HOUSE OF COMMONS

Defence Committee

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

Tuesday 27 November 2018

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Watch the meeting

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

Questions 213-334

Witnesses

I: Catherine Braddick-Hughes, Andy Price and Tim Boughton.

II: Sue Freeth, Chief Executive of Combat Stress, David Richmond CBE, former Chairman of the Contact Group and Tony Wright, Chief Executive of Forward Assist.

Written evidence from witnesses:

Sue Freeth

David Richmond

Tony Wright

Examination of witnesses

Witnesses: Catherine Braddick-Hughes, Andy Price and Tim Boughton.

Q213 **Chair:** Good morning, and welcome to this session on mental health and the armed services, which is the second part of our two-part study. We have two panels today. The first panel of witnesses are people who have had direct personal experience of the adequacy or otherwise of the mental health support that is offered to serving personnel who experience mental health difficulties for all sorts of good reasons.

Instead of just asking the panellists to briefly introduce themselves, I would like to invite each person, if they are up for it, as he or she introduces him or herself to open with a short statement, if they would like to, about their own experiences, before we get into the specific questions. Catherine, may we start with you? Please tell us a bit about yourself and your own experiences.

Catherine Braddick-Hughes: Good morning. My name is Catherine Braddick-Hughes. I am a retired lieutenant colonel. I served for over 21 years with the army legal service, so I am a lawyer by profession.

I have multiple injuries. They come from Bosnia and then, recently, from Afghanistan. With the mental health side of things, it was actually only Afghanistan that brought on the mental health illnesses or injuries that I am currently muddling through—I think that is the phrase.

For me, part of the build-up was that I went out to Afghanistan as an individual augmentee. I was never part of a unit. That means that you are an individual who goes out to join the NATO headquarters as a part of the NATO team. You are not supported by the British. That was a bit of a shock. My original tasking was going to be about six months, which would involve me being in a bunker. It took into account the fact that I had injuries from Bosnia and I was slightly limited in what I could do. However, on arrival in theatre I was collected from the airport and was taken to a completely different job, which in fact required me to be out on the ground around Kabul. It is like any other capital city, you know, with the roadworks and the traffic.

I was not trained for that particular role, in my view. I was not trained to be out on the ground. I was not expecting the Army to say, "We can't be responsible for you—here is a waiver—for providing transport or any other support in the job that you are going to be doing." I was working for a US Marine and I ended up, at the end of it, being the second in command to the whole mission, as legal adviser.

I explain that because, for me, it was partly the lack of training, the lack of expectation and the lack of understanding of what I was going to be involved in, along with a series of security incidents, one of which resulted in my further injury. I ended up down in Bastion Role 3, a medical facility. It starts there for me, really, because while I was down there, sitting in a

corner of the room, hugging my knees, it was not just about the physical injury that I had sustained; it was about the state of my mental health at that time.

I did not leave theatre. I did not get casevaced. That was partly due to my own insistence. This is part of what I am trying to convey—what service personnel feel like when they are doing their duty. I was the second in command and I had troops out there still who, although they were Americans and a Kiwi, I had a responsibility for. I therefore could not leave them until I had done my job.

I was in bits, to be honest. I went to see the medic back in camp, when he was giving me the painkillers. I was supposed to go back down to Bastion for physiotherapy, but the security situation was so bad I could not. When I went on decompression, that was the first instance. That is a two-day stint where you go from Afghanistan out to Cyprus, where the idea is that you decompress. I am not sure what that means, but at that time I was in floods of tears.

I was talking to corporals. You have to understand the rank issue. It was like, "Whoa—I really don't know what to do with this woman." So they gave me to the padre, who was a TA who had come out to do his stint and again did not know what to do with me really.

I returned home and went straight to the med centre. They referred me straight to DCMH because of the level of distress, the level of hyper-vigilance and the state I was in. I was also in a lot of pain from my back injury. I had not appreciated how much post-traumatic stress disorder links into the pain aspect and how it can influence the way you are perceiving threats, so that was also something.

I went back to my original place. I had been up in Shrewsbury as an advisory commander before I deployed. I was then supposed to go straight down to Operational Law in Warminster. I asked for a bit of a deferral because of the injuries, but that was denied.

This is where we get into my experience, I suppose. When I attended my new role, I did not even have a starting interview with my commanding officer. There were no "lessons learned". There was no, "How was the tour? Are there any issues that we can take away?" There was nothing.

Q214 **Chair:** So they were operating on the basis that you were just reporting for duty like anybody else.

Catherine Braddick-Hughes: Yes. It was, "This is what your workload will be. Crack on." To be honest, that is all right for a while, because you can use it as a means of focusing and not letting the hyper-vigilance, anxiety and everything else get out of control. I probably was taking on too much, but nobody within the branch—I think there were 14 of us—discussed it with me or asked me about it.

About 18 months in, I was getting to the stage where I just could not cope any more. I was outed in a meeting of other lieutenant colonels and

colonels, because I had said that I thought that returning lawyers should have time back at the branch, where people know them and they can see whether there are changes that maybe they need to be aware of, to decompress. I was seen as having my own agenda: "Just because you've got PTSD, Cathy, doesn't mean that everybody returns with it." I understand that, but it was a bit brutal. I had been trying hard to keep it all together and that perhaps undermined that slightly.

I had to go and get some help and treatment, but again, I was dealt with first of all by a corporal, who was doing EMDR. But when you have had a number of incidents—I can probably count about seven security incidents, in perhaps three of which I thought I was going to die; I honestly formed that opinion—you cannot unpick one with the EMDR process. It did not work for me.

There was a long period of time when I was not seen by anybody. This was about 18 months after I had got back. I had been asking for help. I had to—I have two children. I feel very much still that males are able to perhaps go down to the gym or see their friends and are able to rely on the wife as that bit of support, whereas I had to be that rock. My husband needed me to be that rock, and my kids did, so I was trying desperately not to affect them at home.

I had a word with John Clack, who was the psychiatrist at DCMH, and he apologised to me by telephone that he could not get me any treatment for a while—there was probably going to be about a six-month delay—because he had to make a stand. They had such a lack of resources at the Tidworth DCMH that I had to be an example. Don't get me wrong: I understood what he said. He said, "I cannot do it. If I put you first, somebody else is going to suffer. I just haven't got the resources to deal with the numbers, but I'm explaining it to you." That was my first experience of thinking, "Wow, okay. So I've got to carry on and do what I'm doing."

Q215 **Chair:** Shall we stop you at this point? That was fantastically helpful, and that is why I felt it quite right to let you get it out there.

Catherine Braddick-Hughes: Perhaps a bit too much!

Q216 **Chair:** No, no—it wasn't at all. I knew what you were going to say because you had sent us similar material in writing, and I wanted to leave to you how much you put it out there, because we were so impressed with what you wrote.

May I go to Andy now? Possibly your evidence could be a little bit more compressed, because otherwise we will not be able to get through to our questions, but that was absolutely perfect, Catherine; thank you. Andy, please introduce yourself first.

Andy Price: I am a former rifleman from 6 Rifles, which is a reserve battalion of the Rifles. I completed three tours of Afghanistan in the six-year period that I was with them. Following that, I have been attached alongside the FCO in Afghanistan and the EU in Libya. I now run the

Veterans Hub Weymouth and Portland, which is a support organisation for veterans and their families. That came about through my own experiences. I am diagnosed with PTSD, depression and anxiety. There is very little support in the area of the country where I live, so we set this up as a way to find out whether anyone else was going through the same thing that I was going through. To be honest, in the last 12 months we have been inundated with people requiring support—not just from recent conflicts, but all the way back to world war two. We have had multiple suicides in the town where I live—all veterans and family men—and multiple suicide attempts as well.

We are out of our depth down there. I am just a rifleman, yet at the moment seven days a week I am supporting men and women from all backgrounds and ranks who are in crisis because there is no support for them. I am taking people to hospital who have tried to take their own lives and have got hold of us to say, "Can you take us to the hospital?" I'm looking after men and women of all ranks who are openly cutting themselves on their arms because they have no other way to express the anger or confusion that they are feeling. Hopefully I am here today to help discuss that with you guys.

Tim Boughton: Thank you for the opportunity to be here. In comparison with Andy and Catherine, my experience is probably not as deep. I served as an Army officer and a naval officer commando pilot for 20 years from 1989 through to 2008. I then left and went into banking in the City, which will be relevant in a second.

I served multiple tours of Bosnia, Iraq, Afghanistan and Northern Ireland, both on the ground and in the air. My PTSD experience was like a glass: we come into the military with a certain amount of our own baggage, and then we see what happens in each of the conflicts, which just grows the water in the glass until it overflows. For me, it was a culmination of many things, including ethnic cleansing in Bosnia and a near helicopter crash there when I was not far out of training with the Commando Helicopter Force—a bad night on an incident recovery. It was then topped up with various things with Iraq. Afghanistan was not on the ground, but there was a system put in place for the Americans and the British firing on the ground against enemy forces. The Americans were using a scheme that was causing blue on blue with the UK forces. As the UK representative on the NATO working group, it was down to me to sort it all out and make the Americans conform to us and the same fires before we lost any more casualties, so the pressure was really on.

It really manifested itself for me as I was coming to the end of my time. My last job was a special forces job in terms of commitments and the Joint Helicopter Command. That was fairly stressful, both in terms of the work and the time out. I was becoming angrier and more aggressive, and it was my wife at the time recognised it. She would sit on the step at home and dread the day of my walking through the door, because she didn't know whether I was going to be angry and storm upstairs or whether I was going to be fairly nice. That also impacted on my daughter at the time.

I refused to believe that I could have PTSD or that I could be mentally unwell, because I am a professional operator and—I know this is a really stupid thing to say—I am an officer. The officers have to be there for the guys: you have to look after them and make sure that they are all right. On my next aircrew medical, I referred myself to the doctor, who said, "Look, I think you need to go and speak to somebody." That was in 2008, when there was one clinical psychologist for the Navy, a guy called Commander John Sharpley, who is now the Surgeon Captain. I went down the route of cognitive behavioural therapy, which didn't work for me. In the first session I had with the psychologist, she broke down in tears because of everything that I was explaining to her, so I ended up reverse engineering the meeting. I was giving her therapy, totally unqualified.

Then we got into EMDR, which as Catherine said had some limited worth, and I think Catherine raises a very valid point: for a single trauma, EMDR is very good, but for multiple trauma, it is probably not so good. Then I found mindfulness, and I am now a trustee of the Oxford Mindfulness Centre, because I truly believe that done in the right way, mindfulness saved my life. It was a case of three weeks of intensive mindfulness, and it just cleared that brain. It took that glass—all of the experiences—down to at least half way, so I could have expansion on a daily basis to live my life.

From that experience, I then went into the City, and I quickly found that veterans in the City were experiencing the same problems but had no one to talk to. I ended up over a period of a few years mentoring 30 to 35 people with PTSD, anxiety, depression and panic attacks over a period of pre-transition, mid-transition and post-transition, which has been a great joy for me. While I say I am not qualified to deliver any of the psychological stuff, I don't. I sit down with them, they listen to the story, I help them, I signpost them, and then I send them on their way, but keep in touch. I hope that gives a flavour of my experience, but I am happy to answer any questions.

Chair: That is absolutely brilliant. Let me just say that if any of you at any time are finding this too much, just indicate. We can always suspend the session for a few minutes, should you need to.

Q217 **John Spellar:** Thank you for those very moving introductions. Did you feel able to report that you had mental health issues through the chain of command while you were in the services?

Catherine Braddick-Hughes: No.

Tim Boughton: Sorry, did I feel I had support?

John Spellar: No, were you able to report it?

Tim Boughton: Yes, in my case, but I did not know how to. I did not know where to go, and I do not think the organisation was set up for it at the time.

Andy Price: In my own experience, shortly after my second tour of Afghan, I went back to Chilwell, which is a mobilisation centre up near Nottingham. I was assessed as being mentally unfit to be able to go back on operations, yet a year and a half later, I was back out in Afghanistan. Because of the problems that I was experiencing, I felt that was the best place for me anyway, so at the time I was not going to argue.

At the moment, just in relation to that question, we support serving soldiers down at the Veterans Hub in Weymouth. We support them because they feel that if they are to go through their chain of command, they will jeopardise their careers. In fact, one guy who I have known for a lot of years said that when he went through his chain of command, he was told to make a decision between his career and looking after his mental health, so he now comes to us for peer support. I am not saying that is generic through the whole Armed Forces, but that is most definitely still a problem, where guys—men and women, sorry—feel that their careers will be jeopardised if they try to get help.

Tim Boughton: I would add to that, echoing what Andy said, that if I had gone ahead and reported in the way that I did and I was on a serving squadron at the time, I would have been removed from flying duties, and that was my career. In that sense, my career would have been dead in the water.

Catherine Braddick-Hughes: From my perspective, because I was going to go and get therapy, I actually had to inform my new commanding officer that I was doing that, but there was a view that there was no support there. The work was still piling up. Before I found it too much, I had gone to the UN to represent the UK on the preventing sexual violence in conflict initiative. I was being asked to go out to Korea to discuss the truce. Those were not little jobs; they were very big, pressurised jobs, but because my senior officer—not my commanding officer—found out about the fact that I was getting treatment, she removed all of my work and made me the visits officer. That was actually what cracked me, because I did not have those protections in place.

Q218 **John Spellar:** In your view, out of all of that, is it a failure in the policy, or is it a failure in the interpretation by individual officers? In other words, is it systemic or down to rules, or is it cultural? If so, how could that be improved?

Tim Boughton: I think it is cultural. The policy is a policy, but it is literally a lottery as to who your commanding officer is, who your chain of command is and what their version of thinking is for how to deal with you. I would say, bearing in mind that this was 2008, that now it has got a hell of a lot better in the military in terms of the commanding officers and their ethos. LAND at the moment are doing a mental health audit that I have been involved with. It is now mandating that all OF-5s and above are having a training course to directly deal with this. Bear in mind that the COs at the time did not know how to deal with this either. They had no training. If you rocked up to your commanding officer and said, "I am feeling a bit funny", to them it is like, "How do I deal with this? RMO,

quickly, try to sort something out." That is a long-winded way of saying that I think it is cultural, but I think that culture is getting better from my experience of 10 years ago.

Catherine Braddick-Hughes: I need to bring in the occupational aspect. As I said in my statement, you have to remember that there is an occupational duty to look after your individuals. If you are therefore reporting to the chain of command or an occupational medic who is part of that chain of command, they have no option but to say, "Actually, you are unfit." Therefore you are effectively ending your career.

When I went to see them, I thought they could cure it. Honestly, I just thought they could get me used to this, to this trauma and everything. I was not discharged because of the PTSD; I was discharged because of my shoulder injury. It is sometimes hard to see where the obligation is to ensure that the employer—I know they are not employers, but I am using that as a term that people understand—has a responsibility for the health and safety of those individuals underneath them. There is that aspect. Is the policy there? Everybody knows about health and safety and risk in the services—of course they do—but I don't think they necessarily see the mental health side as a risk. It is certainly not made a risk that is accountable to a commanding officer, whereas if he committed a health and safety Act breach, he would be held accountable. I do not think it is seen in the right context sometimes.

Q219 **John Spellar:** So should there therefore be an ability to pause somebody's career while they get treatment and a reset so they are then able to move on, as it would be if they had broken their leg, for example?

Andy Price: You just hit the nail on the head. Arguably, it is harder to deal with a mental health issue. We can see what has happened to someone physically, whether they have broken a leg, get shot or caught in an IED—whatever it is—but mental health problems are often pushed aside.

Because of the culture that Tim was just talking about, which we are all part of if we have been in the military—we are taught to suck it up, and I still do that now—we let things fester. Because of the fear that they are going to lose their careers, be mocked or deemed not worthy or fit to do their jobs, people let it fester even more, to the point where they get medically discharged or leave the services, at which point they are handed over to the NHS. With all due respect to the NHS, it is not their problem to deal with the problems brought about by service; that is down to the MoD.

A career break is an absolutely brilliant idea. We would do that in a civvy job. If someone has a mental health breakdown in a civilian job, they are given time out. In the military, that is frowned upon and they lose their careers. I am supporting a guy at the moment who lost his career. He cannot claim his pension until he is 55 or 60. He is relying on a bare minimum disablement pension of £30-something a week, yet he has a mortgage to pay and a family to support. He tried to kill himself the other day because of it. All he wanted to do was stay in the military and be

supported by the MoD until he was in a position where he could make his own mind up as to what to do. I definitely think that that is an issue.

Tim Boughton: The issue you will have there is with tier 1 operators in special forces or with people who are qualified pilots for special duties—anything of that ilk. Taking them out for a period of time is the right thing to do, but putting them back in, will they be able to operate at the same level again in the same side? It is for others to comment, but I would suspect from what I have seen that the answer is no.

Q220 **Chair:** Could there not be a system whereby, even if somebody could not go back into the very same element of the Armed Forces that they had had to leave temporarily while they got better, there could be plenty of other options within the Armed Forces, with an enlightened policy in place?

Catherine Braddick-Hughes: You are still a valued, trained individual.

Q221 **Chair:** Absolutely. Otherwise it is all going to waste, isn't it?

Catherine Braddick-Hughes: Yes, it is.

Tim Boughton: But it is very difficult to tell a qualified commando pilot or a member of a tier 1 unit, "We're going to put you in a HQ job or a ground job, as a pilot." You are still going to have that stigma.

Q222 **Chair:** Catherine, you would have appreciated the opportunity?

Catherine Braddick-Hughes: Oh my god, yes. I asked to go and do part-time work or to do a special project—something that would have allowed me to have a bit of space and time. I would have had the value. When you have everything taken away when you have worked so hard towards it, the element of being broken is a common theme with anybody who has mental health issues, probably from anywhere, but certainly with the military. The fact that you have lost your value and you are broken is significant. If somebody had said to me, "It's all right. What we will do is give you some projects," I would still be there like a shot.

Chair: I will just mention at this point that you will see various members of the Committee coming and going, because they have to go to the Chamber and ask a question, or because they have to attend a statement. I say to all the witnesses in our two sessions today, please don't be put out by that. We intend to give this our fullest attention.

Q223 **Mrs Moon:** May I thank all three of you for the amazing evidence you are giving us? I cannot say how important your evidence is to us.

Catherine, I wonder if I can ask you a particular question. Forward Assist, which I have been working with, has suggested that a lot of the mental health support for post-traumatic stress disorder has been male-orientated, and has not perhaps taken into account different ways in which women think and deal with issues. Has that been your experience?

Catherine Braddick-Hughes: That is very pertinent, because I am an ambassador for Help for Heroes. I did that because I needed to give

something back for the support that I have had. One of the issues that I have had has been as an ambassador. Apparently because of my whole appearance—it being a hidden wound, I suppose, rather than an obvious injury—I have found that, yes, I am completely treated differently.

I was fortunate enough to light the first torch at the Tower of London for their installation, yet the senior officer there asked who I had lost. I was standing there wearing my medals, and he asked who I had lost. It was like, "Okay." The next thing was that a TV interviewer asked, "Whose medals are you wearing?" It is that kind of attitude and approach. That is one event—I could tell you about lots of them.

You are not seen as frontline troops, but, as I explained to Andy, I was out on the ground every week. People would be knocking on our vehicle to see if they could stick a magnetic IED on it. I would be given a shotgun and two grenades. It does not matter what sex you are. That is the experience that I had, and it does not make it easier to deal with. I think you are treated differently. I think the lads are quite often expected to talk about it with the rest of the unit or to go down the pub, or to go to the gym to get rid of their aggression. I do not have that option.

Q224 **Mrs Moon:** Thank you. You talked about pain being an additional pressure and trauma that almost facilitated the PTSD in moving forward and becoming a more powerful component. Are we failing to address that in the medical units when people come in with injuries? That's my first question. Secondly, all three of you have talked about the lack of support and a feeling that, "You are now damaged and therefore of less use, so let's move you to one side." How much did the lack of support, which is a major part of what enables people to do their job within the military, and what was almost a rejection by the organisation, add to the trauma and the difficulty of recovery?

Andy Price: It compounds it. If you are not dealing with something at root level when it first starts, or if it has been dealt with wrongly or you get the wrong support or not enough support, that problem steamrollers and becomes worse and worse. Then you start to doubt yourself as well. After my first tour, for example, I was given the weapon of one of my best friends to clean. He had been killed in a suicide bombing. There was absolutely no reason for me to clean his weapon; it was unserviceable. But I was told to dig the weapon out, and I was picking bits of him out of that weapon. At the end of that tour, having been a Reservist, from Brize Norton I was taken back to my home town and dropped off at a garage, and that was it. There was absolutely no support. As a young man, I couldn't comprehend that. And this has gone on and on. It's a repetitive story that I hear from other people. If it's dealt with at root level within the military, and if you put in place mindfulness or whatever and start to support the guys there, probably retention would go up. Recruitment would go up. People need to be supported.

At the moment guys and gals are leaving the Armed Forces. They are being pushed out into the NHS. A surgeon captain said the other day that it becomes the NHS's problem because the job of the Royal Army Medical

Corps is to make people fit to fight or fit for service. If they can't do that, you are passed over to the NHS. The NHS can't deal with it. They've got the Steps to Wellbeing that offers you six to eight therapy sessions if you can get a slot with them. That isn't enough to deal with multiple traumas or even deal with what veterans have been through. Some of them have been through some horrific events.

Then you've got the TIL service, which is absolutely brilliant, but in the county where I live they haven't got a therapist any more. The therapist that they did have was coming across from Somerset, and has now left because of the pressure she was under trying to support veterans county-wide. Now we have a void. Off the back of that, we had a guy who tried to kill himself the other day because he doesn't know how he is going to push on now that there is no therapy available, and they've turned around and said it will be five months until they can find a replacement for that lady. To answer your question, they are not dealing with it within the Armed Forces.

Also, you asked about pain. If someone is injured, quite often it's, "Fix the physical injury and let them get back to service." A lot of the time, especially if someone is deployed and injured in a contact or whatever it is—I experienced this myself—often it's, "We'll patch them up and get them back out again." People seem to forget about the psychological effect, which can take a few months to materialise, especially if you're on deployments because you're always at it 24 hours a day, but as soon as you get home you start to think about things and then it becomes a real issue.

Tim Boughton: I think I agree with what's been said, but I would add this—I said it to Dave Richmond, who is sitting behind me, when we were outside. Where we were in 2008 and where we are now in 2018 in terms of the support available is a quantum leap. Are we perfect? No, we are not perfect. Are there people from previous campaigns that are feeling the issues to a similar level? Yes, there absolutely are. But I can tell you as a fact that, from being involved with a programme that RAND are doing now around mental resilience training for troops at the lower level or what the Samaritans are doing with their suicide prevention line, we are looking to take this two years before someone leaves the service, in transition and afterwards and have access thereafter. That is a hell of a way forward. Do people fall through the system? Of course they do. We just have to signpost better the support that's available. We have to collaborate and we have to talk to each other because, at the moment, that is where it is failing in large degree. We have so many charities out there who have got LIBOR money in the extreme, but how they are using that and bringing it to support is anyone's guess.

Q225 **Johnny Mercer:** Can I get this right, Catherine? Were you full time?

Catherine Braddick-Hughes: Twenty-one years.

Q226 **Johnny Mercer:** And when you left—when you were medically discharged—it was for a physical injury, not a mental injury.

Catherine Braddick-Hughes: It was for a number—for back, shoulder and PTSD—but it wasn't the PTSD that was stopping me. It was the shoulder, because I can't fire a rifle.

Q227 **Johnny Mercer:** So when you moved into the civilian environment, what was the handover like? Obviously the PTSD would have required ongoing management.

Catherine Braddick-Hughes: Yes, it would be interesting. There was no handover. I didn't even get an office call to say "Goodbye, and thanks for your service." I had nothing.

Q228 **Johnny Mercer:** Where were you working at the time?

Catherine Braddick-Hughes: Andover—at Field Army—and I don't think COS Field Army or the commander knew that he had an individual under his chain of command. I was dealt with under the legal—

Q229 **Johnny Mercer:** Why?

Catherine Braddick-Hughes: I don't know. I can't answer that but, when you were talking about abandonment, on 28 August I had nothing. I didn't even have a call to say "Hope you're okay Cathy, good luck." I had an email this morning from one of the full colonels to say "I thought you left five years ago." We were only 120 in the corps. There are really not a lot of people there, and if you have somebody who is injured—I don't know. No, I didn't have any support.

Q230 **Johnny Mercer:** Andy, you were a reservist?

Andy Price: Correct.

Q231 **Johnny Mercer:** And have you been discharged or are you still serving?

Andy Price: Discharged.

Q232 **Johnny Mercer:** Discharged for?

Andy Price: I discharged myself.

Q233 **Johnny Mercer:** You discharged yourself?

Andy Price: Yes, I left.

Q234 **Johnny Mercer:** Have you got a med discharge?

Andy Price: No, I didn't have a medical discharge. I couldn't get the medical support I needed. I did the three tours. I was trying to get help and it was not available so I made the decision to leave myself, and started self-medicating, and then I ended up working for the FCO in the EU.

To touch on what Catherine was just saying there in regard to the support after you leave the service, I have lost count of the amount of people, Mr Mercer, that come down to me, that have left the regular forces, and they are just—whatever the intent is, of the regular services, and whatever they portray to the public that they are doing—left out and hung up to dry.

There is no follow-up support. It is very rare. I have a guy who is actually in the Royal Marines now. He is leaving soon because of a mental health problem. He is terrified, because he said "There is nothing in place for me. I am going to be left to find my own support, through TILS or whatever it will be."

If you look at the bigger picture as well, under the military covenant guidelines, the NHS is meant to prioritise certain treatments for veterans. Dorset County Hospital, where I am, were not even aware of the military covenant. It was one of my colleagues that advised them of what they were supposed to do in support of a guy that had just tried to kill himself.

Q235 **Johnny Mercer:** And Tim, you were full time and you left. Were you med discharged?

Tim Boughton: No, I wasn't, because the culmination of my PTSD happened when I was outside, so it brewed up as I was leaving and then manifested itself when I was outside.

Q236 **Johnny Mercer:** Andy, lots of different options have been offered up by people like myself and others as to how you bridge that gap—that transition from service, and particularly as a reservist.

Catherine, what happened to you is clearly unacceptable. What we can't change is the deep unprofessionalism of commanders who don't even know who is serving in their unit. What we can change is the process, and the treatment pathway that the MoD can have to get you, in the military, into civilian treatment with primary care, or whatever it might be. What would you do to change that, just briefly, if you could? There are a number of things. For example, we are still the only "Five Eyes" country that does not have a veterans commissioner or department for veterans affairs. I have talked about a department for veterans affairs in this place until I am blue in the face. I asked the Prime Minister to look at setting it up. She has created a department for a lot of other things, but not for veterans affairs. What do you think would be the answer?

Catherine Braddick-Hughes: Veterans affairs would be awesome. The only reason I am able to sit before you is that I have used Help for Heroes at Tedworth House as my transition. It is having that safe place, being able to go and talk to other people who have been through the experiences and realising you are not on your own. Without them, I would not be here, probably.

Q237 **Johnny Mercer:** The reason I think we should have a department for veterans affairs is that the No. 1 factor in improving the lives of veterans who leave with mental health problems is having a job. That is not an MoD issue but a DWP issue. What else would you do to help that process?

Catherine Braddick-Hughes: It goes across the board, doesn't it? You have people like Care After Combat who try to help soldiers going into the prison system because they have gone awry, so you have the Home Office aspect as well as the DWP and the MoD. I would say that the MoD is the least interested in what happens to individuals once they have left. That is reflected not only in their policies and in their failure to hold people

accountable for the failings, but—I hate to say it—in things like their compensation scheme, which they are looking at changing, and how it will impact on people who have left.

Q238 **Johnny Mercer:** The experience that you have recounted to us of an individual not even knowing that you are in a chain of command, let alone looking after you, let alone seeing you through—that is almost criminally negligent. If that was one of my commanders, that is their core duty, so they would not be in a job for very long.

Andy, what would you change?

Andy Price: What you said there. From my perspective, if someone is medically discharged, for whatever reason, it is an MoD problem until they are fit to work again. It should not be passed over to DWP and other services that have nothing to do with the MoD. That would happen to someone working in a civilian firm like my partner's: if someone was injured, she would make sure they were fit to work before they went somewhere else. I kind of understand what you are trying to say there.

Q239 **Johnny Mercer:** But the MoD can't pull together functions from the DWP?

Andy Price: They need to, though, if you are asking men and women to go and do what they are doing for as long as they have been doing it. We have had over 100 years to get this right. We need to be providing the support so they can move on, lead a meaningful life and be able to do something that feels to them like they are achieving something and giving back to their communities.

Catherine Braddick-Hughes: You need accountability. With the veterans ministry, you—

Andy Price: Yes, I think the VA is a great idea. It is similar to what the Americans have—a friend of mine works for them, and it is a great idea. You need to start tracking veteran suicides, and not just back to the Afghan and Iraq campaigns. I am supporting guys all the way back to World War Two. There were a lot of conflicts before Afghan and Iraq, and guys are really suffering. A lot of GP surgeries do not seem to realise that they should be tracking veterans. I think that is really important, and so is making sure that the support services are adequate. We should stop relying so much on the big charities. If the NHS are going to be able to support us, they need to realise that there has to be a different approach to veterans. It is not a quick fix—"Go in there, have a couple of meds, have five therapy sessions, disappear, boom."

Johnny Mercer: Okay. Tim, what do you think?

Tim Boughton: Look at the American system, which is what you are talking about. The Americans put their life on the line. With the Government and the public, wherever they go they are treated like royalty and they want for nothing. They have the systems and they have everything in place, and a lot of that comes from a Department within Government that is solely for veterans affairs.

I would want a Government culture change that would allow the public, or enforce it on the public, to look at what the veterans do on that American basis. We remember them on Remembrance Day, they are very visible and we look at them in times of trouble, but there is no priority boarding on planes as there is for American troops. I know that that is a stupid thing to say, but it is done as a matter of course in America. These are guys who put their life on the line every time they walk out of a vehicle every day of their service, pretty much. Why do we not have something in place from a Government perspective that empowers that to happen?

There also needs to be collaboration between organisations, both military and MoD. There needs to be co-ordination of veterans services, because they are not co-ordinated. The data that Catherine and Andy talk about needs to be there, and public perception and understanding is one of the key ones that we need to conquer.

Q240 **Mrs Moon:** Is part of the problem that we are still unwilling to tell our public that service has consequences, and that it is not all glory and can be damaging? We need to address and deal with that rather than try to shove it under the carpet.

I know we have moved on from saying that you must not talk about mental health in the military but there is still a denial that service can have consequences, be it physical or mental injury. We as a society should take that on board and deal with it rigorously—that is part of our responsibility—rather than deny it. I am sorry if I am not expressing that very clearly.

Tim Boughton: What you are saying is absolutely right. While the public read reports from various esteemed establishments that say that suicide rates in the Armed Forces are negligible and are below the level of what happens in civilian street, there have been 61 this year so far. I am currently involved with various units that are dreading the day that somebody is going to commit suicide—they are very close.

That comes to Catherine's earlier point. You go in, hand in your ID card and it's, "Thanks, bye, don't come back in." That's it. There needs to be a culture. The public will have their own view but it is not helped by the studies that are done saying, "Actually, suicides are well down on what would be outside." Because the public will basically just turn round and say, "It's not that bad. They are making a mountain out of a molehill." That is not the case.

Andy Price: That is really damaging, by the way—some of the reports that we have seen on TV with Mr Ellwood. Reading off statistics is not something he has made up himself but referring to a spectrum of suicides as a statistic and comparing that to civilian statistics is really damaging. It really is. This year alone one of my colleagues, Darren Bowden, who is with 2 Rifles, has had five of his friends kill themselves in the past three or four months. They were all from same platoon and same tour, involved in the same incident. Nothing has been talked about regarding that. I have had four veterans kill themselves in my town alone.

Q241 **Chair:** Are you saying that the statistics are wrong in suggesting that rates of suicide in the Armed Forces are not particularly higher than in civilian life? Or is it more that, even if the statistics are right, they could be a lot lower if individual incidents involving multiple numbers of people were dealt with properly because so many of them arise out of the same incident?

Andy Price: Yes, absolutely. You can't expect men and women to be involved in these incidents and there not to be a consequence. We are not super-human. We are trained to do a certain job and we will do that job. If you've got multiple people involved, especially in a mass incident, that needs to be dealt with. They need to be watched and supported, not just left to go off wherever and do their own thing.

Q242 **Chair:** I just want to get this point clear. We ourselves have reported previously that when you look at the statistics, if anything suicide rates are lower for members of the Armed Forces than for civilians. But your case would be that, even if that is true, they could be a lot lower still, because normally you might expect the sort of people who are healthy and serve in the Armed Forces to have very low levels but they are higher than they need to be. Am I getting that right, Tim?

Tim Boughton: Yes. I am going back to what I said at the start, taking you back to basics. People who join the Armed Forces will join with a certain amount of baggage, be that that they come from a broken home or any other form of trauma that they have in their life. The gap at the top of the glass can vary between very thin and very large.

If we realise that some people are more susceptible to mental health illness or potential suicide, and we put in place—before they leave and transition the service—a method of taking them through a mental health pathway, which leads them to their exit out of service, their transition and the ability to come back, I firmly believe that the suicide rate will come down.

A lot of it is also tied to a sense of belonging. You leave an organisation, you leave a family and you are left going, "Well, what do I do now?"

Catherine Braddick-Hughes: I had not met Andy before today, but in my statement I specifically referred to the regiment that he is talking about, and the fact that there is this instance where a large number of individuals are either killed or injured, yet there is no way of dealing with it in theatre or recording those who are present. The five who have committed suicide this year alone will not necessarily have left on medical discharge. They will not have admitted that they have mental health issues, but survivor's guilt is perhaps an issue that is not really well understood.

Q243 **Mr Francois:** Andy, forgive us—which incident was the trigger incident? In what year and when?

Andy Price: Are you talking about the 2 Rifles incident?

Mr Francois: Yes.

Andy Price: I wasn't with 2 Rifles, but it was an Iraq incident, from what I understand.

Catherine Braddick-Hughes: There was Afghanistan 2009 as well.

Andy Price: Yes, they were in Afghan as well, weren't they?

Catherine Braddick-Hughes: It was Afghan 2009 when they lost six in an attack.

Q244 **Mr Francois:** Okay—2 Rifles had one of the highest casualty rates. They were in Sangin, weren't they? They had a very rough tour.

Catherine Braddick-Hughes: They did.

Andy Price: And it is a hard thing to live with.

Q245 **Mr Francois:** I think they lost 16 people in the end.

You have all mentioned the Armed Forces covenant. When we have taken evidence from MoD Ministers and Department of Health Ministers you get two different interpretations. The MoD says, "Yes, under the covenant military veterans should be given priority treatment in the NHS." Then NHS Ministers say, "Well, no—we do it strictly in accordance with clinical need."

From what you were saying—I do not want to put words in your mouth, but I want to make sure that the Committee has understood you—there was hardly any recognition of the covenant at all within the NHS, and certainly no priority given. Is that correct?

Andy Price: Not in the area where I live, no. Not in Dorset.

Tim Boughton: As I said, mine was in 2008. The answer is no. Now? Maybe—I cannot comment on that—but not at my time, no.

Catherine Braddick-Hughes: To be honest, I have not tested it. I went to Help for Heroes. It was the same as Tim's experience, actually; the therapist broke down in tears and was hugging me. That did not really get me any further forward, so no, I haven't. I am really reluctant to see them, because it is not something that I want to discuss with a civilian. There is too much there.

Chair: We will come on to that specific point a bit later.

Q246 **Mr Francois:** In the Armed Forces now, they have trauma risk management, or TRiM. That was developed in 3 Commando Brigade, was considered to be very successful and was basically exported to the rest of the Armed Forces.

As I understand it, one of the reasons that TRiM is reputedly successful is because your mates absolve you. In an operational theatre, nobody wants to feel that they are letting their mates down, so it is your mates who put their hand on your shoulder and say, "Look, Bill—we can see you're struggling a bit, mate. It could happen to any of us; it just so happens

that it has happened to you. Now come on—stop hiding it. Let's go and see the MO and see if we can help."

I was told, when I was Veterans Minister, that TRiM was actually very good, and had been very helpful, at least for people in service, in addressing problems and trying to nip them in the bud. Do you have any view on that? Is that correct or completely wrong?

Tim Boughton: I think, having worked with 3 Commando Brigade, it is absolutely right, but there are not enough trained—I say that in the loosest sense of the word—people on a TRiM package who people can go to and see. There is always the case where if you get together with your mates for two days in Cyprus, post coming back from Afghanistan, and have a boozy time and get it all out of your system, that will lessen some of the water in the glass, but it will not solve the problem. TRiM is good, but it does not solve the problem of somebody who may have mental health illness or feel suicidal afterwards. It is very good at reducing the level of stress.

Q247 **Mr Francois:** Okay. One of the things that we have discovered is that someone can leave the services in perfectly good order, both physically and mentally. They can have their discharge medical, and to the world around they seem fine. However, they have seen some pretty traumatic stuff in service, and then a few years later there is a trigger event—their father might be diagnosed with cancer and die within a month—and it all comes out. They start yelling at their wife and kids. They are very impatient. They start drinking heavily. They may lose their job. Their life spirals downwards. The wife says, "I love you, darling, but for the sake of the kids I have to leave," and they end up living in a one-bedroom bedsit somewhere. That can all happen within six months. Does any of that ring true?

Tim Boughton: Yes.

Andy Price: Yes.

Catherine Braddick-Hughes: Yes.

Q248 **Mr Francois:** So the Committee is not 180° in the wrong direction? All right. One thing we seem to have discovered is that, when that person starts to go—when they start yelling at the kids and there are warning signs—they do not get help soon enough. We have heard evidence from medical professionals that, in some parts of the UK, even when people are diagnosed as having a problem, it can take up to a year to actually get them into a treatment programme.

I cannot speak for the whole Committee—we have not done our report yet—but that is bloody unacceptable, frankly. What more can be done in order to get to those people quicker, before the family breaks up and they spiral downwards from 30,000 feet? How should the system be modified to prevent that?

Tim Boughton: Andy might have a clearer view, but I have dealt with 30 to 33 people in exactly the position that you are dealing with. I am dealing with one guy now who has attempted suicide three times. He has told his wife that he will not kill himself now, for the sake of his children. That is there.

What would I do? It is about these guys having the belief that, if they open up the really traumatic side of their life, somebody will listen to them and will take care of them. That will give them a sense of belonging and a view that they can get out of this. At the moment, a lot of the organisations that are seen as the go-to places for help are big, amorphous blocks. I am not dissing Help for Heroes, but in the case of a lot of the guys I have seen, it has been that sort of organisation.

If you look at what Samaritans has done, in terms of its 24-hour helpline, it is recruiting ex-military people to be on the end of that line. That has been hugely successful in what it was trying to achieve. Signposting an organisation like that where these ladies and gentleman can go and know that they will be listened to is critical.

Q249 **Mr Francois:** Without putting words in your mouth, we need bespoke tailoring for this, don't we? The general NHS service is not really best suited to dealing with this.

Tim Boughton: No. Catherine and I have said previously that if someone goes before an NHS clinician and talks about somebody who has had their legs blown off or about an incident, and they break down, that will put them back, not forward, and make them more worried about going to a signposted organisation.

Q250 **Mr Francois:** I will come to Andy in a second, but Tim makes a good point, because very often as these guys spiral, and it is mainly guys, although not entirely—

Catherine Braddick-Hughes: That's fine.

Mr Francois: As these people spiral, they are often in denial, aren't they? A bit like the guy in "Bodyguard", they are going downwards, and the people who love them tell them that they are in trouble but they refuse to accept it, partly because they think that, if they do, no one will care anyway.

Tim Boughton: As happened with me.

Q251 **Mr Francois:** I am just asking to make sure that the Committee is not a million miles wrong. Andy, you heard the scenario I outlined and you were nodding your head. What more should we do? How should we change it?

Andy Price: I don't know what can change at the moment. It is such a big problem. Where I am working in Dorset—if you don't mind, I will use my organisation as an example—I was looking to find out if there were people in the same situation as me. Myself, Darren and Lisa, who is sat behind me, set up the Veterans Hub, which is a community café. It is run by

veterans, for veterans. There is nothing clinical about it whatsoever. There is nothing else in our area. Guys and girls of all ages come in and talk to each other. It has done them the world of good, and they all say that it has made a massive difference.

We signpost to other organisations, because there are some people who need more than just talking. However, we have also become a community café, so we are encouraging people to engage with the public while they are there. We think that that is really important, because when someone comes out of the Armed Forces they do not necessarily know how to fit back into civvy street. We are getting people to tell their stories and engage with the public. I think enabling guys and girls to support each other is a good way forward: it gives them a sense of purpose again. Being able to support the people I have served with has definitely saved my life and changed it.

Q252 **Mr Francois:** So it is not just comradeship in the traditional sense? It is, "I'm not the only one here. It's not just me. I am not alone; there are other people going through the same crap that I am going through."

Andy Price: Yes.

Catherine Braddick-Hughes: We were talking about this earlier. I think that the old British Legion clubs, when they existed in their old system and people could go down there to sit and talk, maybe offered the opportunity to talk to people you knew who had been through similar things. That was a forum to do it.

Mr Francois: We still have a very good one in Rayleigh—I am the patron of it.

Catherine Braddick-Hughes: You might well do and I am delighted, but they have been franchised out and are more like social clubs. The British Legion doesn't own them any more; it's a franchise.

Q253 **Mr Francois:** One last thing and then, I'm afraid, I do have to go. I mean no disrespect in leaving; I absolutely want to stress that.

When you join the forces, you complete basic training and have a passing out parade. Your parents, your partner or your relatives are there, you get the DVD, you march off the square, there is a curry and all that stuff. It is done in a very formal way to celebrate the fact that you have joined. When you leave, there is virtually nothing. The MoD are talking about giving people a veterans ID card when they leave, and you could put some helpline numbers on the back: "If you are ever in trouble, Tommy Atkins, just ring this number and someone will help you." I think that is a good idea. Given that we have formal ceremonies when people join, why don't we have a ceremony when they leave at the end of 20 years' service or three years' service? When they hand in their MoD 90, the CO thanks them for their service, in front of their friends and relatives, gives them their veteran's card and says, "Stay in touch, Atkins. If ever you're in trouble, phone this number." Why don't we do that?

Tim Boughton: Cost. It is what should be done.

Q254 **Mr Francois:** But every unit could do that at unit level.

Tim Boughton: Yes. When I left—I don't know about you, Catherine—I got a veteran's badge thrown at me as I walked out the door. In fact, it was some weeks after that I got it thrown at me, having handed my ID card in. One thing was given to me by my last boss, Tony Johnstone-Burt, who is now Master of the Household at the palace. He went through all my previous reports and then went to my current. He extracted all the good lines and produced a valedictory certificate, which he had framed and given to me.

Mr Francois: That is leadership.

Tim Boughton: When we come down to commanders and leadership, that is what makes the difference. Johnny raises a really good point: if you have a great commander on that transition out, it speaks a hundred words. It can really help you and put you in the right place.

Q255 **Mr Francois:** Would there be any value in making it an SOP for people—whether they leave after three years' service or 30—to have at least some kind of formal ceremony to thank them for their service, which their relatives can attend?

Catherine Braddick-Hughes: It depends. I have met people who have had two years at home on the sick, but if their unit hasn't even visited them and then they give them a badge and a nice thank you at the end, no, it's not. They need to enforce the proper policy and ensure that they are looking after those people right up to the end. I think the badge would be a nice touch. Personally, I wrote to the Queen—this is how ridiculous it was—to say, "I'm taking my leave, Ma'am, because I'm leaving the service after 21 and a half years and nobody else seems to be interested. Nobody else has acknowledged my leaving." You know.

Andy Price: I will keep it brief. I think that is a great gesture and it would mean a lot to a lot of people, but, with the greatest respect, people are not killing themselves because they haven't had a ceremony when they leave.

Mr Francois: I get that.

Andy Price: That is what is at the forefront of my mind. I mean that respectfully.

Q256 **Mr Francois:** If we have to change culture, I am thinking that that might help.

Andy Price: Yes, absolutely.

Q257 **Chair:** I cannot resist putting on the record that, as I know Tony and Rachel Johnstone-Burt, it doesn't surprise me for one moment that he behaved so well in your case.

We have two more topics, basically, for this panel. I will just ask one

thing that arises out of a bit of curious historical knowledge. During the second world war, we had disasters happening with terrible regularity. The first person I canvassed, at his own request, when I was adopted in 1996 or 1997 as a candidate for the 1997 election campaign in my constituency was a chap who had been a 16-year-old boy on HMS Barham, the battleship. The topic came up because he had a picture on his mantelpiece and I said, "What battleship is that?" He said, "It's the Barham." I said, "Were you on board when she blew up?" I do not know if anyone has ever looked at the terrible Pathé clip of that battleship turning on her side when she was torpedoed in the Mediterranean. You can see all the men running around on the side of the ship, and then there is a horrific explosion. Over 800 of his shipmates were killed. He said, "Yes, I was on board. I was 16 years old, and the first thing I knew was when I woke up in the water."

Why am I telling that anecdote? Because I wish I had asked him then, in the light of our conversation today, "Has it had any long-term impact on you that you lost over 800 of your shipmates in an instant?" I just wonder: in the sort of wars that we are engaged in and that you were all involved in, the numbers of people involved are relatively small and the numbers of casualties are, fortunately, even smaller, but in a sense when it happens it is so personal and so individual that you are able to empathise with it much more than in a situation like the second world war, when there were very frequently vast numbers of casualties. Do you think in some way it is harder for you because this is so much more individualistic and easy to empathise with in human terms, or do you think it would probably be just as bad if it were happening on a gigantic scale and everyone was suffering?

Catherine Braddick-Hughes: I think it depends. In the second world war, we were acting in self-defence as a country. We knew that people at home needed us—I wasn't there, obviously, but the mentality was that it was a life or death situation. You had to defend the country, because otherwise those people you had left behind were going to be Germans, or—

Chair: Overwhelmed.

Catherine Braddick-Hughes: Overwhelmed, and they could be suffering as a result. The kind of conflicts that we are doing now are not like that. To be honest, one of the issues that I had from a moral trauma point of view was working with the Americans and with some of the other nations who do not have the same views. Whereas I have been trained to a certain standard and trained to expect that other people are going to behave in that way, actually when you go out to a conflict zone and there is a coalition, you are not always exposed to that. You are exposed to what other people do, and that is a moral injury.

Q258 **Chair:** So it is two things. Basically, you are involved with other allies who may not operate to what you regard as the necessary standards, or at least have different standards, but also you don't have the feeling that the whole life of the nation is at stake as it was in world war one or two.

Catherine Braddick-Hughes: Yes.

Q259 **Chair:** Do you have anything to add to that? Do you agree or disagree?

Andy Price: You said that you regret not being able to ask that guy about how he felt. The veterans I have spoken to from that area have definitely suffered over the years, but they were different generations and it was a different war. It was very much that "suck it up" attitude: "Get on with it and move on with your lives." A lot of men and women suffered in silence during that time; I know that from speaking to my family members. I don't think there was much difference when people came home. Guys and girls still struggled and there were still suicides, but it was just not talked about as much and they were told to get on with it.

Q260 **Chair:** But wouldn't you have expected a much greater number of suicides, given the magnitude of the colossal losses?

Andy Price: I think, like now, they were possibly underestimated. I think there would have been a lot. This is just from people I have spoken to—obviously I wasn't there, but people I have spoken to have said that actually there was a big problem.

Tim Boughton: There is an empirical history that the regiments that had numerous battalions being wiped out on the battlefields had a very high suicide rate.

I go back to what I said before: there was a different culture—a different ethos—around those guys who went to war. I sat down with my grandfather before he died; he had been at Anzio, Salerno and the D-day landings as a Royal Marine. He would not speak to me about the war until I had come back from my first tour of Iraq. Then he sat me down and said, "Okay. I am going to say this once and this is what it is. Here is my diary." He had kept a diary throughout all his war years and in it were some pretty traumatic things, such as X getting his head blown off and so-and-so being killed.

The outpouring for him—the way he dealt with that—was through writing it down. But he still carried that throughout his whole life, and he went into the police force afterwards. His view was that, "The stiff British upper lip is what is expected of me. I can't crumble. I've got other people to look after." Hopefully, that ethos is changing and we are dispelling that, and we can say to our veterans, "It is okay to come and speak to us, to let go, to whatever. Don't hold on to it."

Q261 **Chair:** My only slight worry about that point is whether there is a case to be made—I genuinely ask without bias—that that stiff upper lip ethos may have worked to some extent, in that it enabled people to carry on rather than let it all out and possibly do something to themselves?

Andy Price: No, not at all. I will keep it brief. My family grew up in the east end of London but it was going on behind closed doors: heavy drinking, violence, partners getting beaten. It just became a culture. I am not saying it is all down to that. There is no excuse. You can't blame mental health. I am not excusing it. I just think it went on behind closed

doors and it was accepted as well, that it was just the way it was because the guy has been away doing this and that.

Tim Boughton: I don't think you can compare what happened then with what is going on now: technology, the method of delivery of attrition has changed. I feel for Catherine. I don't know if you are a targeting lawyer but the targeting lawyers sit removed when the commander on the ground is saying, "Can we prosecute this target or not?" The decision that lies with someone like Catherine in a remote place, we cannot fathom, but it is still the same effect of somebody being on the frontline of the battlefield. You can't compare the two, I think.

Andy Price: I will say on that that I think everyone here who has been in the Armed Forces will agree. It is also, as you said, a different time and different place. The guys and gals came back from those conflicts and were considered heroes. There was a lot of respect for them. Now there is a lot of confusion, mainly because of social media and the news about what we have done and where we have been. Men and women are scared of being persecuted for doing their jobs. That is something that you, Johnny Mercer, have taken to task, which is brilliant. They are scared of that. There is a lot of confusion about what we do now. There is not a lot of pride, basically.

Q262 **Chair:** This is terrific stuff and we could go on.

Andy Price: I've got all day.

Q263 **Chair:** Sadly, we have to begin to wind up. We have already discussed to a considerable extent the inadequacy of civilian therapists being able to cope with this, so I am going to ditch part of the question I was going to ask. It is fairly obvious that you believe that current and former servicemen and women with mental health issues are best treated by those with a military background. If you do believe that, what would help civilian clinicians who aren't veterans understand the military situation? Or do you think it is just a hopeless task and that there is not any way in which the civilian mental health services could give you adequate support?

Andy Price: It is not a hopeless task at all. There just needs to be more understanding of it.

Q264 **Chair:** So, how? We have heard about civilian therapists breaking down and you having to comfort them, when you tell them.

Andy Price: I have experienced that as well.

Q265 **Chair:** What do we need to do so that they are supporting you and you are not having to support them when they learn what it is you have been through?

Andy Price: Find the appropriate services, using something like TILS. Make sure the appropriate staff are in place. Make sure GPs, or wherever people first go for help, understand that if a veteran is asking for help it is quite often a last port of call. Whereas a civilian may go to a doctor as

soon as they have experienced a traumatic event and say they need a bit of help and are down, many veterans go as a last port of call and yet they are put on to a long waiting list, when they do need immediate support. It also needs to be recognised that it needs to be open-ended support. Everyone's experiences are different within the Armed Forces.

Q266 **Chair:** I am going to ask Catherine this. In practical terms, because you experience this directly, if I were a senior NHS person with responsibility for mental health, what would I have to do and what would I have to put in place to provide therapists who were going to be of help to you, rather than crumble when you told them why you were having difficulties?

Catherine Braddick-Hughes: You have to look at more of an understanding between the military mental health teams, and they perhaps need to be sharing the ways that they have dealt with it with the NHS. There does not seem to be a lessons-learned process where they cross over and share. Maybe it would be like a transition place: maybe they would do work experience; maybe they would do courses provided by the military, so that they could learn what to expect.

The other thing, for me, is very much the medication issue, when you have had a traumatic injury as well as a mental health issue. I was put on drugs such as tapentadol and pregabalin, which were all for my back. The side-effects are increased risk of suicidal thoughts, anxiety and depression. What I found specifically was that it made my flashbacks real. Whereas I could talk myself out of them before, they were now physically happening to me. A joined-up approach of understanding that the veteran may have been taking those drugs for God knows how long because they are just continually prescribed by NHS clinicians, and of how that may be affecting the mental health and the volume button on the mental health, is key. That is why I thought that somewhere like Headley Court or the new National Rehabilitation Centre should be co-ordinating and disseminating this information.

Tim Boughton: I think shared data would help the military-to-civilian transition. I think that we underestimate the amount of our ex-RAMC, ex-Navy, and ex-RAF medics out there in civilian street who have the ability to put their hands up and say, "We have military experience," so you could signpost to them. Local GP practices around Dorset and Somerset now have a high proportion of ex-military people within them. I also think the training of GPs by medical services in what to look out for is key. The big one for me is the fundamentals about going back to university courses and that, when people are training as civilians, they have an MoD or military module in there that gives them an awareness in the back of their minds.

Chair: That is very interesting, thank you.

Q267 **Gavin Robinson:** I thank all three of you, because I think it has been an incredibly powerful session. It is important that we have heard all that you have said. Just to recap for our benefit and for the record, I think you made an important point, Catherine, about being of senior rank and the difficulties associated with engaging someone who is more junior than

you and whether that frustrates the ability to help therapeutically. I think that was an important point to make. You also mentioned the obligation occupationally, as employers—if we can put it that way—with the risk assessments. Indeed, the point that you made about being medically or mentally unfit but still being deployed is something that we need to focus on with the MoD and try to get some figures on how many deployments there have been of people who have been categorised as unfit for deployment. The potential for career breaks and pauses for treatment is a very important point to come out of today's session.

Following the question that Mr Francois asked, you indicated to us, Andy, your involvement in crisis intervention, and steps you have taken to assist people when they are at their lowest ebb. Mark had referred to some services' access to treatment taking up to a year. When we heard from charities last week, they indicated that it can be up to a year, but that it is triaged, so if it is up to a year, it is probably not that severe an issue. If it is a severe issue, intervention would be much quicker than that. What is your reflection on that? Based on your experience, is that true, or are you finding that people who need crisis intervention are simply not being triaged or getting the attention that they need, when they need it?

Andy Price: In my personal experience, my partner took me to a walk-in clinic because I was unable to talk. She said, "I believe he is suicidal. I found out he has made a plan to kill himself. Can you help?" We were turned away, because there were no beds and no one sufficient enough to support a veteran—that is what she was told. The crisis line was so overwhelmed that it was going to take a week before they could do a phone assessment with us. Combat Stress does an amazing job, but it is so overwhelmed, again, and it has so many people through its books that it was going to be a long period before we could have the initial assessment to see how I would be triaged, and then it is a wait of up to 10 to 12 months. That is not unusual at all. We know people who have had no help. We know people who are just on long waiting lists. We know people who have been turned away from services, because they are deemed to be too unwell to respond to the treatments that those services provide. They are turned away and left to fend for themselves.

We had one guy—if I can bring him up—called Geoffrey Trott, who took his own life. He was medically discharged. He did not even have enough money to get a bus down to a food bank to get food for himself. He was mentally unwell and had lost his family. Three times he took an overdose with his prescribed medication in the hope that someone would take him seriously. On the third time, he was turned away from the hospital, because they had no beds. He went home and hung himself. This is the kind of stuff that we are dealing with just where I am. From what I understand from networking with other organisations, it is not that much of a different story across the country.

Q268 **Gavin Robinson:** Thank you. We will get a chance in the next session to ask some of the charities those questions. Tim, when you commenced your comments this morning, you referred to the impact on your wife and then made reference to your daughter. If you don't want to go into this,

it is okay. You have talked about your own personal involvement with support services, but could you share with us your reflections on the support available for your family? The covenant is meant to extend to veterans' families as well. Did your wife and daughter require services as a consequence of assisting you, and coping with the consequences of your service and how that impacted you? If they didn't, did you feel the support was there, should they have needed it? If not, what changes could be made?

Tim Boughton: It is a very important question, because she undoubtedly saved my life, although she would not say that. I think she was overwhelmed by the situation and did not know how to do it. She is very gentle on the outside, but very robust on the inside. She would not have known who to go to. She would not have known what was going on per se. She just knew that something was wrong and therefore to say, "You need to go and see somebody, otherwise this is just going to be really bad."

It is interesting: one of the things I have written down here is that the families require just as much intervention as the veterans themselves. I was with a specialist unit last week and one of the people turned round and told me that he had been away for six out of 20 years, his wife is on antidepressants, his son is in CBT and his daughter is also going through therapy. That, by the way, was very common among the group.

What is working—I have seen it and put it in place in some units—is the ability for wives to come together, whether through just talking, mindfulness or having the ability to reduce that stress that they have in some way. Therefore, they can understand what their husbands or wives are going through at the time, so they can have that empathy. It means that when they walk through the door after an operational tour and life is normal in the household, but they are going in kicking off and the balance is really thrown out of the window, there is somebody they can talk to about it. Whether that is in support groups, or access to the CPNs on the bases or the local DCMHs, I think it is critically important. Do I think enough is being done around that? Absolutely not. Thank you for raising that question, because it is a really important question, about which a lot more needs to be done when we are thinking of veterans as a whole, because a happy home is a happy soldier, to some degree.

Q269 **Gavin Robinson:** Did any of your family have to avail themselves of services for themselves?

Tim Boughton: No, it was not required.

Q270 **Gavin Robinson:** Catherine, from the gender point of view, you shared that you felt there was an additional strain, almost, on you as a mother in the household and that while the men may go off and have a pint, and so on, you would share some of the other duties that were required of you, that you couldn't set aside. Do you have any reflections on the services available to families associated with that?

Catherine Braddick-Hughes: There was nothing available to my family at all. When I was under an attack, which lasted 20 hours, they called my

husband to see whether he wanted to go to the dinner night, because they didn't know it was ongoing. They didn't contact him when I got back. They didn't tell him when I had gone to—I was casevaced down to Bastion. I am afraid there was nothing for him, and that meant that he just tried to keep it for the kids, and keep the kids away from it, at the time, because they were younger. It is only recently—the one thing that we have had engagement with: we went to a Battle Back event, which was a three-day family one, for the first time. I wanted to show them that I wasn't broken. I am not sure I managed, but that was the only support we have had.

Q271 **Gavin Robinson:** Thank you. Andy, you are involved, obviously, indirectly, in service provision—I know you are as well, Tim—and you have talked about the hospitals not being aware of what the covenant entails: what commitments we as a state or society have made to veterans. Do you have any reflections on the extension of that to families and whether that features at all in the understanding? I think you were indicating that covenant understanding is limited.

Andy Price: I can only talk about my experiences where we live, and there is very little support through the NHS, as well, for the families—I know that for a fact—and the kids that come in. We don't just have veterans coming through our doors, now; we have family members and we have children coming through as well. The other week I was conversing with a 15-year-old whose father is a Falklands veteran, and he has PTSD, and he has no support whatsoever. He got hold of us and said "How can I best support my dad? I don't want to see him going through this anymore." And his dad doesn't have any support either. Again, I am not saying it is across the board, or across the country, but locally we have evidence to show that the whole family is left out to dry.

Q272 **Johnny Mercer:** Andy, you have talked a lot about veteran suicide—it is clearly a very emotive issue. What would you say to those who would say, "Look, there are a lot of factors that go into veteran suicide, that lead to an individual taking his own life"? As a veteran, scientifically and in the evidence, you are less likely to take your life than your equivalent cohort in civilian life. That is the data that is shown very clearly in a number of studies now. It still remains the biggest killer of men under 44 in this country, but I worry that, in trying to address the problem, we are missing some of the solutions that are available—by misunderstanding the problem. What would you say to that?

Andy Price: You are 100% right. Why people commit suicide is a very individual thing, but if you use 2 Rifles as an example—five men who went through the same experiences at the same time—the starting point of their mental health problems was there, whether it was Afghanistan or Iraq. What happens years later, when they actually kill themselves—it could be for any number of reasons. It could be marriage breakdowns, career loss, or whatever it is, but the starting point was the same thing, and that is what needs to be dealt with.

I cannot talk much about statistics when it comes to suicide rates—I do not want to get anything wrong—but just where I am four men have taken

their own lives, and they all knew each other as well. They might not have served in the same places, but they all knew each other. On top of that, we are continually dealing with guys attempting to take their own lives, just where I live. I talk to the emergency services down there. We have good links with the local police, good links with the inland rescue, the coastguard. They give us some figures, which is that four to five people a day are making attempts on their lives or self-harming, and a large proportion of them are veterans. We are top-heavy with it with veterans. I cannot speak for the whole country, Mr Mercer. I get what you are saying—

Johnny Mercer: I see the Government have been really slow in collecting the data on this, and that is really the fundamental issue, because without the data we cannot really do policy that is going to work. They have now said they are going to move towards that. It comes back to what I was saying previously about a whole-systems approach to veterans' care, because there will be a number of different issues that lead an individual to that tragic place. It is really interesting hearing your experience. I know that in particular units, for example, it is a more prevalent issue than in others, and I do not think that we have done enough work on that either. It is really interesting to hear what you say.

Andy Price: Thank you.

Chair: Can I conclude the session by saying that you have done a service to Parliament by appearing before the Committee? I think you have done a service to the public and to your comrades as well. This inquiry is, after all, about people who go through what you have all been through, and we cannot thank you enough for the comprehensiveness and the openness with which you have given your evidence today. We will now change over to the second panel.

Examination of witnesses

Witnesses: Sue Freeth, David Richmond and Tony Wright.

Q273 **Chair:** May I thank the witnesses on our second panel very much indeed for waiting patiently? That was quite a long first session, but I hope you agree that it was well worth while. As always, I invite panel members to introduce themselves briefly. Sue, welcome back—we know you well, but say a few words.

Sue Freeth: Thank you. I am Sue Freeth, and I am the chief executive of Combat Stress. I have been working in the veterans sector for the last 14 years. I previously worked at the Royal British Legion, so I have been around veterans' mental health for well over a decade, although my experience is actually in the third sector in general.

David Richmond: I am David Richmond. I served as an Army officer for 26 years. I was the commanding officer of the UK battle group in Musa Qaleh in 2008, where I was seriously wounded. That led to my medical discharge four years later. I joined Help for Heroes as the director of

recovery, and I created their recovery services. I left Help for Heroes in December and have since worked for myself. In between, I founded Contact, which I chaired until 1 September this year, when I handed it over.

Tony Wright: Hello, I am Tony Wright. I am CEO and founder of Forward Assist, which is a veteran-centric charity up in the north-east of England, where we operate a veterans health and wellbeing hub in the community.

Q274 **Johnny Mercer:** Sue, is there enough funding for Government and charity providers to meet the current demand for mental healthcare?

Sue Freeth: It is very difficult to know exactly how much funding is actually being invested in veterans' mental health.

Q275 **Johnny Mercer:** Why is that?

Sue Freeth: Because it is in a number of different places, and that is not co-ordinated. In terms of how we get to the answer to that question, it needs to be the responsibility of a single authority in order to be able to co-ordinate it better and report it.

Q276 **Johnny Mercer:** And who is that authority?

Sue Freeth: That is a difficult question. There is not a natural lead agency at the moment, hence the suggestions earlier about—

Q277 **Johnny Mercer:** Surely someone in this country is responsible for veterans' mental health.

Sue Freeth: At the moment it is a joint responsibility although delivered by NHS England. The Veterans Minister has a policy and influencing responsibility, but the delivery is devolved to the different nations, and mental health services, by the NHS at least, are delivered by those individual authorities.

Q278 **Johnny Mercer:** So who is fundamentally in charge of veterans' mental health in this country? If the Veterans Minister can merely influence, who is in charge of ensuring that we do our duty by these people?

Sue Freeth: The Secretary of State for Health.

Q279 **Johnny Mercer:** The Secretary of State. David, do you think there is enough money in this sector?

David Richmond: I don't. I think Sue makes a good point, in that it is incredibly difficult to work out how much money is in the sector. The Byzantine structure of the NHS, just in England before you count Scotland and Wales, makes it incredibly difficult to work out funding and also what services are delivered. It makes it incredibly difficult for organisations to try to co-operate and collaborate with them, because they are so devolved and you have to have so many conversations with different organisations; it becomes almost impossible.

Q280 **Johnny Mercer:** Tony, what would you say?

Tony Wright: I can only answer that question from the point of view of a grassroots charity operating within a community. The answer is no, I don't think the distribution of money is fair and equitable in response to some of the fantastic services being delivered. If you take Andy's fantastic project, he's doing that as a volunteer. Other organisations are operating on a volunteer basis only. Our tiny little grassroots charities that do so much to enable people to engage and have somewhere to go are not funded in the way they should be.

Q281 **Johnny Mercer:** I will ask you first, David. From where we are sitting, over the last 10 years over £970 million of LIBOR money has gone into the veterans care sector. On top of that you have the amazing fundraising efforts of people like you Sue, Help for Heroes and others. You're looking at over £1 billion, so how on earth is any veteran in this country not resourcing their care correctly? What's gone wrong?

David Richmond: I can't help agreeing with the sentiment behind the question.

Johnny Mercer: But what has gone wrong in your view?

David Richmond: There has been for some considerable time a fundamental lack of transparency across what is being provided. There has been a lack of collaboration around who is best placed to deliver and provide, not only in the current sense but in terms of how one plans what the future looks like. It is done in silos with little collaboration in terms of real crunchy collaboration that would deliver an outcome. And I think the fragmented nature of statutory services fritters away money. That is in tension with servicemen and women who serve the Armed Forces of this nation, and that isn't fragmented—it's a holistic whole. They leave their service and they go back into a society where services are fragmented and what services are provided for you all depends on where you live in the country. That strikes me as being at odds with the nature of service and what I believe to be the duty of the nation to support servicemen and women and families during their service and when they leave. There needs to be consistency, and that consistency does not exist.

Q282 **Johnny Mercer:** Sue, what is your take on that? To your average person on the street, that is shocking. With that amount of money going to veterans' care, and organisations like yours seeing a reduced commitment to you financially from Government and so on, what on earth has gone wrong? Okay, we started at a standing start in 2003, but that's 15 years ago now. What on earth has happened to all that money? Why are veterans coming here and saying, "We haven't got enough money"?

Sue Freeth: I think it goes to the heart of a lack of co-ordination and a common shared intent. The sum of money you're quoting, of course, hasn't all been directed at veterans' mental health. Even within the sum that has gone towards mental health, a lot of it has gone to preventive, emotional and social support activity. Very little of it has gone towards actual treatment and support from professional specialists and recognised

practitioners. That's really where more needs to be going, because there isn't enough of that practical, proven evidence type of activity.

Q283 **Johnny Mercer:** That is a really interesting point. You have this pot of LIBOR money. If you are facing the challenge of veterans' care, surely in handing out this money you will be drawn towards professional organisations that practice evidence-based care, have a complaints structure and have their accounts audited. You are saying that the LIBOR funds have not been handed out in that way at all.

Sue Freeth: I think it has taken some time—quite a long time, really—for us to organise things so that the LIBOR funds are granted in a way that is efficient. The Ministry of Defence and others have agreed with that. Grant giving is not something the Ministry of Defence or the Cabinet Office are necessarily as experienced in with this sector, which is, as David has said, very fragmented. It is only now that there is the beginning of proper marshalling and a focusing on evidence-based activity.

Q284 **Johnny Mercer:** When all the money has been spent.

Sue Freeth: I am afraid you asked me the question, so I am being very open and honest. Evidence-based practice, which is what Combat Stress work is designed around, is what we should be expecting for all people who apply for Government funding. I think that sort of thing—

Q285 **Johnny Mercer:** Who made decisions as to where this money went?

David Richmond: The big issue for me has been the lack of a strategically big idea. With all this money, wherever it has gone—it has not all gone to mental health care—what was the big idea? What were we trying to create? Certainly with the Covenant Reference Group fund, I had the impression for several years—not all of that was for mental health, I accept—that the motivation was, "How do we spend £10 million a year?", not, "What could we do with £100 million in 10 years?" I use that as an illustration. Where is the big idea? What is the strategic idea here so that we can embrace the statutory bodies, the smaller local organisations that know the scene on a local basis and the national organisations that sit in the third sector and together deliver something that really makes a difference?

Q286 **Johnny Mercer:** Whose responsibility is it to come up with a future vision for what veterans' care should like in the UK?

David Richmond: One would say the Veterans Minister, but the Veterans Minister sits in the Ministry of Defence, which has little leverage—I would not say no leverage—over veterans affairs. Healthcare is provided with the Department of Health and Social Care and the national health service, and there is also the Department for Work and Pensions and so on. There are many, many players. There is an issue in there about lining up funding authority responsibility and so on—all those good things. The next question is likely to head along the lines of a department for veterans affairs. That might well work, if it had teeth, but just adding another agency to the mix does not necessarily answer the problem, unless it has

the right authorities and funding and the leverage to do something beneficial. Otherwise, it just becomes another body.

Sue Freeth: At the moment, it is the Cabinet Office that is leading the strategy for serving personnel across all Government agencies and engaging the charity sector as and when it can.

Q287 **Johnny Mercer:** Yes. Clearly it is heartbreaking to see veterans coming here, broken, saying that they have not got enough money when you are now saying, "We have spent £1 billion"—this is not your fault—"and now we should think about what we are going to spend it on." That is a strategic fatal failure for some of our veterans. It is shocking. Can you meet demand now?

Sue Freeth: That is going to be a struggle. We envisage, looking at the latest research that has been published by King's, that we will expect to see a third more people, particularly in the area we are working in—people with complex needs or multiple traumas—over the next 10 years. Without substantial further support, we will be asking the public to put their hands in their pockets, which is becoming increasingly difficult to do. Combat Stress is very fortunate that the public have been very supportive of us, but to have the resources to continue to provide the range of services we believe work well and are needed without Government funding will be very difficult.

Q288 **Johnny Mercer:** Tony, you have kind of answered this already, but in terms of whether you can meet demand, you are saying that basically you can't at the moment.

Tony Wright: No, we can't. The issue is that we get a lot of our referrals from the brilliant TIL Service, who are overwhelmed by the demand. The other thing about medical interventions that we really have to pick out here is that a medical intervention does not last very long, so if you go to see your GP, what do you get these days? 10 minutes. If you have a chance to see a mental health therapist, you are lucky if you get an hour and a little bit more. The idea of having a community-based hub is that it is available five or six days a week, plus evenings, so people can drop in. When people go away to Combat Stress, they are away for six weeks—it is residential—but in my view they need somewhere when that finishes so that they don't drop off the edge of a cliff. They need to come back to engage with the community, where there is support, food, coffee and people who understand them, and where they can talk about things. That old adage of a problem shared is a problem halved is absolutely true. People being able to talk about the issues and to share their experience with other people who understand them is crucial, but we are overwhelmed. With no funding, I am beginning to wonder whether we need to change direction in 2019 so we can be equally effective but perhaps in a more cost-effective way.

Q289 **Chair:** Tony, just on that point, what you are saying sounds like a parallel to civilian mental health issues in that, with the wholesale closure of in-patient institutions, a side-effect was found, which used to be known as

the revolving door. The idea was that after someone had had a spell in an acute in-patient unit, they would know themselves quite well and, from time to time, realise that they were heading towards a trough, so they could always go in at any moment, not to stay but to have a top-up service as it were, to use a motoring analogy. I take it that that is what you are saying has to be provided here, because a concentrated in-patient stay by itself can unravel if you don't have the top-up of the revolving door facility.

Tony Wright: Absolutely. The other thing that I didn't mention is that I am also a qualified, registered social worker, so my business is care co-ordination. When someone comes into our organisation, we are very quickly able to devise a package of care—for want of better words, although it is a package of care—where we plug them into the services. We don't just refer on—I think referring on is the last irresponsible act—we refer and chaperone people, so we get veterans mentoring and taking people to appointments to make sure they get there and to build that therapeutic relationship. I have met most of the people we refer, so I know the personalities involved. It is a crucial moment.

There is another crucial issue. If we look at this from a veteran's point of view, the bit we don't do well in a civilian setting and don't do in the military setting—our Achilles' heel, if you like—is transition. The transition from military to civilian life needs a lot more work done on it. If you get back to civilian life and you fail, end up getting involved in the criminal justice system and go to prison, you will eventually need to make a transition back to civilian life from there, albeit with added difficulties and problems to overcome. Again, if you have a drug and alcohol problem—in the old days, there was residential care, where you went away for treatment—you also have to come back to your community. We are a big fan of helping people to get well in the communities that made them sick. From a veterans perspective—veterans are not understood, or have a sense of disconnect—it is the civilian community that makes them feel unwell, so that is the area we have to work in.

Q290 **Chair:** Do you believe, as our previous panel believed, that the personnel who supply the support and therapy need to be themselves experienced in military matters?

Tony Wright: Yes and no—not exclusively. I think you can get some fantastic mental health workers, and it really doesn't matter where they come from. If you understand the military background, all the better. I have a mix in my team at the minute, and they all have different functions and roles. There is a bit about engaging people, so our community navigators—who run a drop-in for information, advice and guidance—are all veterans of various ages. They are able to assess people's needs, plug them into the services and patch them in.

Q291 **Chair:** Sue and David, what is your view? You heard some pretty strong expressions on this topic.

Sue Freeth: As you said, we have heard of some very disappointing practice on an individual basis. We think that education is needed, in

particular at key points in a pathway. We would like psychiatrists to have the opportunity to have an understanding in their education. We would like a number of key health professionals to have that in their early education. It is also about working with organisations. A number of the organisations understand and have veterans—people with experience—working alongside them. It is a collective action that will make the system work more effectively.

Q292 **Chair:** David, isn't it pretty hopeless if someone has to wait for some considerable time to get NHS therapy, and then it turns out that the people giving the therapy are rendered distraught by the stories of the people needing the therapy?

David Richmond: They are shocking stories. Yes and no would be my answer. Some guys do not want to talk to somebody with a military background, so you need to offer them that choice. Having some understanding of the culture, the ethos and the service way of life is really important. Combat is brutal, bloody, terrifying and snotty. You would not expect people who walk the streets of the United Kingdom on a daily basis to understand what that is, but you would expect them to have some understanding of the organisation you were in that took you there. That is very important.

Q293 **Gavin Robinson:** Throughout this inquiry we have tried to ascertain different levels of service throughout the United Kingdom. David has helpfully and illustratively talked about the Byzantine processes in NHS England—it is bad enough without considering Scotland and Wales and, of course, Northern Ireland, which I will not focus on. I think that illustrates some of the difficulties that we have to traverse. We understand that you have about 300 staff in Combat Stress, the majority of whom are clinical.

Sue Freeth: It is 250, actually.

Q294 **Gavin Robinson:** There are 267 full-time equivalents, but 300 staff. You know that Northern Ireland makes up 3% of the population but 5% of service personnel and veterans. We heard from Dr Oscar Daly a number of weeks ago. He indicated that he is able to dedicate two days out of five per week, and that he has one therapist, one community psychiatric nurse and one occupational therapist. That is a staff of three and two-fifths. How can it be right, proportionately, that you have such pitiful clinical service in Northern Ireland when our population suggests that we should have a greater proportion of your staff, and our contribution and commitment to armed services in this country is much greater?

Sue Freeth: I inherited our arrangements for resource allocation when I joined the organisation about three years ago. We have recently reorganised ourselves and we are about to move from dividing our resources into three regions across the UK into four. That will allow us to reallocate our resources for Scotland and Northern Ireland. We will start getting into that piece of work next year. Our first priority was to balance our books— to balance the expenditure for our resources and plans with the income we are able to raise, given some of the recent shocks we have

had. What we provide in Northern Ireland currently is provided entirely charitably. We get a very small grant from Victim Support.

Q295 **Gavin Robinson:** Why is that?

Sue Freeth: We have been unable to secure funding.

Q296 **Gavin Robinson:** You're funded from LIBOR moneys. That is a national contribution.

Sue Freeth: We have had LIBOR funding for very specific activities. We had some two years ago for general support for one year. We had £500,000 of LIBOR funding last year to help us to create the fourth region.

Q297 **Gavin Robinson:** You are indicating that you get no Government support whatever for services in Northern Ireland.

Sue Freeth: That is correct.

Q298 **Gavin Robinson:** I think that is amazing.

Can I turn to your telephone line? Reference has been made to two telephone lines. There is the MoD helpline, which you run, and then there is the veterans helpline.

Sue Freeth: We have two telephone lines. They are serviced by the same team. The first line has been established for six or seven years. That was originally established with LIBOR funding, after the Murrison report. We now mostly fund that helpline ourselves, with a very small sum coming to us from Veterans UK. That is for serving personnel and their family members to use, and for third parties.

Earlier this year, the Veterans Minister wanted to create a dedicated line for serving personnel and their family members and we took on the responsibility for opening a new line. That line has been running since March of this year. We get a small sum of money from the Surgeon-General's team for the running of that service. I think £30,000 is what we are intending to get.

Q299 **Gavin Robinson:** The veterans helpline is the new service.

Sue Freeth: No, the veterans helpline is our long-standing service, and the serving personnel line is the relatively new service.

Q300 **Gavin Robinson:** When we look at the figures, it suggests that in both cases, only around 6% or 7% of the calls are from family members. Is that right?

Sue Freeth: Yes.

Q301 **Gavin Robinson:** You will have heard the questions we were asking earlier about support for family members. Can I ask for your reflections on services available for family members? Are the calls you are getting from family members concerns around their loved one who is a veteran, or are they displaying symptoms and issues themselves?

Sue Freeth: I will answer that in two slightly different ways. On your second point, we certainly do get calls, often from partners—I have listened to them myself—trying to establish whether they should be encouraging their partner to ask for help. They often ask, "Are these signs and symptoms the kind of things that are normal or should I be encouraging my partner to ask for help?" In some situations, it will be someone saying, "I want to put my partner on this line because my partner is now very close to being in crisis and I need to make sure someone can actually help them." We have those sorts of phone calls regularly.

On the basis of that data, which we have had for some time, and contact that we have with veterans in our six-week intensive treatment programme—we have always brought partners in at the midpoint of the programme to bring them in to the support that veterans are receiving and to help them afterwards—we have done our own research. First, we did a piece of research on what their health needs were, as partners. We are in the middle of a piece of research that is looking at a model of intervention from the VA in Michigan in the States, which is a combination of education and psychological education for the partner, and sharing information that will help them to support their partner. We are in the middle of trialling that. We very much hope that at the end of that we will have a service intervention that we can introduce into our portfolio because we really feel that partners' needs are not being well met.

They are difficult needs to support because those family members are often the primary economic earner for the family and often have other caring responsibilities. The research that we did and published demonstrates that their health needs are greater than those of other carers in similar situations. We are quite concerned about the safeguarding of their needs. At the moment, we don't think that the services that any of us have available are properly meeting their needs.

Q302 **Gavin Robinson:** How do you know that your calls are helpful? How do you know that when somebody puts down the phone, you have helped the individual who has called?

Sue Freeth: We have a principle of follow-up for all the different interventions that we provide. That is very important for us, because we are increasingly raising that money, and we are accountable either to agencies for it or to the public for the funds that they raise to enable us to deliver those services, so we evaluate, monitor and collect data about all our interventions. We haven't yet had good enough data from the helpline to be able to publish that, but we have established a new relationship with a new provider—it is now nearly two years old—and we will be starting to publish that. We will be very happy to publish the benefits. Where we need to improve it, we would publish the improvements that we will be making.

Q303 **Gavin Robinson:** Can you outline what qualifications the call handlers have to deal with the myriad of issues they face?

Sue Freeth: Yes. The call handlers in the contact centre that we buy our service from are really very experienced. They are hand-picked for our line, which is probably the most complex line that that organisation provides. It is a specialist call handler for the third sector; it is a social enterprise. The individual call handlers are selected for lived experience as well as being trained regularly, both by experienced call handlers who come in to the service and in a weekly and monthly training and development programme. We have a dedicated team, and when we have a surge we have access to a group of call handlers who work in mental health. Our first line of call handlers are generalists, not trained specialists. This year, we have introduced a triage nursing system in the call centre, so we have qualified mental health nurses.

Q304 **Gavin Robinson:** When you talk about training on a weekly and monthly basis, who trains the call handlers?

Sue Freeth: The call handlers are trained by the organisation that we buy our service from, which regularly acquires accolades from the call handling sector. It is highly thought of. It is a social enterprise, not a business, and it largely works with—

Q305 **Gavin Robinson:** Who is it?

Sue Freeth: It is Connect Assist. It is also the call handling organisation for Veterans Gateway, the British Legion, Mind and Shelter. They are very experienced call handlers.

Q306 **Gavin Robinson:** Do you monitor, appraise and test the advice and their ability to handle those calls?

Sue Freeth: Yes, we do. My medical director, who is sitting behind me, has been there with a number of other members of our team to ensure that we top up the training and support that they get. All calls are recorded and we have access to them. We regularly go and listen in on the calls that are made. I have to say that I believe the service we get from that organisation is really of a high class. We would not have selected them otherwise.

Q307 **Gavin Robinson:** You heard the evidence session earlier. Have you detected any issues with people who are reaching out for help engaging with civilians who do not have sufficient understanding, or who are shocked, go beyond empathy and cannot cope with the story that they have heard? Have you detected that in your call handling system to date?

Sue Freeth: No. We have an on-call system. The organisation itself has its own on-call system, so there are always experienced people who are able to come into a call if the individual needs that. They also have a crisis escalation system, and I am aware that we have had a number of calls on our line—we have done for many years—where people are at the point of taking their own lives and we have connected them to emergency services. The call handlers have stayed on the line with the individuals and helped the ambulance service to find them wherever they are. We are certainly the only one of that organisation's contracts that has that kind of

intensive activity. Ours is a listening line as well as an information-giving line.

Q308 **Gavin Robinson:** In terms of information-giving, you mentioned triage. You said that you have qualified nurses handling the calls, but you also refer to others. Who do you make referrals to?

Sue Freeth: The contact centre has a wide range of information on its systems, including within the veterans sector—it has the contract for Veterans Gateway and a number of other major organisations, so the call handling organisation knows a lot of them—and access to the Samaritans and a number of other well-thought-of, well-managed and well-led national and local charities. It is developing that capability and its understanding of it all the time. It is currently working with Newcastle University to make that system even better, so it is more local and more granular.

Q309 **Gavin Robinson:** I am appalled, not by your answer, but by the evidence you have given that there is no LIBOR funding for clinical services in Northern Ireland. You said that you are conducting the admirable work that you do, which we heard about from Dr Daly, through charitable subscriptions. I think that is a stain on this country's support for veterans, because the sacrifice and service of an individual veteran applies equally, no matter which part of this United Kingdom they live in. Could I impose on you and ask you to write to the Committee confirming that to be the case? It may feature in your published accounts, but can you indicate the funds you have, including those from Government, and how they are distributed throughout the United Kingdom? Can you give a breakdown of the four regions?

Sue Freeth: I would be very happy to do that.

Q310 **Chair:** How do those of you who supply services to treat veterans, or groups of veterans, think that the assistance you provide to veterans differs from the assistance that NHS therapists would supply to members of the general public who were going through mental trauma?

Tony Wright: We spoke earlier about being veteran-specific. My organisation is based in a local authority community centre. You can enter that building and there is no stigma attached to it. You can walk in off the street. It contains a plethora of different organisations. People seek us out for lots of reasons—it may be that the logoed minibus makes them say, "That's a veterans service. I'll go there and see them". From there we are able to draw up some sort of usable plan for that individual. It differs in the sense that we are saying, "We know you are a veteran. We know your issues are different", and in order to do that we have a generic drop-in—I mentioned it before—which gives information, advice and guidance. On Wednesday, we also have a women veteran-specific drop-in.

Q311 **Chair:** As you brought that up—this was the only other point I was going to ask—in what way does the service you offer differ for female veterans?

Tony Wright: As you heard earlier, women can feel very isolated and dismissed. Their military service is perhaps not recognised or understood

in the same way as that of male veterans. When we talk to some of the younger veterans who served in Iraq or Afghanistan, they say really interesting things. They are looking at how they can move on. We have said, "Why do you not go and join your regimental associations?", and they say, "Well, they all look like you, Tony. They are all old. They want to talk about the past, and all we want to talk about is the future". That is a really interesting thing. Women are a lot more open and will share things with each other—males generally do not have a wonderful, extensive emotional vocabulary, but women perhaps do. Sometimes it might take us a few weeks as people get to know and trust each other before they start talking about the real issues. Women are more likely to talk to each other in that way, which we have found really helpful.

Q312 **Chair:** When you are treating people in groups, do you mix them?

Tony Wright: I would not say that we "treat"; we do activities based around health and wellbeing—that could be horticulture, art or photography. For the groups that address some of the key issues that women veterans might have experienced, such as isolation and feeling like they are a hidden population with no voice, it is best to do that in a women-only setting.

David Richmond: I caveat my answer because I left my role a year ago. I think what the charities are able to do is specifically offer support to veterans, families and servicemen that is tailored for them. An NHS service is often not tailored for an individual. It is a service, some of which may have "veteran" in the title and a degree of understanding, but most services do not have that understanding, and that is the fundamental difference.

Support networks are developed within those groups—Tony described the drop-in arrangement that he has, and an organisation has just been created called Casevac Club, for all the guys wounded in Afghanistan and Iraq since 2001. When we get together, you don't have to explain yourself to each other. You know each other; you know each other's background. If you don't know each other personally, you understand how they got there anyway. Taking away those barriers instantly makes for a warmer embrace in the organisation and a greater degree of understanding.

Tony is spot on with the lack of emotional vocabulary in the male population, but actually, given a bit of time with mates you have spent time with at Headley Court, at Selly Oak or at the Queen Elizabeth, the vocabulary comes on board. That is what third-sector organisations can offer, which sets them apart from statutory bodies.

Sue Freeth: Combat Stress is a specialist service provider. I believe that every element of our service is specialist. Our 24-hour helpline is unusual. I do not think that there are many other helplines that you can ring as often as you need to and that will spend as long as you need to listen to support you. It is part of our service, but is also connected if necessary to the crisis parts of the NHS.

Our assessment and then our programmes are delivered by a multidisciplinary team, which everyone gets access to. It is not rationed to some; if you need support from us then you will get it from an OT, a nurse, a psychiatrist and a psychologist. They work together to be part of your programme throughout your treatment with us and beyond.

The new veterans peer support programme is delivered by volunteers who are veterans with lived experience of trauma and trauma-related military mental health issues. Again, that makes for another element of specialist service. We have that because we know it results in better outcomes, better engagement, and much higher levels of engagement than when we do not have that available for veterans, particularly those with complex and complicated situations. We know that more people complete their treatment when they have that kind of service.

Chair: I am pleased to say that we have been augmented by our colleague Graham Jones, who is having to prepare for a major session of the Committees on Arms Export Controls, which he chairs, later today. Although your presence is fleeting, Graham, please do make a contribution now, and ask questions.

Q313 **Graham P. Jones:** Sue, Tony, how do you ensure that the treatments and care that you offer are effective for a veteran's mental health problem?

Sue Freeth: The programmes of treatment and support that Combat Stress uses are based on three areas of research that we have been investing in increasingly over the last 10 years or so. First of all, we identify the need. We do not start a programme until we have identified the need.

We then have an area of research that is about making sure that we trial, pilot, develop, anglicise if necessary, and then deliver the programmes of treatment that we adopt. We therefore know that we have evaluated those with the people who are going to experience them.

We also have a field of research where we work very collaboratively with other universities across the country and across the world, looking at new treatment methods and new datasets to learn from those and to plough that back into the programmes of work that we do. We have one of the largest databases of case experiences of veterans in the UK. In fact, other countries in the world are quite jealous of that dataset, and we are increasingly connecting it to others.

Having an evidence base is very important for having effective programmes. People who come into our support services or treatment programmes complete before, during and after returns. Our staff are all involved in the collection of data and research as part of what we produce and publish. That is why we hold such a great store in research.

Tony Wright: It is pretty similar. You were not here at the beginning of the session, but people can leave the military and feel very much lost and alone, and disconnected from the civilian community. People come to us,

and from there we are able to help them to navigate the civilian world and the services available to them.

We do not refer anybody to Dr Snake Oil. Everybody we refer to will be a clinical practitioner of some sort. The key thing there is that a lot of people are not registered with GPs, or with a dentist. We go right back to basics and make sure that those processes are put in place and that people are registered, and then we get them in touch with the services that help them. As well as that, because we are in a community centre, we invite those services to come out and actually see people.

To look at the evidence base of why I think it is working, everything we do is with the intent of causing no harm, be that psychologically or physically. Touch wood, we have been very lucky. I have been doing this work since 2009; we have not had any veteran suicides, and the people who have been involved with the criminal justice system have not gone back into the criminal justice system, so we are getting something right there. That is not just our work; that is a collective responsibility, and it is about the power of working in partnerships to share that collective responsibility, which includes the police for some people. We have to work together to make sure that the veterans and the families who access our services are safe, and their needs are paramount.

Q314 **Graham P. Jones:** For me, and for some of the veterans in my area, one of the questions is about the long-term care that those veterans need. I often raise that subject in this Committee, as well as that of the families. How do you provide for those who need longer-term care or support? I am presuming that it will be cyclical, or it starts off that they are in a peak—they have left the Army, and they may get a job and employment—but later, PTSD or mental ill health descends on them, and they go into a trough. How do you pick them up through that longevity, or will they always be considered as veterans who are vulnerable?

Tony Wright: To a degree. That is a really good point, well presented. The longest intervention we have had with any individual is over three years. It could have been longer; he chose to move on once he was able to access the support of Combat Stress and Help for Heroes, once he got a diagnosis of post-traumatic stress disorder, which we were involved with. One of the beauties of our organisation is that we are not time limited. I have older veterans who are in their 60s and 70s, and I am sure they will be with us for some considerable time, until their time comes to shuffle off this mortal coil.

The point is that you can come back to us and get support and help when you need it, how you need it, in whatever form. Life is difficult: we all suffer traumas and difficulties, whether relationship breakdowns, ill health or whatever. Having to go and retell your story again is a problem for a lot of people, whereas if you come back to us, we can pick up where we left off and move on. When I set that up, the whole idea was to be community based and not set up a veterans accommodation project, so that they could always come back and get that support.

Q315 **Graham P. Jones:** Sue, do you want to come in on that?

Sue Freeth: I do, because you were talking about working together better—I say "better", because we are still not proactive about that. Certainly, more of Combat Stress's services used to be available for respite and that kind of ongoing support. As resources have become scarcer, we now focus all our resources on to areas where there is measurable, demonstrable improvement.

What that means is that areas that are softer—like respite, for example—are much more difficult for an organisation like ours to provide, although they have value. Those services are needed and valued, both by veterans and their partners. We recognise that, and in fact that has been evident more recently: one of our previous veterans who has been supported by us has raised it.

However, respite care, and particularly residential respite care, is now virtually not available in the way that it used to be. That is a shame, because for some veterans, that was the top-up they needed to keep going, and their families needed it. At the moment, there just are not the resources for an organisation like ours to make that available. It may be that other organisations need to step up.

Q316 **Graham P. Jones:** That begs the question, given that some of our veterans may suffer years later, of what sorts of random check-ups are done over the long term on some of our veterans—people who may have been okay, but who have factors in their life other than their previous service, which collide into a downward spiral? It may not all be attributable to their service years. What sort of follow-ups and checks do we do on members of our Armed Forces, to ensure that?

Tony Wright: Every couple of weeks with our client base we do a "How are you doing? Safe and wellbeing," telephone call. Nothing more than that. Most of the time, they go, "I'm fine, I've got a job. See you later." But we do that check, which is a very simple and cheap way to check how people are.

You have actually hit on the nub of the problem about the whole veterans issue. The key issue is that, if you are veteran with a difficulty, you have to initiate and ask for help. Whereas, I think there should be a need for the MoD or someone else to write to the veteran, perhaps every year, and ask, "How are you doing? What's going on? Do you know this is available? You can access this and that. This is in your community." That proactive approach should start to be introduced because it would make a huge difference.

You are quite right. You go away; you get a job; you upset your manager; you're out of job; you go back home; your partner—if you have one: they are usually divorced, by the way—says, "I'm not happy with that." Then you have relationship discord and are in that horrible spiral out of control. It is that point that we need to intervene before things get too difficult and people self-isolate and refuse to meet and talk to people.

David Richmond: There is a suite of services available; I go back to Help for Heroes as an example. One of the most powerful services is fellowship, which does not provide a clinical intervention at all. Its role is to develop a relationship with the Band of Brothers who are the servicemen and women and the Band of Sisters who are the family members, so it covers both sides, and ensure that relationship is in place on an enduring basis.

The individuals may choose to be rather closer to that relationship but further away over time. That relationship is there, not just on a national basis but on a local one, such that, if people start to develop issues or challenges that need to be addressed, the fellowship team are often the first people to find out and can start the conversation that brings them into a network of wider services.

We can become very focused on clinical services. Actually, the non-clinical services are often the ones that allow you to keep tabs on how people are progressing over time. I would say, through my own experience, if individuals want to drop off the radar, they drop off the radar, and there is nothing you can do to get them to pop back on again until they are ready to do so. Some of them drop off the radar consciously—and why not? Some drop off the radar because they are going into a bad place, but it is very difficult to raise them again, until they are ready to be raised, or somebody else does if for them.

Q317 **Graham P. Jones:** I have very strong views on this issue. Parking my views for a moment, I want to press you. You are effectively saying that a framework like Alcoholics Anonymous has, which exists there as a community, is probably the closest we have at the moment, unless you have a good local or charitable NGO. Nationally, it is probably the Royal British Legion that provides that fellowship. That would be first port of call, unless you have one that is local.

Sue Freeth: Our peer support network is of veterans who have had treatment and made a successful recovery coming back in and helping people who are just beginning to engage. We certainly hope that will provide some of the glue that you are just describing.

Combat Stress is a consortium member of the Veterans' Gateway. In the most recent ministerial announcement, we have been asked to look at whether some kind of proactive approach could be taken to give people a call-back. As David said, individuals would still have to agree to that. Certainly, in our experience, that is a pattern, particularly for people with complex PTSD, that they will disappear. We have to build a network, formalise what we can of it, but also provide enough informal methods for people to be found and looked out for, even if they don't necessarily want to be.

Chair: Thank you. We have a maximum of 20 minutes left, and we have one topic each for Johnny, Gavin and myself, so please keep an eye on the time, colleagues, starting with Gavin.

Q318 **Gavin Robinson:** I will throw this out and whoever wants to pick up the ball can. Should charities offering treatments be accredited or regulated,

and if so, by whom?

Tony Wright: I personally think yes, they should. I do not know by whom, but I think it should almost be on the same principle as an Ofsted inspection, if you like—that is not the best example for a medical intervention, but something similar. As a social worker, I would welcome that as well.

Q319 **Gavin Robinson:** Just to drill into that, there are so many levels of different types of treatment and service. Individually, you might have the RQIA looking at one part and the Royal College of GPs or midwives or nurses—whatever it may be—at another. Would that be an overarching regulation or would it be separate and distinct?

Tony Wright: That is a moot point. You are going to have to look at an overarching issue. I think the structures are already there, to be quite honest; they just need adapting a little bit to become veteran-centric, including families. We do not have to reinvent the wheel on this; we just have to go and finely tune or tweak something that is already there and say, "Let's make this work." But yes, it should happen.

David Richmond: Charities delivering therapies are currently subject to the same regulation as anybody else delivering a therapy. What we—

Gavin Robinson: Which is dependent on what treatment it is—

David Richmond: Depending on what the therapy is. One of the ironies in this—there is a logic, but also an irony—is the more highly qualified you are, the more regulated you are. There is something sensible and also ridiculous about that.

What we did at Contact—we looked at the range of therapies open to people, which is extraordinary—is we produced a set of minimum standards of practice guidelines in two forms. One was for those clinicians or therapists, and it describes in clinician-type language the things we would expect of a good service, even if it is not regulated.

We also produced it in layman's language, for individuals who might be looking for a therapist and who, if they did not want to approach one of the well-known charities, would understand the sorts of questions they should ask but also the answers they should expect. We produced those to help people to navigate that patchwork of therapists out in society.

Q320 **Gavin Robinson:** Sue, you were agreeing there with the existing levels of regulation for individual treatment.

Sue Freeth: Yes, but the answer—I agree with Tony—is that the regulatory bodies are already there. It is about educating veterans, their family members and third parties who are involved in supporting them to encourage people to look for registrations, look for practitioners who are regulated and look for the best practice and make sure that they understand the system that they are working in—to do a little bit of relatively easy due diligence. That is actually the easiest thing for us to achieve and that is really why Contact did it.

There are five questions. I have brought them with me, they are very simple. It was a multidisciplinary group of people and organisations who created them. It is just getting them practised, so now we always think about asking, in the same way we do now for a GP—we kind of know what to look for.

Q321 **Gavin Robinson:** Sure. Because there are so many different levels of regulation depending on the service or the treatment that you avail yourself of, how does Combat Stress—forgive me, it is because you are here—deal with a complaint? Do you direct a service user to the regulatory body for that service or do you deal with it yourselves? You could have somebody saying, "Look, the hot stone therapy wasn't good enough, because the stones weren't warm enough," to somebody who was engaged with a clinical psychologist and felt that it was detrimental and the treatment was unsuccessful. If there is no individual regulation or one point of call, how do you as an overall charity deal with the labyrinthine nature of various regulators for each service?

Sue Freeth: In terms of how we deal with them as a charity ourselves, we are accountable to all the bodies who regulate our practice. Our practice is actually regulated as a whole. Our service is now all Care Quality Commission-registered—everything that we provide is—so we have the three levels of complaints procedure that you would expect of an organisation that is registered and regulated by the CQC. All our professional staff have to have registrations and we oversee and monitor that and report. When there are incidents or situations where we have to report to their regulated body, we do those reports as appropriate. Very often, some people still feel that while our service may not have done everything they expected from it, at the end of the day, if they have exhausted our own complaints procedure, which is very transparent and open, they have the right to go to the CQC or the Health Ombudsman. Our own procedure, once they have exhausted it, directs people to go to those regulatory bodies, to have their complaints addressed. That is what we should all be doing, really.

Q322 **Gavin Robinson:** I guess that is important. That is what we should all be doing. You have Combat Stress at one end of the spectrum and then you will have smaller charities that draw on volunteerism and so on throughout the country, with the best endeavours, trying to do what they can for veterans, but which do not have the same back office support. Do you have any suggestions as to how to assist smaller charities when navigating regulation or the duties that they have for the care they are providing?

David Richmond: That is a tough one. I think the first challenge is sometimes knowing they are there in the first instance. There are charities that we know are there, because you work with them or refer to them, or you consciously, perhaps, decide not to refer to them, because you don't think they are producing the goods to the standards required. That was part of the rationale behind those minimum practice guidelines. Part of this was that if you don't subscribe to these, the member charities of Contact would not refer to you and would not grant fund you, so you are not part

of this group. That is what you can do to those who don't, but you can embrace those who do. The role of Contact going forward—I say this conscious that I am not the chairman any more—is that you can put your arms around those organisations which are, increasingly, delivering clinical services, and this is specifically about clinical services or therapies, and are subscribing to those standards, and you can start to be much more inclusive about that. Over time, you are generating momentum through that.

Gavin Robinson: Does that sound right to you, Tony?

Tony Wright: Yes and no. For a long time it has felt like open season on small charities. There has been considerable negative publicity saying that there are too many small charities. It is all around the regulation issue. You have unincorporated community groups. You have well-meaning people on Facebook, Twitter and every other form of social media. You have community interest companies setting up, all specialising in the veteran, as it were. Nobody has any way of regulating what happens there. There is also a lot of replication and duplication of services as a result. I'm with Johnny, I think we desperately need a department of veterans affairs—yesterday wouldn't be quick enough for me. That is absolutely crucial, so that we could actually start to formalise that. As a small charity at the beginning, I have sometimes felt that we are outside of the tent. Do you know what I mean? Becoming a member of Cobseo was a really significant moment for us. We have learned a lot from that, and the governance and support we get from Sir John McColl is absolutely fantastic. For a charity that is nearly ten years in, I am still learning every day, which is fantastic.

Gavin Robinson: It has been nice for Johnny to receive some support on the Committee.

Johnny Mercer: Very rare.

Chair: A perfect lead-in to the man himself.

Q323 **Johnny Mercer:** Tony, just touching briefly on that point around regulation of small charities, in my view—I know that you feel it has been open season on small charities—I don't think we have gone far enough, because systems like the one advocated by David will look after charities like you, who do it well, are regulated, provide a service and have their accounts audited, but we have to be aggressive in going after these fraudsters who are using veterans care as an excuse to raise money.

Tony Wright: I totally agree.

Johnny Mercer: I am afraid that they are getting access to some of our most vulnerable people and it does not help the core mission. Do you see what I mean? I understand why small charities steer away from regulation and all the rest of it, because of the cost, but if it could be shared out, you could learn some of the lessons from the bigger charities and they can get you into the tent. I think that is the way forward. On that point—Sue, I will ask you, actually—have we got a common needs assessment yet?

Sue Freeth: No. However, there is a desire to have one. There is work going on. There is genuine commitment to that work going on, now, and certainly Contact is trying to spearhead that work. It did under David's chairmanship. It is now under, I think, the new chairman's leadership.

Q324 **Johnny Mercer:** Who is in charge of Contact now?

Sue Freeth: Charles Winstanley has recently taken over the chair. He has a number of public appointment roles across the UK; he was a Deputy Lieutenant of Greater London and the chairman of NHS Lothian in Scotland. He was quite closely involved in Veterans First Point when it was first created, and was a serviceman himself. He has just stepped in, since it was handed over in September.

Q325 **Johnny Mercer:** So when are we likely to see a common needs assessment?

Sue Freeth: We all want to see one, because we know—

Johnny Mercer: But we have been saying this for 10 years.

Sue Freeth: I know we have, yes.

Johnny Mercer: So when are we actually going to see a common needs assessment?

Sue Freeth: I hope we have one in the next 12 months. There is no reason why we can't. We need to prioritise it, and that is the message we have actually given Charles, really. We need to release our staff to achieve it. That is what we have to do.

Q326 **Johnny Mercer:** Coming from your perspective, Tony, when an individual has been through a treatment programme with Combat Stress or Hidden Wounds, or whatever it is, with Help for Heroes, and they come to you, is there any way—because obviously there are massive challenges around data sharing and things like that—that you can reach into those organisations and get a bit of a steer, so that this guy or girl are not constantly retelling their story?

Tony Wright: Yes. For instance, Combat Stress actually operates out of our community centre. They run their peer-led support groups from there and refer on to us when they have got clients. Combat Stress staff and any clients that come in also get free coffee, because we have got a wonderful public in the north-east and we have a pay-it-forward sort of agreement; you buy a coffee, and you buy another one for a veteran in need. We have currently got 335 coffees to get rid of, so the more people the better. So it is really good, but it actually engenders that wonderful communication. Combat Stress is a really good one. The British Legion and form A is always a good one, as well. We were talking to them recently about getting our staff doing the form A training, so that we are able to fast-track people into getting the support they need from both the British Legion and SSAFA. We also ask them to sign that they don't have an issue with sharing data, so once they have done that I can go back to people and say, "Here it is, have a look at our assessment form."

Sue Freeth: I think the difficulty around data sharing—and it definitely would be good to do more of it—is systems, because we are talking about a variety of different organisations with different quality of systems. Also, with clinical data and personal data now there are some things that can't be shared, unless they are shared with clinicians. We don't want data protection to be the excuse for why we do not collaborate and co-operate, but the world is a bit more complicated now. We may need some assistance to be able to share our systems. It might be that that is where Government could be investing, I think.

Q327 **Johnny Mercer:** David, just, finally, in two minutes: you have a magic wand. You are Prime Minister for a day. What are you going to do to sort out veterans' care? You have a unique position on this, having been at Help for Heroes when it started, seen all that growth all across, chaired Contact—what would you do?

David Richmond: The first thing is you need to craft a collaborative vision for what the future looks like in 10 years' time for veterans. Once you have decided what you want it to look like you then design the system and the processes to deliver it. Too often we start with the system and the process and try and work out where it is going to take us. That vision that I talked about at the start is the bit that has been fundamentally missing for 10 years. It has been fundamentally missing and that is why LIBOR money went to 101 different places, some of which were no doubt very effective, an awful lot of which no doubt weren't—but who checks? Who knows?

I would certainly look at that, and I am not against a department of veterans affairs, I have to say. I am slightly on the fence. I am not quite sure which way I am leaning. I think if we are going to have a joint, collaborative vision, not just created by Government Departments but involving the stakeholders, small and large, then we will need somebody who can execute it. Whether that is somebody sitting in the Cabinet Office, somebody sitting in the department of veterans affairs, or somebody somewhere else—who knows—that body needs to be created to deliver it and it needs to be led. The vision and the leadership have been lacking, so put that in place first, design something to deliver it and go from there, but pitch the ball ahead. We are not worrying about what happens next year or the year after; we are looking 10 years ahead.

Johnny Mercer: You have all been very nice about me, and so was the previous panel, but the reality is that I just go off in this place. You guys do the work and get your hands dirty, so thank you so much for everything you do and for coming in today.

Q328 **Chair:** Finally, this is your last chance to make a closing comment on anything else that you think can and should be done to support the mental health of families, carers and veterans.

Sue Freeth: I would like to make two points. I support everything that David has said, but what we need is to look at the long term and at sustainability. There is too much interruption and jerking from one

initiative to another. There are some very good interventions that need drawing together and scaling up. We need to do fewer things, but more of the things that we know work well.

David Richmond: I probably summed up in my previous answer, but there are a couple of personal observations that I would like to offer. When you explore this area, it is very easy to look at servicemen as victims. I served for 26 years and I would do it all over again. I loved it, and I know an awful lot of people who loved it too. The vast majority of people are hugely proud of their service; they are hugely proud of what they did, and they have transitioned and gone on to perfectly satisfactory and successful civilian lives. Out of all the people I know who I went through Headley Court, hospital and goodness knows what with for four years, I do not know a single one who considers themselves a victim. That is the last thing that they would want to be considered as. I think we must shy away from shining a torch too sharply on this and ignoring all the others around the outside.

Q329 **Chair:** Can I cut in at that point? You mentioned Headley Court. I can understand that people who have suffered physical injuries may not wish to be seen as victims or regard themselves as victims, but what about people who have suffered mental trauma? Is that not a different situation?

David Richmond: Point taken entirely, but don't think that people who have suffered physical injuries have not suffered mentally in some way as well.

Sue Freeth: We are neglected, perhaps, but not victims. I don't think any of us want to be perceived in that way.

David Richmond: I echo what Tim Boughton said in the previous session. Ten years ago I was injured, and there was nothing. It has changed hugely in 10 years. I would say that the system that supports wounded, injured and sick servicemen with physical and mental injuries is now one of the best in the world, if not the best.

Q330 **Chair:** We know that for physical injuries. What this inquiry is trying to establish is whether mental injury treatment has kept pace with that. You are shaking your head, Sue.

Sue Freeth: I genuinely don't think it has. Compared with other nations, which we are very well connected with at Combat Stress, we are not getting the same investment in mental health.

Q331 **Chair:** Let me get this clear, because I do not want any ambiguity. When you shake your head, are you referring only to the mental injuries side?

Sue Freeth: Yes.

Q332 **Chair:** So you are both agreeing that we have made huge progress with physical injuries, but you are disagreeing about how much progress we have made with mental injuries.

David Richmond: I hadn't actually finished my sentence! The end of the sentence is "—but it isn't perfect." There is a lot of work to do in the mental health care area. That has to catch up; that is exactly what I was about to say.

Q333 **Chair:** Frankly, the testimony we heard before completely runs counter to any suggestion that we have reached a world-class level of support for people with mental injuries.

David Richmond: I am not suggesting that we have, for that group of people.

Q334 **Chair:** But this inquiry, with respect, is about that group of people. You have brought in physical injury; I am just trying to set that to one side, because we want to be clear what your views are about the people who have suffered mental injury.

David Richmond: I am about to offer that. I think what we have created in the physical arena has come about because we worked together. We worked very closely with the NHS, with the Ministry of Defence and with a number of other service charities. That degree of collaboration has not been present to the same degree in the mental health arena. That was where I was going to finish.

Tony Wright: If I were to put my social hat on—this is specifically in response to therapists who might find talking to veterans particularly difficult—I think we need much more thorough veterans awareness training. There are some brilliant examples in the country, but I think we need a theory of change for veterans.

There are four key points to address. We need to look at people who are going through transition; at people who are having difficulties around their new identity as a civilian; at those who are still struggling to adjust to civilian life, to a life-changing injury or to a mental health problem; and at how we assimilate people back into the community.

I am using a model that, strangely enough, is all about being, belonging, becoming. The becoming is that aspirational goal. The being is the now—it's the nine life domains. The belonging is how you see yourself now and view yourself as a civilian. You are a citizen, and I really believe we should embrace that. Rather than saying "Civvies are idiots, and the civvy world's not great," we should say, "You have served your country, you are a citizen of this country and you are respected." From that basis, we can build people up and take them to the next level.

Funding would be my next one. We never got any of that LIBOR money, Johnny.

Johnny Mercer: I wasn't giving it out!

Chair: Thank you all very much indeed. It has been a most enlightening and comprehensive session.