Health, Wellbeing and Local Government Committee
HWLG(3)-14-10-p7 Pathways
22 September 2010

Steven Hughes MB BS FRCS FRCS(Orth)
*Consultant Trauma and Orthopaedic Surgeon*

**Written Brief provided on request prior to oral evidence to:**

The National Assembly for Wales
Health Wellbeing and Local Government Committee
Inquiry into Post Traumatic Stress Disorder Treatment for Services Veterans

## Conflict of Interest Statement

I am Vice-Chairman of the Board of Trustees of Pathways PTSD Treatment Service for Veterans, Registered Charity Number 1130474, based at Telford House, Bangor.

## Status

I am Steven James Hughes, a fully registered Medical Practitioner. My qualifications are MB, BS, obtained by Degree at the University of London in 1980, LRCP, MRCS FRCS obtained by Conjoint Diploma of the Royal Colleges of Physicians, and Surgeons of England in 1980, FRCS obtained by Diploma of the Royal College of Surgeons of England in 1987, and FRCS (Orth) obtained by Diploma of the Intercollegiate Board of Orthopaedic Surgery in 1995.

I hold a Certificate of Accreditation in Trauma and Orthopaedic Surgery dating from 17th November 1995. I am registered on the Specialist Register of the General Medical Council under the specialty of Trauma and Orthopaedic Surgery.

I am employed as a Consultant Orthopaedic and Trauma Surgeon at Heart of England NHS Foundation Trust), West Midlands.

My background in the field of Post-Traumatic Stress Disorder (PTSD) is outlined in my Annexe A.

I commence my evidence with the responses of Freedom of Information requests to the Assembly dated 8 September 2010

"Dear Mr Hughes

**Freedom of Information Request Number 4459**

I refer to your email of 11 August 2010 requesting information under the provisions of the Freedom of Information Act 2000 (the Act).

You asked the following:

> **1. "How many service veterans are resident in Wales?**
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> **2. How many prisoners in Welsh jails are ex-servicemen or women?**
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> **3. How many homeless persons are there in Wales? Are there any statistics as to how many homeless are ex-services?**
>
> **4. How many Consultant Psychiatrists or Consultant Psychologists in Wales have a specialist interest in the treatment of Combat Related Post Traumatic Stress Disorder?**
>
> **5. How many ex-servicemen/women have been given a specific diagnosis of Post-Traumatic Stress Disorder?**
>
> **6. Are there any statistics available to the success of treatment of Combat Related PTSD in Health Board Mental Health Units?"**

In response:

> **1. How many service veterans are resident in Wales?**
>
> According to the latest survey undertaken for The Royal British Legion in 2005, there were 4.8 million veterans in the UK, with a further 3.63 million adult dependents comprising an adult ex-service community of 8.43 million. According to the survey, some 5 per cent of the adult ex-service community were resident in Wales.

**2. How many prisoners in Welsh jails are ex-servicemen or women?**

Responsibility for the Prison Service is non-devolved and the Welsh Assembly Government does not hold data on the number of ex-service personnel in Welsh prisons.

**3. How many homeless persons are then in Wales? Are there any statistics as to how many homeless are ex-services?**

Figures collected on homelessness by the Welsh Assembly Government relate to households rather than persons. A household is accepted as statutory homeless by a local authority if it is eligible, unintentionally homeless, and falls within a defined priority need category.

The latest figures collected from local authorities cover the period January to March 2010. There were 1,468 households accepted as homeless by the local authorities and therefore owed the main statutory duty to rehouse.

Of these, four households were classified as being in priority need as a result of leaving the armed forces.

**4. How many Consultant Psychiatrists or Consultant Psychologists in Wales have a specialist interest in the treatment of Combat Related Post Traumatic Stress Disorder?**

This information is not held by the Welsh Assembly Government.

**5. How many ex-servicemen/women have been given a specific diagnosis of Post-Traumatic Stress Disorder?**

This information is not held by the Welsh Assembly Government.

**6. Are there any statistics available to the success of treatment of Combat Related PTSD in Health Board Mental Health Units?**

This information is not held centrally by the Welsh Assembly Government.

Opinion

Given the speculative data as to the number of Veterans residing in Wales, the lack of data as to the number of Welsh Veterans suffering from PTSD, and the lack of data as to the number of experts in this complex condition, I can only speculate myself on such figures.

However, given no data on the size of the problem, and no idea as to who is affected, no idea as to who is competent to treat PTSD, it seems that WAG is happy to leave vulnerable veterans to the whims of local Mental Health Services.

PTSD is a life-long risk condition. I.e. The only statement one can make about its manifestation is that it only does so before death. Incidence figures therefore have to be based on long term follow up. My figures at 5 years (very early) were 24 %. The Americans and the Israelis agree on about 25 %. The Assembly cites figures from Royal Marines as 22%. This would fit with my contacts with Brigadier Charlie Hobson, Chief Executive of the Royal Marines Benevolent association.

I have declared my conflict of interest, but, in truth Pathways has no specific financial imperative to treat Welsh veterans. We have clients enough from the rest of the UK. However, because we are based in Wales we have cases from the Principality referred to us, or often they refer themselves. We cannot take them on because we know that they will not be funded. As a Welshman, born in Newport, educated at Gowerton Boys Grammar School, I find this sad.

Doubly so, because 28 years ago, on the foreshore in Fitzroy Water, I coordinated the treatment of the severely burnt and traumatized Welsh Guardsmen who off the Sir Galahad, and Sir Tristram. I knew then that sometime this would “come home to roost.”

**Steven Hughes MB BS LRCP MRCS FRCS FRCS(Orth)**
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**Vice-Chairman, Pathways PTSD Treatment Service**

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## Post-Traumatic Stress Disorder is NOT a Psychiatric illness.

Post-Traumatic Stress Disorder (PTSD) is a natural emotional reaction to a deeply shocking and disturbing experience.

It is a ***normal*** reaction to an ***abnormal*** situation.

*(One of the first descriptions of PTSD was made by the Greek historian Herodotus.....in 490 BC.)*

PTSD is a debilitating condition that affects people who have been exposed to a major traumatic event, or events, and is characterized by upsetting memories or thoughts of the ordeal, "blunting" of emotions, increased anxiety, and sometimes severe personality changes. Amongst combat veterans there is a common pattern of attempted symptom suppression by alcohol and/or drug abuse, with a downward spiral of employment difficulties, relationship problems, confrontation with the law, and even suicide.

Over 100,000 American veterans have committed suicide since the Vietnam War; - 55,000 died in the War. In the UK context, more Falkland veterans have committed suicide since the Falklands Conflict than those who died in action.)

My own research figures five years after the Falklands Campaign indicated that 25% of serving PARAs were demonstrated to have PTSD. We have no idea of the percentage of ex-servicemen from the Falklands Campaign are so affected. We do know that approximately 10% of the prison population (and probably more) are ex-service personnel. 2,000 are estimated to have PTSD. 12% of the homeless population are veterans.

I come from a background of being the Regimental Medical Officer of the 2nd Battalion, The Parachute Regiment during the Falklands Campaign. We were the first troops ashore. We were first into battle at Darwin and Goose Green, where we lost our Commanding Officer, amongst many good men. (Just under 400 paratroopers defeated 1500 plus Argentines.)

2 PARA was the only functioning unit in Fitzroy when the Sir Galahad and Sir Tristram were hit, if you view the video footage, those red berets treating Welsh Guardsmen are 2 PARA, and mostly ordinary soldiers, not medics. The only battalion to go into battle for a second time was 2 PARA, on Wireless Ridge.

Within 2 years of the conflict, despite having left the Battalion, I knew "we" had problems. My study into the PTSD in "a PARA Battalion", 5 years after the conflict, revealed a PTSD rate of nearly 25%.

*O'Brien LS, Hughes SJH. Symptoms of post-traumatic stress disorder in Falkland veterans five years later. B J Psych 1991; 159:135-141.*
The work for this paper was done "5 years later", i.e. 1987. It finally received clearance from MOD in 1990.

6 years after the conflict, in 1988, I developed PTSD myself. I was admitted to the Maudsley Hospital in London, where the diagnosis was missed, and only subsequently by virtue of my friendship with! Surgeon Captain Morgan O'Connell, Psychiatrist to the Falkland Task Force was the diagnosis made, and treatment facilitated at Princess Alexandra Hospital, RAF Wroughton. (At this stage there was still a network of service hospitals in the UK, and they treated ex-servicemen and women.)

I described my experiences in a paper in the British Medical Journal in 1990

*Hughes SJ. Inside Madness. Br Med J. 1990; 301:1476-78.*

A copy of this paper is appended to the end of this document.

I have been involved in campaigning for adequate treatment facilities since 1985, when I initiated the study into the incidence of PTSD in 2 PARA veterans of the Falklands Conflict.

I have facilitated referral of 2 PARA veterans (who contact me as their "doc") to a small number of psychologist or psychiatrists who have offered their services pro-bono, independent of the NHS, with little or no thanks other than from their very grateful patients, and their families.

There has not been a year gone by since 1985 that I have not had a least 2 of my former charges contact me seeking help with PTSD related problems.

Focused appropriately veterans can make a spectacular turnaround, and very often dedicate their lives to helping their peers find their way out of the mire that is PTSD. 3 of the Outreach Workers for Pathways are ex-Falkland veterans of 2 PARA.

**Current Provision of Care**

On discharge from the Services the treatment of veterans becomes the responsibility of the National Health Service. Discharged servicemen and women are disseminated throughout the UK. Often they do not realise that they have PTSD. If they have a GP he may not know they have experienced combat; even if the GP does, he or she may have no experience of PTSD.

If the diagnosis is made, the local Mental Health Services may have no understanding how to treat PTSD; and there may be no treatment facility. There is no national treatment strategy. To date neither the Ministry of Defence, nor the Department of Health seems to want to take ownership of the problem. It remains to be seen what approach will be taken by the Coalition Government.

> The paucity of treatment facilities is an on-going news item, with one of the more damning most recent criticisms of MOD made by Lance Corporal Johnson Behary VC, on 28 February 2009.
>
> *"The NHS don't have my record, so they don't know my problems, they don't know my trauma. So if I go with a problem I need to explain everything to them again which at the time I was in so much pain, I was so angry with myself, I was so angry even with the people around me because of the way I was feeling. I don't want to explain anything."*

## Thought for the Day

If a veteran had sustained complex physical injuries beyond the expertise of his local hospital he would be treated at an appropriate specialist unit. It might even be heavily funded by a charity, like Help for Heroes. This is obviously not the case if a veteran carries psychological, rather than physical Scars of War.

Why?

Steven Hughes
21 September 2010

**Inside Madness**

Steven Hughes

British Medical Journal VOLUME 301 22-29 DECEMBER 1990

"It's a funny thing, stress," said the boss, little realising how prophetic his words would prove to be in the ensuing month. He was a worried surgical consultant comforting an even more worried surgical trainee. The previous night, Saturday, on call in a London teaching hospital, I had suffered a profound, incapacitating, panic attack. For no obvious reason I had suddenly been overwhelmed by a crescendo of blind unreasoning fear, defying all logic and insight.

Bewildered and summoning my last reserves of concentration, I had referred myself to the duty psychiatrist and had been sedated and admitted to the psychiatric ward of my own hospital.

As an army medical officer I had served in the Falkland Islands campaign in 1982, but nothing that General Galtieri's men had generated compared with the terrors that my own mind invented that night. Having looked death full in the eye on a windswept isthmus outside Goose Green and again, but two weeks later, on a barren hillside called Wireless Ridge, I think I can honestly say I no longer feared death or the things real and imagined that usually become the objects of phobias. I was afraid that night of the only thing that could still frighten me, myself.

I was terrified of losing my control. No logic could rationalise what had happened. I could not let go in case I lost control, and the more I battled against my fear the more the panic increased. I had been completely physically and mentally exhausted when they had sedated me. Now, in the cold light of Sunday morning, with my parents and my consultant with me, I was feeling foolish but far from sane. What had happened to me? What was to stop it happening again?

In an effort to save me embarrassment the psychiatric staff tried to find me a bed in another London hospital. It took several hours on the telephone but eventually one was found. I was transferred to a world centre, where I was admitted by the duty registrar. He apologised, the only bed available was in a forensic psychiatric ward. Thus, an hour later, I found myself in a side room (a cell), in a ward for the criminally insane.

I amused myself with the thought that two years with the Parachute Regiment must equate to a criminal record. I couldn't be completely mad if I could still smile at my predicament. So far I had been seen by a senior house officer and a senior registrar at my own hospital and a registrar and a senior registrar at the second hospital. Sedation had been started and subsequently stopped. I had been clerked several times, but the only person who had really communicated with and helped me was the senior house officer on the night

of admission, the newest recruit to the specialty. We had met once before when he had been a medical senior house officer and I a surgical registrar in another hospital.

I struggled not only to regain but also to retain my sanity in an environment out of One Flew Over the Cuckoo's Nest. At least the nurses in the film wore name badges and uniforms. Here, you could barely tell staff from patients. Who were the minders and who were the minded? Drugs were dispensed on the Pavlovian stimulus of a bell and the summons to "medication time"; patients shuffled in a queue to receive their pills from a hatch. Never the same face.

After 48 hours in hospital I started to get restless. I wanted to see the same face twice. I wanted to know why it had happened. I knew that getting agitated was counterproductive so I lay on my bed to try and calm down when one of the nurses came in to tell me I had 30 minutes to pack for the move to another hospital. I pointed out that someone ought to tell my parents, who would be setting off to visit me, and that I needed my wallet from the safe.

Hurriedly bundling my possessions, I was escorted to a waiting ambulance, only to be asked to dismount as they didn't yet have clearance to carry me. Clearance eventually forthcoming, we departed for one of the famous Surrey "bins."

The new ward was less forbidding, although the absence of uniform or name badges and the summons to medication proved to be the same. I was told that I would be accompanied by a nurse at all times-it seemed that I was now under a close supervision order. There had been no such restrictions on me until then. I was, after all, a voluntary patient.

I couldn't now go for a pee without my shadow, but this was short lived. The duty psychiatric registrar came to admit me. He was dressed reassuringly in a collar and tie; he looked and talked like a doctor. We discussed our attitudes to dress and patients' expectations of their doctor. We held similar opinions; until recently he had been a physician.

Thankfully, he decided that I might be agitated and depressed but that I was neither dangerous nor suicidal. He dismissed my minder but after he had gone one of the nurses appeared. They had discussed me among themselves and decided that if I wasn't to have a minder they wanted my ties and belts. Holding on to my trousers and my dignity, I handed them over. In jest, I volunteered that perhaps they should take my plastic laundry bag in case I put my head in it. The bag was confiscated, leaving me with an untidy pile of soiled clothes. I knew by now that things had got out of control. I was no longer confident as a patient. If I was going to keep things together I had to assert myself.

Thus I adopted my safe "doctor" persona again. It was no use playing "patient" because all that happened so far had served only to destabilise me. The system wasn't helping me. At least I knew now what discharge entailed. I would have to wait to be seen by the consultant on his ward round at the end of the week. I was discovering that psychiatrists do not share the same time scale as other clinicians, particularly surgeons. This only added to my sense of apprehension and frustration. During the three days waiting to see the consultant I acquired something of an entourage of fellow patients. I found companionship and comfort and they found reassurance in knowing someone who knew how to stall the system.

I found surprising talent and compassion besides the sadness and torment: many remarkable people with surprising abilities but temporarily lacking the capacity to cope with the world outside. It was us against the system. I became indebted to my family and friends visiting. Thank God for the telephone. It was easy to imagine becoming lost to the outside world. How many souls have disappeared into the British psychiatric archipelago?

On Friday I faced inquisition, passed, and was duly released to my home for two weeks to convalesce. Thus a fortnight later, more than a little confused by events, I returned to work. After 12 days it happened all over again. Panic consumed me, again out of the blue, at a trauma conference. I sought sanctuary in a nearby casualty department.

This time I really thought that I was losing my grip on sanity. I will never forget the bizarre fixations on inanimate objects as I tried desperately to divert my attention from the unhinging of my world; -an electric socket, a patient trolley-was this madness? Help from a young nurse, human contact and understanding rescued me. A young student nurse talked me out of the fog and calmed me down until the arrival of the psychiatric senior registrar. I related my story, including the nightmare of my earlier stay in hospital, and was by now much calmer. Thankfully, he decided against admitting me. It was a mark of my terror that, despite what I had experienced two weeks before, it had been the lesser evil to return for help to that system, but as the panic passed anything was preferable to another fruitless stay in an NHS ward.

Agitated but functioning I drove home to my country cottage, my only remaining sanctuary. My parents came as soon as I called and stayed with me that night and the next day. It was they who persuaded me to contact a naval psychiatrist friend for advice. As I put the telephone down from speaking to him the penny finally dropped. He had also been with the Falkland taskforce and after speaking to him I flashed back. I suddenly found myself back at Goose Green, in the rain and the smoke and the horror. I felt again the fear, the despair, the grief, and the anger; an overwhelming maelstrom of emotions long since buried deep in my soul. I had PTSD-post-traumatic stress disorder.
Distraught by this stage, my parents did the only sensible thing, they called

my general practitioner. He was superb-prompt, professional, calm, and reassuring. He had a discussion with the military, and my admission to a service hospital was arranged. My subsequent treatment was the way out of the abyss.

The contrast with the NHS was stark. Crisp pressed uniforms, mutual respect, and the implied expectancy of return to normality and duty were powerful advantages of dealing with predominantly stress related conditions in a service hospital. But is that beyond the NHS? It was not pleasant, but it was the way to normality. I started to address what I had never acknowledged let alone come to terms with, the hidden memories and feelings of those black days of 1982. I had never had the time to release the suppressed emotions that I had dared not show as I fought to keep alive those gallant young men, Argentineans and Brits, friend and foe, on that desolate Goose Green isthmus. Aware of the eyes of my medics on me, their leader, I had got on, seemingly impassively, with the job at hand, even when the bodies of some of my closest friends lay only yards away.

With the seriously wounded needing lifesaving help, there is no place for the cold, still image of the friend, joking but a few hours before, now with a 7.62 mm entry wound in the middle of his forehead, his body half hidden under a tarpaulin next to that of the charismatic commanding officer we both so admired and loved.

Goose Green was my ultimate nightmare. The subsequent memories of the Galahad disaster and Wireless Ridge pale into insignificance by comparison. Whatever snapped did so in the burning gorse at Goose Green. They do say you can feel only one pain at a time. Returning home to a society that had simply watched another war movie on television, I never seemed to get the space to grieve for my friends. As time passed so I supposed and hoped had the need. It was as if I had erased the emotion from the tape in my head that records those memories.

Although I had instigated and co-written a research study on post-traumatic stress disorder in Falkland veterans, I had ignored all the symptoms in the mirror. My rehabilitation is not over yet. Indeed, it may never be. If ever I come fully to terms with the nightmare that is war then perhaps I will have changed for the worse. Perhaps, by sharing my experiences I can find peace. Certainly, the process of treatment seems to be one of sharing and thus dispersing the hurt. In a way it is like the dissipation of energy, the greater the area of impact the less the damage.

What can be learnt from my tale? Professionally, we must seek a better way of treating sick doctors when it comes to mental illness. Doctors have greater insight of the system than most patients and are often treated by staff and patients alike as aliens. For this reason they are even more vulnerable to the whims of the system and need special efforts to engender reassurance, comfort, and stability.

On an individual level, perhaps we should strive to be less insular about our reactions to stress, particularly when talking to each other. Surgeons are hardly renowned for being caring individuals; most of us affect an impersonal, impassive, protective facade. What surprised me was the tremendous support of my surgical colleagues, contemporary, and senior. The almost universal reaction seemed to be, "If it can happen to Steve could it happen to me?"

It's a pity it takes a breakdown to elicit that support. I would encourage any doctor in similar straits to seek help early from colleagues-we're only human, no matter how invincible we try to appear. It was the young who coped and communicated best with me. Honesty and humanity are so precious.

Finally, my story represents only the tip of an iceberg. It is not just other Falkland veterans, somewhere in the region of 20% of the combatants, and veterans of other military conflicts who are having problems, or even the survivors of the string of civilian disasters of recent years. It is the individual whose personal disaster does not rate media or, sometimes, even medical recognition but none the less leaves him or her psychologically damaged and, with the increasing fragmentation of the family, less able than ever to find help. Many, like me, will not even be aware that they have a problem. It is for these other victims that I regard the telling of my story to be essential. In the words of John Bradford, "But for the grace of God...."