



House of Commons
Defence Committee

Mental Health and the Armed Forces, Part Two: The Provision of Care

Fourteenth Report of Session 2017–19

*Report, together with formal minutes
relating to the report*

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The Defence Committee

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Summary

We concluded in Part One of our inquiry into Mental Health and the Armed Forces that the vast majority of veterans leave the Services with no ill-effects. However, the minority of serving personnel and veterans who do suffer from mental health conditions clearly need timely and appropriate care.

The Ministry of Defence and the four health departments in the UK have together sought to improve the care available over the last decade and reduce the sense of stigma surrounding mental health. We welcome this and recognise that there have been tangible improvements, including the introduction of veteran-specific specialist mental health services across much of the UK.

Despite such improvements, there is no doubt that some serving personnel, veterans and their families who need mental health care are still being completely failed by the system.

For those in service, fear for their careers remains a key barrier to seeking help: even if they do, it is unacceptable that the quality of care received is not always up to standard, with shortfalls in staff exacerbating the problem.

Furthermore, it is a scandal that in an NHS budget of over £150 billion UK-wide, less than £10 million per annum (0.007%) has been allocated to veteran-specific mental health services. We found that the availability of government-provided care varies significantly depending on where they live and whether they are fortunate enough to have a GP who is aware of veterans' mental health needs and services. Indeed, the continued lack of knowledge of the Armed Forces Covenant in the civilian health care system is a cause of deep concern and there is still an urgent need for clarity over how the Covenant's principle of priority care is implemented in practice across the UK.

Even when specialist care is available, such services are clearly swamped by the scale of demand, leading to some veterans having to wait up to a year for treatment. Many of these veterans see their conditions deteriorate further whilst waiting for access to treatment and, in the most extreme cases, they take their own lives whilst awaiting help. To prevent this, patients must be continually monitored and reassessed during the gap between initial diagnosis and the commencement of treatment.

There needs to be a highly professional place of safety to which these veterans can be sent as soon as they are diagnosed, in order to be stabilised and to begin to receive assistance for their recovery. The Committee strongly believes that it makes sense for such a centre to be co-located with the new state-run Defence and National Rehabilitation Centre (DNRC) for physically injured serving personnel at Stanford Hall. The DNRC evolved from Headley Court, which rightly established a world-class reputation for the treatment of the physically wounded from conflicts such as Iraq and Afghanistan and it should be a national aspiration to establish a similar world-class centre for the treatment of mental injuries relating to service as well. The NHS should urgently consult with the Ministry of Defence and the DNRC in order to establish this facility with an initial operating capability within the next 12–18 months.

Specialist care is often too time-limited, which means those veterans with the most complex and long-term mental health needs find themselves alone or dependent on Armed Forces charities.

Thus, many veterans have to rely on the valuable services provided by these charities; but the sector remains stove-piped and does not work together to the full benefit of the veterans. The Government must “knock heads together” to provide a far more joined-up service.

With specific mental health care provision for Armed Forces families also non-existent, it is no surprise that many veterans and their families believe that they have been abandoned and that the promises made to them in the Armed Forces Covenant have not been kept.

It is vital that the improvements which the Ministry of Defence, the four UK health departments and the rest of Government are making in this field fully address these gaps and prove to the Armed Forces communities that, if they have mental health problems, they will be supported. Those who have worn the uniform of their country deserve no less.

Key Facts

Armed Forces Provision

- The Care Quality Commission rated **two out of four** MoD mental health centres as inadequate or needing improvement between April 2017 and January 2019. (paragraph 10)
- There were at least **50% shortfalls** in both uniformed and civilian psychiatrist posts in 2017–18. (paragraphs 19 and 20)

Transition

- Armed Forces charities have found that it can take **four years on average** before Iraq and Afghanistan veterans seek help for mental health issues. (paragraph 45)
- Despite this, the Ministry of Defence follow-up period for writing to veterans is only **one year after discharge**. (paragraph 43)

Veterans Provision

- Veterans in England wait **18 days, on average**, for an assessment from the Transition, Intervention and Liaison Service after referral against a target of 14 days, according to NHS England. (paragraph 80)
- Veterans can wait **up to a year** for mental health treatment after assessment, particularly in Northern Ireland. (paragraphs 80 and 83)
- We estimate that total government spending on veteran-specific mental health services in England, Scotland and Wales is less than **£10 million** a year. However, there are **no** such services open to all veterans in Northern Ireland. (paragraphs 55 and 59)
- It is difficult to obtain authoritative statistics on veteran suicides. However, a study conducted for ITV last year, produced a figure that at least **71 serving personnel/veterans** unfortunately took their own lives in 2018. Even as a rough estimate this gives a good idea of the scale of the problem. (paragraph 110)
- There were **76** UK Armed Forces charities providing mental health support in 2017, according to the Directory of Social Change and the Forces in Mind Trust. Of these, one-third exclusively focused on mental health. (paragraph 115)

1 Introduction

1. The subject of mental health has become increasingly prominent both across the UK Armed Forces, not least following UK operations in Afghanistan and Iraq, and across UK society generally. In January 2018 we launched the first part of our inquiry into Armed Forces mental health, and published a report, *Mental Health and the Armed Forces, Part One: The Scale of mental health issues*, in July 2018. This focused on the extent of mental health issues among both serving personnel and veterans.¹
2. We concluded that the vast majority of veterans leave the Services with no ill-effects and that the public perception that most veterans are ‘mad, bad or sad’ was not only a myth but harmful to veterans.
3. However, we were convinced that the minority of serving personnel and veterans who do suffer from mental health conditions need timely and appropriate care. The evidence we received suggested that they were not receiving this, that veterans had to wait too long to access treatment, and that the provision of care varied across the UK—as did implementation of the Armed Forces Covenant principle of ‘priority care’ for veterans. We therefore decided to look at the provision of mental health care for serving personnel, veterans and their families.

Terms of Reference

4. On 25 July 2018, we launched the second part of our inquiry, *Mental Health and the Armed Forces, Part Two: The Provision of Care*. Our call for evidence asked for submissions which addressed the following questions:
 - To what extent do serving and former Armed Forces personnel require specific mental health care for treatment to be most effective, either as a whole or for specific groups?
 - How far does Government provision for mental health services to serving and former Armed Forces personnel in the UK meet both these specific care requirements and the Armed Forces Covenant’s principle of priority care, including during transition?
 - To what extent are Armed Forces charities covering any gaps in Government mental health care provision?
 - Are veterans and their families aware of the mental health services available, and how effective have initiatives such as the Veterans Gateway and 24hr helplines been in helping awareness and access?
 - Are GPs and other NHS medical practitioners sufficiently aware of the needs and entitlements of veterans and their families to provide appropriate advice and referrals?
 - Do veterans receive the mental health care and support they need quickly once they seek help?

1 Defence Committee, Eleventh Report of Session 2017–19, [Mental Health and the Armed Forces, Part One: The Scale of mental health issues](#), HC813

- How does the provision of care and the outcomes achieved for veterans differ across the UK?
- How are the families of serving personnel and veterans with mental health issues supported?
- To what extent are government departments, local authorities and charities across the UK aligned and working together effectively to provide mental health services to veterans?

The inquiry

5. We held four oral evidence sessions, with contributions from veterans; Armed Forces charities; the Scottish Veterans Commissioner; medical practitioners and academics from across the UK; a journalist; and a member of our own Committee, Johnny Mercer MP. Our final session, where we heard from Government witnesses, was with the Parliamentary Under Secretary of State and Minister for Defence People and Veterans, Rt Hon Tobias Ellwood MP; the Chief of Defence People, Lieutenant-General Richard Nugee CVO CBE; the Parliamentary Under-Secretary of State for Mental Health and Inequalities, Jackie Doyle-Price MP; and the Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning at NHS England, Kate Davies CBE.

6. We also received 120 written submissions, with over two-thirds from serving personnel, veterans and their families, setting out their experiences of seeking and receiving mental health care in the UK. We did not publish individual submissions because of the personal and sensitive information in them. Instead we have set out in an Annex a detailed summary of the key issues raised by their experiences. We also quote their anonymised submissions throughout this report.

7. We thank all our witnesses for their oral and written evidence. We are also grateful to Combat Stress for facilitating our visit to their residential treatment centre at Tyrwhitt House, Surrey, in December 2018, to Professor Neil Greenberg, King's College London,² who acted as a Special Adviser to the inquiry and to Claire Kao, a Hansard Scholar from Cornell University, who helped prepare the Annex to this report.

2 Professor Greenberg's declared interests were: Professor of Defence Mental Health, King's College London; Trustee at Forces in Mind Trust and Walking with the Wounded; Lead for Military and Veterans' Health, Royal College of Psychiatrists and a Director at March on Stress.

2 During Service

Current provision

8. The Ministry of Defence (“the Department”) is responsible for providing mental health care to all currently serving military personnel and mobilised Reservists, primarily through its Defence Medical Services.³ As at the start of April 2018, there were 146,560 Regular UK Armed Forces personnel, plus a further 36,480 Reservists.⁴ The Department reported that in 2017–18, 3.2% of serving personnel were diagnosed with a mental health disorder.⁵ However, this figure represents only those who sought help from Defence Medical Services, and we concluded in our Part One report that this may be a significant underestimate of how many serving personnel have mental health conditions.⁶

9. Defence Medical Services provides specialist mental health care at 20 locations across the UK, including through 11 Departments of Community Mental Health (DCMHs), which have multi-disciplinary mental health teams.⁷ They do not have in-patient facilities, which are instead contracted out to a consortium of eight English and Scottish NHS Trusts and used by around 300 serving personnel each year.⁸ The Department also pays Combat Stress to provide a 24-hour mental health helpline for serving personnel, while NHS England commissions the Big White Wall to provide 24-hour online support for all serving personnel, veterans and their families across the UK.⁹ The Department expects to spend around £22 million a year on mental health services over the next decade.¹⁰

Quality and effectiveness of care

Independent inspections

10. Although it is not a requirement that the services provided by Defence Medical Services should be inspected by the Care Quality Commission (CQC), the Department invited the CQC to conduct a programme of inspections, initially for 2017–18 but subsequently also for 2018–19.¹¹ By January 2019, the CQC had reported on four DCMHs—including one follow-up report—rating two as meeting or exceeding standards and two as failing to do so (Table 1). Key failings included poor leadership and “destructive interpersonal relationships within the management and staff team” at DCMH Scotland, as well as inadequate staffing and poor facilities at DCMH Brize Norton.

3 Ministry of Defence ([POC0111](#))

4 Ministry of Defence, [UK Armed Forces Quarterly Service Personnel Statistics 1 April 2018](#), May 2018, Table 1

5 Ministry of Defence, [UK Armed Forces Mental Health: Annual Summary & Trends Over Time, 2007/08 - 2017/18](#), June 2018

6 Defence Committee, Eleventh Report of Session 2017–19, [Mental Health and the Armed Forces, Part One: The Scale of mental health issues](#), HC813, paras 43 and 56

7 Ministry of Defence, [Defence Medical Services](#), website accessed 14 February 2019

8 Qq8–10; Ministry of Defence ([POC0129](#)); Ministry of Defence, [Defence Medical Services](#), website accessed 14 February 2019

9 Ministry of Defence ([POC0111](#)) and Big White Wall ([POC0114](#))

10 Ministry of Defence, [Defence Secretary shows commitment to Armed Forces mental health with over £220-million funding and new helpline](#), 25 February 2018

11 There is no statutory requirement for Defence Medical Services to be registered under the Health and Social Care Act and so its services are not subject to inspection by the Care Quality Commission. Care Quality Commission, [Defence Medical Services CQC inspection programme – Year 1 \(2017/18\)](#), p6.

Table 1: Care Quality Commission inspections of Armed Forces mental health centres between April 2017 and January 2019

Department of Community Mental Health	CQC overall rating
DCMH (Colchester)	Outstanding
DCMH (RAF Digby and RAF Marham)	Good
DCMH (RAF Brize Norton)	Requires Improvement
DCMH (Scotland)	Inadequate (first report)
	Requires Improvement (follow-up report)

Source: Care Quality Commission¹²

11. The Rt Hon Tobias Ellwood MP, Minister for Defence People and Veterans, and Lieutenant-General Nugee, the Chief of Defence People, told us that the Department welcomed the CQC findings which had identified where “things are lacking”. General Nugee added that there had since ‘been a huge amount of work’ done to rectify these problems and that the Department had asked the CQC to return to DCMH Scotland to report on the improvements made. Both emphasised that the issues reported arose from infrastructure problems and manning levels at the two DCMHs and that the CQC had rated the care provided as at least good in all cases.¹³

Individual experiences of care

12. Some serving personnel and veterans praised the care they received from Armed Forces mental health services. For example, one individual told us that:

I felt compelled to let you know about my experiences over the last year as all I have seen at DCMH is utter professionalism and life changing treatment, not only for myself but for fellow Royal Marines of all ranks.¹⁴

Professor Alan Finnegan, Professor of Nursing and Military Mental Health at Chester University and Armed Forces nurse consultant until 2015, also told us that a survey during his time in Service found 94% of soldiers were satisfied with the support they received from military mental health services.¹⁵

13. However, other serving personnel and veterans had poor experiences with the care they received (Case examples 1).

12 Care Quality Commission, [Defence Medical Services](#), website accessed 14 February 2019

13 Q355 and Q369; Ministry of Defence ([POC0129](#))

14 Annex 1: Summary of individual responses received

15 Q6

Case examples 1: Poor care experienced by veterans

“It was very difficult for me to take that first step in seeking out aid, mainly due to stigma whilst serving in an infantry unit. But to be diagnosed by an RAF Corporal who was an unqualified psychologist and my treatment was a guidebook with no future referrals is a complete farce.”

“We have had greater success personally funding regular sessions with a private counsellor over a 2-year period rather than the haphazard military MH [mental health] care pathway.”

“The infrastructure of these resources is also very poor, e.g. Mental Health Unit RAF Cranwell, is shoved into a rotting porta cabin, the door of which for several years was so swollen and rotten with damage the physical security of the buildings records could easily be compromised”

Source: Annex 1: Summary of individual responses received

14. Serving personnel and veterans also reported differences in how quickly they were treated. One said that “access to mental health services for me was swift (once the need for them was recognised) and well organised”. However, another had to wait over a year to be seen, telling us that he “was invited to a DCMH appointment 6 months after referral and 15 months after originally seeking support and was almost immediately discharged”.¹⁶ In oral testimony, Catherine Braddick-Hughes, a recently retired Lieutenant-Colonel, told us:

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 a word with [the psychiatrist], 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.¹⁷

Accessing care overseas

15. A few witnesses told us they had found it difficult to access mental health care because they were overseas or had not been deployed as part of a unit. One witness stated: “There is no MH med [Mental Health medical] plan provision for France to my knowledge”.¹⁸ Lt-Colonel Braddick-Hughes also felt that she was not supported by the UK Armed Forces, when she joined the NATO Headquarters in Afghanistan as an individual augmentee.¹⁹

16. General Nugee told us that all deployed personnel should have access to a medical centre regardless of how they were deployed. Serving personnel also now have the option of going direct to a DCMH, without needing to be referred, as the Armed Forces are piloting self-referrals.²⁰

16 Annex 1: Summary of individual responses received

17 Q214

18 Annex 1: Summary of individual responses received

19 Q213

20 Q357

17. We are deeply concerned that the Ministry of Defence is not consistently providing the quality of mental health care to its Servicemen and women that they deserve. We welcome the Department's invitation to the Care Quality Commission (CQC) to inspect the care provided by Defence Medical Services. However, two of the four Departments of Community Mental Health (DCMHs) inspected failed CQC standards. Service personnel have reported a wide range of experiences of military mental health care provision, including problems with speed of, and access to, treatment. This situation is completely unacceptable.

18. *We recommend that the Ministry of Defence should fully review how it manages military mental health services in order to understand why there are such variations in the care offered to Servicemen and women. The Department should also set out what it is doing to ensure that the other DCMHs are up to the standards necessary to pass future Care Quality Commission inspections and how best practice is being shared across all its mental health centres.*

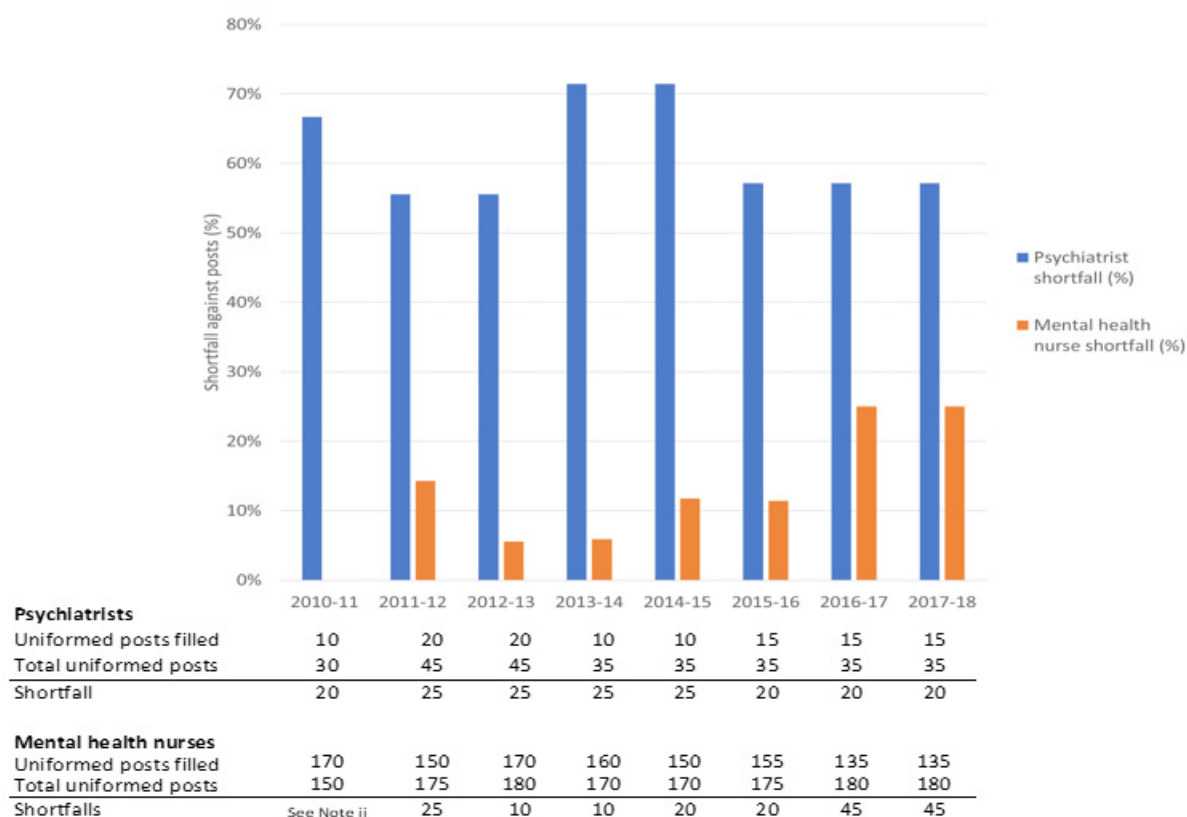
Staffing

19. Our analysis of the Department's data shows that, since the start of the decade, the Armed Forces have had at least a 50% (20 posts) shortfall in filling the number of uniformed psychiatrist posts required, although in recent years the shortfall has been reduced (Chart 1). It has also had an increasing shortfall in mental health nurses. General Nugee pointed out that during the last few years increases in the number of mental health nurses needed by the Armed Forces, particularly in reservist posts, had increased the size of the shortfall.²¹ Matthew Green, a journalist, however, told us that mental health nurses generally stayed for only three years and left once they qualified.²² The Department also reported that the shortfalls in its mental health staff were generally higher at officer ranks.²³

21 Q372

22 Q17

23 Ministry of Defence ([POC0129](#))

Chart 1: Shortfalls in uniformed psychiatrists and mental health nurses against posts since 2010–11**Notes**

- i) Figures show total shortfall across both Regular and Reservist posts.
- ii) In 2010–11 the number of mental health nurses employed exceeded requirements by 13% (20 nurses)
- iii) Actual manning figures for uniformed psychiatrists may be slightly higher as, other than in 2012–13, fewer than five Reservist psychiatrists were in post in each year. As the Department's manning figures were rounded to the nearest five, we have assumed that no Reservist psychiatrists were in post, other than in 2012–13.
- iv) Shortfall figures are measured against the number of staff not in post, as the Department states that all military personnel are full-time.

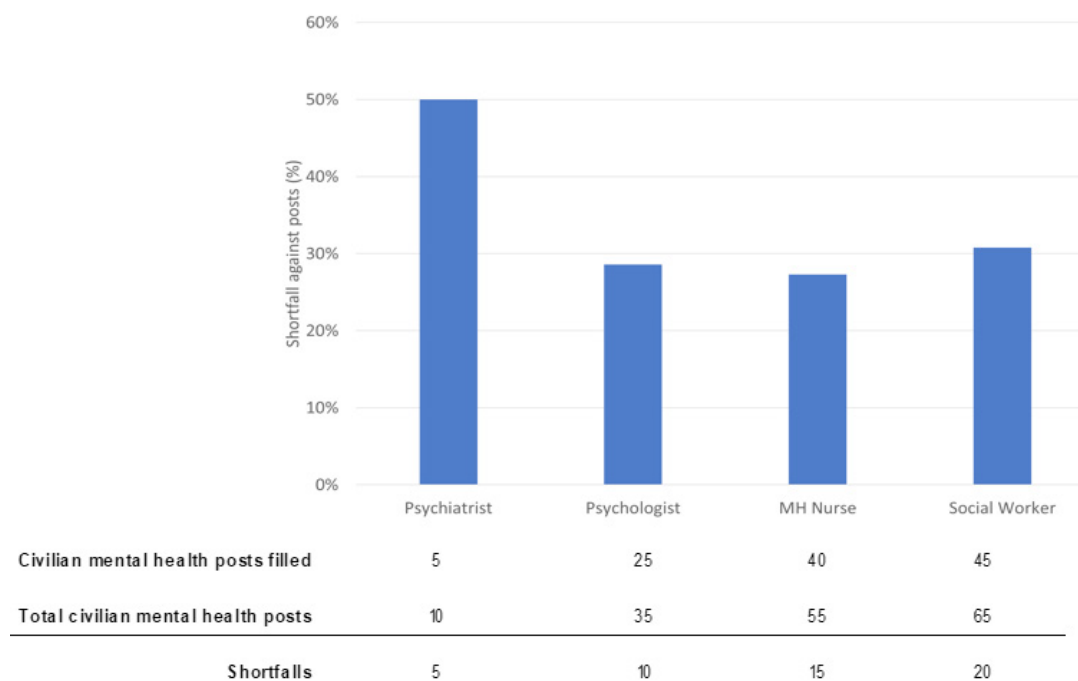
Source: Defence Committee analysis of Ministry of Defence data²⁴

20. To manage these gaps, the Department has sought to employ full-time civilians instead, with more civilian posts created; but it is seeing similar levels of shortfall. The Department did not centrally hold data on civilian manpower requirements for mental health roles until 2015–16. However, our analysis of 2017–18 figures shows that, like their uniformed counterparts, there was a 50% shortfall (5 posts) in the number of filled civilian psychiatry posts and a 27% shortfall (15 posts) in filled civilian mental health nursing posts (Chart 2). Even in military mental health posts that are solely filled by civilians,

24 The Ministry of Defence has previously employed a small number of uniformed psychologists in addition to civilian psychologists, but these have been fewer than five per year. In 2017–18, it employed no uniformed psychologists. PQ [195457](#), 4 December 2018

such as psychology and social work, there were shortfalls of around 30%.²⁵ As a result, the Department has had to employ temporary staff, particularly mental health nurses, to cover these gaps.²⁶

Chart 2: Shortfalls against civilian mental health posts in 2017–18



Notes

i) Shortfall figures are measured against the number of posts not filled.

Source: Defence Committee analysis of Ministry of Defence data²⁷

21. The Department told us that it has taken steps to reduce the shortfalls but stressed that mental health staff recruitment was a national issue. The Department's written evidence stated that the new Delivery Improvement Plan 2018–2020 had been formally launched in March 2018 with £2.3m funding. It is expected that this funding would be used to recruit 18.5 full-time equivalent staff to reduce the reliance on temporary staff and increase capacity.²⁸ The Minister, Tobias Ellwood MP, denied however that the inadequate 'offer' of pay and other rewards for mental health posts was a reason for the shortfall. General Nugee told us that:

We made one change to our recruiting mechanisms in where we recruit. Previously we recruited in competition with the NHS. Now, we are recruiting with the NHS. It is proving to be more beneficial. By working in partnership with them, we have increased the number of people coming through into the military as a direct result of a different approach with the NHS on recruiting.²⁹

25 Ibid

26 Ibid; Ministry of Defence ([POC0129](#))

27 Ibid

28 Ministry of Defence ([POC0111](#)) and Ministry of Defence ([POC0129](#))

29 Qq371–372

The Royal College of Psychiatrists said that it had been working with the Defence Medical Services to launch a campaign to encourage more trainee doctors to choose a career as a psychiatrist in the Armed Forces.³⁰

22. The Department accepted that these shortfalls have affected the speed of care provision.³¹ The Minister, Tobias Ellwood MP, admitted that although the target was for 95% of patients to be seen within 15 working days, figures were now at 91% though they had been as low as 75%.³² Matthew Green told us that long waiting lists over the past few years had resulted in welfare officers suggesting that serving personnel go outside the military for treatment. He knew of at least one case of someone self-funding private care.³³ Other witnesses also reported similar cases.³⁴

23. We are disappointed that the Department continues to struggle to address its longstanding shortages of mental health staff. With continued 50% shortfalls in some mental health posts, it is no surprise that some serving personnel are not being seen sufficiently quickly and a few are having to take the drastic step of funding their own care elsewhere. *If recruitment does not improve, we recommend that the Department should review what it can offer in pay and other benefits to attract people into military mental health roles, either as Regulars or Reservists.*

Seeking care during Service

24. Witnesses were clear that the early diagnosis and treatment of mental health issues is vital for preventing the development of more serious mental health conditions. Andy Price told us that “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”.³⁵ A number of individual submissions reported cases where mental health issues had not been diagnosed for some time, and in some cases the delay led to serious consequences (Case examples 2).

30 Royal College of Psychiatrists ([POC0112](#))

31 Ministry of Defence ([POC0111](#)) and Ministry of Defence ([POC0129](#))

32 Q371

33 Qq3–4

34 Case examples 1 and Paragraph 15

35 Q224

Case examples 2: Mental health issues being missed

“In the seven years since his first deployment and major change in behaviour and increased aggression there was never a suggestion made by anyone that his change in demeanour might be related to mental health.”

“No one picked up that my son was suffering in silence and he was finally diagnosed with severe PTSD in 2018 it had got that bad.”

“Despite showing signs of deteriorating mental health as early as the late 1990s, I was not diagnosed with PTSD until 2018. During the intervening 20 years my condition worsened and became more deeply embedded but was not recognised by myself, military Medical Officers, my GPs, or any other clinician until the day that I was gently talked off Beachy Head.”

Source: Annex 1: Summary of individual responses received

25. We noted in our Part One report the continuing stigma around mental health issues, and why serving personnel may not seek help. High profile campaigns, such as the Royal Foundation’s Heads Together and the Department’s own “Don’t Bottle It Up” and “Time to Change”, are seeking to challenge this.³⁶ However, we heard during this inquiry that stigma remains a barrier for some in coming forward with their mental health issues, fearing the consequences for their careers. One witness told us that:

Serving personnel seeking help with mental health come forward with great courage, in fear of reprisal, repercussion and potential career loss ... This is a fundamental reason that Service personnel hide & suppress their suffering from their chain of command, and an underlying cause of self-medicating through various coping mechanisms, such as becoming a workaholic, substance misuse, alcohol, violence, disciplinary issues and suicide.³⁷

26. The Felix Health Group, an informal group of retired Ammunition Technical Officers and Ammunition Technicians, and Tim Boughton, a veteran, raised the particular difficulties of raising mental health issues in specialist roles. Tim Boughton told us 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.³⁸

27. Servicemen and women also reported that their unit and chain of command did not offer a supportive environment for reporting a mental health issue, because of the culture, their rank or their role. One family member of a Serviceman told us that “There is a culture of ‘man up and get on with it’ ... It was clear that people were afraid to show their weaknesses, especially senior NCOs and officers in positions of command”.³⁹

36 Defence Committee, Eleventh Report of Session 2017–19, [Mental Health and the Armed Forces, Part One: The Scale of mental health issues](#), HC813, para 47 and 48 and Ministry of Defence, [Defence People Mental Health and Wellbeing Strategy 2017–2022](#), p19

37 Annex 1: Summary of individual responses received

38 The Felix Health Group ([POC0102](#)) and Q217

39 Annex 1: Summary of individual responses received

28. Witnesses believed that the role of the commanding officer was vital in tackling this stigma. Matthew Green provided us with an example of a Parachute Regiment battalion commander leading the conversation about mental health by discussing his own in front of his troops.⁴⁰ Johnny Mercer MP told us that:

It comes back to what I was saying before about the personalities of the individuals involved. I was with somebody today who presented with a mental health problem and was immediately cut off by his commanding officer. That was only last year. You can have all the structures around them you like, but while you still have individuals who do that, it comes down to personal command decisions.⁴¹

29. A few witnesses suggested that a career break could help those with mental health issues. Andy Price, a veteran, told us that: “A career break is an absolutely brilliant idea ... 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”.⁴² However, Tim Boughton believed it could be difficult for those in the Special Forces or in other specialist roles to return to those units.⁴³ General Nugee told us that “sending somebody to recover at home is probably one of the worst things you can do, because they need to have a degree of continuity”. He thought, however, that the flexible working option being introduced in the Armed Forces from 1 April 2019 could allow people more time to recover but still keep them in work.⁴⁴

30. General Nugee also accepted that, despite assurances from the Department, Servicemen and women still believed that their careers would be damaged if they reported mental health problems. Nevertheless, he strongly emphasised that Servicemen and women should seek help.⁴⁵ The Minister, Tobias Ellwood MP, confirmed that support would be provided without affecting someone’s career:

We promoted this at every single level in all three Services all the way down, including every ship’s captain and every platoon commander, to say, “Look out for each other. It is okay if you are not okay. You can go and get support for that without any detriment to your potential career, promotion prospects and so on”.⁴⁶

Occupational health

31. Witnesses raised the tension between the need of the Armed Forces to have Servicemen and women returning to duty and what individuals might need to treat their mental health conditions. For example, Matthew Green and Lt-Colonel Braddick-Hughes raised the point that the Armed Forces medical services are there to provide an occupational health service.⁴⁷ As a result, treatment is time-limited, with one witness telling us that “many DCMH units have a 6-week treatment policy and if you require further treatment

40 Q21
 41 Q444
 42 Q219 and Q222
 43 Q219
 44 Q388
 45 Qq389–391
 46 Q392
 47 Q10 and Q218

it has to be approved by the OC [Officer Commanding]”. Conversely, another witness told us that a colleague was not referred to a DCMH as “the doctor stated it was not in the ‘interests of the service’ to medically downgrade him from active duty”.⁴⁸

32. The Department was clear that the occupational need to treat Service personnel is particularly significant for the Armed Forces compared to other employment sectors, as the forces are “diminishing in size and [Service personnel] have access to weapons and equipment that may be used to harm themselves or others. Their fitness for role must be maximised”.⁴⁹ As a result, the Armed Forces may also consider that it would be better for some Service personnel to be medically discharged so they could continue to receive care in the civilian health system instead.⁵⁰

33. Early intervention can be crucial in preventing mental health problems from developing into more severe conditions. However, despite significant improvements in how mental health issues are perceived in the Armed Forces, the fear of damaging their career remains a significant barrier to Servicemen and women coming forward for help, with the level of support often being dependent on individual commanding officers. As we reported in Part One, we support the Department in campaigning against the stigma surrounding mental health issues and promoting help-seeking. Yet it is obvious that more still needs to be done.

34. We also appreciate that the Armed Forces medical services have an occupational health role focused on returning Servicemen and women back to full duties. However, this needs to be balanced against the time and care that an individual might need for recovery, and medical discharge should be only a last resort.

35. We recommend that the Department should clearly demonstrate to Servicemen and women that mental health problems are taken seriously and their reporting does not lead to the end of their careers. This could be done by publicising examples of senior officers or non-commissioned officers (NCOs) across a wide range of Armed Forces specialisms who have sought mental health help previously without adverse effects upon their careers.

36. We also recommend that the Department must provide better mental health awareness training to officers and NCOs so that they can respond effectively and sympathetically to anyone in their unit coming forward to seek help.

48 Annex 1: Summary of individual responses received

49 Ministry of Defence ([POC0111](#))

50 Ministry of Defence Part One inquiry evidence ([VMH0029](#)) and Q10 [Matthew Green]

3 During the transition to civilian life

37. We concluded in our Part One report that a successful transition is an important part of ensuring that veterans manage any mental health issues as they seek to reintegrate back into civilian life. We recognised that support from the Department was available, but were concerned that some veterans fall through the gaps and lack continuity of care when they moved into civilian health care.⁵¹

38. In its response to our report, the Department said that it “provides extensive and comprehensive support to Service personnel as they transition out of the Armed Forces”.⁵² The Minister, Tobias Ellwood MP, also told us in June 2018, that “the vast majority of personnel serve well, transition well and leave well”.⁵³ The Scottish Veterans Commissioner, Charlie Wallace agreed and emphasised that context:

We must also remember that a vast majority of veterans go into the community very successfully, and bring some particular skills that are of a real benefit to the community. We must not forget that, as we deal with the small minority who have particular issues.⁵⁴

39. However, we heard during this inquiry that many veterans did not feel supported when they left the Services, and indeed felt abandoned. The Felix Health Group, representing an informal group of retired Ammunition Technical Officers and Ammunition Technicians, told us that most of them were unaware of the support available to them and that:

In one case, one person suggests that despite their condition being serious enough to discharge [him] from the service he has never received any follow up treatment or contact since leaving. This suggests that the ‘fire and forget’ attitude of the MoD still exists.⁵⁵

We also heard similar cases from individual veterans and their families (Case examples 3).

Case examples 3: Veterans not supported after discharge

“Before leaving the service I was in the care of DCMH, they took over 5 years to diagnose me with PTSD and once I left they just left me to find help by myself. It took a lot to admit I had a problem and then to be left to find help once out of the service was hard. It seemed that once my termination date was reached I wasn’t DCMH’s problem anymore.”

“I spiralled back into my depression and was suicidal again within days. My family tried to contact DCMH for help, but those horrible words, of our Duty of Care has been done, you will have to go through the NHS.”

Source: Annex 1: Summary of individual responses received

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- 51 Defence Committee, Eleventh Report of Session 2017–19, [Mental Health and the Armed Forces, Part One: The Scale of mental health issues](#), HC813, para 27
- 52 Defence Committee, Twelfth Special Report of Session 2017–19, [Mental health and the Armed Forces, Part One: The Scale of mental health issues: Government Response to the Committee’s Eleventh Report](#), HC1635, para 18 and 19
- 53 Defence Committee, Eleventh Report of Session 2017–19, [Mental Health and the Armed Forces, Part One: The Scale of mental health issues](#), HC813
- 54 Q141
- 55 The Felix Health Group ([POC0102](#))

40. Some witnesses also did not believe that the Armed Forces provided adequate care once discharge had been accepted. The Ulster Defence Regiment and Royal Irish Aftercare Service reported that “it was seeing worrying evidence that WIS [Wounded, Injured and Sick] personnel discharged with MH [Mental Health] issues have had only fragmented and relatively superficial treatment before leaving the Armed Forces” and believed that it was due to “a resource and systemic/organisational issue”.⁵⁶ One veteran also told us that “once you no longer meet those [medical fitness] requirements treatment falls off”.⁵⁷

41. Other witnesses were critical of the continuity of care as veterans were transferred from the military to the civilian health care systems, particularly the quality of subsequent care and the transfer of notes (Case examples 4). The Department offers veterans continued access to Departments of Community Mental Health up to six months after discharge, but Combat Stress reported that this is not consistently applied.⁵⁸

Case examples 4: Veterans’ experiences of continuity of care

“When he was discharged into the care of the local NHS Trust, Norfolk and Suffolk NHS Foundation Trust, the care received could not be recognised as good care.”

“The MoD can discharge you if there is suitable treatment available on the NHS. In my own case they didn’t actually hand any notes to my now civilian GP nor did they follow up on how any treatment may or may not have been going.”

“From experience of the NHS and settling into a different medical system. I would suggest that increasing the availability of mental health care for those that leave with mental health issues is increased by six months to a full year. Initially setting up my NHS medical care was difficult, and the paperwork I was given to hand to my NHS medical centre was dated... and looked at with amusement and somewhat scepticism by the staff at the centre.”

Source: Annex 1: Summary of individual responses received

42. The Minister, Tobias Ellwood MP, accepted that the Department had learnt the “hard way” through not providing for those who came back from Afghanistan and Iraq and who then left the Services without the “necessary support they deserved”. He believed, however, that the links between the Department and the NHS had been improved. Lieutenant-General Nugee, Chief of Defence People, told us that they have tried to create “at least a year of seamless transition between us and the NHS for any service person who is leaving as a result of mental illness” as the Transition, Intervention and Liaison Service in England can engage with leavers six months before discharge and link them to their local NHS trust or GP, while veterans can also access DCMHs for up to six months after discharge.⁵⁹

56 UDR & R Irish Aftercare Service ([POC0041](#))

57 Annex 1: Summary of individual responses received

58 Combat Stress ([POC0080](#))

59 Q377 and Q383

Follow-up

43. The Department currently contacts veterans a year after discharge and the Minister told us that it is now doing so more proactively, “to see how they are and whether they have shown any signs whatever”.⁶⁰ General Nugee accepted that not all leavers consent to being contacted. However, following changes to GDPR [General Data Protection Regulations], the Department can now potentially access the details of everyone who has left, for example on HMRC databases.⁶¹

44. David Richmond, a veteran and former Chairman of the Contact Group, pointed out some of the challenges of following up veterans:

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 it for them.⁶²

45. Witnesses generally believed that there should be longer-term follow-up of veterans, particularly as mental health issues may not appear for some years after discharge (Case examples 5). A Help for Heroes survey in December 2018 found that it took veterans four years on average to seek mental health support and some waited far longer.⁶³ Dr Busuttill, Medical Director at Combat Stress, told us for our Part One inquiry that the time between leaving the Services and seeking help was falling for younger veterans, compared to those who served in the Gulf War or Northern Ireland. However, it was still about “two years for Afghanistan after they leave the military and it’s about three or four years for Iraq veterans”.⁶⁴

Case examples 5: Veterans’ views of longer follow-up

“Since I’ve left the military the only contact my former family has had with me is an email from the resettlement team with information on possible jobs/career paths I might like. After 16 years this is just not good enough, I deserve a call, hi how are you, are you well, coping with civilian life and people ok. My answer would have been no. Appreciation, Consideration, Direction... I believe would have been crucial in helping me stabilise my mental health.”

“It is only after veterans have left for several years that I am seeing the real problems. By this stage their former service is all but forgotten and they receive absolutely no prioritisation, despite what they have sacrificed for their country.”

Source: Annex 1: Summary of individual responses received

60 Q397

61 Qq397 and 398

62 Q316. For more details of the Contact Group see paragraph 138

63 Help for Heroes, [Cut the Clock](#), website accessed 14 February 2019

64 Defence Committee, Eleventh Report of Session 2017–19, [Mental Health and the Armed Forces, Part One: The Scale of mental health issues](#), HC813, para 75

46. Ulster University Veterans Research Group had also found that “during transition, support is more practical in nature, and focused on employment and training post-transition... as such, services focused only on this period are not likely to meet the long-term needs of this population”.⁶⁵

47. Both Lt-Colonel Braddick-Hughes and Andy Price believed that some groups of veterans needed follow-up and support at particular times of the year, such as the anniversary of an attack on their unit that led to a number of deaths in a single day. They cited the example of 2 Rifles who lost six soldiers in one day in Afghanistan and the fact that since then a number of veterans from that unit had taken their own lives on or about the anniversary.⁶⁶ (We consider the issue of veterans’ suicides further in paragraphs 109–114.) General Nugee told us that the Department is currently gathering information to identify what units would be most susceptible at certain times of the year for particular operations or particular incidents.⁶⁷ Once it had that information, the Department would determine what could be done, particularly as there are concerns about whether a formal process may also have detrimental impact on some veterans’ mental health.⁶⁸

48. We agree with the many veterans who believe that the Armed Forces are not doing enough to support and follow up with them once they have left the Services, leading them to feel that they had been abandoned. The Department has transition support programmes in place and, at least in England, there is now potentially greater coordination with the NHS for someone who is being discharged. However, there is little follow-up to establish what else might be needed once a veteran has begun to adapt back to civilian life or to identify any development of mental health issues. We recommend that the Department revises its follow-up policy, so that there is regular engagement and offer of further support to veterans for at least five years after discharge, including a formal medical health check for each leaver a year on. This engagement should ideally be supplemented by personal contact, for example a phone call, rather than just a derisory email.

Armed Forces Compensation Scheme

49. One of the challenges faced by veterans with service-related mental health issues is applying for, and receiving, adequate compensation from the Armed Forces Compensation Scheme (AFCS). Combat Stress believed that the scheme “does not reflect the severity of those who are most seriously mentally unwell”.⁶⁹ Some veterans also reported that they found the application process stressful and a barrier to applying or appealing, with one veteran telling us that:

The methods and time line that AFCS use to assess claims is inadequate and adds a great deal of pressure and anxiety to personnel; as compensation or not makes a difference to the employment choices they have to make. I

65 Ulster University Veterans Research Group ([POC0106](#))

66 Qq242–244

67 Q407

68 Ministry of Defence ([POC0129](#))

69 Combat Stress ([POC0127](#))

want to appeal, but producing all the documentation necessary is causing me such anxiety that I feel paralysis each time I attempt to start the appeals process.⁷⁰

50. Some witnesses saw the difficulties with the Compensation Scheme as an illustration of the lack of support available once they had left the Services. During the Committee's visit to Combat Stress, one veteran described it as the 'biggest crime', while Lt-Colonel Braddick-Hughes told us that:

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.⁷¹

51. Following the Department's review of the Compensation Scheme in 2016 and progress update in 2018, the Department reports that it is making improvements to the scheme regarding mental health. For example, it will be increasing the maximum level of award for those with the most severe conditions from April 2019, although it believes that only a few cases would qualify for this. However, it recognises that more still needs to be done to improve the scheme generally, for example on improving understanding. The Independent Medical Expert Group, a body that provides medical and scientific advice to the Department, is also currently following up recommendations from its own 2013 review, including how mental health is diagnosed and assessed.⁷²

52. The significant difficulties that some veterans, especially those with more complex conditions, have faced with the Armed Forces Compensation Scheme is one particularly glaring example of why veterans feel unsupported once they have left the Services. We welcome the Department's work to improve the scheme but clearly more needs to be done and we look forward to receiving the results of its expert group's follow-up review and the Department's subsequent response.

70 Annex 1: Summary of individual responses received

71 Q237

72 Ministry of Defence ([POC0129](#)); Ministry of Defence, [The Quinquennial Review of the Armed Forces Compensation Scheme 'One Year On' Report](#), 9 April 2018

4 Statutory provision for veterans

53. The Government defines a veteran as anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations.⁷³ There are around 2.5 million UK Armed Forces veterans living in the UK and nearly half are aged 75 or more. Both the Royal Hospital Chelsea and Northumbria and Chester Universities emphasised that veterans over retirement age have their own particular mental health challenges, such as dementia and social isolation.⁷⁴

54. The King's Centre for Military Health Research (KCMHR), King's College London, has been conducting the largest study into the effects of operations in Afghanistan and Iraq on UK Armed Forces. Its latest results, published in September 2018, found that on average the rate of Post-Traumatic Stress Disorder (PTSD) was 6% in their sample of veterans and still serving personnel who had deployed on those operations.⁷⁵ A joint Help for Heroes and KCMHR study in 2015 suggested that at least 10% of veterans who served over the last 20 years may present mental health conditions that need treatment.⁷⁶ However, as we concluded in our Part One report, there is no clear and agreed understanding across the sector as to what the full scale of the mental health problem is across serving personnel and veterans.⁷⁷

Current provision

55. Statutory responsibility for mental health care to veterans falls to the four health departments for England and the devolved nations.⁷⁸ Veterans can access the mental healthcare services available to the general population, but some nations also provide veteran-specific specialist services. We estimate that total spending on such services is less than £10 million a year across England, Scotland and Wales, as set out below.

England

56. NHS England reported that it spends £6.4 million a year on veteran-specific specialist services, including:

- Transition, Intervention and Liaison Service (TILS)—launched in April 2017, it provides a regional-based outpatient service for both serving personnel approaching discharge from the Armed Forces and veterans experiencing

73 Ministry of Defence Part One inquiry evidence ([VMH0029](#))

74 Ministry of Defence, Annual Population Survey: UK Armed Forces Veterans residing in Great Britain, 2017, January 2019, p3; Ulster University and Forces in Mind Trust, [Current and Future Needs of Veterans in Northern Ireland](#), November 2017, p12; Royal Hospital Chelsea ([POC0128](#)) and Northumbria and Chester Universities ([POC0096](#))

75 King's Centre for Military Health Research, King's College London, [The Mental Health of the UK Armed Forces \(September 2018 version\)](#)

76 Help for Heroes Part One inquiry evidence ([VMH0021](#)) and King's Centre for Military Health Research, King's College London, [Counting the Costs](#), November 2015, pp iii and iv

77 Defence Committee, Eleventh Report of Session 2017–19, [Mental Health and the Armed Forces, Part One: The Scale of mental health issues](#), HC813, para 82

78 Ministry of Defence, [Defence People Mental Health and Wellbeing Strategy 2017–2022](#), July 2017, pp31–32

mental health issues, including assessment, therapy sessions and referral to more specialist treatments as part of a coordinated package of care. Individuals can be referred to the service by their GP or Armed Forces charity or can self-refer.

- Complex Treatment Service (CTS)—launched in April 2018, it provides more intensive care and treatments for those who have complex mental health issues that earlier interventions have not been able to improve.

In addition, the Veterans Trauma Network was set up in 2012 to support veterans recovering from service-related trauma and is linked to both TILS and CTS services.⁷⁹

Scotland

57. In Scotland, Veterans First Point (VIP) is co-funded by central and local government to provide a veteran-specific outpatient service. First established in 2009, it is a network of six regional teams providing coordinated care for mental health issues, including psychological and pharmacological treatment and supported onward referrals.⁸⁰ The Scottish Government also commissions Combat Stress to provide residential care treatment.⁸¹ Together, the Scottish Government expects to spend £5.8 million in total on these services between 2018–19 and 2020–21.⁸²

Wales

58. Since 2010, the Welsh Government has funded a veteran-specific outpatient service that provides assessment and therapy treatment through Veterans' NHS Wales.⁸³ The Welsh Government considers Wales to be the only nation in the UK with a national service of this kind and increased its funding to the service to nearly £700,000 in 2018–19.⁸⁴

Northern Ireland

59. There is no statutory veteran-specific mental health provision in Northern Ireland, although Northern Ireland's Health and Social Care Board has agreed a care pathway for veterans to access Combat Stress' residential care treatment in Scotland.⁸⁵ The Ulster Defence Regiment and Royal Irish Aftercare Service provides mental health treatment to veterans as part of its welfare support provision, but its remit is limited to those who served in those particular regiments during Operation Banner, the UK military operation in Northern Ireland.⁸⁶

79 Q384; Defence Committee, Ninth Report of Session 2017-19, [Armed Forces Covenant Annual Report 2017](#), HC707, para 120; ITV News, [Oxfordshire woman calls for more mental health support for military veterans suffering from PTSD](#), 13 November 2018; NHS England (POC0113); NHS England, [Veterans: NHS mental health services](#), website accessed 14 February 2019 and NHS England, [Transition, intervention and liaison mental health service for armed forces personnel approaching discharge and veterans](#), April 2017

80 Veterans First Point Part One inquiry evidence ([VMH0024](#))

81 Combat Stress ([POC0080](#))

82 The Scottish Parliament, [Meeting of the Parliament official report - Veterans \(Health and Wellbeing\)](#), 17 May 2018

83 Veterans' NHS Wales ([POC0078](#))

84 Department of Health and Social Services, Welsh Government ([POC0119](#))

85 Ulster University Veterans Research Group ([POC0106](#)) and Ministry of Defence ([POC0111](#))

86 UDR & R Irish Aftercare Service ([POC0041](#))

Key issues with current provision

60. Since the start of UK operations in Iraq in 2003 and in Afghanistan in 2006, witnesses recognised that there had been significant improvements in the provision of mental health care to Service personnel and veterans, including the introduction of veteran-specific services. However there remains much that could still be improved, and we will examine the main issues in the rest of this Chapter. For example, Tim Boughton, a veteran, believed that the difference in support available was a “quantum leap” but that people were still falling through the system.⁸⁷

61. The Royal British Legion told us that veterans were unlikely to seek further treatment if their initial experience had been poor.⁸⁸ Northumbria and Chester Universities went further:

It is imperative that veterans access care from the right person at the right time and in the right place. Otherwise, there is a “revolving door” pattern, where patient’s treatment is compromised.⁸⁹

Understanding of military mental health by civilian health professionals

62. Witnesses across the board, for example Anglia Ruskin University, Icarus Online and veterans (Case examples 6), believed that, for a veteran’s mental health care and treatment to be effective, it is important that the medical practitioner understands military culture and the issues that veterans might be suffering.⁹⁰ NHS England also stated in its written evidence that:

Good therapeutic relationship between the therapist and patient is a core factor to positive outcomes. This means the education of GPs, psychologists, psychiatrists in better understanding of military culture is a key component to helping veterans have confidence that they can engage and will be understood.⁹¹

87 Q224 [Tim Boughton] and Q437 [Johnny Mercer]

88 The Royal British Legion ([POC0104](#))

89 Northumbria and Chester Universities ([POC0096](#))

90 Anglia Ruskin University ([POC0083](#)) and Icarus On-Line ([POC0046](#))

91 NHS England ([POC0113](#))

Case examples 6: Views on need for an understanding of military culture

“Mental health care must be provided by those who understand military service, the psychological impact of training, deployment, and transition, and the effects on family life. In my observations, forces personnel tend to ‘play down’ their symptoms and there is a culture of stoicism, that is at odds with the prevailing healthcare culture of speaking openly about symptoms.”

“Military personnel do not respond well to the ‘professionals’ that are in this field. They do not feel a ‘civvy’ will understand them and will certainly not relate to anyone they feel is patronising and does not understand their mindset. Straight away there is a barrier in place and they are unlikely to engage.”

Source: Annex 1: Summary of individual responses received

63. We heard that civilian health professionals, such as GPs, generally lacked a sufficient understanding of military culture (Case examples 7), which made seeking treatment difficult for veterans. Some witnesses, such as The Thistle Foundation and the Scottish Veterans Commissioner, believed that location, for example if they were near to a military base, was a factor in the level of a GP’s understanding.⁹²

Case examples 7: Cases where health professionals lacked understanding

“When my wife spoke to our son’s local GP in [Norfolk], he had no knowledge of PTSD and she had to refer him to a book and website explaining it! There was some knowledge of veterans having priority to some services but it was a bit patchy. The recently announced introduction of having one GP in every practice trained in this area is very welcome.”

“I was referred to a civilian doctor via Service Veterans, and I viewed that assessment as fairly useless. I found it hard to explain to a civilian how I felt or how things had come to pass, and this attitude was reflected by my civilian GP, who I found obtuse and negative. Hence, although things have remained as bad as they were before, I have sought no further medical help.”

Source: Annex 1: Summary of individual responses received

64. Witnesses also told us about the importance that clinicians who provide treatment have an understanding of what the veteran may have experienced. For example, all three of the veterans who gave oral evidence told us that they had ended up having to switch roles and comfort their civilian psychologist or therapist, because they were affected by the experiences the veterans were telling them.⁹³

65. Matthew Green, a journalist, however, believed that “we should not perpetuate the myth that only veterans can treat veterans, because I think that does a disservice to some really excellent civilian clinicians”.⁹⁴ David Richmond, a veteran and former Chairman of the Contact Group, also raised the point that some veterans “do not want

92 Q74 [Charlie Wallace] and Thistle Foundation ([POC0072](#))

93 Q245 [Catherine Braddick-Hughes]; Q263 [Andy Price]; Q216 [Tim Boughton]

94 Q29

to talk to somebody with a military background, so you need to offer them that choice”.⁹⁵ Government departments and the Royal Colleges of General Practitioners (RCGP) and Psychiatrists (RCPsych) recognise the importance of ensuring that clinicians have a better understanding of military culture, what serving personnel and veterans may have experienced and the mental health services available to a veteran. For example, NHS England has been working with bodies such as the Royal Colleges and Chester University to improve training options on military mental health for GPs, nurses and other health professionals, particularly those at the start of their careers, and it is part of the membership examination for the RCGP.⁹⁶

66. The RCGP is also now rolling out its scheme of veteran-friendly GP practices. Following a pilot in the West Midlands, there are now nearly 150 and it will be extended across England. NHS Digital statistics show that there were just over 7,100 GP practices in England at the start of July 2018.⁹⁷ Dr Jonathan Leach, Honorary Secretary of the RCGP, also told us that there are discussions about how this could be established in other nations.⁹⁸

67. The lack of civilian medical practitioners’ understanding of military culture and military mental health issues remains a significant barrier to veterans accessing and receiving effective treatment for their mental health conditions. We welcome the work being done to improve the understanding of civilian medical practitioners, such as the creation of veteran-friendly GP surgeries. However, this remains small-scale and much more still needs to be done to stop veterans feeling let down by the health care system.

68. We recommend that the Department of Health and Social Care updates us within six months on progress in improving civilian practitioners’ awareness of veterans’ mental health, including how this has been measured and what other actions it has since taken or plans to take for further improvement. The Department should also update us on the work to exchange best practice with the other nations in the UK.

Coverage and consistency of statutory services

69. As we have reported above in paragraphs 55 to 59, the different approaches taken by the four nations to providing veteran-specific care mean that there is variability across the UK in what a veteran could receive in mental health care.

70. Even within nations, the coverage and consistency of the veteran-specific services can vary. For example, the British Psychological Society told us that there were parts of Scotland, such as the Highlands, where due to lack of funds there is no Veterans First Point coverage.⁹⁹ While Andy Price, a veteran, set up his own community centre in Dorset in 2017 due to a lack of veteran mental health support in his area.¹⁰⁰ He added:

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

95 Q292

96 NHS England (POC0113); Royal College of Psychiatrists (POC0112); Q65 [Professor Finnegan], Qq 144–146 and Q168 [Dr Leach] and Q154 [Dr MacManus]

97 GPOne.com, [Number of GP practices in England falls by 263 in 12 months](#), 20 July 2018

98 Qq 144–146 and Q168 [Dr Leach]

99 The British Psychological Society (POC0093)

100 Q216

they did have was coming across from Somerset, and has now left because of the pressure she was under trying to support veterans countywide. Now we have a void.¹⁰¹

Other veterans and their families also told us of similar cases, including the variation in care when accessing mainstream NHS mental health services (Case examples 8).

Case examples 8: Geographical variation in care

“I saw two different people from Veterans First Point. Both were not professional in their approach and did not explain their roles. The second was a therapist who said they could not offer assessment because I was in Fife and a psychiatrist’s time had not been provisioned for in Fife but if I lived in Lothian I would have got this service. I felt poorly supported so chose to speak with my GP to be referred back to the NHS Fife Adult Psychology Service.”

“Now having moved up to live with family who are both ex-military, he has been seen by a NHS Team at Reading, Berkshire. This is far superior service than South Devon Health Care provided... NHS Reading Berkshire told us they are one of the most efficient in the country for military mental health. I do not think this is right. All military personnel should be treated in the same amount as time all over the country.”

Source: Annex 1: Summary of individual responses received

71. We concluded in our Part One report that the Department retains responsibility for ensuring that veterans across the UK are receiving the level of care set out in the Armed Forces Covenant, despite the devolved nature of healthcare. Yet it has an inadequate understanding of the extent of veterans’ mental health issues across the UK to ensure that there is sufficient coverage and adequacy of mental health services for veterans. This is due to differences in how each nation collects data on veterans’ mental health and we recommended that the Ministry of Defence works with the four UK health departments “to develop and publish a single set of statistics on the number of veterans seeking help and being treated across all of the UK”.¹⁰²

72. In its response to our Part One report, the Department told us that, through Defence Statistics, it was already working with NHS England and the devolved administrations to “develop measures on veterans seeking help, and in treatment for mental health conditions, to support the Armed Forces Covenant”. They were also looking at how they can share statistics with Armed Forces charities such as Help for Heroes and the Royal British Legion.¹⁰³

73. In the course of our current inquiry, Armed Forces charities continued to raise the lack of data on the outcomes of the veteran-specific services, and how this makes it harder to understand the effectiveness of the treatments offered, particularly by the two new

101 Q224

102 Defence Committee, Eleventh Report of Session 2017–19, [Mental Health and the Armed Forces, Part One: The Scale of mental health issues](#), HC813, para 92 and 93

103 Defence Committee, Twelfth Special Report of Session 2017–19, [Mental health and the Armed Forces, Part One: The Scale of mental health issues: Government Response to the Committee’s Eleventh Report](#), HC1635, para 18 and 19

NHS England services.¹⁰⁴ Dr MacManus, of the Royal College of Psychiatrists, believed that an official comparison of veteran outcomes across or between the regions would be “a very helpful piece of work on which to base decisions about which areas are doing better and what aspects of the care that is delivered are working best”.¹⁰⁵

74. NHS England also reported that early findings from the ‘Map of Need’ study suggested that there are “significant regional variations in disease presentations, patterns of accessing services and accessing patterns between NHS services and charities”.¹⁰⁶ The ‘Map of Need’ study is being run by the Northern Hub for Military Veterans and Families Research, Northumbria University and had been commissioned by the Armed Forces Covenant. It seeks to map those veterans that receive treatment from statutory or Armed Forces charities to “determine the level of MH [mental health] issues regionally and identify specific concentrations and variances” and is ongoing for the devolved nations.¹⁰⁷

Coordinating with other government services

75. In addition to the Ministry of Defence and health departments, veterans with mental health issues interact with other government bodies. Some witnesses raised the need for these bodies to consider veterans as a group with specific needs. For example:

- A few veterans with mental health issues reported that they found the repeated cycles of Department for Work and Pensions disability assessments exacerbated their mental health conditions and put them off claiming. One veteran told us that when his Employment Support Allowance was suspended following his annual assessment it led to a relapse in his mental illness. Another recommended that:

It should be that a veteran is diagnosed, assessed, then automatically put on all the benefits, and allowances across DWP, Veterans UK, NHS, Local Authorities. Without having to be assessed multiple times. It nearly killed me.¹⁰⁸

- Some witnesses also raised the needs of veterans who are in the criminal justice system. Both Dr Jonathan Bashford, Director at Community Innovations Enterprise, and Dr Deirdre MacManus, Royal College of Psychiatrists, believed that this was a small group, but with significant issues. Dr MacManus told us that there are few veteran-specific services for those in prison outside of London.¹⁰⁹

76. The differences at both local and national level in the availability of statutory veteran-specific services have led to wide variations in the care a veteran might receive. The worst affected are veterans living in Northern Ireland as there is no statutory provision for many of them. The four UK health departments have the responsibility for ensuring consistency within their nation and for meeting increasing demand.

104 The Royal British Legion ([POC0104](#)); Combat Stress ([POC0080](#)) and Help for Heroes ([POC0069](#))

105 Q192

106 Early findings were based on veterans accessing the mainstream NHS Improving Access to Psychological Therapies (IAPT) programme and Combat Stress treatment. NHS England ([POC0113](#))

107 Northumbria and Chester Universities ([POC0096](#)) and Northumbria University, [Mapping the needs of veterans across the UK](#), website accessed 14 February 2019

108 Annex 1: Summary of individual responses received

109 Q65 and Q211

However, as we concluded in Part One, even though health care is devolved, the Department cannot abdicate its responsibility for ensuring that all veterans receive comparable care regardless of where they live.

77. *We recommend that the Ministry of Defence works with the health departments of England, Scotland and Wales, to address urgently the gaps in veteran-specific provision across the UK. We also repeat our recommendation from Part One on the development of a shared set of methodologies for collecting and analysing veteran mental health data across the UK. This should include outcomes so that best practice can be identified and shared across the four nations.*

78. *We also recommend that the Department sets out how it will help veterans living in Northern Ireland to access veteran-specific mental health treatment available to those living in the rest of the UK.*

Speed of access

79. We heard that a number of veterans have struggled to be seen quickly enough by mental health professionals (Case examples 9). A number of Armed Forces charities also believed that veterans are not receiving treatment quickly enough, with for example, the RAF Association reporting that veterans “often present to mental health services at crisis and a delay in providing treatment can be detrimental to a population who require prompt attention”.¹¹⁰

Case examples 9: Waiting times experienced by veterans for treatment

“For my issues, seeing the GP was very quick (same day as crisis). However, appointments with appropriately trained mental health professionals was very slow (many months). I believe far more resources are required for mental health provision, particularly for veterans.”

“In our case, once my husband ‘broke down’ and was made to go to the GP, he had to wait 2 months for an initial consultation and then subsequently told he would have to wait 6 months for a first consultant appointment. He was covering up that he was suicidal and what were we to do in the meantime?”

“I had to wait 6 months after discharge before NHS sent me to a sub-contractor civilian psychologist, for a set number of sessions (which ended up doubling) but had no useful effect on my condition.”

Source: Annex 1: Summary of individual responses received

80. Current statistics on veteran-specific services in England and Wales show that, although the majority of veterans are seen within the target waiting times, they could still be waiting months for treatment. Data on waiting times for Scottish veterans attending Veteran First Point assessments and treatment was not available.

- In England, the average waiting time for an assessment through the Transition, Liaison and Intervention Service (TILS) was 18 days in June 2018, 4 days over the

110 For example, Forward Assist ([POC0057](#)); Icarus On-Line ([POC0046](#)); The RAF Association ([POC0089](#)); The Felix Health Group ([POC0102](#)) and Thistle Foundation ([POC0072](#))

target, while 86% of veterans accessing TILS treatment are seen within 4 weeks after assessment against a target of 95%.¹¹¹ The average waiting time between referral and attending an appointment for its Complex Treatment Service was 13.5 working days between April 2018 and November 2018.¹¹²

- In Wales, all veterans should be seen within 6 months (26 weeks), but Veterans' NHS Wales have managed this for less than 80%. Mark Birkill, therapist at Veterans' NHS Wales, told us that most regions saw veterans within 18 weeks, but in North-East Wales some were waiting for 49 weeks.¹¹³

81. In comparison to the general population, where the waiting time target to access psychological treatments is 18 weeks, for veterans the target to access treatment through veteran-specific services in England is shorter at 4 weeks. This means that despite veteran-specific services not meeting waiting list targets, many veterans should be able to access mental health care through these services quicker on average than the general population through mainstream NHS mental health care.¹¹⁴

82. If care was needed urgently, a veteran might seek help from mainstream NHS crisis teams. Dr Oscar Daly, a psychiatrist at Combat Stress Northern Ireland, reported that this support could be received within hours in Northern Ireland.¹¹⁵ However, some veterans reported that such crisis care was not necessarily immediate. Andy Price told us that when he sought help, "the crisis line was so overwhelmed that it was going to take a week before they could do a phone assessment with us".¹¹⁶ Another veteran reported that:

That night I took an overdose, as I waited to die I happened to notice a picture of my youngest girl, at 2am I woke my wife and told her what had happened and she took me to be committed in Hospital. Unfortunately due to the number of inmates I was put under the Crisis Team and told to see my GP yet again. They then referred me to the local mental welfare team, but with a waiting period of 12 to 18 months.¹¹⁷

83. Health officials and clinicians reported that insufficient capacity was a key reason why some veterans were having to wait longer than they should for assessment and treatment.

- Jackie Doyle-Price MP, Parliamentary Under-Secretary of State for Mental Health and Inequalities, and Kate Davies, Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning at NHS England, accepted that demand was higher than expected for the new NHS England Services which was why further funding had since been allocated.¹¹⁸
- Veterans' NHS Wales reported that the demand for its services has been outstripping its psychological therapist capacity, despite two previous increases in Welsh Government funding for more staff. In 2017 Help for Heroes provided

111 NHS England ([POC0113](#))

112 Department of Health & Social Care ([POC0130](#))

113 Q72 and Q111; Veterans' NHS Wales ([POC0078](#)) and Veterans' NHS Wales, [Annual Report April 2016 March 2017](#)

114 NHS Digital, [Psychological Therapies Report on the use of IAPT services, March 2018 Final Summary Report](#), June 2018;

115 Q82

116 Q267

117 Annex 1: Summary of individual responses received

118 Q335 and Q385

£500,000 to Veterans' NHS Wales to employ the equivalent of three additional full-time therapists until 2020.¹¹⁹ Mark Birkill, therapist at Veterans' NHS Wales, also told us the fact that a few Welsh veterans had had to wait for a year was because they were not able to travel to other clinics in Wales for treatment.¹²⁰

- Ulster University's Veterans Research Group reported that funding for mental health care in Northern Ireland is significantly lower than in the rest of the UK and Dr Oscar Daly, Psychiatrist at Combat Stress Northern Ireland, believed that lack of resources was the reason for waiting times of up to a year in Northern Irish civilian mental health services.¹²¹

84. However, as we concluded in Part One, there is no clear and agreed understanding across the sector of what the full scale of the mental health problem is across serving personnel and veterans. Without this data, the Government is unable to determine the resources required to care for those who need it. We recommended that the sector develop a common understanding of what the demand for care services might be from serving personnel and veterans and for both Government and the Armed Forces charity sector to provision care accordingly.¹²²

85. **The creation of veteran-specific services has meant that veterans should generally be able to access mental health care more quickly than the general population. However, it can still take far too long for veterans to be able to access care when they need it, with missed waiting list targets meaning veterans could be waiting up to a year. In many cases, this is because capacity cannot keep up with demand. When veterans seek help for their mental health issues, some may need immediate treatment to prevent the problem from quickly worsening. Failure to do so can lead to serious, and even fatal, consequences.**

86. *We repeat our Part One recommendation that the Ministry of Defence and the four UK health departments, alongside charities, must develop a common understanding of demand for veteran mental health care and ensure that enough resources are allocated to meet demand so that waiting time targets are fully met.*

Priority treatment

87. In our Part One report, we raised particular concerns that the Armed Forces Covenant principle of priority treatment, when a condition is service-related, is not being consistently applied across the UK. The Department of Health and Social Care considers that the NHS founding principles of equality and clinical need constrain how it can provide priority treatment to veterans and believes that the provision of veteran-specific services resolves this tension. We concluded, however, that the confusion over how it was being implemented may be adding to veterans' perceptions that the health service is failing them and recommended that the Government should set out clearly in the forthcoming Veterans Strategy how priority treatment should be implemented in practice.¹²³

119 Veterans' NHS Wales ([POC0078](#))

120 Q79

121 Ulster University Veterans Research Group ([POC0106](#)) and Qq82–83

122 Defence Committee, Eleventh Report of Session 2017–19, [Mental Health and the Armed Forces, Part One: The Scale of mental health issues](#), HC813, para 82 and 83

123 Defence Committee, Eleventh Report of Session 2017–19, [Mental Health and the Armed Forces, Part One: The Scale of mental health issues](#), HC813, paras 51, 58 and 59

88. In its response to our Part One report, the Department agreed in September 2018 that the Veterans Strategy was an opportunity “to ensure that veterans and their families get a better understanding of priority treatment and what it means for individual veterans”.¹²⁴ However, when the Veterans Strategy was published in November 2018, there was no mention of priority treatment and only one reference in the accompanying public consultation paper.¹²⁵ The Department for Health and Social Care told us as part of this inquiry that it recognises that more can be done and the Partnership Board between it and the Ministry of Defence was working towards a clearer definition of priority care for 2019–2020.¹²⁶

89. The importance of clarifying what priority treatment means in practice has been reinforced by the evidence we have received from many witnesses that, for the most part, mainstream NHS health providers have not heard of the priority treatment principle or even the Armed Forces Covenant (Case examples 10). Other witnesses reported similar issues across the country:

- York St John University found that the majority of health and social care staff attending its course on Military Culture and Transition were unaware of the Armed Forces Covenant and its principle of priority care.¹²⁷
- Dr Kitchiner, Director of Veterans’ NHS Wales, told us “that priority Treatment continues to be an issue in Wales... despite continued efforts by Welsh Government and key stakeholders to promote the guidelines ... Veterans report a varied and inconsistent response from NHS Consultants”.¹²⁸

There is no priority treatment in Northern Ireland, as confirmed by the Ministry of Defence in its Government response, “due to Section 75 of the Northern Ireland Act”.¹²⁹ The Health Service in Northern Ireland instead seeks to ensure equity of access for serving personnel, veterans and their families on the same basis as the rest of the population.¹³⁰

124 Defence Committee, Twelfth Special Report of Session 2017–19, [Mental health and the Armed Forces, Part One: The Scale of mental health issues: Government Response to the Committee’s Eleventh Report](#), HC1635, para 12 and 13

125 HM Government, The Strategy for our Veterans, [Cm 9726](#), November 2018 and HM Government, The Strategy for Our Veterans: UK Government Consultation Paper, [Cm 9727](#), November 2018

126 Department of Health & Social Care ([POC0130](#))

127 York St John University ([POC0091](#))

128 Veterans’ NHS Wales ([POC0078](#))

129 Defence Committee, Twelfth Special Report of Session 2017–19, [Mental health and the Armed Forces, Part One: The Scale of mental health issues: Government Response to the Committee’s Eleventh Report](#), HC1635, para 18 and 19

130 Department of Health & Social Care ([POC0130](#))

Case examples 10: Veterans' experience of receiving priority treatment

“In my experience of supporting both my husband, his former colleagues and members of his regiment ... many NHS providers have not heard of the armed forces covenant. When GPs are aware of it, they are unable to prioritise referrals, because they are not accepted as priority by mental health services.”

“I have seen no evidence of the Armed Forces Covenant's principle of priority care. The suicidal soldier I met yesterday was not offered a bed as he was not viewed as a risk, even though he had just tried to take his own life a few hours before. He was sent home... this one specific case and many anecdotal cases show there is zero priority given to veterans”.

“I can personally testify (as can many others), that quoting the requirements of priority treatment in accordance with the Armed Forces Covenant, and even with an endorsement by local NHS management, access to treatment was not reduced and actually exceeded the 6 months maximum. This is another example of veteran's expectations being crushed by the MoD and the supporting NHS system”.

Source: Annex 1: Summary of individual responses received

90. Witnesses also raised the lack of clarity within the veteran community about priority treatment. For example, Dr Deirdre MacManus, of the Royal College of Psychiatrists, told us that “some [veterans] do not know about priority care at all, and some expect to have priority care for every health need they have”. She believed, however, that there needed to be clarity on the clinical side first before raising awareness of what priority treatment a veteran was entitled to.¹³¹

91. We expressed significant concerns about the confusion surrounding priority treatment in our Part One inquiry, and it is clear that many veterans are not receiving priority treatment for their service-related injuries, with civilian medical practitioners' lack of knowledge of this principle of the Armed Forces Covenant—and indeed of the Covenant itself—being a key factor. We welcome the work by the Ministry of Defence and Department of Health and Social Care to establish a clearer definition of priority treatment by 2019–20. However, this must be accompanied by a clear strategy to ensure that the definition and its consequences are understood and implemented across the NHS and that best practice is shared with the devolved administrations.

92. We repeat our recommendation from Part One that the Government should ensure that once it has set out how priority treatment should be implemented in practice, this clarification is cascaded down to both NHS staff and veterans and their families across the whole of the UK. For example, it may be that the only way to prioritise service-related mental health conditions is to have separate specialist facilities at which to treat them, but this approach needs to be made clear to all.

Complex and long-term care

93. Care for veterans who have complex mental health conditions and require long-term mental health care is a significant gap in the statutory provision. Help for Heroes reported that this area is “severely under resourced” while Sue Freeth, Chief Executive of Combat Stress, was concerned by the lack of respite care now available, “because for some veterans, that was the top-up they needed to keep going”.¹³² Matthew Green emphasised that veterans with complex needs were falling through the gaps in care.

The reality is that there are ex-forces—we do not know exactly how many, but significant numbers—who have really severe, complex presentations of post-traumatic stress disorder, often combined with alcohol misuse, which is an extremely toxic and dangerous combination. That is the gap in services. That is where there is literally nowhere for them to go. They cannot go to Combat Stress if they are not stabilised sufficiently. They will end up bouncing into an NHS secure or emergency psychiatric ward and then bouncing back to their family again.¹³³

94. Complex treatment provision may be time limited or not suitable for the most complex cases (Case examples 11). The Department for Health and Social Care reported that the 32 weeks of support offered by the Complex Treatment Service in England was already longer than that recommended by the National Institute for Health and Care Excellence (NICE) for less complex PTSD.¹³⁴ However, Help for Heroes did not believe that this was sufficient for those with complex needs given that the International Society for Traumatic Stress Studies recommended that a sufficient duration would be closer to 18–24 months.¹³⁵ Other witnesses also criticised the limited number of sessions available for other treatments. Councillor Dryburgh told us that although veterans can access support quickly in Dumfries and Galloway, such support was short term and:

We are constantly fighting for further support packages for the person or in many cases the family members, as they are not cheap and sometimes are multi-agency support packages.¹³⁶

Case examples 11: Veterans with complex mental health issues seeking care

“[His GP] referred him and he was offered another course of CBT [Cognitive behavioural therapy]. On the initial assessment appointment he was told that he had too many issues and was too complex a case and was sent away feeling very let down and on his own.”

“I had no effective treatment for nearly 28 months before placement on their [Combat Stress] ITP [Intensive Treatment Programme]—however, because NHS Scotland and the Scottish Government are involved with funding, there is a caveat that individuals attending the ITP do it once, anything after is community outreach, if available”.

Source: Annex 1: Summary of individual responses received

132 Help for Heroes ([POC0069](#)) and Q315

133 Q29

134 Department of Health & Social Care ([POC0130](#))

135 Help for Heroes Part One inquiry evidence ([VMH0049](#))

136 Councillor Archie Dryburgh ([POC0010](#))

95. Some witnesses believed that a national centre would be the solution. Help for Heroes noted that many other countries offered specialist military treatment clinics and argued that the Defence and National Recovery Centre (DNRC) could fulfil this role for veterans in the UK or that there could be a centre in each of the four nations.¹³⁷ Matthew Green believed that a national centre was the ‘missing piece of the puzzle’, to ensure that there was provision of care even for very complex cases.¹³⁸

96. Others were more cautious, believing that a national centre might help some but not all patients, and that there would still be a need for more local, community support. For example, Dr Oscar Daly told us that a residential course, including Combat Stress’ own six weeks’ course, helped but would not cure a patient, who would still need “significant community services as well”. Professor Alan Finnegan, Professor of Nursing and Military Mental Health at Chester University, also raised concerns that it might “isolate the veteran away from family and friends”.¹³⁹ Mark Birkill believed that residential treatment

comes into its own for those veterans who do not get better in a community service, or maybe have an attitude to NHS or civilian services that perhaps would not allow them to make best use of those services.¹⁴⁰

97. Kate Davies, emphasised to us that the existing Defence and National Rehabilitation Centre, not only treats the physical trauma injuries that Servicemen and women are admitted for at the centre, but also their mental health injuries.¹⁴¹ However, she acknowledged there is no national mental health residential rehabilitation centre that is exclusively for either serving or ex-serving personnel.¹⁴² As part of a detailed review of mental health services in 2016 to veterans and other source of evidence, NHS England believed that a community-based service would be more effective to veterans overall than residential care in a limited number of locations, thus the new Transition, Intervention and Liaison and Complex Treatment Services.¹⁴³

98. The new Transition, Intervention and Liaison and Complex Treatment Services were created, not just to help veterans but also to try and get around the dichotomy whereby the Ministry of Defence and the Armed Forces Covenant argue that veterans should receive priority treatment in the NHS, whereas the Department of Health and Social Care traditionally prioritises strictly according to clinical need. The creation of a bespoke service for Armed Forces veterans is very much to be welcomed. Nevertheless, it is scandalous that in an NHS budget of over £150 billion UK wide, less than £10 million per annum (0.007%) has been allocated to this service, which is swamped by the scale of demand. *Health Ministers need urgently to recognise this deficiency and use part of the very significant increase in NHS funding envisaged under the new NHS Ten-Year Long-Term Plan to increase substantially the resources provided to the TIL and CT services, in order to make them truly fit for purpose. Those who have worn the uniform of their country deserve no less and NHS Ministers must be prepared to be held firmly to account on this matter.*

137 Help for Heroes ([POC0069](#))

138 Q34 [Matthew Green]

139 Q34 and Q117

140 Q115

141 Q364

142 Q367

143 Department of Health & Social Care ([POC0130](#))

99. We are very concerned by the insufficient provision of long-term statutory care of veterans with complex mental health conditions. Time limits on treatment—which anyway may not be effective for the most complex cases—mean that those with the greatest need have nowhere to go. *We recommend that the Ministry of Defence, in conjunction with the four UK health departments, set out how it will develop long-term care provision for veterans with complex mental health conditions.*

100. Far too many veterans, whose relationships have broken down and who are in crisis, having already been diagnosed as suffering from severe conditions, such as PTSD, are having to wait up to a year to enter into a suitable treatment programme. This is utterly unacceptable. Many of these veterans only see their condition deteriorate further whilst waiting for access to treatment and, in the most extreme cases, they take their own lives whilst awaiting help. *To prevent this, patients must be continually monitored and reassessed during the gap between initial diagnosis and the commencement of treatment.*

101. There needs to be a highly professional place of safety to which these veterans can be sent as soon as they are diagnosed, in order to be stabilised and to begin to receive assistance for their recovery. Following residential treatment, they should then be discharged directly into a TILS/CT programme back in their own locality but without any discontinuity of treatment or gap in their care pathway.

102. *The Committee strongly believes that it makes sense for such a centre to be co-located with the new state-run Defence and National Rehabilitation Centre (DNRC) for physically injured serving personnel at Stanford Hall. The DNRC evolved from Headley Court, which rightly established a world-class reputation for the treatment of the physically wounded from conflicts such as Iraq and Afghanistan and it should be a national aspiration to establish a similar world-class centre for the treatment of mental injuries relating to service as well. The NHS should urgently consult with the Ministry of Defence and the DNRC in order to establish this facility with an initial operating capability within the next 12–18 months.*

Mild Traumatic Brain Injury

103. One potentially complex or long-lasting condition that current and former Servicemen and women may have developed as a result of service is mild traumatic brain injury (mTBI). It is often acknowledged in academia as the ‘signature injury’ of the conflicts in Iraq and Afghanistan, although there are currently differing views about the extent and long-term effects of mTBI on mental health.

104. As we reported in our Part One inquiry, research by King’s College London found only small rates of mTBI cases (3.2%) in UK forces deployed in Afghanistan during 2011 with little evidence to show that mTBI had anything but limited lasting mental health effects. In comparison, the rate in US forces has been found to be around 23% and, for this inquiry, Blind Veterans UK and the UK Acquired Brain Injury Forum referred to US research that suggests that repetitive exposure to mTBI can result in “long-term

degradation of brain nerve cells” and conditions such as dementia.¹⁴⁴ Dr Michael Grey, Reader in Rehabilitation Neuroscience at the University of East Anglia, also told us that it could lead to progressive sight loss or worse.¹⁴⁵

105. We concluded in our Part One report that the current lack of understanding in areas such as mTBI and neurotoxicity from sources including the anti-malarial drug, Lariam, means that there is uncertainty over whether the Department is capturing the full extent of mental health issues amongst its personnel and is providing appropriate care.¹⁴⁶ We recommended that the Department conducted further research and set out mitigating actions to reduce the risk from these conditions.¹⁴⁷ In its response, the Department set out its reliance on external experts to understand conditions such as mTBI and neurotoxicity.¹⁴⁸ Furthermore, General Nugee, the Chief of Defence People, told us as part of this inquiry that its Independent Medical Expert Group have been trying to fully understand mTBI but that it is very difficult to diagnose in order to know what action might be taken.¹⁴⁹

106. Mrs Mandy Bostwick, a specialist trauma psychotherapist, told us in her Part One evidence that “services to detect mTBI in the UK have not been developed to any standard” and that “it is widely researched that MRI will not detect a mTBI”.¹⁵⁰ The National Centre for Trauma reported that there were two specialist scanners in the UK, at Aston and Nottingham Universities, which may be able to identify cases of mTBI.¹⁵¹

107. The need to identify mTBI in both current and former Servicemen and women was raised by Blind Veterans UK and the UK Acquired Brain Injury Forum, who told us that mTBI and Post Traumatic Stress Disorder (PTSD) share many symptoms and there is a risk that brain injuries in serving personnel may be misdiagnosed as PTSD. For example, the most common mTBI symptoms includes headache, confusion, dizziness and difficulties with concentration and attention. As a result, this could be “making treatment and recovery more difficult”.¹⁵² Dr Michael Grey told us that “the primary treatment with PTSD, as you are all aware, is cognitive behaviour therapy, and that does not necessarily work with people who have sustained mild traumatic brain injuries”.¹⁵³

108. The Government has a duty to not treat patients incorrectly as a result of misdiagnosis. In particular, Post-Traumatic Stress Disorder (PTSD) and mild Traumatic Brain Injury (mTBI) share some similar symptoms, which increases the risk of misdiagnosis of these conditions in serving personnel and veterans. We

144 Defence Committee, Eleventh Report of Session 2017–19, [Mental Health and the Armed Forces, Part One: The Scale of mental health issues](#), HC813, para 13 and Blind Veterans UK and UK Acquired Brain Injury Forum ([POC0126](#))

145 Q178

146 In response to this inquiry, Dr Ashley Croft ([POC0081](#)), a consultant public health physician, also raised the mental health effects of Q fever. The Ministry of Defence is currently being sued by a veteran for not protecting him from the disease, which may be a test case for other veterans who have contracted Q fever. BBC News, [‘Dozens’ of British troops diagnosed with Q fever](#), 22 January 2019

147 Defence Committee, Eleventh Report of Session 2017–19, [Mental Health and the Armed Forces, Part One: The Scale of mental health issues](#), HC813, para 19 and 20

148 Defence Committee, Twelfth Special Report of Session 2017–19, [Mental health and the Armed Forces, Part One: The Scale of mental health issues: Government Response to the Committee’s Eleventh Report](#), HC1635, para 4

149 Qq428–430

150 Mrs Mandy Bostwick Part One inquiry evidence ([VMH0047](#))

151 Q428

152 Blind Veterans UK and UK Acquired Brain Injury Forum ([POC0126](#))

153 Q177

recommend that the Ministry of Defence and the four UK health departments support further research work into mTBI, including the testing of methods for clearly identifying this condition.

Suicides

109. Witnesses raised the number of tragic cases of serving personnel and veterans taking their own lives as a result of not being able to cope with their mental health issues, particularly during 2018.¹⁵⁴ For example, Andy Price, a veteran, told us what he saw in his area in Dorset, where:

four men have taken their own lives, and they all knew each other as well ... 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.¹⁵⁵

110. ITV news also reported in December 2018 that, with the help of veterans' organisations, it found that at least 71 currently serving personnel and veterans had taken their own lives during 2018, with at least a third having suffered from post-traumatic stress disorder.¹⁵⁶

111. However, there are no comprehensive figures for veteran suicides in the UK as coroners are not required to record whether the deceased had been a veteran.¹⁵⁷ Matthew Green told us in September 2018 that “various veterans groups online come up with different figures from the data they have gathered, but the fact is that nobody actually knows for certain how many veteran suicides happen”.¹⁵⁸ This was a data gap that we raised particular concerns about in our Part One report, as it means that Government health bodies and Armed Forces charities may be missing opportunities to help those most in need and we recommended that:

the Ministry of Defence works with the justice departments across the four nations to record and collate, as part of existing suicide records, whether someone had been a veteran to monitor the level and locations of veteran suicides. This will enable it to identify whether there are particular groups of veterans or particular locations where more effort is required to prevent such tragic events from occurring.¹⁵⁹

112. The Minister, Tobias Ellwood MP, subsequently told us in December 2018 that the Department is “absolutely engaged” with developing a better understanding of veteran suicides and he is working with the Ministry of Justice on datasets.¹⁶⁰ However, the

154 Annex 1: Summary of individual responses received and also Jimmy Johnson who wrote to the Committee as co-founder of the charity, Veterans in Prison.

155 Q272

156 ITV News, [71 military personnel and veterans have taken their lives in 2018, ITV News understands](#), 21 December 2018

157 UK Government and Parliament e-Petition [225899](#), Ministry of Justice response

158 Q38

159 Defence Committee, Eleventh Report of Session 2017–19, [Mental Health and the Armed Forces, Part One: The Scale of mental health issues](#), HC813, para 45

160 Q413

Ministry of Justice has no plans to require coroners to record the deceased's occupational history given the potential difficulties of accurately identifying this information.¹⁶¹ In the same evidence session, General Nugee also told us about other work in this area, including:

- A study by the Department on the number of suicides by those who served in Iraq and Afghanistan from 2001 onwards, by comparing Ministry of Defence records to NHS suicide records. This began in July 2018 and he hoped it would be completed by Spring 2019.
- The University of Manchester is conducting work into veterans' suicide.¹⁶² Dr Leach had told us in an earlier evidence session that NHS England was commissioning a follow-up of the university's 2009 study on veterans' suicide rates and risk factors.¹⁶³

113. The Health Minister, Jackie Doyle-Price MP, also emphasised the importance of veterans seeking help early for their mental health issues, telling us that “the biggest vulnerability that we have with all suicides is that two thirds of people who take their own life are not in contact with any kind of mental health service”.¹⁶⁴

114. We welcome the Department's work on improving its identification of veteran suicides following our recommendation in Part One, including working with the Ministry of Justice and Department for Health and Social Care. We look forward to receiving an update on progress as part of the Government's response to this report, including the results of the study into suicides by Iraq and Afghanistan veterans. We recommend that the Department considers options for regular statistical releases on veteran suicides once sufficient data is available and includes these options as part of its response to this report.

161 Ministry of Defence ([POC0129](#))

162 Q412

163 Q210

164 Q413

5 Armed Forces charities

115. In addition to the civilian health care services, veterans can also turn to Armed Forces charities for mental health care and support. A 2017 report by the Directory of Social Change and the Forces in Mind Trust identified 76 charities working in this field, about 7% of the total number of UK Armed Forces charities. About a third of the 76 exclusively focused on mental health.¹⁶⁵ Some charities are also commissioned by national and local governments to provide care services.¹⁶⁶

116. Many witnesses argued that veterans should not have to rely on charities to get help, particularly for complex needs. Both Dr Deirdre MacManus, Royal College of Psychiatrists, and Dr Jonathan Leach, Honorary Secretary of the Royal College of General Practitioners, believed that some gaps in provision, such as inpatient treatment of complex PTSD, should not be quickly filled by charities since those were areas for which the Government should be providing resources.¹⁶⁷ Veterans and their families also felt that having to go to charities for help was an indication of the poor statutory provision available (Case examples 12).

Case examples 12: Veterans' views on accessing charity care

“Now before I had seen anyone face-to-face, I was well advised to self-refer myself to Combat Stress—As great a name that they are, They are a CHARITY, not an NHS service... No member of our serving and ex-serving community should be referred to a charity by our own care system.”

“Again I must emphasise that funding for the agencies involved must come from government and not rely on the charity of the population at large; most of whom are disgusted by the way Veterans are treated once the services cease to have responsibility for their welfare.”

Source: Annex 1: Summary of individual responses received

117. The Department believes that there is “no clear line of demarcation between what is appropriate for state funding and what might fall to the voluntary and community sector”.¹⁶⁸ The Department stressed the historic importance of Armed Forces charities providing support to veterans alongside publicly funded services. As the Minister, Tobias Ellwood MP, put it during our Part One inquiry, the Department is “reliant on the expertise and the knowledge and depth of experience that these charities provide ... Some charities have existed for more than 100 years, doing an absolutely incredible job, which we rely on”.¹⁶⁹

Effectiveness of services

118. Many witnesses praised the mental health care provided by Armed Forces charities (Case examples 13). We also heard similar praise from veterans we met during our visit to Combat Stress. As David Richmond, a veteran and former chairman of the Contact Group, told us:

165 Directory of Social Change and Forces in Mind Trust, [Focus on: Armed Forces Charities' Mental Health Provision](#), June 2017, p4

166 NHS England ([POC0113](#))

167 Q212 and Royal College of Psychiatrists ([POC0112](#))

168 Ministry of Defence ([POC0111](#))

169 Defence Committee, Eleventh Report of Session 2017–19, [Mental Health and the Armed Forces, Part One: The Scale of mental health issues](#), HC813, para 35

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.¹⁷⁰

Case examples 13: Veterans’ views on the quality of care received from charities

“I found Combat Stress extremely helpful, being amongst similarly affected Veterans removed some of the stigma I felt. Alongside other agencies; RBL [Royal British Legion], H4H [Help for Heroes] and HighGround as well as various forms of medication I have learnt many coping mechanisms and have been able to begin to realise a more fulfilling life.”

“My wife did a search online and found a small advert for Combat Stress and as a final attempt phoned and asked for help. Within 2 weeks we were visited by a welfare officer who did a quick assessment, before leaving I was in tears as for once someone listened to what I was saying, not what they thought I should be saying. Within another month I was invited for a 1 week assessment where I was given a written diagnosis of severe PTSD. My life was about to change.”

Source: Annex 1: Summary of individual responses received

119. However, some veterans also reported poor experiences, particularly difficulties in accessing care, because of a charity’s limited capacity and limits on the treatment they could provide (Case examples 14). Matthew Green, a journalist, reported that he knew many veterans “who have knocked on the doors of those bigger organisations and have not received the support that they need”.¹⁷¹ Dr Jonathan Bashford, Director at Community Innovations Enterprise, also told us that:

To some degree, yes, they [Armed Forces charities] are plugging gaps. Some of that might be appropriate; some of it might be due to the systems not being adequate enough, and we don’t give enough support to those charities to enable them to deal with that level of demand. I know from cuts in local authority services that, across the board, charities have absorbed additional referrals—cases—sometimes with more complexity than they were designed to deal with, as a result of other system problems. That is equally true of the military charities.¹⁷²

170 Q312

171 Q58

172 Q57

Case examples 14: Veterans with negative experiences of charity care

“I did get him down to [a charity] and saw a gentleman doctor there that was ex services and so he went for a two-week inpatient course which was totally the wrong thing to do for him... (think they opened up the wound even more and then said good bye).”

“I forced him to contact [this charity] and they arranged to have someone come to see him, but it was a long wait at the time. So, before that happened, he then took a huge overdose of his medication. It was enough to be fatal, but I found him in time.”

“[This charity] was contacted but we had a nightmare with them. To the point where we were told that my son didn’t qualify to be treated by them.”

Source: Annex 1: Summary of individual responses received

120. Sue Freeth, Chief Executive of Combat Stress, told us that the charity will struggle to meet the increasing demand for complex treatment over the next ten years:

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... 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.¹⁷³

121. Witnesses also raised concerns that some charities offer mental health care services that are not evidence-based and which could potentially be harmful to the veteran. For example, Anglia Ruskin University reported that there are organisations “offering spurious interventions based on flawed or pseudo-scientific understandings of psychology ... , with the effects upon veterans receiving such care largely unknown”.¹⁷⁴ Northumbria and Chester Universities, however, noted that it was not well understood as to why veterans choose to go to these charities for help.¹⁷⁵

122. We heard a range of views on whether charities providing mental health treatment should be regulated to ensure veterans received evidence-based treatment. Dr Jonathan Leach believed that it should fall under the Care Quality Commission, although legislation would need to be changed to do so.¹⁷⁶ Tony Wright, Chief Executive of Forward Assist, agreed with the principle of regulation and believed that the necessary structures already existed, but would have to be adapted to be “veteran-centric”. David Richmond and Sue Freeth told us that regulations already existed for any organisation offering therapies and the need was to educate veterans and their families:

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.¹⁷⁷

173 Q287

174 Anglia Ruskin University ([POC0083](#))

175 Northumbria and Chester Universities ([POC0096](#))

176 Qq199–205

177 Qq319–320

123. David Richmond also told us that the Contact Group, as the umbrella organisation for charities involved with mental health, had established a set of practice guidelines for its members. The Group has also produced a layman’s version to help individuals “navigate that patchwork of therapists out in society”.¹⁷⁸ Anglia Ruskin University, however, noted that Cobseo [the Confederation of Service Charities under which the Contact Group sits] does not have the capacity to serve a regulatory function, with no “powers to enforce standards of practice, evidence or evaluation”.¹⁷⁹

124. The Department of Health and Social Care told us that some Armed Forces charities’ mental health services are already within the remit of the Care Quality Commission (CQC) but recognised that this is not comprehensive across all services. Following its Five Year Forward View for Mental Health in February 2016, the Department is considering how to regulate psychological therapy services but confirmed that any change to the CQC’s remit would require legislation.¹⁸⁰

Coverage of services

125. The level of provision that Armed Forces charities offer varies across the UK (Case examples 15). Councillor Dryburgh, Dumfries and Galloway Council, explained that charities understandably tended to be focused on larger towns, where there were more veterans.¹⁸¹

Case examples 15: Veterans’ experience of geographical provision of charity care

“From there I underwent their 6-week Intensive Therapy Program (ITP). But then, apart from a 1 hour, 6-week review over the phone, that is all I can get from [them]—they don’t have a community outreach program further than the Central Belt—fantastic if you live in Glasgow, not great if you live in Aberdeenshire, like myself!”

“Many veterans live in isolated locations away from their former peers and away from where charitable organisations are based. To compound matters, many have lost their driving licences due to alcohol abuse so simply can’t travel to make meetings.”

Source: Annex 1: Summary of individual responses received

126. There are very few Armed Forces charities in Northern Ireland which provide mental health care to veterans. Dr Bethany Waterhouse-Bradley, Lecturer at Ulster University, emphasised that Combat Stress was the only voluntary sector organisation specifically set up to deal with mental health issues, out of about 20 veterans charities set up for Northern Irish veterans.¹⁸²

127. Dr Oscar Daly, Psychiatrist at Combat Stress Northern Ireland, told us that they had only four clinical staff to provide care to veterans.¹⁸³ Sue Freeth, Chief Executive of Combat Stress, told us that they will be reallocating resources to Northern Ireland following a

178 Q319

179 Anglia Ruskin University ([POC0083](#))

180 Department of Health & Social Care ([POC0130](#))

181 Councillor Archie Dryburgh ([POC0010](#))

182 Q73

183 Q98

reorganisation but emphasised that Northern Ireland work was not Government funded.¹⁸⁴ In follow-up evidence, Combat Stress reported that it spent £800,000 in Northern Ireland in 2017–18, of which £150,000 was funded through a grant from the Armed Forces Covenant Fund that ended in January 2019.¹⁸⁵

Navigating the range of services

128. The range of statutory and charity mental health care services available means that it can be difficult for a veteran or their family to know where to go for help, an issue raised by witnesses including Icarus Online. This may be a concern as veterans may not know what is available when they need it.¹⁸⁶ For example, a survey in summer 2018 by Armed Services Advice Project, Lanarkshire Region, found that out of 52 veterans who responded, 24 were not aware or not sure of what mental health support services were available.¹⁸⁷ Some veterans and their families believed that the difficulties of finding the service they need can be discouraging for those who seek help (Case examples 16).

Case examples 16: Veterans' and family members' views on finding the right care

“Why are there so many charities trying to offer similar things? ... I'm confused who does what, but for the service person who likes avoidance and minimisation its likely a factor that may put them off rather than encourage engagement.”

“Whilst there is a vast support network available through charities that information is not readily accessible through a single POC. It requires major investigation which makes it difficult for someone who is struggling with MH issues, adding to stress and anxiety.”

“The environment can be mindboggling to a veteran in need of support and quite simply put them off seeking support. This in turn can lead to those that need it most, not seeking help.”

Source: Annex 1: Summary of individual responses received

Veterans Gateway

129. The Veterans Gateway—an Armed Forces Covenant-funded initiative and run by charities—is intended to provide a focal point and a single point of contact for veterans and their families to access services which meet their needs.¹⁸⁸ The Royal British Legion reported that between its launch in April 2017 and July 2018, the Gateway had received 1,272 support queries in relation to mental wellbeing as well as recording nearly 1,200 self-referrals to Combat Stress.¹⁸⁹ The Gateway also announced in January 2019 that it would now conduct follow-up calls with veterans who have contacted them for support.¹⁹⁰

184 Q294

185 Combat Stress ([POC0127](#))

186 Icarus On-Line ([POC0046](#)) and The Veterans Hub Part One inquiry evidence ([VMH0020](#))

187 Armed Services Advice Project, Lanarkshire Region ([POC0105](#))

188 Defence Committee, Ninth Report of Session 2017–19, [Armed Forces Covenant Annual Report 2017](#), HC707, para 39

189 The Royal British Legion ([POC0104](#))

190 Ministry of Defence news story, [Veterans' Gateway begins new trial proactive call service to support ex-forces community](#), 21 January 2019

Professor Finnegan, Professor of Nursing and Military Mental Health at Chester University, however questioned whether veterans were really aware of the Gateway, a view reflected by some of the veterans who submitted evidence.¹⁹¹

130. Mental health care providers, such as Veterans' NHS Wales and Help for Heroes, also raised the lack of data, such as how many referrals had been made to providers.¹⁹² In our last report on the Armed Forces Covenant annual report, we recommended that the Government devise Key Performance Indicators (KPIs) for the Gateway and commit to publishing performance against them in the Covenant Annual Report and we await an update from the Ministry of Defence on their review of the KPIs.¹⁹³

131. Armed Forces charities play a significant role in the provision of mental health services to veterans and we highly value the work that they do. However, some Armed Forces charities exist only because of a gap in statutory provision and veterans report going to charities for their mental health issues because of poor NHS experiences or because they do not know where else to go. This emphasises the need for the four UK health departments to improve their statutory provision as we have already set out. Where it is more cost-effective to do so, however, we agree that the health departments should be working closely with and help fund Armed Forces charities to provide the services that are needed.

132. Veterans and their families continue to struggle to navigate the complex landscape of mental health providers across the UK, particularly in crisis situations when the veteran needs help the most. The Department established the Veterans Gateway to address this problem, but as we reported last year in our Armed Forces Covenant report, we await Government statistics to show whether the Gateway has been effective.

133. Furthermore, like the care provision provided by Government, there are issues with the services that Armed Forces charities offer. In particular, demand often exceeds their capacity which means that veterans either have a lengthy wait or miss out entirely. Where and how veterans can access a charity's service is also geographically dependent, with Northern Ireland particularly lacking in charity provision. As we set out further below, it is critical that there is greater coordination of services and resources across the sector to ensure a greater consistency of care provision, regardless of where a veteran is in the UK.

134. Mental health care provided by Armed Forces charities is not necessarily accredited or quality assured, leading to some providing treatments that are not evidence-based and potentially even harmful to patients. *We recommend that the four UK health departments work with the charity sector to identify and implement an enforceable form of regulation so that treatment is evidence-based or that the veteran is fully aware of the risks if not. This could include reviewing whether current legislation regarding the scope of the Care Quality Commission should be revised to extend its remit to charities. Such consideration should also include how to help smaller charities to comply with the regulations and to publicise them to veterans so that they are aware that mental health treatment is regulated.*

191 Q58 [Professor Finnegan] and Annex 1: Summary of individual responses received

192 Veterans' NHS Wales ([POC0078](#)) and Help for Heroes ([POC0069](#))

193 Defence Committee, Eleventh Special Report of Session 2017–19, [Armed Forces Covenant Annual Report 2017: Government Response to the Committee's Ninth Report](#), HC1571, p8

Coordination

135. There are a number of structures in place to coordinate veterans' mental health care across the four nations and between government and Armed Forces charities, much of those within the wider governance surrounding the Armed Forces Covenant. The written evidence submitted by the Government and Veterans' NHS Wales, sets out many of these in more detail, including those specifically related to mental health.¹⁹⁴

136. Many witnesses did not believe, however, that the mental health sector was effectively coordinated. For example, Help for Heroes argued that government departments and local authorities “do not share the drive and desire to collaborate” and that this “leads to serious blockages and failings in service provision and failure to abide by the Armed Forces Covenant”.¹⁹⁵ Dr Jonathan Bashford, Director at Community Innovations Enterprise told us that:

We are siloed from the top, right down from departmental level, and there are iron curtains between those boundaries that prevent joint working. Yes, we need to have that specific, central leadership, but there is no point to that if it is not then linked to what is happening locally. We have an increasingly devolved and fractured system of health and social care, even where it is integrated.¹⁹⁶

This was a view shared by veterans and their families (Case examples 17).

Case examples 17: Veterans' views on how well services are coordinated

“There is no cohesive strategy to co-ordinate the response from all the different organisations offering support. Because of the debilitating symptoms of PTSD, veterans are not able to plan their own course through the minefield that is out there.”

“There is little to no evidence of govt departments, local authorities and charities across the UK working together in any meaningful way.”

“I hate money being wasted and I think there is a lot of waste with the military charities not working collaboratively and dove tailing their provision with each other and the governments provision.”

Source: Annex 1: Summary of individual responses received

137. There were examples of close partnership working. Tony Wright, Chief Executive of Forward Assist, told us how Combat Stress directly operates out of his charity's community centre.¹⁹⁷ Both Veterans' NHS Wales and Councillor Dryburgh, Dumfries and Galloway Council, reported how Armed Forces champions could help develop such partnerships at all levels, with some success stories.¹⁹⁸ Kate Davies, Director of Health & Justice, Armed

194 Ministry of Defence ([POC0111](#)) and Ministry of Defence ([POC0129](#)); Department of Health & Social Care ([POC0130](#)); NHS England ([POC0113](#)) and Veterans' NHS Wales ([POC0078](#))

195 Help for Heroes ([POC0069](#))

196 Q19

197 Q326

198 Councillor Archie Dryburgh ([POC0010](#)) and Veterans' NHS Wales ([POC0078](#))

Forces and Sexual Assault Services Commissioning at NHS England, also told us that all NHS England service commissioning was a collaboration with charities to ensure a multi-agency approach, particularly at local level.¹⁹⁹

The Contact Group

138. The Contact Group was set up in 2016 as a forum to coordinate mental health providers across the UK. It is a collaboration of Armed Forces charities and other entities working with the NHS and the Ministry of Defence. It also acts as the Mental Health hub within the Confederation of Service Charities (COBSEO).²⁰⁰ It was founded to improve service impact and best practice across the sector. The Royal College of Psychiatrists is a member and welcomed its creation but believed that “it is not yet clear how effective this forum is at ensuring the various providers do work together” and that many charities may not be aware of the Group.²⁰¹ Another member, PTSD Resolution, thought it was “just another talking shop”.²⁰²

Coordinating funding

139. Witnesses identified the way in which mental health services were funded—particularly the use of LIBOR funding—as a key example of the lack of coordination of mental health care provision. We recognised in our most recent Armed Forces Covenant report that LIBOR funding had delivered positive results but we raised concerns about how some of this money had been used.²⁰³ During this inquiry, Sue Freeth, Chief Executive of Combat Stress, told us that very little of the funding had been directed towards mental health clinical treatment service.²⁰⁴ David Richmond, former chairman of the Contact Group, raised the lack of a long term vision for how this funding was used:

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?” ...²⁰⁵

140. Instead, charities and other organisations are competing for the available public funding and charitable donations. Smaller charities, for example, do not necessarily believe that the distribution of funding is fair in reflecting the services being delivered. Tony Wright, Chief Executive of Forward Assist, told us that “our tiny little grassroots charities that do so much to enable people to engage and have somewhere to go are not funded in

199 Q401

200 [COBSEO, Welfare, Health and Wellbeing Arena](#) and [The Contact Group](#), websites accessed 14 February 2019

201 [Royal College of Psychiatrists \(POC0112\)](#)

202 [PTSD Resolution \(POC0122\)](#)

203 Between 2012 and 2015, the Government fined banks to a total of £973 million for manipulating the banking markets, including the London Interbank Offered Rate (LIBOR)—a benchmark interest rate for inter-bank loans—for profit. Much of this went to Armed Forces charities. Defence Committee, Ninth Report of Session 2017–19, [Armed Forces Covenant Annual Report 2017](#), HC707, para 58–69

204 Q282

205 Q285

the way they should be”.²⁰⁶ Icarus Online went further, believing that the larger charities “continue to think in silos, guarding their own preserves preciously, to the detriment of a seamless service across the UK”.²⁰⁷

141. There is a risk that insufficient funding may lead to services reducing their scope or even closing. For example, two of Veterans First Point centres covering the Grampian and Highlands regions in Scotland closed in 2017 as a result of the end of LIBOR funding.²⁰⁸ Tony Wright believed that Forward Assist might have to change how it operates given the lack of funding.²⁰⁹ The Government announced in the 2018 Autumn Budget that £10 million would be made available to projects to support veterans’ mental health and wellbeing needs, as part of the Armed Forces Covenant Fund Trust, with applications accepted from May 2019.²¹⁰

Sharing information between providers

142. Another example of poor coordination between care providers was the frustration many veterans felt at having to repeat their story again and again as they moved from one provider or stage of care to another. Tony Wright, Chief Executive of Forward Assist, told us that “having to go and retell your story again is a problem for a lot of people”, while one veteran told us that with no long-term continuity of care “this can lead to duplication, re-living and re-telling the “story” five or six times”.²¹¹

143. Dr Deirdre MacManus, Royal College of Psychiatrists and lead psychiatrist for the London Transition, Intervention and Liaison Services, told us that this was something she also commonly hears and that TILS “is trying to overcome” this so where “data-sharing can happen, it does”. For example, she will ask patients coming into TILS for their consent to contact their previous providers for their assessments.²¹²

144. We were disappointed to hear that there was no long-term vision for the use of LIBOR funding. As a result, although we noted in our Armed Forces Covenant report in June that the funding had delivered positive results, an opportunity has been missed to have used the funding for long-term investment in areas such as veterans’ mental health services. Instead charities continue to compete for short-term funding from both Government sources and public donations, risking the closure of services if future funding is lost, restricting their ability to plan long-term and with the possibility of resources not going where they might be most needed.

145. The lack of coordination of mental health care funding and services across the UK continues to demonstrate the lack of strategic direction and accountability from the Government on the Armed Forces Covenant. It has structures in place for cross-government working, such as the Veterans Board, and the Contact Group has been formed specifically for coordinating the mental health sector. However, their effectiveness is questionable and some veterans see only a disjointed system that fails

206 Q280

207 Icarus On-Line (POC0046)

208 BBC News, [Decision due on ‘lifeline’ service for Grampian veterans](#), 21 August 2017 and Scottish Parliament debate, [Veterans and Armed Forces Community](#), 16 November 2017

209 Q288

210 Armed Forces Covenant Fund Trust, [Veterans Mental Health and Wellbeing Fund](#), website accessed 14 February

211 Q314 and Annex 1: Summary of individual responses received

212 Qq156–165

them when they need it, not least by repeatedly forcing them to retell their story as they move from provider to provider. We will continue to urge the Government to improve its governance of the Armed Forces Covenant, as part of our annual inquiry, to ensure that the Covenant is being fully implemented across the UK.

146. *We recommend that the Ministry of Defence works with the other partners in the Contact Group to ensure that it develops into an influential body, effective at coordinating funding and service provision across the whole mental health sector. This should include bringing more of the smaller charities into the Group and increasing stakeholders' awareness of its work.*

147. Charities are of course sovereign bodies, many of which wish to do the right thing—but only on the understanding that they will do it their way. Ministers have no formal power, other than via the Charity Commission which deals only with governance, to compel charities to do anything against their will. *Nevertheless, given the stove-piping and lack of joined-up working clearly identified in the charitable sector within this report, Ministers should be prepared to work with COBSEO and the Contact Group to do whatever they practically can to “knock heads together” in the charitable sector to try and provide a far more joined-up service, which is to the benefit of the veterans rather than the charities themselves.*

6 Families

148. We concluded in our Part One report that the stresses of Service life can also affect Armed Forces families. Spouses and other family members can be affected by a traumatic event suffered by serving personnel or by constant redeployment. We recommended that the Government placed a greater focus on Service and veterans' families as part of its mental health care provision, including greater research.²¹³

149. In its response to our report, the Ministry of Defence acknowledged the pressure that can be placed on Armed Forces families and suggested that most families can seek mental health support help through the mainstream civilian health systems for their nation. If necessary, the new veteran-specific services in England could also offer some support to families. It also told us that a charity, the Centre for Mental Health, has a Mental Health Research Programme focused on veterans, with the impact on families being one of its priorities.²¹⁴ In January 2019 the Ministry of Defence also announced that it had commissioned a study to assess the support available to Armed Forces families. It is expected to report in Summer 2019.²¹⁵

150. Armed Forces charities, such as the Royal British Legion and the Naval and Army Families Federations, believed that Armed Forces families did have specific mental health needs different from those of the general population. As the Contact Group told us, this is “due to unique stressors, including deployment and needing to support a spouse or partner with their own mental health problems”.²¹⁶ The British Psychological Society and the family federations also identified Armed Forces' children aged under 16 as a specific group at risk, not least given the lack of children's mental health services in general.²¹⁷ As Tim Boughton, a veteran, told us:

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.²¹⁸

151. Like veterans, families looked for understanding by civilian medical practitioners of their particular circumstances as military families. A survey by the Naval Families Federation found that, nearly 60% of those who accessed NHS care, believed that the GP or other NHS medical professional was “not sufficiently understanding of their

213 Defence Committee, Eleventh Report of Session 2017–19, [Mental Health and the Armed Forces, Part One: The Scale of mental health issues](#), HC813, para 111 and 112

214 Defence Committee, Twelfth Special Report of Session 2017–19, [Mental health and the Armed Forces, Part One: The Scale of mental health issues: Government Response to the Committee's Eleventh Report](#), HC1635, para 26 and 27

215 Ministry of Defence, [Defence Secretary commissions new report to step up support for service families](#), 19 January 2019

216 The Royal British Legion ([POC0104](#)); Contact Group ([POC0107](#)); The Naval Families Federation ([POC0054](#)) and Army Families Federation ([POC0044](#))

217 The Naval Families Federation ([POC0054](#)); Army Families Federation ([POC0044](#)) and The British Psychological Society ([POC0093](#))

218 Q216 [Tim Boughton]

circumstances as part of an AF [Armed Forces] family”. It was also reported that NHS staff did not understand that this had any relevance.²¹⁹ One spouse told us that she simply did not feel comfortable talking to her GP about her issues, while another told us that:

We are dealing with specific mental health issues which sometimes cannot be addressed or understood by civilians. I have attended IAPT [Improving Access to Psychological Therapy] assessment appointments only to be told to find a private counsellor or do some CBT [Cognitive Behavioural Therapy]—unfortunately the private counsellors just do not understand the circumstances in which we live in.²²⁰

Current provision

152. There is very little current statutory provision of Armed Forces’ family-specific specialist mental health services. Veterans’ NHS Wales said that they were only funded to treat veterans while the Big White Wall, funded by NHS England, provides online mental health support to the Armed Forces, including families, but no treatment.²²¹ The Contact Group reported that some NHS Transition, Intervention and Liaison Services (TILS) provided support to families.²²² However Dr Deirdre MacManus, Royal College of Psychiatrists and lead psychiatrist for the London TILS, told us that they had identified this area as a gap in the service and were bidding for further funding to allow them to provide services.²²³

153. There is also limited provision by the Armed Forces charity sector, as the Royal College of Psychiatrists and The Contact Group reported to us.²²⁴ Combat Stress reported that Walking with the Wounded and The Big White Wall have been seeking to introduce family services, but there remain challenges over clinical governance.²²⁵ However, Mark Birkill, therapist at Veterans’ NHS Wales, and Dr Jonathan Bashford, Director at Community Innovations Enterprise, told us that there are local charities that provide at least some support to families.²²⁶ NHS England reported that it is working with the charity sector to improve the mental health care provision for Armed Forces families.²²⁷

154. Witnesses also reported that family members might not seek help. Research by Help for Heroes found “16 per cent [of those surveyed] saying they would try to cope with any issues alone, with only 5 per cent saying they would seek help from a mental health professional”. It also found that stigma was the main reason for not seeking help, with over 40 per cent believing that they “need to be the strong one”.²²⁸ One mother told us:

I also joined The Ripple Pond it took me several goes of telephoning and putting the phone down. Not having the courage to do it, not wanting to

219 The Naval Families Federation ([POC0054](#))

220 Annex 1: Summary of individual responses received

221 Veterans’ NHS Wales ([POC0078](#)) and the Big White Wall ([POC0114](#))

222 The Contact Group ([POC0107](#))

223 Q155

224 Royal College of Psychiatrists ([POC0112](#)) and the Contact Group ([POC0107](#))

225 Combat Stress ([POC0080](#))

226 Q50 and Q131

227 NHS England ([POC0113](#)) and Ministry of Defence ([POC0111](#))

228 For example, Combat Stress ([POC0080](#)); The British Psychological Society ([POC0093](#)) and Help for Heroes ([POC0069](#))

feel guilty. Eventually after one argument too much with my son I did it. They were amazing. I was breaking my heart. They listened and gave me advice.²²⁹

155. Kate Davies, Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning at NHS England, recognised the importance of family members in supporting those with mental health needs and, in its written submission, NHS England reported that carers of veterans were involved with NHS England care provision to veterans.²³⁰ However, veterans and Armed Forces families said there was inadequate support for their efforts to help their Armed Forces' family members to manage mental health issues (Case examples 18).

Case examples 18: Veterans' and family members' views on support as carers

“The impact of MH on families seems to be wholly underestimated and unrecognised. We provide support 24/7 and have first-hand experience of how our partners are coping. We receive no training in how to support our loved ones or how to cope with someone with MH issues. This leads to a detrimental impact on our own mental health (as I can personally testify).”

“There should be information sent out to wives of ex military personnel of symptoms to look for, they are the front line and take the brunt of a husband/partner with PTS.”

Partners and soldiers/veterans' families (not only wives) should be provided with adequate support and be invited to discuss the issues they are facing and receive guidance and support to enable them to best assist the soldier/veteran.

Source: Annex 1: Summary of individual responses received

156. We are very concerned by the lack of Armed Forces' family-specific specialist mental health care in the UK, including the very limited provision within the Armed Forces charity sector. As we reported in Part One, the mental health of families can be just as exposed to the stresses of Service life, especially if they are living with serving personnel or veterans who have complex mental health issues. Yet many may be reluctant to seek help, perhaps because of the perceived stigma or because civilian medical practitioners would not understand their situation as an Armed Forces' family member.

157. We repeat our recommendation from Part One that the Ministry of Defence, in conjunction with the health departments of the four nations, should place a greater focus on service and veterans' families as part of their mental health care provision. This should include providing additional funding to statutory services, such as the Transition, Intervention and Liaison Service in England, to assist families. We also recommend that the Ministry of Defence, alongside the four health departments, review what assistance can be provided to family members of serving personnel and veterans with mental health issues.

229 Annex 1: Summary of individual responses received

230 Q379 and NHS England ([POC0113](#))

Conclusions and recommendations

During Service

1. We are deeply concerned that the Ministry of Defence is not consistently providing the quality of mental health care to its Servicemen and women that they deserve. We welcome the Department's invitation to the Care Quality Commission (CQC) to inspect the care provided by Defence Medical Services. However, two of the four Departments of Community Mental Health (DCMHs) inspected failed CQC standards. Service personnel have reported a wide range of experiences of military mental health care provision, including problems with speed of, and access to, treatment. This situation is completely unacceptable. (Paragraph 17)
2. *We recommend that the Ministry of Defence should fully review how it manages military mental health services in order to understand why there are such variations in the care offered to Servicemen and women. The Department should also set out what it is doing to ensure that the other DCMHs are up to the standards necessary to pass future Care Quality Commission inspections and how best practice is being shared across all its mental health centres.* (Paragraph 18)
3. We are disappointed that the Department continues to struggle to address its longstanding shortages of mental health staff. With continued 50% shortfalls in some mental health posts, it is no surprise that some serving personnel are not being seen sufficiently quickly and a few are having to take the drastic step of funding their own care elsewhere. *If recruitment does not improve, we recommend that the Department should review what it can offer in pay and other benefits to attract people into military mental health roles, either as Regulars or Reservists.* (Paragraph 23)
4. Early intervention can be crucial in preventing mental health problems from developing into more severe conditions. However, despite significant improvements in how mental health issues are perceived in the Armed Forces, the fear of damaging their career remains a significant barrier to Servicemen and women coming forward for help, with the level of support often being dependent on individual commanding officers. As we reported in Part One, we support the Department in campaigning against the stigma surrounding mental health issues and promoting help-seeking. Yet it is obvious that more still needs to be done. (Paragraph 33)
5. We also appreciate that the Armed Forces medical services have an occupational health role focused on returning Servicemen and women back to full duties. However, this needs to be balanced against the time and care that an individual might need for recovery, and medical discharge should be only a last resort. (Paragraph 34)
6. *We recommend that the Department should clearly demonstrate to Servicemen and women that mental health problems are taken seriously and their reporting does not lead to the end of their careers. This could be done by publicising examples of senior officers or non-commissioned officers (NCOs) across a wide range of Armed Forces specialisms who have sought mental health help previously without adverse effects upon their careers.* (Paragraph 35)

7. *We also recommend that the Department must provide better mental health awareness training to officers and NCOs so that they can respond effectively and sympathetically to anyone in their unit coming forward to seek help. (Paragraph 36)*

During the transition to civilian life

8. We agree with the many veterans who believe that the Armed Forces are not doing enough to support and follow up with them once they have left the Services, leading them to feel that they had been abandoned. The Department has transition support programmes in place and, at least in England, there is now potentially greater coordination with the NHS for someone who is being discharged. However, there is little follow-up to establish what else might be needed once a veteran has begun to adapt back to civilian life or to identify any development of mental health issues. *We recommend that the Department revises its follow-up policy, so that there is regular engagement and offer of further support to veterans for at least five years after discharge, including a formal medical health check for each leaver a year on. This engagement should ideally be supplemented by personal contact, for example a phone call, rather than just a derisory email. (Paragraph 48)*
9. The significant difficulties that some veterans, especially those with more complex conditions, have faced with the Armed Forces Compensation Scheme is one particularly glaring example of why veterans feel unsupported once they have left the Services. We welcome the Department's work to improve the scheme but clearly more needs to be done and we look forward to receiving the results of its expert group's follow-up review and the Department's subsequent response. (Paragraph 52)

Statutory provision for veterans

10. The lack of civilian medical practitioners' understanding of military culture and military mental health issues remains a significant barrier to veterans accessing and receiving effective treatment for their mental health conditions. We welcome the work being done to improve the understanding of civilian medical practitioners, such as the creation of veteran-friendly GP surgeries. However, this remains small-scale and much more still needs to be done to stop veterans feeling let down by the health care system. (Paragraph 67)
11. *We recommend that the Department of Health and Social Care updates us within six months on progress in improving civilian practitioners' awareness of veterans' mental health, including how this has been measured and what other actions it has since taken or plans to take for further improvement. The Department should also update us on the work to exchange best practice with the other nations in the UK. (Paragraph 68)*
12. The differences at both local and national level in the availability of statutory veteran-specific services have led to wide variations in the care a veteran might receive. The worst affected are veterans living in Northern Ireland as there is no statutory provision for many of them. The four UK health departments have the responsibility for ensuring consistency within their nation and for meeting increasing demand.

However, as we concluded in Part One, even though health care is devolved, the Department cannot abdicate its responsibility for ensuring that all veterans receive comparable care regardless of where they live. (Paragraph 76)

13. *We recommend that the Ministry of Defence works with the health departments of England, Scotland and Wales, to address urgently the gaps in veteran-specific provision across the UK. We also repeat our recommendation from Part One on the development of a shared set of methodologies for collecting and analysing veteran mental health data across the UK. This should include outcomes so that best practice can be identified and shared across the four nations.* (Paragraph 77)
14. *We also recommend that the Department sets out how it will help veterans living in Northern Ireland to access veteran-specific mental health treatment available to those living in the rest of the UK.* (Paragraph 78)
15. The creation of veteran-specific services has meant that veterans should generally be able to access mental health care more quickly than the general population. However, it can still take far too long for veterans to be able to access care when they need it, with missed waiting list targets meaning veterans could be waiting up to a year. In many cases, this is because capacity cannot keep up with demand. When veterans seek help for their mental health issues, some may need immediate treatment to prevent the problem from quickly worsening. Failure to do so can lead to serious, and even fatal, consequences. (Paragraph 85)
16. *We repeat our Part One recommendation that the Ministry of Defence and the four UK health departments, alongside charities, must develop a common understanding of demand for veteran mental health care and ensure that enough resources are allocated to meet demand so that waiting time targets are fully met.* (Paragraph 86)
17. We expressed significant concerns about the confusion surrounding priority treatment in our Part One inquiry, and it is clear that many veterans are not receiving priority treatment for their service-related injuries, with civilian medical practitioners' lack of knowledge of this principle of the Armed Forces Covenant—and indeed of the Covenant itself—being a key factor. We welcome the work by the Ministry of Defence and Department of Health and Social Care to establish a clearer definition of priority treatment by 2019–20. However, this must be accompanied by a clear strategy to ensure that the definition and its consequences are understood and implemented across the NHS and that best practice is shared with the devolved administrations. (Paragraph 91)
18. *We repeat our recommendation from Part One that the Government should ensure that once it has set out how priority treatment should be implemented in practice, this clarification is cascaded down to both NHS staff and veterans and their families across the whole of the UK. For example, it may be that the only way to prioritise service-related mental health conditions is to have separate specialist facilities at which to treat them, but this approach needs to be made clear to all.* (Paragraph 92)
19. The new Transition, Intervention and Liaison and Complex Treatment Services were created, not just to help veterans but also to try and get around the dichotomy whereby the Ministry of Defence and the Armed Forces Covenant argue that veterans should receive priority treatment in the NHS, whereas the Department of

Health and Social Care traditionally prioritises strictly according to clinical need. The creation of a bespoke service for Armed Forces veterans is very much to be welcomed. Nevertheless, it is scandalous that in an NHS budget of over £150 billion UK wide, less than £10 million per annum (0.007%) has been allocated to this service, which is swamped by the scale of demand. *Health Ministers need urgently to recognise this deficiency and use part of the very significant increase in NHS funding envisaged under the new NHS Ten-Year Long-Term Plan to increase substantially the resources provided to the TIL and CT services, in order to make them truly fit for purpose. Those who have worn the uniform of their country deserve no less and NHS Ministers must be prepared to be held firmly to account on this matter.* (Paragraph 98)

20. We are very concerned by the insufficient provision of long-term statutory care of veterans with complex mental health conditions. Time limits on treatment—which anyway may not be effective for the most complex cases—mean that those with the greatest need have nowhere to go. *We recommend that the Ministry of Defence, in conjunction with the four UK health departments, set out how it will develop long-term care provision for veterans with complex mental health conditions.* (Paragraph 99)
21. Far too many veterans, whose relationships have broken down and who are in crisis, having already been diagnosed as suffering from severe conditions, such as PTSD, are having to wait up to a year to enter into a suitable treatment programme. This is utterly unacceptable. Many of these veterans only see their condition deteriorate further whilst waiting for access to treatment and, in the most extreme cases, they take their own lives whilst awaiting help. *To prevent this, patients must be continually monitored and reassessed during the gap between initial diagnosis and the commencement of treatment.* (Paragraph 100)
22. There needs to be a highly professional place of safety to which these veterans can be sent as soon as they are diagnosed, in order to be stabilised and to begin to receive assistance for their recovery. Following residential treatment, they should then be discharged directly into a TILS/CT programme back in their own locality but without any discontinuity of treatment or gap in their care pathway. (Paragraph 101)
23. *The Committee strongly believes that it makes sense for such a centre to be co-located with the new state-run Defence and National Rehabilitation Centre (DNRC) for physically injured serving personnel at Stanford Hall. The DNRC evolved from Headley Court, which rightly established a world-class reputation for the treatment of the physically wounded from conflicts such as Iraq and Afghanistan and it should be a national aspiration to establish a similar world-class centre for the treatment of mental injuries relating to service as well. The NHS should urgently consult with the Ministry of Defence and the DNRC in order to establish this facility with an initial operating capability within the next 12–18 months.* (Paragraph 102)
24. The Government has a duty to not treat patients incorrectly as a result of misdiagnosis. In particular, Post-Traumatic Stress Disorder (PTSD) and mild Traumatic Brain Injury (mTBI) share some similar symptoms, which increases the risk of misdiagnosis of these conditions in serving personnel and veterans. *We recommend that the Ministry of Defence and the four UK health departments support further research work into mTBI, including the testing of methods for clearly identifying this condition.* (Paragraph 108)

25. We welcome the Department's work on improving its identification of veteran suicides following our recommendation in Part One, including working with the Ministry of Justice and Department for Health and Social Care. We look forward to receiving an update on progress as part of the Government's response to this report, including the results of the study into suicides by Iraq and Afghanistan veterans. *We recommend that the Department considers options for regular statistical releases on veteran suicides once sufficient data is available and includes these options as part of its response to this report.* (Paragraph 114)

Armed Forces charities

26. Armed Forces charities play a significant role in the provision of mental health services to veterans and we highly value the work that they do. However, some Armed Forces charities exist only because of a gap in statutory provision and veterans report going to charities for their mental health issues because of poor NHS experiences or because they do not know where else to go. This emphasises the need for the four UK health departments to improve their statutory provision as we have already set out. Where it is more cost-effective to do so, however, we agree that the health departments should be working closely with and help fund Armed Forces charities to provide the services that are needed. (Paragraph 131)
27. Veterans and their families continue to struggle to navigate the complex landscape of mental health providers across the UK, particularly in crisis situations when the veteran needs help the most. The Department established the Veterans Gateway to address this problem, but as we reported last year in our Armed Forces Covenant report, we await Government statistics to show whether the Gateway has been effective. (Paragraph 132)
28. Furthermore, like the care provision provided by Government, there are issues with the services that Armed Forces charities offer. In particular, demand often exceeds their capacity which means that veterans either have a lengthy wait or miss out entirely. Where and how veterans can access a charity's service is also geographically dependent, with Northern Ireland particularly lacking in charity provision. As we set out further below, it is critical that there is greater coordination of services and resources across the sector to ensure a greater consistency of care provision, regardless of where a veteran is in the UK. (Paragraph 133)
29. Mental health care provided by Armed Forces charities is not necessarily accredited or quality assured, leading to some providing treatments that are not evidence-based and potentially even harmful to patients. *We recommend that the four UK health departments work with the charity sector to identify and implement an enforceable form of regulation so that treatment is evidence-based or that the veteran is fully aware of the risks if not. This could include reviewing whether current legislation regarding the scope of the Care Quality Commission should be revised to extend its remit to charities. Such consideration should also include how to help smaller charities to comply with the regulations and to publicise them to veterans so that they are aware that mental health treatment is regulated.* (Paragraph 134)
30. We were disappointed to hear that there was no long-term vision for the use of LIBOR funding. As a result, although we noted in our Armed Forces Covenant

report in June that the funding had delivered positive results, an opportunity has been missed to have used the funding for long-term investment in areas such as veterans' mental health services. Instead charities continue to compete for short-term funding from both Government sources and public donations, risking the closure of services if future funding is lost, restricting their ability to plan long-term and with the possibility of resources not going where they might be most needed. (Paragraph 144)

31. The lack of coordination of mental health care funding and services across the UK continues to demonstrate the lack of strategic direction and accountability from the Government on the Armed Forces Covenant. It has structures in place for cross-government working, such as the Veterans Board, and the Contact Group has been formed specifically for coordinating the mental health sector. However, their effectiveness is questionable and some veterans see only a disjointed system that fails them when they need it, not least by repeatedly forcing them to retell their story as they move from provider to provider. We will continue to urge the Government to improve its governance of the Armed Forces Covenant, as part of our annual inquiry, to ensure that the Covenant is being fully implemented across the UK. (Paragraph 145)
32. *We recommend that the Ministry of Defence works with the other partners in the Contact Group to ensure that it develops into an influential body, effective at coordinating funding and service provision across the whole mental health sector. This should include bringing more of the smaller charities into the Group and increasing stakeholders' awareness of its work.* (Paragraph 146)
33. Charities are of course sovereign bodies, many of which wish to do the right thing—but only on the understanding that they will do it their way. Ministers have no formal power, other than via the Charity Commission which deals only with governance, to compel charities to do anything against their will. *Nevertheless, given the stove-piping and lack of joined-up working clearly identified in the charitable sector within this report, Ministers should be prepared to work with COBSEO and the Contact Group to do whatever they practically can to “knock heads together” in the charitable sector to try and provide a far more joined-up service, which is to the benefit of the veterans rather than the charities themselves.* (Paragraph 147)

Families

34. We are very concerned by the lack of Armed Forces' family-specific specialist mental health care in the UK, including the very limited provision within the Armed Forces charity sector. As we reported in Part One, the mental health of families can be just as exposed to the stresses of Service life, especially if they are living with serving personnel or veterans who have complex mental health issues. Yet many may be reluctant to seek help, perhaps because of the perceived stigma or because civilian medical practitioners would not understand their situation as an Armed Forces' family member. (Paragraph 156)
35. *We repeat our recommendation from Part One that the Ministry of Defence, in conjunction with the health departments of the four nations, should place a greater focus on service and veterans' families as part of their mental health care provision.*

This should include providing additional funding to statutory services, such as the Transition, Intervention and Liaison Service in England, to assist families. We also recommend that the Ministry of Defence, alongside the four health departments, review what assistance can be provided to family members of serving personnel and veterans with mental health issues. (Paragraph 157)

Annex 1: Summary of individual responses received

Overview

- 1) The House of Commons Defence Select Committee put out an open call for evidence in relation to its inquiry into *Mental Health and the Armed Forces, Part Two: The Provision of Care*. It was particularly keen to hear from both current and former Servicemen and women and their families on their experiences of seeking and receiving mental health care.
- 2) The Committee, however, recognised that such submissions were likely to include sensitive personal information and set out as part of its call for evidence that it would not be publishing submissions relating to individual experiences. Instead, the Committee would publish this detailed review of all such submissions received to draw out the key themes.

In total submissions from 84 individuals were received, including:

- 14 from serving personnel
- 46 from veterans
- 19 from family members of veterans or currently serving personnel²³¹

3) Please note that the Committee did not actively solicit evidence from individuals and the submissions received are likely to demonstrate ‘self-selection’ or ‘volunteer’ bias, whereby they over-represent individuals who have strong opinions or interests. This review is intended to summarise and reflect the key perspectives of the individuals as outlined in the submissions received. It should not be interpreted as representative of the experiences of all current and former Servicemen and women and their families who have received mental health care. Where extracts have been used, these have been anonymised to protect the privacy of the individuals and their families. Please note that readers may find some of the extracts distressing.

During Service

4) Over half of the submissions received discussed the provision of mental health care by the Armed Forces. A small number praised the mental health care they received from the Armed Forces.

I felt compelled to let you know about my experiences over the last year as all I have seen at DCMH is utter professionalism and life changing treatment, not only for myself but for fellow Royal Marines of all ranks ... I had an appointment made for an assessment within two weeks of seeing the PMO [Medical Officer] and then started treatment three weeks later which I felt

²³¹ It was not possible to identify the status of 5 individuals who submitted evidence. See last section on submissions

was very quick and was needed for me at this time as I regrettably had considered taking my own life due to the pain that I couldn't stop leaking out of my mind and body. (POC0002)

DCMH Donnington provided lasting, effective care for me. (POC0034)

I had a mild mental illness last year which was dealt with extremely well by my military GP and local DCMH—timely and efficient and effective. (POC0056)

I found the provision of treatment in the military very good. I was diagnosed with long-term PTSD in Dec 2015 and had been downgraded, with no further access to weapons and ammunition. I hoped there might be improvement, but I was disappointed—though not for lack of effort from the staff. (POC0084)

5) In many other submissions however, the experiences reported were negative and set out a number of key issues around effectiveness, access to treatment and how long that took, lack of early intervention and how actions by the Ministry of Defence affected their mental health.

Effectiveness of treatment

6) Some individuals reported that the care or treatment provided was poor or inappropriate, citing poor staff skills and inconsistent care.

In my opinion my care was appalling, it was a waste of a promising [sailor]. I suffered many years of mental health issues because the causing Factor was ignored until I put my notice in. As a downgraded serviceman at my time of leaving, I feel I should have been medically discharged and had ongoing care to prevent further risk of suicide. (POC0014)

It was very difficult for me to take that first step in seeking out aid, mainly due to stigma whilst serving in an infantry unit. But to be diagnosed by an RAF Corporal who was an unqualified psychologist and my treatment was a guidebook with no future referrals is a complete farce ... A 6 page guide on how to identify when I feel stressed and how to deal with anxiety ... I have continued my army career thus far with no further interaction from DCMH. (POC0037)

Our priority would be for consistent treatment from one person over a prolonged period and for that person to have the specialist MH [Mental Health] skillset whether civilian or military. We have had greater success personally funding regular sessions with a private counsellor over a 2 year period rather than the haphazard military MH care pathway. (POC0062)

I believe he needed some pastoral support and signposted him to Welfare and the medical centre to access DCMH. He was unable to be referred to DCMH (no reason was given), and the doctor stated it was not in the 'interests of the service' to medically downgrade him from active duty. (POC0097)

7) A few also noted the time-limit on their treatment of a certain number of weeks or sessions and the reduced level of care once the decision has been taken to discharge someone.

Many DCMH units have a 6-week treatment policy and if you require further treatment it has to be approved by the OC of the unit. (POC0074)

Once decided you are to be medically discharge then medical treatment tails off, no matter how long it takes to discharge. Service treatment does not provide clear diagnosis or prognosis or a treatment plan for transition... The medical staff are employed by the MoD and have a remit under joint service policy (and single service policy) to ensure you meet with certain employment standard of medical fitness, once you no longer meet those requirements treatment falls off. I presume this is in part due to the conflict of interest which is caused by claims under the AFCS [Armed Forces Compensation Scheme] and AFPS [Armed Forces Pension Scheme] being assessed on the service medical notes. I believe that due to their occupation restrictions that the mental health treatment in the service is limited. (POC0048)

Speed of access

8) Individuals who had accessed Armed Forces' mental health care experienced a range of waiting times for assessment and treatment. Some were seen quickly, but a struggle for others.

Access to metal health services for me was swift (once the need for them was recognised) and well organised. (POC0034)

Delay in treatment and waiting lists in the services has increased the risk of long-term detrimental effect, especially when individuals are signed off sick for long periods without unit support. (POC0048)

A serious incident... led to my returning to severe depression, and I reported my concerns to the TRIM administrator following the incident. It all poured out and I was quickly referred to the padre, and the MO of the camp I was at. He referred me immediately to a DCMH, and I began weekly treatment. (POC0084)

I was invited to a DCMH appointment 6 months after referral and 15 months after originally seeking support and I was almost immediately discharged... (POC0097)

Access to treatment

9) A few individuals raised the physical difficulties of accessing DCMHs, which may discourage serving personnel from seeking help early.

The infrastructure of these resources is also very poor, e.g. Mental Health Unit RAF Cranwell, is shoved into a rotting porta cabin, the door of which for several years was so swollen and rotten with damage the physical

security of the buildings records could easily be compromised ... Often, such a St Georges Barracks, North Luffenham near Graffam Water, the mental health provision is within an un-used part of a medical centre, with little privacy, and a significant distance from the domicile of the patient. (POC0006)

DCMH is known to be very hard to access, because there are only certain 'hubs' across the UK, necessitating travel, time away from work and difficulty in getting appointments in a timely fashion. All of this, to a depressed person, makes life much harder, and (together with lack of chaplain availability) means that they are less likely to seek help at an early stage where their problems are less critical. (POC0052)

10) A small number of others also reported that it was particularly difficult to access mental health care when stationed outside of the UK, particularly if they were not stationed overseas as part of a unit.

There is no MH med [Mental Health medical] plan provision for France to my knowledge. The nearest MH facility to France is in BFG [British Forces Germany]. Therefore the choice was stark, cut the tour short, move home early or get no treatment. (POC0007)

I went to the medical centre to ask for help. It took some time but was well organised. I did not want to go to the medical centre as I was afraid it would impact my career, however I had little choice living in Germany. (POC0108)

11) One individual also raised the concern that some civil servants who deployed alongside the military during Afghanistan and Iraq also developed mental health issues as a result, but received "very little of the support given to returning military personnel" (POC0005)

Early intervention

12) A number of submissions emphasised the importance of early intervention in helping to manage and treat mental health issues as they developed. They believed that if intervention or treatment had taken place earlier in their cases than it might have forestalled the development of more serious mental health conditions.

No one picked up that my son was suffering in silence and he was finally diagnosed with severe PTSD in 2018 it had got that bad. (POC0086)

13) Submissions suggested reasons as to why early intervention had not occurred, including stigma, the lack of recognition of mental health symptoms and the fact that the mental health issues had stemmed from or were exacerbated by the Ministry of Defence itself.

Stigma

14) Serving personnel may not come forward in the early stages of their own mental illness because the stigma associated with mental illness makes them fear for the consequences of ending their careers.

Serving personnel seeking help with mental health come forward with great courage, in fear of reprisal, repercussion and potential career loss ... This is a fundamental reason that service personnel hide & suppress their suffering from their chain of command, and an underlying cause of self-medicating through various coping mechanisms, such as becoming a workaholic, substance misuse, alcohol, violence, disciplinary issues and suicide (POC0045).

Unfortunately, it remains better financially and for career progression for front line military personnel to keep mental health issues a secret than to seek help. (POC0099)

Recognising the symptoms of mental health

15) Some submissions also suggested that early intervention did not occur as the signs of mental health were missed, not just by the Serviceman or woman but also by those around them, including medical personnel, family, and colleagues. This was particularly the case for older veterans

No one had ever heard of PTSD as we looked after ourselves, normally by drinking ourselves to oblivion. (POC0032) [Veteran who had been deployed to Northern Ireland]

Despite showing signs of deteriorating mental health as early as the late 1990s, I was not diagnosed with PTSD until 2018. During the intervening 20 years my condition worsened and became more deeply embedded but was not recognised by myself, military Medical Officers, my GPs, or any other clinician until the day that I was gently talked off Beachy Head. (POC0060)

16) A few individuals believed that there still remains a general lack of knowledge of mental health issues which makes it difficult to correctly identify changing behaviour as a potential indication of mental health issues and then to know what actions to take.

Senior staff throughout the Army were clearly inadequately trained in the signs and symptoms of PTSD, and in the seven years since his first deployment and major change in behaviour and increased aggression there was never a suggestion made by anyone that his change in demeanour might be related to mental health. (POC0082)

Exacerbation of mental health issues by the Ministry of Defence

17) A small number of submissions reported that their mental health issues stemmed from or were exacerbated by mismanagement of their cases by the Ministry of Defence or poor administration. This ranged from bullying issues that were not investigated and complaints about their chain of command that were not resolved to the administration requirements of applying for Armed Forces compensation.

The military should actively identify and remove toxic managers. Such personnel should be prevented from reaching Senior Management positions where they can negatively influence more junior members of staff. (POC0034)

The methods and time line that AFCS [Armed Forces Compensation Scheme] use to assess claims is inadequate and adds a great deal of pressure and anxiety to personnel; as compensation or not makes a difference to the employment choices they have to make. I want to appeal, but producing all the documentation necessary is causing me such anxiety that I feel paralysis each time I attempt to start the appeals process. (POC0074)

A number of wrongs however were 'done to me'... by the Chain of Command and in my efforts to recover injustice I was treated with contempt, alienated, discriminated against and victimised to the point that my health deteriorated as a result of the betrayal I endured by the Chain of Command. (POC0100)

Preventative mental health provision

18) To help with early intervention, a few submissions referenced or recommended the need for better preventative mental health work to assist with early intervention. This included looking out for early signs of mental illness and identifying 'at risk' individuals to provide early emotional support.

Another recommendation that I would suggest is that there needs to be a better screening/evaluation process for those who may be classed as 'high risk' to mental health issues. With the increase in mental health issues ... it's my understanding that there should be some form of record for those who have experienced traumatic incidents, whilst on tour and that this should be logged and those individuals involved either directly or indirectly (secondary trauma conditions) can be evaluated and the appropriate support, either sign posting or referral to a specialist to be available. (POC0033)

Mental health care and transition

19) Over a third of submissions expressed views about the transition from service life to civilian life, with many believing that they were unsupported and left to deal with mental health issues alone.

Upon leaving the Navy I had no aftercare whatsoever. I have dealt with my issues myself. (POC0014)

I support our Armed Forces totally, but feel that when an individual leaves their Service, too little is done to prepare them for "civvy street!" This is a very important matter to address as it directly affects the Mental Health of all ex-forces. Too many people are unprepared for 'going solo', without a network of support around them. (POC0035)

This common indoctrination is meant to end when your service ends, but few are prepared for the transition. When they leave and return to a (safe and stable?) life in civvie street, many, though not all, cannot switch off and they descend into a spiral of drink and drugs, violence, low self-worth, unemployment, debt and mental ill health. (POC0123)

20) To help address this, many recommended better and longer follow-up by the Ministry of Defence after discharge. Individuals believed this would be a good source of emotional and practical support and act as preventative mental health practices.

Since I've left the military the only contact my former family has had with me is an email from the resettlement team with information on possible jobs/career paths I might like. After 16 years this is just not good enough, I deserve a call, hi how are you, are you well, coping with civilian life and people ok. My answer would have been no. Appreciation, Consideration, Direction... I believe would have been crucial in helping me stabilise my mental health. (POC0018)

As a veteran having served 15 years, I left the service in 1980. Since my discharge the only contact with the MoD has been for them chasing me with 'Long Term Reserve' paperwork and telling me I must advise them of my whereabouts until I was 45. NOT ONCE has anyone enquired about my health, welfare or wellbeing or even if I had found employment. (POC0029)

One thing you get when you leave the forces is help from the Career Transition Partnership for two years. It is believed that it takes 3–4 jobs before you find your niche. As a medical discharge I believe this support should be extended to at least four years as your time to resettle out of the military is normally less than a year and this would help compensate. (POC0125)

21) Some also suggested a 'buddy' or mentor system be put in place.

Transition period in the last year of service to have monthly interviews with health professionals to spot mental health issues before discharge date. Reward those that attend ... Anyone leaving the forces should have a two year mentor assigned, just to check in occasionally, and to make sure they are hitting the correct milestones in treatment. Veterans TILs NHS are starting to do this, and the fact that the team are ex Mil makes life easy. (POC0008)

I would love to see all personnel that are medically discharged be offered a kind of 'buddy' for a period of at least 18 months. This 'buddy' I would like to see then 'check in' with the service person on a weekly basis to begin with, perhaps for a period of 6 months before dropping down to perhaps monthly calls. I would like these calls to be placed to both the Veteran AND the spouse (as often the spouse will be more forthcoming about difficulties the service person may be facing in civvy street). (POC0092)

Transition between the Ministry of Defence and civilian health care

22) Some individuals raised concerns about how veterans who were already being treated by the Armed Forces were then transferred to civilian health care.

The MoD can discharge you if there is suitable treatment available on the NHS. In my own case they didn't actually hand any notes to my now civilian GP nor did they follow up on how any treatment may or may not have been going. (POC0021)

I accepted the treatment from DCMH Catterick (RAF Leeming)... it helped a great deal and I was very appreciative of the help. However, I was no wiser of my condition, apart from a few hand outs and a few coping mechanisms. So only a few weeks after my treatment, stopping my medication due to thinking I was cured, and life was back to normal. I spiralled back into my depression and was suicidal again within days. My family tried to contact DCMH for help, but those horrible words, of our Duty of Care has been done, you will have to go through the NHS. (POC0047)

My son was discharged... with PTSD. He had been receiving treatment [from the Armed Forces]. He did receive some good care, as a former registered mental health nurse I know what good care looks like. When he was discharged into the care of the local NHS Trust, Norfolk and Suffolk NHS Foundation Trust, the care received could not be recognised as good care. (POC0061)

Before leaving the service I was in the care of DCMH, they took over 5 years to diagnose me with PTSD and once I left they just left me to find help by myself. It took a lot to admit I had a problem and then to be left to find help once out of the service was hard. It seemed that once my termination date was reached I wasn't DCMH's problem anymore. Don't get me wrong I am grateful for them diagnosing me but why did it take so long and why did they just discard me once my tx date was reached. (POC0065)

- 23) Individuals particularly recommended better coordination and transfer of medical files between the Ministry of Defence and the civilian health services.

There is no visible transition period of medical care when leaving the services; you leave and you're on your own! However, this could be easily achieved and administrated, prior to discharge by Unit medical centres, ensuring registration and initial medical screening appointments (including drug history) are completed, with subsequent health check appointments booked in as standard. Military medical documents need to be seamlessly transferred to the NHS/GP system, including historical access to FMed4 archives. The MoD must also be up front and honest when service medical documents (pre-DMICP) "have been lost" and the surgeon general must not accept this as the norm. (POC0045)

From experience of the NHS and settling into a different medical system. I would suggest that increasing the availability of mental health care for those that leave with mental health issues is increased by six months to a full year. Initially setting up my NHS medical care was difficult, and the paperwork I was given to hand to my NHS medical centre was dated ... and looked at

with amusement and somewhat scepticism by the staff at the centre. This needs to be urgently updated and maybe re-issuing with updated details, maybe referring to the Armed Forces Covenant and TILS. (POC0075)

Statutory provision for veterans

24) Most submissions discussed their experiences of mental health care in the civilian health system and a number of common issues were raised including a lack of understanding of the military culture by civilian medical practitioners, variation in care, speed of access and a lack of provision for complex and long-term cases.

Understanding of military culture by civilian medical practitioners

25) Many believed that veterans needed to be treated by medical practitioners who understood their military background, the mental health issues they were suffering from or the services available to a veteran and a number provided examples of how this led to ineffective treatment.

When my wife spoke to our son's local GP in [Norfolk], he had no knowledge of PTSD and she had to refer him to a book and website explaining it! There was some knowledge of veterans having priority to some services but it was a bit patchy. The recently announced introduction of having one GP in every practice trained in this area is very welcome. (POC0067)

I was referred to a civilian doctor via Service Veterans, and I viewed that assessment as fairly useless. I found it hard to explain to a civilian how I felt or how things had come to pass, and this attitude was reflected by my civilian GP, who I found obtuse and negative. Hence, although things have remained as bad as they were before, I have sought no further medical help. (POC0084)

Veterans complain that they simply shut down to the healthcare specialists very quickly as it is obvious very quickly that they simply have nothing in common. (POC0087)

My partner's GP did not understand what he needed or was entitled to. One example of how this has impacted us is that he has been on the wrong medication for over four years. He was recently referred to the Complex Mental Health Service for veterans, they have identified that he should have been referred to a psychiatrist at six month intervals by his GP but this never happened, and he continued to collect his prescription for inappropriate medication for his condition. (POC0088)

Military personnel do not respond well to the 'professionals' that are in this field. They do not feel a 'civvy' will understand them and will certainly not relate to anyone they feel is patronising and does not understand their mindset. Straight away there is a barrier in place and they are unlikely to engage. (POC0098)

Mental health care must be provided by those who understand military service, the psychological impact of training, deployment, and transition,

and the effects on family life. In my observations, forces personnel tend to 'play down' their symptoms and there is a culture of stoicism, that is at odds with the prevailing healthcare culture of speaking openly about symptoms. (POC0124)

Variation in care across the UK

26) Over a dozen submissions also highlighted the differences, both in quality and availability, in civilian mental healthcare, which depended on where a veteran lived in the country.

Postcode lottery, guys in remote areas struggle, and there is too much big city centric outreach centres, London, Birmingham, Salisbury, there is a North South divide and its makes life hard for veterans to travel for a whole day for a fifteen minute appointment. (POC0008)

I saw two different people from Veterans First Point. Both were not professional in their approach and did not explain their roles. The second was a therapist who said they could not offer assessment because I was in Fife and a psychiatrist's time had not been provisioned for in Fife but if I lived in Lothian I would have got this service. I felt poorly supported so chose to speak with my GP to be referred back to the NHS Fife Adult Psychology Service. (POC0039)

Now having moved up to live with family who are both ex-military, he has been seen by a NHS Team at Reading, Berkshire. This is far superior service than South Devon Health Care provided... NHS Reading Berkshire told us they are one of the most efficient in the country for military mental health. I do not think this is right. All military personnel should be treated in the same amount as time all over the country. (POC0086)

Speed of access

27) Many submissions also criticised how long it took to access specialist mental health treatment, even if care was critically needed, arguing that this was due to insufficient capacity within the system to meet demand.

I had to wait 6 months after discharge before NHS sent me to a sub-contractor civilian psychologist, for a set number of sessions (which ended up doubling) but had no useful effect on my condition. (POC0006)

After a particularly bad attack by me, my wife woke with me strangling her while I was asleep which led to me also attacking my daughter and grabbing her by the throat and lifting her off the floor choking her, my family had had enough. There was nowhere to go, the GPs were stuck with waiting lists, I was seriously ill and my wife on the edge of suicide herself. The Crisis Team was also cutback in that time so they were no help. (POC0032)

For my issues, seeing the GP was very quick (same day as crisis). However, appointments with appropriately trained mental health professionals was very slow (many months). I believe far more resources are required for mental health provision, particularly for veterans. (POC0040)

I have been waiting over 3 months after being assessed for severe PTSD from NHS Mental Health Team. The Government has fell well short of the Covenant. (POC0059)

In our case, once my husband 'broke down' and was made to go to the GP, he had to wait 2 months for an initial consultation and then subsequently told he would have to wait 6 months for a first consultant appointment. He was covering up that he was suicidal and what were we to do in the meantime? ... There is an insufficient number of psychiatrists and psychologists to support the number of mental health casualties. (POC0090)

Priority treatment and the Armed Forces Covenant

28) Of those submissions that referred to the Armed Forces Covenant and its principle of priority treatment for veterans, nearly all believed that there was a lack of awareness within the civilian health sector of either, with only one or two examples where a veteran did receive priority treatment. As a result, veterans and their families felt that the Armed Forces Covenant is ineffective and does not deliver what it promised.

I can personally testify (as can many others), that quoting the requirements of priority treatment in accordance with the Armed Forces Covenant, and even with an endorsement by local NHS management, access to treatment was not reduced and actually exceeded the 6 months maximum. This is another example of veteran's expectations being crushed by the MoD and the supporting NHS system. (POC0045)

I have seen no evidence of the Armed Force's Covenant's principle of priority care. The suicidal soldier I met yesterday was not offered a bed as he was not viewed as a risk, even though he had just tried to take his own life a few hours before. He was sent home... this one specific case and many anecdotal cases show there is zero priority given to veterans... It is only after veterans have left for several years that I am seeing the real problems. By this stage their former service is all but forgotten and they receive absolutely no prioritisation, despite what they have sacrificed for their country. (POC0087)

I was seen very quickly after this referral, apparently being advanced in the queue due to my veteran status. (POC0099)

In my experience of supporting both my husband, his former colleagues and members of his regiment ... many NHS providers have not heard of the armed forces covenant. When GPs are aware of it, they are unable to prioritise referrals, because they are not accepted as priority by mental health services. (POC0124)

29) A few submissions also raised examples of difficulties with other Government Departments:

However, every year I am subjected to a Work Case Assessment, and at my last one was deemed fit enough to work full time. My ESA was suspended, which in turn led me back onto anti-depressants and another relapse with mental illness. In the past 8 months I have had my ESA suspended 3 times and each time it has been reinstated. Whilst I would like to return to make a full contribution to society, the Benefits system, I feel does not allow for people, including myself. (POC0027)

They are stove-pipe organisations, there is a faux emphasis on cross department talking but in reality it does not work. If a veteran is on War Pension, he has to go through assessments for PIP, and assessments for other benefits. Why not just one assessment, and then all departments can respond to that. Veterans are put through more stress that way, and in the case of multiple appeals, it puts a strain on your recovery... It should be that a veteran is diagnosed, assessed, then automatically put on all the benefits, and allowances across DWP, Veterans UK, NHS, Local Authorities. Without having to be assessed multiple times. It nearly killed me. (POC0028)

Complex and long-term mental health issues

30) A small number of submissions also specifically raised concerns over the insufficient care available to those with complex mental health needs, including the limitations on repeat treatment.

I had no effective treatment for nearly 28 months before placement on their [Combat Stress'] ITP [Intensive Treatment Programme]—however, because NHS Scotland and the Scottish Government are involved with funding, there is a caveat that individuals attending the ITP do it once, anything after is community outreach, if available. (POC0012)

Anyway I found out about the new complex mental health service coming out on April the 1st 2018 and I rang them, yet to be told my husband was too complex/severe. Yet again hopes raised and then come tumbling down with a crash. [NHS England later told her that the Complex mental health team could take him on no matter what] (POC0020)

[His GP] referred him and he was offered another course of CBT [Cognitive behavioural therapy]. On the initial assessment appointment he was told that he had too many issues and was too complex a case and was sent away feeling very let down and on his own. (POC0077)

Veteran suicides

31) A number of submissions raised cases where a veteran had taken or tried to take their own life as a result of mental health issues. A few also criticised the lack of recording of the deceased being a veteran by coroners.

Should a veteran feel that their last or only option that remains to them is suicide, please let it be recorded that they were a veteran. Coroner's currently do not acknowledge veterans, nor the correct number of veterans who have committed suicide. Please at least help to change this. This is only my opinion, but one that is shared. (POC0003)

I myself am suffering with PTSD, it has destroyed my life ... I attempted to kill myself a few years back but failed! luckily for me my ex-partner contacted Combat Stress, I then spent in total 8 weeks with them that helped me tremendously, I managed then to sort my life out to a point ... I have signed this petition [on recording suicides by veterans] because of the above and because a friend who I served with took his own life a couple of weeks back because of PTSD, also in the last couple of months I know of at least 8 veterans that have committed suicide for the same reasons. Something must be done to stop this epidemic! (POC0030)

Sadly we are losing too many ex service personnel to suicide, many of them not recorded as 'service related' It is difficult for family members to know what is best to do to help or, more importantly, what not to do and make things worse. My greatest concern is for those who are alone with no family support. (POC0077)

Armed Forces charities mental health care provision

- 32) Around half of the submissions received made reference to the provision of mental health care provided by Armed Forces charities.
- 33) Several submissions, however, criticised the Ministry of Defence and the health services for veterans having to rely on charity provision in order to receive the care they need.

Now before I had seen anyone face-to-face, I was well advised to self-refer myself to combat stress—As great a name that they are, They are a CHARITY, not a an NHS service. No member of our serving and ex-serving community should be referred to a charity by our own care system. (POC0003)

There are many organisations that have been set up to help Veterans, especially with mental health issues, and the very difficult transition from military life to being a civilian. The fact that these organisations are charities is a complete disgrace, a dark and bloody stain on our society; it makes a mockery of the supposed covenant we were promised. The Gateway scheme is a step in the right direction, but these charities must be funded by government and not left to the goodwill of citizens. (POC0004)

Again I must emphasise that funding for the agencies involved must come from government and not rely on the charity of the population at large; most of whom are disgusted by the way Veterans are treated once the services cease to have responsibility for their welfare. (POC0036)

The hotch potch of charities who provide support do an admirable job at present but they are not equipped or resourced well enough to cope with this massive issue. The UK government must step up to the plate on this. (POC0094)

Experiences of care received

34) Some submissions praised the mental health care provided by charities

My wife did a search online and found a small advert for Combat Stress and as a final attempt phoned and asked for help. Within 2 weeks we were visited by a welfare officer who did a quick assessment, before leaving I was in tears as for once someone listened to what I was saying, not what they thought I should be saying. Within another month I was invited for a 1 week assessment where I was given a written diagnosis of severe PTSD. My life was about to change. (POC0032)

I found Combat Stress extremely helpful, being amongst similarly affected Veterans removed some of the stigma I felt. Alongside other agencies; RBL, H4H and HighGround as well as various forms of medication I have learnt many coping mechanisms and have been able to begin to realise a more fulfilling life. (POC0036)

Our experience is that nothing has been provided by central government and that the limited help that has been provided for our son has been via charities such as Combat Stress, the British Legion and Walking with the Wounded... They are the very overstretched provision. Without them, there would be nothing that we have found accessible. (POC0067)

35) However, others reported issues with the care received, due to for example a lack of capacity or limitations on the care they could provide.

I forced him to contact [a charity] and they arranged to have someone come to see him, but it was a long wait at the time. So, before that happened, he then took a huge overdose of his medication. It was enough to be fatal, but I found him in time. (POC0013)

I did get him down to [a charity] and saw a gentleman doctor there that was ex services and so he went for a two-week inpatient course which was totally the wrong thing to do for him... (think they opened up the wound even more and then said good bye). We were then told he was too severe for [them] to treat and with no sign posting to any other service (and the fact also that they were controlling his medication and then they stopped his care caused huge problems for us and his GP as they said they had no experience in this area). (POC0020)

My mental health deteriorated I begged charity's for help I was passed around charity to charity, this went on for years. Nothing. (POC0026)

[This charity] was contacted but we had a nightmare with them. To the point where we were told that my son didn't qualify to be treated by them. (POC0086)

- 36) A few also raised the lack of consistent coverage across the country.

From there I underwent their 6-week Intensive Therapy Program (ITP) in May/June of this year. Apart from a 1 hour, 6-week review over the phone, that is all I can get from [them]—they don't have a community outreach program further than the Central Belt—fantastic if you live in Glasgow, not great if you live elsewhere (POC0012)

However, one of the problems unique to my regiment is the distance to reach face-to-face support. Many veterans live in isolated locations away from their former peers and away from where charitable organisations are based. To compound matters, many have lost their driving licences due to alcohol abuse so simply can't travel to make meetings. (POC0087)

Navigating the range of services

- 37) At least a quarter of the submissions reported on the challenges of identifying where to seek help, given the range of Government and charity mental health providers. Some also believed that the difficulties might result in veterans choosing not to seek help.

Why are there so many charities trying to offer similar things? Is there a central hub/service centre that can support the veterans to access what they need and direct to most useful service? Help for Heroes/RBL [Royal British Legion/SAFFA/Combat Stress/Veterans Gateway etc etc... I'm confused who does what, but for the service person who likes avoidance and minimisation its likely a factor that may put them off rather than encourage engagement. (POC0064)

Whilst there is a vast support network available through charities that information is not readily accessible through a single POC. It requires major investigation which makes it difficult for someone who is struggling with MH issues, adding to stress and anxiety. (POC0062)

The environment can be mindboggling to a veteran in need of support and quite simply put them off seeking support. This in turn can lead to those that need it most, not seeking help. There are members of my veteran group, that were not aware of what charities do what, or even aware they can apply for a veteran's badge. This is the sort of information that can be pushed through veteran's workplace groups. (POC0125)

Since my dealing with the mental health services in 2013, I found it a very individual and splintered service at best. I believe that now it is catching up with the likes of, the Gateway, and charities raising awareness of the problems with PTSD. (POC0047)

38) Of the small number of submissions that referenced the Veterans Gateway as an initiative to help signpost veterans to the right organisation, some veterans had not heard of it until responding to our inquiry's terms of reference, others chose not to use it or believed that it needed improvements.

A simple example is—as an ex officer who had been through MH treatment in service and then via the NHS for life threatening conditions, as someone who is press, social media and defence aware, I hadn't heard of the Veterans Gateway until... a few weeks ago. I rest my case... The veterans gateway is reconfigured to include a triage capability able to signpost people quickly to the Samaritans, NHS Crisis team, or lastly service charity. Reliance on Charities first MUST STOP. The MoD must take responsibility for each and every person notified to it and coordinate their care until discharged. (POC0063)

I had never heard of the Veterans' Gateway until reading this... The Scots Div Veterans' Support Group on Facebook has 3,500+ members and I have yet to see a single reference to the VG. (POC0087)

Coordination between mental health care providers

39) Around a quarter of the submissions also received criticised the lack of coordination between national and local government and charities, with some believing that there needed to be a single 'umbrella' organisation to oversee mental health provision to veterans.

The committee needs to understand the dynamics of mental health within the current serving and veterans community there should be an overarching charity like the VA in the United States and in each County where there is a central mental health of excellence and drop in centre running therapy, advice in all disciplines of life and activities. (POC0022)

There is little to no evidence of govt departments, local authorities and charities across the UK working together in any meaningful way. As someone who is politically savvy, I haven't heard of any initiatives, nor have any of the colleagues or veterans who I have spoken. (POC0063)

There is no cohesive strategy to co-ordinate the response from all the different organisations offering support. Because of the debilitating symptoms of PTSD, veterans are not able to plan their own course through the minefield that is out there. What is needed is a body overseeing all of this that allocates individuals to support and advise them - advocates who can oversee their progress through their problems. (POC0067)

From my experience, many charities are trying to cover gaps in the system but they are disjointed, stove-piped in their approach and fiercely protective of their budget. I believe that a Mental Health 'Tsar' appointed by Government would have a large effect in bringing them all together. At the moment too many people have an opinion for the system to deliver in an efficient and effective manner. (POC0120)

40) Some highlighted the consequences of this lack of coordination, including poor transfer of information and duplication. Others also raised the frustration of having to repeat their experiences again and again as they pass through the system.

No long term continuity for patients needing long term mental health access to psychologists and psychiatrists and psychiatric nurses, or social workers. The latter two in military scenarios are mainly contractors, the former often high ranking medical officers who have specialist psychiatrist military body of knowledge. This can lead to duplication, re-living and re-telling the “story” five or 6 times. (POC0006)

Also at each stage the veteran has to repeat their story, traumas, and medical ad infinitum to complete strangers for assessment and treatment. (POC0008)

There is a lot of money wasted with duplication and information not being passed on (data protection must be the most overused reason for not doing anything I have heard during the last 9 years). I hate money being wasted and I think there is a lot of waste with the military charities not working collaboratively and dove tailing their provision with each other and the governments provision. (POC0098)

There is little evidence that they are working together effectively. There seems to be duplication of effort to assess veterans, but little coordination of treatment and limited resources for families. (POC0124)

Families

41) Around a quarter of the submissions received referenced to the mental health needs for Armed Forces families. Many expressed concerns over the lack of specific provision of care for them, particularly as they believed that, like veterans, they needed clinicians who understood their circumstances.

Why are there no services (or if there are why are they not advertised) to support the children of personnel with dealing with the PTSD what it means, impacts on them for the future. I remain concerned about the impact of my husband’s emotional and mental health on the wellbeing of my children. Currently and for the long term future it’s a condition that will not go away (POC0064)

As a partner of a veteran with mental health issues I often find life very difficult and I really still don’t know where to turn to or where to get help. I don’t feel comfortable talking to my GP about it. I have reached out to [a local charity] for support and I am on a waiting list for therapy however I have been on the waiting list for a long number of months now. (POC0088)

I have attended IAPT assessment appointments only to be told to find a private counsellor or do some CBT—unfortunately the private counsellors just do not understand the circumstances in which we live in. The mental health of the partner should have no bearing on whether the person/ people

they live with get help. In fact, addressing the wife/ husband/ partner would be more beneficial to the serviceman/ woman as we would have more slack for their behaviours. (POC0101)

- 42) A few submissions also noted that the definition of family should be extended to beyond who the serving personnel is living with.

Having received treatment I am well aware of what is available within the system. However, the MoD could do more to signpost support for families. The support is well publicised to families living in Service Families Accommodation but more should be done to advertise to wider family members. E.g. most young soldiers have families elsewhere and the burden of mental health support often falls on them when soldiers go home for the weekend/ leave. The families then do not know how to engage the Army without worrying that they will adversely impact a serviceman's career. (POC0108)

- 43) A few reported that they also found it difficult to decide to seek help

I also joined The Ripple Pond it took me several goes of telephoning and putting the phone down. Not having the courage to do it, not wanting to feel guilty. Eventually after one argument too much with my son I did it. They were amazing. I was breaking my heart. They listened and gave me advice. I now go regularly to my local group. I try so hard to help others as I am further down the line than some of them. I get great feeling that my knowledge can help others. (POC0086)

- 44) Another common theme was the view that family members receive no training or support in looking after someone still serving or a veteran with mental health issues.

There should be information sent out to wives of ex military personnel of symptoms to look for, they are the front line and take the brunt of a husband/partner with PTSD. MoD became insular during the cold war period, we had military hospitals around the country that could help out veterans, and we got rid of them because the military reduced in numbers. (POC0032)

The impact of MH on families seems to be wholly underestimated and unrecognised. We provide support 24/7 and have first-hand experience of how our partners are coping. We receive no training in how to support our loved ones or how to cope with someone with MH issues. This leads to a detrimental impact on our own mental health (as I can personally testify). (POC0062)

Tolerance of poor mental health behaviours was shown on base, but no help given to families, where domestic violence erupted. (POC0073)

Partners and soldiers/veterans families (not only wives) should be provided with adequate support and be invited to discuss the issues they are facing and receive guidance and support to enable them to best assist the soldier/veteran (POC0082)

Submissions reviewed

Statistics on the submissions reviewed

	Male	Female
Serving Personnel	11 (2)	5
Veteran	54 (15)	8 (1)
Other	4	2 (1)
TOTAL	69 (17)	15 (2)

Note 1: Numbers in brackets denote how many submissions out of the total were provided by a family member of the individual serving personnel or veteran

Note 2: Other includes submissions relating to civil service experiences and experiences as a family member

Submissions from individuals reviewed

1	POC0001	22	POC0024	43	POC0049	64	POC0077
2	POC0002	23	POC0025	44	POC0052	65	POC0079
3	POC0003	24	POC0026	45	POC0053	66	POC0082
4	POC0004 and POC0036	25	POC0027	46	POC0055	67	POC0084
5	POC0005	26	POC0028	47	POC0056	68	POC0086
6	POC0006	27	POC0029	48	POC0058	69	POC0087
7	POC0007	28	POC0030	49	POC0059	70	POC0088
8	POC0008	29	POC0031	50	POC0060	71	POC0090
9	POC0009	30	POC0032	51	POC0061	72	POC0092
10	POC0012	31	POC0033	52	POC0062	73	POC0094
11	POC0013	32	POC0034	53	POC0063	74	POC0097
12	POC0014	33	POC0035	54	POC0064	75	POC0098
13	POC0015	34	POC0037	55	POC0065	76	POC0099
14	POC0016	35	POC0038	56	POC0066	77	POC0100
15	POC0017	36	POC0039	57	POC0067	78	POC0101
16	POC0018	37	POC0040	58	POC0068	79	POC0108
17	POC0019	38	POC0042	59	POC0070	80	POC0115
18	POC0020	39	POC0043	60	POC0071	81	POC0116
19	POC0021	40	POC0045	61	POC0073	82	POC0120
20	POC0022	41	POC0047	62	POC0074	83	POC0123
21	POC0023	42	POC0048	63	POC0075 and POC0125	84	POC0124

Formal minutes

Tuesday 19 February 2019

Members present:

Rt Hon Dr Julian Lewis, in the Chair

Rt Hon Mr Mark Francois Ruth Smeeth

Gavin Robinson

Draft Report (*Mental Health and the Armed Forces, Part Two: The Provision of Care*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 157 read and agreed to.

Summary, Key Facts and Annex agreed to.

Resolved, That the Report be the Fourteenth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Tuesday 26 February at 10.30am

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Tuesday 11 September 2018

Question number

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

[Q1–66](#)

Tuesday 13 November 2018

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

[Q67–142](#)

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

[Q143–212](#)

Tuesday 27 November 2018

Catherine Braddick-Hughes, **Andy Price** and **Tim Boughton**

[Q213–272](#)

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

[Q273–334](#)

Tuesday 18 December 2018

Rt Hon Tobias Ellwood MP, Parliamentary Under-Secretary of State and Minister for Defence People and Veterans, Ministry of Defence; **Lieutenant-General Richard Nugee**, Ministry of Defence; **Jackie Doyle-Price MP**, Parliamentary Under-Secretary of State for Mental Health, Inequalities and Suicide Prevention, Department of Health and Social Care; and **Kate Davies**, Director of Health & Justice, Armed Forces and Sexual Assault Services Commissioning, NHS England

[Q335–432](#)

Johnny Mercer MP

[Q433–448](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

POC numbers are generated by the evidence processing system and so may not be complete.

- 1 Anglia Ruskin University ([POC0083](#))
- 2 Armed Services Advice Project, Lanarkshire Region ([POC0105](#))
- 3 Army Families Federation ([POC0044](#))
- 4 Big White Wall ([POC0114](#))
- 5 Blind Veterans UK and UK Acquired Brain Injury Forum ([POC0126](#))
- 6 Combat Stress ([POC0080](#))
- 7 Combat Stress ([POC0127](#))
- 8 Contact Group ([POC0107](#))
- 9 Councillor Archie Dryburgh ([POC0010](#))
- 10 Department of Health & Social Care ([POC0130](#))
- 11 Department of Health and Social Services, Welsh Government ([POC0119](#))
- 12 Dr Ashley Croft ([POC0081](#))
- 13 Forward Assist ([POC0057](#))
- 14 Help for Heroes ([POC0069](#))
- 15 Icarus On-Line ([POC0046](#))
- 16 Ministry of Defence ([POC0050](#))
- 17 Ministry of Defence ([POC0111](#))
- 18 Ministry of Defence ([POC0129](#))
- 19 NHS England ([POC0113](#))
- 20 Northumbria and Chester Universities ([POC0096](#))
- 21 PTSD Resolution ([POC0122](#))
- 22 Royal College of Psychiatrists ([POC0112](#))
- 23 Royal Hospital Chelsea ([POC0128](#))
- 24 The British Psychological Society ([POC0093](#))
- 25 The Felix Health Group ([POC0102](#))
- 26 The Naval Families Federation ([POC0054](#))
- 27 The RAF Association ([POC0089](#))
- 28 The Royal British Legion ([POC0104](#))
- 29 Thistle Foundation ([POC0072](#))
- 30 UDR & R Irish Aftercare Service ([POC0041](#))
- 31 Ulster University Veterans Research Group ([POC0106](#))
- 32 Veterans' NHS Wales ([POC0078](#))
- 33 York St John University ([POC0091](#))

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website. The reference number of the Government's response to each Report is printed in brackets after the HC printing number.

Session 2017–19

First Report	Gambling on 'Efficiency': Defence Acquisition and Procurement	HC 431
Second Report	Unclear for take-off? F-35 Procurement	HC 326
Third Report	Sunset for the Royal Marines? The Royal Marines and UK amphibious capability	HC 622
Fourth Report	Rash or Rational? North Korea and the threat it poses	HC 327
Fifth Report	Lost in Translation? Afghan Interpreters and Other Locally Employed Civilians	HC 572
Sixth Report	The Government's proposals for a future security partnership with the European Union	HC 594
Seventh Report	Beyond 2 per cent: A preliminary report on the Modernising Defence Programme	HC 818
Eighth Report	Indispensable allies: US, NATO and UK Defence relations	HC 387
Ninth Report	Armed Forces Covenant Annual Report 2017	HC 707
Tenth Report	UK arms exports during 2016	HC 666
Eleventh Report	Armed Forces and veterans mental health	hc 813
Twelfth Report	On Thin Ice: UK Defence in the Arctic	HC 388
Thirteenth Report	Future Anti-Ship Missile Systems: Joint inquiry with the Assemblée nationale's Standing Committee on National Defence and the Armed Forces	HC 1071
First Special Report	SDSR 2015 and the Army	HC 311
Second Special Report	Armed Forces Covenant Annual Report 2016	HC 310
Third Special Report	Investigations into fatalities in Northern Ireland involving British military personnel: Government Response to the Committee's Seventh Report of Session 2016–17	HC 549
Fourth Special Report	Gambling on 'Efficiency': Defence Acquisition and Procurement: Government Response to the Committee's First Report	HC 846
Fifth Special Report	Unclear for take-off? F-35 Procurement: Responses to the Committee's Second Report	HC 845
Sixth Special Report	Sunset for the Royal Marines? The Royal Marines and UK amphibious capability: Government Response to the Committee's Third Report	HC 1044

Seventh Special Report	Rash or Rational? North Korea and the threat it poses: Government Response to the Committee's Fourth Report	HC 1155
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