is the cohort study being done between the military and King's, which Deirdre is involved with. As it goes forward, that will be looking at psychological problems for those who are veterans of Iraq and Afghanistan. It is actually looking at physical health as well as mental health.

The other aspect is the report—the research—done by Manchester University at the Centre for Suicide Prevention that Deirdre discussed. As



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NHS England, we have been in conversation a lot with them, essentially to commission further research regarding that. What they did last time, because there is no database for veterans, was to take all the deaths by suicide or by unexplained death and cross-match them in terms of names and dates of birth to everybody who was a veteran. That was the study they did before.

We are in the process of commissioning that now, through Professor Nav Kapur up at Manchester University, first to see whether the findings he found before—as Deirdre said, the rate overall is not higher, but we are concerned about the younger age group. As he said at the time—I beg your pardon; I have lots of data here. He said before that there were three risk factors: the stress of transitioning to civilian life, the exposure to adverse experiences within the military, and the vulnerability to suicide before entering the military. Those were the three conclusions that came from that study before. As the NHS, we are looking at that again.

We are also looking into whether there are any other themes, but very importantly, given what I described at the beginning, whether there are other initiatives that we could do that would actually prevent. That is the important message here.

The final piece is that we talked quite a lot about the TIL and the complex treatment service. Of course, a lot of this is about accessing services. The view that many of us would have is about joining this up, particularly with what I would describe as the blue light services. The police, the ambulance service, the mental health trusts and A&E in particular are frequently the ones who would actually respond, if you like, at a time of crisis. We as the NHS are working on that, so actually, I talked about the strategic aim over here, which was to improve the overall services of everybody—the better understanding and the better response—and that is exactly what we are trying to do.

Q211 Graham P. Jones: Finally, I want to ask you where you think the current provision of statutory services and charities could be improved.

Dr Leach: It is not big enough. We are seeing—sorry that was off the cuff. I have a particular bias, because of the fact that I have been heavily involved in the design and delivery of the English service. I cannot get away from that. We are seeing the number of patients accessing it going up. The TILS now has 4,400-odd referrals in, with 290 into complex treatment service. It is about 30,000 in England per year who access IAPT. That is the veterans piece.

We are finding—this is a good thing—that people are coming forward earlier. That was completely in the design. Deirdre discussed the two-week KPI. What I have said to the providers is this. In one sense I apologised to them that the two-week KPI is going to cause them problems; I know it is going to cause them problems to meet that. But in another sense I do not apologise, because what I am trying to do and what we are trying to do is to intervene earlier in order to be able to prevent some of the things that, Chair, you have discussed. So I think there is something about the



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resource and the size of the service, given the demand. That is probably the bit I would talk about.

Dr MacManus: May I raise a particular group that I think are quite neglected? That is veterans in the criminal justice system. A lot of the research that I have done has highlighted the fact that veterans are more at risk of committing violent offences than similarly aged males from the general population, and that mental health problems are a specific risk factor for their offending behaviours, but so are social and welfare issues, such as housing and employment. We have done a big piece of work on comparisons involving veterans in liaison and diversion services. That is a service within the criminal justice system that individuals can be referred to if a psychosocial problem has been identified. We know that veterans, compared with offenders who have not served in the military, are much more likely to present with high rates of anxiety problems. That is a strong risk factor for violent offending. And they are more likely to present with alcohol misuse, which is a risk factor for motoring offending. So we are identifying that they have a different spectrum of mental health problems and offending behaviours, and there really isn't any specific service for veterans. Actually, we have been running veteran prison in-reach services in London for the last few years, but there is a postcode lottery across the rest of the country. This is definitely a gap in service provision.

Q212 **Chair:** May I invite you to make any final point that you would like to put to us, on any of the subjects that we have been discussing this afternoon? Michael, would you like to start?

Dr Grey: Sure; thank you for the opportunity. We have heard a lot today about the evidence base. I want to make the point strongly that to get that evidence base, we really need to do the research. I will not globalise; "some" aspects of the discussion are very poorly researched, and I think that it would help if, for example, a Committee such as this could inform UK research councils that these are important issues. If we make special calls, the researchers will come to them. That doesn't mean that we need to be adding more money. Maybe we need to be redirecting the money into areas of priority.

Another important point for establishing the evidence base—we have touched on this a little—is that it is really important that researchers have access to anonymised medical data that will actually allow us to do this. At the moment, we do not generally have access to veterans data, and that would be really helpful.

Dr Leach: I think that a big area—if I am not pinching Deirdre's point—is families. It is the families who are really important in this. The NHS has done some things for families, but I don't think we have done enough. There is a brilliant charity called the Ripple Pond. Their analogy is with a rock that goes into a pool and the ripples going out. I have listened—with shame, I must say—to some of the stories. The spouse, the partner, is the person there at 2 o'clock in the morning trying to prevent the person from committing suicide. If there is an area where we have done some work but



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need to do considerably more, it is the support of the family, because without the family, you cannot support the individual.

Chair: The final word goes to you, Deirdre.

Dr MacManus: The other two have stolen my thunder! My first point would be research. Of course we need to have a good evidence base. But that is not just about research; it is also about service evaluation within the services that we have been talking about. If we do not have the evidence of good outcomes, should we be continuing funding? So we need to be pushing to have services producing outcomes.

I would definitely talk about families and children. There is a big gap in service provision there.

I think I would say I am slightly concerned that gaps are quickly filled by the charitable sector. I guess something that the royal college would say is, "Great, if that is in the area of welfare or specialist mental health services, but it should not be in areas where the Government should be providing the resource to provide that care."

Dr Leach: I would agree.

Chair: Thank you. It is an absolute pleasure to have three such star witnesses, all clearly at the top of their game. You have given up a great deal of time this afternoon, both in your actual session and in waiting for it. We are extremely grateful to you and we hope you will feel that your time has been well spent when you see the final report, with conclusions and recommendations, that we produce.