# Cynulliad Cenedlaethol Cymru
# The National Assembly for Wales

## Y Pwyllgor Iechyd, Lles a Llywodraeth Leol
## The Health, Wellbeing and Local Government Committee

**Dydd Mercher, 22 Medi 2010**
**Wednesday, 22 September 2010**

**Cynnwys**
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**Aelodau'r pwyllgor yn bresennol**
**Committee members in attendance**

| | |
|---|---|
| Lorraine Barrett | Llafur<br>Labour |
| Andrew R.T. Davies | Ceidwadwyr Cymreig<br>Welsh Conservatives |
| Veronica German | Democratiaid Rhyddfrydol Cymru<br>Welsh Liberal Democrats |
| Irene James | Llafur<br>Labour |
| Ann Jones | Llafur<br>Labour |
| Helen Mary Jones | Plaid Cymru<br>The Party of Wales |
| David Lloyd | Plaid Cymru<br>The Party of Wales |
| Val Lloyd | Llafur<br>Labour |
| Darren Millar | Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor)<br>Welsh Conservatives (Committee Chair) |

**Eraill yn bresennol**
**Others in attendance**

| | |
|---|---|
| Paul Cleary | Hafal<br>Hafal |
| John Davies | Hafal<br>Hafal |
| Paul Estebanez | Grwp Cymorth Cyn-filwyr y Rhondda<br>Rhondda Veterans Support Group |
| Dr Steven Hughes | Pathways<br>Pathways |
| Ian Hulatt | Coleg Nyrsio Brenhinol<br>Royal College of Nursing |
| Chris Jones | Grwp Cymorth Cyn-filwyr y Rhondda<br>Rhondda Veterans Support Group |
| Neil Kitchiner | Therapydd Iechyd Meddwl Cyn-filwyr Cymunedol<br>Community Veterans Mental Health Therapist |
| Peter Nicholson | Cymdeithas Orthodonteg Prydain<br>British Orthodontic Society |
| Chris O'Neill | Forces for Good<br>Forces for Good |
| Pamela Stephenson | Cymdeithas Orthodonteg Prydain<br>British Orthodontic Society |
| Lisa Turnbull | Coleg Nyrsio Brenhinol<br>Royal College of Nursing |

**Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol**
**National Assembly for Wales officials in attendance**

| | |
|---|---|
| Marc Wyn Jones | Clerc<br>Clerk |
| Sarita Marshall | Dirprwy Glerc<br>Deputy Clerk |

*Dechreuodd y cyfarfod am 9.04 a.m.*
*The meeting began at 9.04 a.m.*

## Cyflwyniad, Ymddiheuriadau a Dirprwyon
## Introduction, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everyone. Welcome to this committee meeting. I particularly welcome our witnesses. I remind everyone that translation facilities are available via the headsets that are in front of everyone. The simultaneous translation feed is available on channel 1, while channel 0 plays the language being spoken, which you can amplify. If it is necessary to evacuate the room or the public gallery in the event of an emergency, everyone should follow the instructions of the ushers who will be able to guide you to the appropriate exit. I remind everyone, including witnesses, that the microphones are operated remotely. You do not have to press any buttons; they will come on as you speak and go off when you have finished.

9.05 a.m.

## Ymchwiliad i Wasanaethau Orthodontig yng Nghymru—Casglu Tystiolaeth
## Inquiry into Orthodontic Services in Wales—Evidence Gathering

[2] **Darren Millar:** We are starting two new inquiries at our meeting today, the first of which we will start in a moment, namely our inquiry into orthodontic services in Wales. You will know that, today, we are delighted to have as our guests and witnesses Peter Nicholson and Pamela Stephenson from the British Orthodontic Society. Thank you both for the paper that has been presented to the committee, which has been circulated to everyone. If we can, we will move straight into questions on that paper.

[3] We know that there are some problems in parts of Wales with regard to access to orthodontic treatment. The reality of that very much comes through in some Assembly Members' postbags. What evidence is out there about whether there is a shortage of orthodontic practitioners in Wales?

[4] **Mr Nicholson:** I will begin. I have some figures here. My paper was a response on behalf of the south-east Wales managed clinical network for orthodontics, although I am here representing the British Orthodontic Society. So, these are figures for south-east Wales. At the moment, to be precise, 1,521 patients are on hospital treatment waiting lists in south-east Wales and they represent a wait to start treatment of somewhere between 14 and 27 months. These are patients who have been assessed. They have had a new patient appointment with a consultant and they have been assessed as requiring hospital treatment, which is a very restricted part of the market. These are the most complex cases requiring multidisciplinary care. So, they are assessed patients who require high-level treatment for which there is a very high demand. We have 1,500 of those in south-east Wales at the moment.

[5] Much of the treatment is carried out within hospital units with our specialist trainees, and we have had a fallow year in that the university takes in trainees for only two years out of three. So, we are just coming to the end of our fallow year. We have new postgraduates starting in October and those waiting lists will look somewhat better, probably by about next April. Nonetheless, there is a big wait there.

[6] As far as the specialist practitioners are concerned, they take a different route to seeing their patients. In the hospital, we have always kept our new patient waiting lists very short so that we can offer advice to dentists, general practitioners, hospital colleagues and so on. So, any new patient referred to a hospital consultant in south-east Wales will be seen

within 10 to 12 weeks. Of course, we have had Government targets for that, so those are pretty short.

[7] Specialist practitioners have a limited contract; it is limited by the number of units of orthodontic activity that they have been awarded as part of their contract. They tend to see patients when they have capacity, so they have very long new patient waiting lists but when those patients have been seen by the orthodontist, they start treatment straight away. That means that their waiting lists are not validated in any way. Currently, 5,498 patients are on specialist practitioners' waiting lists in south-east Wales. We know that those are inflated figures, because there will be duplicate referrals and inappropriate referrals, and a number of those patients will not want treatment. You could lose 50 per cent. It is very difficult to be sure about that.

9.10 a.m.

[8] I have spoken to colleagues over the past few weeks to gather this information, and some practices are telling me that they are not starting any new patients because they have used up their UOA allocation for this year.

[9] **Darren Millar:** Sorry, what is UOA?

[10] **Mr Nicholson:** Units of orthodontic activity. That is the currency of the orthodontic contract in specialist practice. They say, 'I have used up my allocation for this year, so I will not be seeing any patients off my waiting list until next April'. Some of them have told me that, even assuming a normal uptake, they have more patients waiting than next year's contract will cover. So, it is a serious issue.

[11] **Darren Millar:** Sorry, but we are having difficulties with some of the equipment. Can you just run that by me again? In terms of the waiting list that you referred to, you have the hospital and the specialist waiting lists, effectively. The specialist orthodontic waiting list has 5,498 on it, but did you say that is not validated in any way?

[12] **Mr Nicholson:** It is just what is on their waiting list. Nobody has seen those patients yet.

[13] **Darren Millar:** What would be the average wait for one of those patients, acknowledging that those figures may not be accurate?

[14] **Mr Nicholson:** If you look across the specialist practices in south-east Wales, there are people who say that they have no waiting list, and there are others who say that they have a 30-month waiting list.

[15] **Darren Millar:** Right. Can you comment on the Wales-wide picture?

[16] **Ms Stephenson:** I can comment from the hospital point of view, because my remit was to respond from the Welsh consultant orthodontists group. Peter mentioned that 1,500 patients are waiting on the hospital waiting list for treatment in south-east Wales, and that figure rises to between 2,000 and 2,200 patients in Wales on hospital waiting lists. They will wait anywhere from 15 months in some units to 28 months in other units before they start their treatment.

[17] **Darren Millar:** Okay.

[18] **Val Lloyd:** I just want to take you back to the comment about the 1,500 patients waiting for specialist treatment in south-east Wales.

[19] **Mr Nicholson:** That is the number of patients on hospital waiting lists. The difference between the two is that we know that the 1,500 patients on a hospital waiting list have been assessed, have a very high need for treatment and a need for complex treatment, whereas the 5,500 sitting out there who have been referred in by dentists are completely non-assessed at this stage, other than by the fact that their dentist has generated a new patient appointment or referral.

[20] **Val Lloyd:** What I wanted to focus in on—and I am sorry I did not qualify that figure correctly—is whether they are waiting for orthodontic treatment or perhaps something nearer maxillofacial treatment? Is it definitely orthodontics?

[21] **Mr Nicholson:** It is for orthodontics.

[22] **Val Lloyd:** How many orthodontist specialist practitioners do you have in south-east Wales?

[23] **Mr Nicholson:** Sorry, but are we talking—

[24] **Val Lloyd:** How many of the practitioners that those 1,500 people are waiting to see do you have in south-east Wales?

[25] **Ms Stephenson:** The 1,500 people relate to the hospital service, and there are approximately 16 members of the Welsh consultant orthodontists group, who are consultants or people who already have a specialist qualification and are training to be consultants. So, there are those 16, and then there are also, usually, approximately six to eight trainees in Wales, though their number varies from year to year. There will also be a small number of non-orthodontic specialist staff who will do some treatments under the direction of the consultants. So, we are probably talking about fewer than 30 specialist and non-specialist practitioners who are working within the hospital system, and they are mainly consultants and those in training.

[26] **Val Lloyd:** Is that for south-east Wales or is it for the whole of Wales?

[27] **Ms Stephenson:** My figure is for the whole of Wales.

[28] **Mr Nicholson:** The number on the waiting lists is something like 2,200.

[29] **Darren Millar:** Are the waiting lists increasing? How do they compare to those of 12 months ago, two years ago, or three years ago?

[30] **Ms Stephenson:** For the hospital waiting lists, they are increasing, partly because when the new contract was brought in for the specialist practices, they limited who could be treated in a specialist practice to those with fairly high need. Therefore, we have had more referrals from general dental practitioners to the hospital system hoping that we might be able to treat those patients, because they are not being treated in a specialist practice.

[31] **Mr Nicholson:** I must emphasise again that that would be our new patients, while the numbers that we are talking about with regard to the hospital are patients who have been assessed as having a high treatment need and a complex treatment requirement that needs hospital management rather than specialist practice management.

[32] **Darren Millar:** Okay, so you are saying that the number has increased, but by what sort of order?

[33] **Mr Nicholson:** I think that the number is creeping up rather than leaping up. I think that we have had an increase in new patient referrals as a result of the contract, because of the pressure that the limited contract put on waiting lists generally, which means that dentists have perhaps tried to look to us to provide management. We are also getting an increasing number of requests for second opinions, because the new contract for the specialist practices has a bottom limit below which NHS treatment is not funded. Your average mum may not agree with that and would therefore often request a second opinion, so I think that we have an increasing number of those as well.

[34] **Darren Millar:** Okay, thank you.

[35] **Veronica German:** You just mentioned the waiting list for practices rather than hospital. They have not been assessed yet, and you said that there are about 5,500.

[36] **Mr Nicholson:** Indeed, yes. That is in south-east Wales.

[37] **Veronica German:** Presumably, then, that is replicated across Wales. My point is that you said that half of these might not actually really be suitable. It could be up to half, though it may not be.

[38] **Mr Nicholson:** It could be, yes.

[39] **Veronica German:** I believe that dentists are supposed to use the index of orthodontic treatment need. In your opinion, do local dentists understand that index and apply it? Presumably, it is important, because of the level being assessed.

[40] **Mr Nicholson:** No. I think that it is tricky. I undertook an audit at the Royal Glamorgan Hospital, which is my base unit. Twenty-seven per cent of the referrals that I received as a hospital consultant were inappropriate. I made a huge effort to educate my local referring practitioners, and I got that number down to 16 per cent. So, that is a saving. The only trouble is that, two years on, nearly all the young associates in practice have moved on. It is an ongoing process and it is difficult. There is undoubtedly, I think, a gain to be achieved by educating general dental practitioners better.

[41] The other problem is that they tend to be one-stop referrers. My beef to them is that they need to be discerning referrers. They need to say what looks like a really complex case that has big issues and should be sent to the hospital, what is fairly routine stuff that should go to the specialist, and what does not have a treatment need. You would like to think that they could make that discerning referral. In fact, they tend to refer everything either to me or to the specialist, and they flip-flop depending on where the waiting list is. That is an issue. It is a real problem.

[42] It is even more of an issue if you consider a patient with a very high objective need for treatment and a complex treatment requirement who gets referred to a specialist practitioner, waits two and a half years to see them, and the practitioner says, 'No, sorry, you need to be seen at the hospital'. I then get a referral from one of the specialist practices asking me to see this patient as quickly as I can. That is inappropriate, of course.

[43] **Veronica German:** So, what would be the route to ensure that dentists in general practice are trained? They are trained at one point in their life, no doubt, to use this index, but how can we ensure that that is what they are doing and that they are kept up to date?

9.20 a.m.

[44] You are doing that in your particular case. You are going to the people who are

referring to you, but is it your responsibility? Whose responsibility is it to ensure that they are doing that properly?

[45] **Ms Stephenson:** One issue is that general dental practitioners are not orthodontists, and although the patient may not need treatment, they need advice. So, some of the 5,000 patients on the waiting list to be seen for assessment will only need advice and will not necessarily go on for treatment. The general dental practitioners are not trained to identify an orthodontic case. That is very difficult to do unless you are an orthodontist.

[46] There are several levels at which they can be educated, starting with undergraduate training and then proceeding into postgraduate training and courses throughout life. As Peter said, if we as consultants train our local general dental practitioners, it is not a static population and it does flow and ebb, so you are constantly training and re-educating them. So, it is at three levels: university education, postgraduate education and within the hospital consultant remit as well.

[47] **Mr Nicholson:** Speaking as an orthodontist, I would love for IOTN training to be mandatory for general dental practitioners, but it is not. There are some things that they have to do: they have to do cross-infection and various other aspects that are a requirement of their continuing professional development; training in IOTN is not one of them. The General Dental Council would probably say that it is not important enough, but speaking as an orthodontist, I would love for all practitioners to be trained in IOTN and to be retrained constantly. It would certainly make our lives a lot easier.

[48] **Darren Millar:** It sounds as though there are a lot of inappropriate referrals.

[49] **Mr Nicholson:** Yes, there is a significant number.

[50] **Ann Jones:** What is your involvement with the British Dental Association? Do you get together to decide what you are going to refer as part of an adequate training programme? You have said you would love for them all to be trained in IOTN, so is there not an onus for someone to say, 'Look, what you are doing as dentists is fine, but you really need to do this second stage as well so you have an understanding'. It does not seem that your association and the BDA are working together at all.

[51] **Mr Nicholson:** I would not say that that was true. We are in constant touch with, for example, the dental postgraduate department. It puts on courses. The trouble is that what you tend to get if you put on an orthodontic training course is that you are preaching to the converted. The people who come to the courses are the people who have an interest in orthodontics. As I say, speaking as an orthodontist, I would like that training to be mandatory.

[52] **Ann Jones:** Who can make it mandatory? It is all right sitting here and saying, 'We would like it to be mandatory' but you have identified that there is a shortfall somewhere.

[53] **Ms Stephenson:** It would be the General Dental Council.

[54] **Ann Jones:** Are we having it in during this inquiry?

[55] **Darren Millar:** I do not think that we are. It is an important point and we are grateful to you for making it.

[56] **Irene James:** In your paper, you state that specialist orthodontic practices have been awarded contracts representing their 2003 starts rather than the volume of their patient care at the start of the contract in 2006. What impact do you think this had on the provision of orthodontic care and the services provided for NHS patients?

[57] **Mr Nicholson:** The mechanism used for setting up the the new dental contract introduced in April 2006 was that they took a reference period of roughly October to October finishing the previous year. Under the old contract, orthodontists were paid at the completion of treatment. They received some small interim payments, but they received their fee when the treatment was complete.

[58] If you take a practice that was well-established and running at a constant level, the mechanism said, 'This is what you earned and how much work you did in that one-year period; we are going to take that sum and make that your new income; we will pay it to you in monthly doses and we expect you to do this amount of work based on this number of UOAs'. That is how it was set up.

[59] That was fine for well-established practices, but for developing practices—such as a practice in north Cardiff that had just taken on a young associate, and I know there were issues in expanding practices in south-west Wales—under the old contract during the first year, you hardly earned a bean. There were some small interim payments that covered set-up costs and the like. Thereafter, there was a period before you started completing cases, because orthodontics work takes 18 months to two years to complete. So, someone who started up in the period just before the reference period might have very little income during the reference period. It was an obvious flaw in the way that the contract was set up. The British Orthodontic Society and just about every orthodontist said, 'This is not a good way to do it for expanding practices'. The Government at the time said, 'We appreciate that this is an issue—we will make some adjustments'. Those adjustments never really happened. Ultimately, the adjustment was done by leaving it to local health boards, whose orthodontic pot was fixed by that period, and they did not have any extra money to pick up practices.

[60] So, by April 2006, people in expanding practices were, perhaps, working full-time, effectively, but they had a contract that represented only a day and a half or two days' worth of work in a week. They were seriously short-changed and a lot of people were pretty badly done by.

[61] **Andrew R.T. Davies:** I just want to clarify something, because I recognise the practice that you have identified in Cardiff, and that point has been raised with me. You said that the issue was raised and would have been addressed with the Government at the time. You indicate that there has been no progress, but you are referring to some four or five years back. Has there been any progress to date, given that the problem is known and that the solution is in hand if there is a will to put it in place? Has there been any progress in allowing the transition from being a new practitioner in a practice to gaining a salaried position within that practice?

[62] **Mr Nicholson:** No. The orthodontic pot was fixed during that period for specialist practice, and has largely been upgraded with inflation since, although not for the last two years. I do not undertake specialist practice—

[63] **Andrew R.T. Davies:** So, has there been no progress?

[64] **Mr Nicholson:** No. There were some small additional contracts; they found a small additional amount of money somewhere in Cardiff at the time to slightly increase one contract.

[65] **Andrew R.T. Davies:** However, there has been no meaningful progress?

[66] **Mr Nicholson:** No.

[67] **Ms Stephenson:** There were limited contracts early on, but for the last two or three years there has been no expansion in contracts and, therefore, no expansion of practices and no more patients being taken on for treatment, even though the demand has increased.

[68] **Darren Millar:** Why is demand increasing?

[69] **Ms Stephenson:** Partly because patients and the public are more aware of their dental health and are more aware of orthodontics and the benefit that it can have. The psychosocial wellbeing of patients is very important, and it is increasing as people become more focused on dental healthcare and what is available. So, although braces were a 'no-no' 20 or 30 years ago, people now understand that they have very good benefits to patients and are happy to carry out the treatment.

[70] **Helen Mary Jones:** This might be a slightly provocative question. If we are talking about people's socio-psychological wellbeing, are we saying that we are getting an increasingly American attitude to teeth? I say this as the mother of a 14-year-old girl. Are we treating people for the sake of their appearance, rather than for the sake of their dental wellbeing? For example, people want their front teeth straightened when, in fact, there is no problem with where the back teeth are configuring and no likelihood that that is going to cause problems in later life. This is purely anecdotal from personal experience and I could be wrong. I raise the question about whether we ought to be treating on the national health on the basis of making people feel better about the way that they look.

9.30 a.m.

[71] **Ms Stephenson:** I agree. The psychosocial aspect is one aspect of it. There are many other dental health benefits from doing orthodontic treatment, in terms of trauma—patients' teeth are often subject to trauma if they stick out too far—and longevity. The benefit of the IOTN—index of treatment need—is that it takes only a small account of the aesthetics. The majority of it is related to dental health need benefits. So, those patients who are treated on the national health service have a high need for dental health reasons, not for aesthetics. I think that patients want to have their aesthetics improved even though they may not have a high dental need. That is why the demand has increased.

[72] **Helen Mary Jones:** Would that partly account for inappropriate referrals, perhaps not to hospital but to specialist treatment?

[73] **Ms Stephenson:** Possibly, yes.

[74] **Mr Nicholson:** This is the source of our second opinions. The dental health component of IOTN says, 'Sorry, you are not—'

[75] **Helen Mary Jones:** This is not causing you a health problem.

[76] **Mr Nicholson:** 'This is not a health problem; therefore, you are not going to have treatment under the NHS.' Sometimes that is difficult to explain to an educated middle-class mum.

[77] **Darren Millar:** What proportion of the waiting lists are second opinion requests?

[78] **Mr Nicholson:** An increasing proportion, but not a huge proportion. It is something that we as consultants have noticed. It might account for only 5 per cent or something like that. It is a relatively small figure. It is just that it usually takes longer to explain to somebody why they are not having treatment than to explain to them that, 'Yes, you do need treatment. We will put you on a waiting list and we will get going as soon as we can'.

[79] **Helen Mary Jones:** That figures.

[80] **Irene James:** Following on from that, what action is needed to reduce long waiting times and to address the backlog of NHS patients?

[81] **Mr Nicholson:** What is needed?

[82] **Irene James:** Yes.

[83] **Mr Nicholson:** It is treatment capacity. I know that means money and I know that is an awkward thing at this stage. There is a real issue of treatment capacity in the hospitals because we know that those 2,000-plus patients on hospital waiting lists have a high treatment need. As to the rest, yes, it is a problem and it is one that, essentially, requires resources.

[84] The other thing that has to be addressed is the backlog. Even if we had adequate contracts to cope with the current demand and workload, there is a big backlog in the system. It is not a matter of introducing a one-off new patient waiting list initiative that can quickly sweep the backlog under the carpet with a bit of money in time for 31 March, as has been done in the health service, as we know. This is a two-year commitment to ongoing treatment for quite a lot of kids to catch up.

[85] For many of these children, while orthodontic treatment can be carried out at most ages, if your 12-year-old has prominent, ugly teeth that are upsetting them, the optimum time for treatment is now, rather than putting them on a two-year waiting list so that they get treatment when they are angst-ridden and beginning to stress about their GCSEs. So, it is an issue. The backlog is a huge problem.

[86] **Ms Stephenson:** For the hospital system, what we need to do to address the backlog is to attract and recruit more consultants into the service. Going further down the specialist training line, it would be beneficial to recruit more specialist registrars who are training to be orthodontists. At the moment, within our area, we have five trainees and we would like to see that number increase to six trainees at any one time. That would start the process of their becoming eligible for their further training to become a consultant. So, if we can get more specialist trainees locally, they are more likely to stay within the area and then apply for consultant positions within Wales.

[87] **Darren Millar:** However, one of the issues with these inappropriate referrals is that if you could take them down to an acceptable level, would you need to put further investment into the system? You have acknowledged we are in difficulties at the moment.

[88] **Mr Nicholson:** I know; I nodded. I think that the answer is ‘yes’, and one of the things that has been developing is managed clinical networks. The one in south-east Wales is relatively new. We have only just had the approval of the different health boards, and we can start looking at the issues in south-east Wales on a basis where the clinicians and management can resolve a number of these problems. We have to get our own house in order, but there is still a problem there.

[89] **Darren Millar:** There is still going to be a gap.

[90] **Ms Stephenson:** However, within the hospital system, the 2,000 or so patients on the hospital waiting list are not the result of any inappropriate referrals. Those have already been weeded out, so these are the ones who need treatment; they have a complex and high need for orthodontic treatment.

[91] **Mr Nicholson:** Yes, the inappropriate referrals relates to the number of those among the 5,500 on the south-east Wales specialist practice waiting list who really will need treatment.

[92] The other point that should be made is that there might be a big drop-out rate on that. What we have not recorded is the number of patients who have been seen—perhaps the orthodontist has assessed them and they are a little bit early and are on pre-treatment review. I looked back at some figures I had available for when I ran my own practice, and pre-treatment reviews represented 60 per cent of the patients on my waiting list. So, there is a hidden group out there who have been seen; they have not been rejected for treatment on the grounds that it is inappropriate; and we are waiting for them to get older, grow teeth, whatever. There is a big, hidden group of patients. I would not mind betting—I know that is probably not helpful—that that number would just about counterbalance getting rid of those inappropriate referrals.

[93] **Darren Millar:** Okay. Andrew, do you want to come in?

[94] **Andrew R.T. Davies:** Can I just pick up on a couple of points? Since I indicated to the Chairman you have covered one or two of them. We often hear from witnesses like your good selves, and you give the profession's opinion of the matter under discussion. You touched on the structures, and said that the reorganisation might offer some hope of making the system more efficient. Am I right in thinking that you saw that as one of the potential solutions? If the structures do bed down in that way, could that be one aspect, aside from extra money, of improving the service?

[95] **Mr Nicholson:** It can only help. Until now, the process has been disparate, and it is obviously helpful if health boards understand the issues from the clinicians' side, and vice versa. It is likely to make the system more efficient, but I do not think that we can kid ourselves that it is going to resolve the problem.

[96] **Andrew R.T. Davies:** Is that because, fundamentally, additional resource is required—namely, money? Have you any idea as a profession—and maybe it is somewhat unfair to ask this, but it is possible that you will know—what sort of money we are talking about, given your experience? I am thinking back to this committee's inquiry into stroke services where we were able to elicit a figure that the committee could work to in its recommendations.

[97] **Mr Nicholson:** I would like to go away and think about that for a while with a piece of paper. [*Laughter.*]

[98] **Andrew R.T. Davies:** Asking for more money per se is the obvious answer, is it not?

[99] **Mr Nicholson:** Sure.

[100] **Andrew R.T. Davies:** Quantifying that request with some substantive evidence to say, 'This is what you would get for your money' would add more weight, I would suggest, to a recommendation or committee report.

[101] **Mr Nicholson:** Yes. I certainly think that as we have got together as a managed clinical network, one of the things that has become apparent is the paucity of data. Orthodontics is an awkward specialty in that sense. It is not just a one-off intervention. So, in the hospital service, my postgraduate coming in this October will start a bunch of patients; the next year she will not start or finish any patients; and the year after that she will finish a lot of patients. It makes recording activity very difficult, and it makes funding difficult because health boards, if they are looking at specialist practice, have to think of the commitment for

two years.

[102] **Andrew R.T. Davies:** The point I am trying to make is that, as a politician, perhaps having sympathy and wanting to assist, it is difficult to quantify the demand.

9.40 a.m.

[103] I hear what you say about the length of time of treatment and all the rest of it, but it is then very difficult to quantify that demand if I or other Members cannot elicit that sort of information. I think that you are saying that the quality information is not out there to provide the support.

[104] **Mr Nicholson:** You are asking me for something off the top of my head at this stage, and I think that if you had managed clinical networks in operation for six or nine months you would probably have much better information. We would need to fill consultant posts, more training posts with specialist registrars, and I would imagine that we would need a significant amount of additional manpower within the specialist practice area.

[105] **Darren Millar:** I am conscious of the time, but it is important that we have spent time getting this background for the rest of the inquiry. There are quite a few more questions that we want to get through this morning. There is no time to answer them all because the clock is against us, but we will take a few more over the next 10 minutes before we move on with the agenda. The next question is from Ann Jones.

[106] **Ann Jones:** You just mentioned the south-east Wales orthodontic managed clinical network helping you to get to grips with the problems in the area. Is that something that you would see being extended across the whole of Wales? Are you going to be the people who will be doing it?

[107] **Mr Nicholson:** We are based in south-east Wales; I suppose that I took the lead in getting the clinical network together. It has taken about a year, and we are just about at that official stage where it exists now. There are plans in south-west Wales and north Wales to put together a similar structure, and I think that it is the way forward with regard to managing. The change in the health boards has made a difference; it was impossible when we had 22 local health boards.

[108] **Ann Jones:** So, it is easier now?

[109] **Mr Nicholson:** Yes, but even now it cannot be on a health board basis. It is a bigger issue.

[110] **Ann Jones:** Are there any parts of Wales where there is no orthodontic provision? If so, do you know how that is being addressed?

[111] **Ms Stephenson:** There are quite a few parts of Wales where there is no orthodontic provision, mainly in the rural areas. So, we are talking about mid, west and north Wales, where accessing orthodontic provision would mean travelling at least two hours for an appointment. As far as I know, there are no plans to try to attract providers into the area.

[112] **Ann Jones:** People are prepared to travel for specialised treatment. For example, everyone keeps saying that they want neurosurgery in every district hospital. No, thank you; as I have always said, I would want to go to the centre where the specialist is. You mention travel time, so is it about trying to look at where we put centres?

[113] **Ms Stephenson:** Yes, I think that it is, partly. Treatment time for orthodontics, of

course, goes on for two years, and appointments are every six to eight weeks. So, we are talking about 15 to 20 or more appointments. That not only affects the patient, but also the parent who has to take time off work every six weeks. It can sometimes mean a whole day off work, which is very difficult for them.

[114] **Ann Jones:** So, there is a case, then, for bringing orthodontic services a lot closer, and away from the specialised centres.

[115] **Ms Stephenson:** If you can attract specialists into rural areas, then that would be a good idea.

[116] **Ann Jones:** Okay, thank you.

[117] **Mr Nicholson:** I know that a solution has been proposed that what you need is a specialist with some therapists, but you must remember that these orthodontic practices are privately funded. They are not like a doctor's surgery. So, if you are talking about setting up a practice in Llandrindod Wells, for example, which is somewhere where I have done clinics over many years in the past, then you are asking someone to cover a big capital cost and then, because of the rural nature, possibly only having two or three days' worth of work, even if you can come up with a contract for them. Therefore, there are commercial interests. Orthodontists in specialist practice want to look after their patients, but they also have a business to run.

[118] **Darren Millar:** Val, you wanted to come in here, and then Dai on the therapists.

[119] **Val Lloyd:** Would it be possible to have a situation where the medical practitioner travelled for one day or had a quick overnight stay and saw a group of patients who would then have less distance to travel?

[120] **Mr Nicholson:** I did that for 15 years, travelling from the Vale of Glamorgan up to Llandrindod Wells. It is hard work.

[121] **Val Lloyd:** I did not mean on a daily or a weekly basis, but on a six-weekly basis or something.

[122] **Mr Nicholson:** It is an inefficient way of using experienced manpower. A mutual friend of ours flies around the highlands and islands of Scotland, and I am not sure whether that is the most efficient way of doing it.

[123] **Ms Stephenson:** You would also be missing someone who is available to look after patients with any problems; they are often not available.

[124] **Mr Nicholson:** You must also attract someone into that kind of post.

[125] **Val Lloyd:** Thank you; I just wanted to explore that a little.

[126] **Darren Millar:** You raised the issue of therapists, on which Dai wants to ask a question.

[127] **David Lloyd:** I just want to flesh out the concerns in your paper about the wider orthodontic workforce, particularly as regards orthodontic therapists. You mentioned concerns about the legislation being a bit vague as regards training and so on. Could you elaborate on that?

[128] **Mr Nicholson:** It is not vague with regard to training, but the biggest issue for

orthodontists is that the legislation states that therapists must work under the supervision of a dentist, not someone who is a specialist. That caused huge grief at the time and the General Dental Council did not listen to the profession.

[129] **David Lloyd:** So, they are not getting their full quota of orthodontic experience, but more general dental experience. Is that what you are trying to say?

[130] **Mr Nicholson:** Therapists have a role, but, apart from anything else, having them requires a totally different way of setting up your working environment. You cannot just graft therapists into an already established practice. You need extra surgeries, for example, because most hospital units were not designed for therapists. We will have much greater use of therapists, but I think that you are looking at 10, 15 or 20 years before really starting to use them well. It will involve rebuilding and lots of capital investment.

[131] **Helen Mary Jones:** We have spent a lot of time on waiting lists, but I just have a very straightforward question. Has the Government target for hospital waiting lists helped to improve outcomes for patients or not?

[132] **Ms Stephenson:** We do not have a hospital target waiting list or hospital targets.

[133] **Helen Mary Jones:** Would a target help to concentrate the minds of the local health boards?

[134] **Ms Stephenson:** Yes, if it was a sensible target.

[135] **Mr Nicholson:** We have had discussions up the road on referral to treatment time targets. A sensible target would probably concentrate the minds of our managers. The trouble is, if you do not have a target, you are a non-person in the hospital because hospitals have become target driven. On the other hand, if the target is not sensible it just creates mayhem.

[136] **Darren Millar:** What do you think is a sensible target?

[137] **Ms Stephenson:** In England, the time for referral to treatment for everything is 18 weeks and we do not think that that is necessarily sensible. So, we would be looking at between 26 and 52 weeks for referral to treatment times.

[138] **Helen Mary Jones:** For hospital patients?

[139] **Ms Stephenson:** Yes.

[140] **Darren Millar:** Is the current longest wait 28 months?

[141] **Ms Stephenson:** Yes, in my unit.

[142] **Darren Millar:** That is incredibly different.

[143] **Helen Mary Jones:** My next question is on access to these services for people who face barriers to accessing them. Has the community dental health service helped to improve access to specialist care for vulnerable groups of people, specifically for disabled people and those with additional learning needs? Is there enough understanding of the system and communication between the different providers to make that work?

[144] **Ms Stephenson:** As Peter pointed out, the communication between different providers is facilitated by a managed clinical network, so that is ongoing and is at the embryo stage. The community dental service has a great role in treating disabled and other patients

who have difficulty in accessing care, but it is only a very small part of the whole orthodontic service.

[145] **Mr Nicholson:** I do not think that I have ever seen that as a barrier. It might be a barrier to treatment within specialist practice because they need to run efficiently. That is not to say that we do not run efficiently in the hospital—

[146] **Helen Mary Jones:** It is not the same pressure, is it?

[147] **Mr Nicholson:** We are not under the same pressures. I have waiting list figures for the community dental service orthodontists in south-east Wales. They currently have 202 patients waiting for initial assessment and 234 patients on their treatment waiting list.

9.50 a.m.

[148] **Helen Mary Jones:** Thank you, that is helpful.

[149] **Darren Millar:** I think that we will have to stop there, as the clock has beaten us. We have a few other questions, which we will forward on to you. We would appreciate a response to those as soon as you can provide it. If you have any further points that you would have liked to have made in your previous paper, please send those in to us. I am sure that they will be a very important contribution to our inquiry.

[150] Thank you both, Peter Nicholson and Pamela Stephenson, for your assistance today.

[151] **Ms Stephenson:** Thank you for inviting us.

9.52 a.m.

## Ymchwiliad i Driniaeth ar gyfer Anhwylder Straen Wedi Trawma i Gyn-filwyr y Lluoedd Arfog: Casglu Tystiolaeth
## Inquiry into Post-Traumatic Stress Disorder Treatment for Veterans: Evidence Gathering

[152] **Darren Millar:** We will move on to item 3 on our agenda—slightly later than advertised, but I am sure that you will appreciate that there were some important questions that we needed to get through with the previous witnesses.

[153] I am very pleased to welcome Ian Hulatt, mental health adviser for the Royal College of Nursing, Lisa Turnbull, policy and public affairs adviser for the RCN, John Davies, practice leader from Hafal, and Paul Cleary, a staff volunteer from Hafal. Welcome to you all.

[154] I would like to thank both sets of witnesses for the information that they have provided to the inquiry. Those papers have been circulated to Members, so if it is okay, we will go straight into questions on those particular papers.

[155] This question is to all of the witnesses. Perhaps the RCN can answer first and then Hafal afterwards. How widespread do you think that the problem of post-traumatic stress disorder is in veterans, and how does it affect the lives of veterans and their families? It is a big question to begin.

[156] **Ms Turnbull:** Clearly, it is a significant issue and, for those suffering from PTSD, it will have a tremendous impact on their lives and the lives of those around them in trying to carry out work and caring responsibilities, and all of those kinds of things. So, it is a

significant issue. The one point that we would also highlight, though, is that it is a significant issue among others that can affect veterans, such as anxiety, depression, and issues relating to alcohol misuse. It is an important issue to address, but it is part of a spectrum of issues and of care needs that require addressing.

[157] **Darren Millar:** Are you able to say how widespread it is among the veteran community? Do you have any indication or handle on that?

[158] **Ms Turnbull:** There are some measures. I think that perhaps the simple answer is 'no', because you are looking at the people who have come forward to access help; you are not necessarily able to quantify the unknown need, as it were. There are statistics on the proportion of those suffering from PTSD in the National Institute for Health and Clinical Excellence guidelines, and the evidence is quite clear about the type and numbers of people in the population at large who will suffer from PTSD. You could perhaps apply those to the veteran population in Wales. That would be a reasonable measure for trying to work out the scale of the issue.

[159] **Darren Millar:** Okay, thank you.

[160] **Mr Hulatt:** Just to reinforce what Lisa said, it may be many years before an individual presents with PTSD. People talk sometimes about 12 years maybe being an average period of time before someone is diagnosed or formally receives services. So, there is a lengthy trajectory of emotional and psychological difficulties, difficulties within social contexts, issues related to familial difficulties, domestic issues and, in some cases, unfortunately, crime as well. There is a lengthy trajectory before an individual contacts services. So, the numbers known might be small, but that does not mean that there is not a large number of people waiting to be formally diagnosed, assessed or receive services.

[161] **Darren Millar:** Thank you for that. Hafal?

[162] **Mr Davies:** As the others said, there are no statistics. Probably what is the most interesting is that real concept of hidden harm. PTSD does affect service people, as well as the communities and the families. In many cases, they can be the first point of contact, and maybe go to get help for their loved ones. It is probably going to be a growth industry for mental health services, both in the NHS and the voluntary sector.

[163] **Darren Millar:** So, early intervention and identification is key to preventing problems. Twelve years is a long time for someone to have to go through the pain of developing symptoms that are significant enough for services to kick in, is it not? That pain, of course, can cause all sorts of problems.

[164] **Mr Davies:** Yes.

[165] **Darren Millar:** Okay, thank you for those opening remarks. The next question is from Lorraine Barrett.

[166] **Lorraine Barrett:** In its written evidence, Hafal has said that, while research is ongoing into these matters of information and awareness raising, it believes that it is too limited to the post-traumatic stress disorder in relation to a traumatic event rather than encompassing the broader context of mental illness in forces personnel. This is a question to all of you, really. How effective are the current arrangements for identifying the incidence of PTSD? You said, Ian, that there is a long run-in, and I suppose that a part of that is, maybe, not identifying the problem in veterans and the need for services to treat it. How can the arrangements for identifying the incidence be improved?

[167] **Mr Davies:** It is about education. The first point of contact for many people will be either general practitioners or, sadly, criminal justice services. By the time people are in the criminal justice services they will have a tag as being a villain or a criminal. By the time they have seen a GP, maybe after that window period of 12 years, there will be all those other factors then. There will be that mishmash, so what will the GPs diagnose? Will it be PTSD or are they going to diagnose someone as being depressed, because they may have been unable to work, get benefits or housing?

[168] So, it is a multifaceted sort of problem, which is without resource and education. It is about education and involving communities. I think that it will be a growth industry unless something is done. It is just going to be like a revolving door for people that are hurting, including families.

[169] **Lorraine Barrett:** On that point, with regard to education, are you talking about education in the medical service?

[170] **Mr Davies:** Across the board.

[171] **Lorraine Barrett:** So, you are talking about education everywhere, wherever public services impact on people, and wherever there is that contact to identify.

[172] **Mr Davies:** Yes.

[173] **Lorraine Barrett:** Okay, thank you.

[174] **Mr Hulatt:** A point to make is that the Royal College of Nursing is in a position where it provides services to individuals who have PTSD and other mental health issues, but we also have many members who serve in areas of conflict. Therefore, we have an interest in them as consumers of the service as well. That is where we would just make a few points of concern about the issue of screening and assessment.

[175] Following deployment, when a nurse has been in an area of conflict and is returning from a period of service, I understand that they will go to somewhere such as Cyprus, for example, for a 48-hour period, where they will be seen by a psychiatric nurse for an assessment. At that point, if someone wants to get home, you can imagine the sort of answers that they might provide. So, there is a question there about assessment as a one-off. We know that assessment changes every time you assess, so the results of that assessment are worth thinking about from the point of view of a follow-up period when the individual is home.

10.00 a.m.

[176] During that period when an individual is on post-operative tour leave—I am thinking about a territorial army nurse—for six weeks, they are not allowed back into work or to be in touch with their unit; it is a sort of decompression period. Another way to look at that is that it is a period of isolation: a period of reflection on what has happened, perhaps by revisiting some of those traumas, and that is a difficult point.

[177] An interesting issue is that if they are out of the country for three months, when they return, they are off-listed by their GP, which means that they have to re-register. So you go back to your familiar GP who says, ‘Unfortunately, I cannot see you because you have been out of the country for three months’, so you will have to re-register and go through that bureaucratic process. So my access point for aftercare is then diminished. It can be accessed, but that could be perceived as being quite rejecting.

[178] So, there is an issue here about the care that we provide to individuals. For example,

do we know that this person is a veteran? I know the idea of marking records and tagging and labelling may sound unpleasant, but practically could we not know that that individual has served so that if someone comes in with alcohol issues or depression, it makes sense that that is a consequence of what they have experienced elsewhere in the theatre of war?

[179] So, there is a point here about awareness and education, but also if we are going to establish a covenant of reality for people who have served, both nurses and combatants, then we need to know about those individuals so that when they approach a service with an issue, that issue can then be seen in the context of the service that they have given and the traumas that they may have experienced. That is perhaps a practical example of how that could be taken forward.

[180] **Lorraine Barrett:** That is useful. Chair, I do not know if we need to pursue that any further because I was going to ask how you address raising that level of awareness among healthcare professionals. Would that be done through training or are there special modules that need to be provided in terms of training for everybody in the health sector?

[181] **Mr Hulatt:** I would argue that mental health awareness is a part of the pre-registration training for nurses. Obviously, mental health nurses specialise in it. I think that post-traumatic stress disorder needs to be covered and it needs to be a focus in terms of preparing nurses, but what also needs to be included is the broader issue of the mental welfare of individuals and being able to assess competently an individual's mental state and see them in the context that they are in.

[182] I return to the point that if someone is presenting with sleeplessness, irritability and alcohol use, you can understand that in one context, but if you know that that person has served two tours in Iraq, Afghanistan or previously in Kosovo or even Northern Ireland, it puts it in a context that is useful for you to know. However, are we in a position where we know that about people that present? That is the question.

[183] **Helen Mary Jones:** I have been thinking about the usefulness of tagging records, but just in my very limited constituency experience, some of the former soldiers that I talk to would not want their records labelled because they no longer see themselves as soldiers. Some of them are so alienated, particularly in recent wars, by some of the things that they have been asked to do, it is very difficult for them because they are not necessarily fighting another soldier. Is there not an issue there? I completely agree with you that if you are the GP and somebody turns up with these symptoms and you know they have served, then you are putting them in a different context, but what if that person does not want to be labelled as ex-forces anymore? What if they want to leave that bit of their life behind? I do not know the answer, but I thought it was important to ask that question.

[184] **Ms Turnbull:** We recognise that issue. If you look at the National Institute for Clinical Excellence guidelines and at the way in which it approaches addressing PTSD as an issue for the general population—because obviously it also affects the general population at large—it puts an emphasis on the need for healthcare staff in primary care and in emergency care departments to be sufficiently aware of the disorder to recognise its symptoms and to ask the right questions. The point is made that sometimes there can be a reluctance among staff, because they do not necessarily want to intrude or say the wrong thing, but the guidance strongly emphasises that the more questions they ask and the more direct they are, the more the problem is likely to be identified.

[185] Going back to the point that was raised earlier, another way of tackling this issue is by ensuring that that healthcare staff has access to that training. That is a point that we have made repeatedly as the Royal College of Nursing. The pressure on the staff at the moment is so intense and we know that levels of access to continuing professional development are

incredibly low—much lower in Wales than elsewhere. We are not talking about days off necessarily, but about something simple. We have developed 15-minute online sessions that you can do to try to update and refresh your knowledge of a wide range of areas. One way of approaching this issue, for example, could be to ensure that that education is available to general healthcare staff.

[186] **Andrew R.T. Davies:** I seek some clarification for my understanding. You said that they will be de-listed by their GP after three months of being out of the country. I am assuming that that is for serving personnel or is it that you get de-listed after you have left the forces, have gone abroad for a certain period of time and are out of the country? Would you be de-listed while you are serving? Obviously tours of duty come around very frequently now, regrettably.

[187] **Mr Hulatt:** That is my understanding. That is what I have been told, yes.

[188] **Andrew R.T. Davies:** That just seems—

[189] **Mr Hulatt:** Bizarre.

[190] **Andrew R.T. Davies:** It is bizarre to say the least, especially if you are serving in the armed forces.

[191] **Mr Hulatt:** Yes.

[192] **Andrew R.T. Davies:** I just wanted to seek that clarification.

[193] **Mr Hulatt:** That is my understanding; that is what I have been told by a member who is serving.

[194] **Darren Millar:** Yes, we will check that. Can I just come back to this point of the label? I appreciate the point that Helen Mary made, quite rightly, in that some people do not want that label. However, others would be very happy and very proud to have that label, understandably, because of what they have been involved in.

[195] This issue of the military covenant that you touched on is very important, is it not? If it is taking up to 12 years for people to be able to access services that they are in need of because they are not being assessed appropriately, what would you say if there were some kind of system whereby there was an annual assessment for ex-services personnel? For example, they would not be labelled as such by their local GP or anyone else in the public services, but there would be an opportunity for them to go for an assessment on an annual basis post their service years.

[196] **Mr Hulatt:** Yes, that is an argument that I have had presented in background meetings with individuals. There should be an interest in the health and mental welfare of an individual who has served or of a TA nurse who will be expected to serve again. When someone does a tour, returns to work, probably in a trauma department, for example, in a local hospital, if they fit back in, there is an assumption that they are okay; that is quite a large assumption. People do not always reveal the distress that they are feeling and they find ways to cope with it that may or may not put them in touch with the health services. It may, as you have already said, be something the families are more aware of than colleagues. So, I think that there should be an interest in the welfare of an individual and part of that could well be demonstrated through an annual assessment.

[197] **Darren Millar:** Thank you, that is useful. Veronica German has the next question.

[198] **Veronica German:** This question is for Hafal. In your evidence, you said that it is not necessarily only combat that can cause problems. I am interested to know what services you provide to veterans experiencing PTSD and what you think is the best approach to treating it in the cases that you have seen.

[199] **Mr Davies:** We are an employment move-on project and we are both based in Rhondda Cynon Taff. I think that the first part of the question is to look at mental health, not just as PTSD, but in its wider spectrum. You can use that mental health diagnosis to cover a lot of things. The life journey through mental illness may culminate in PTSD, so it is quite complicated. The only way you are ever going to get around that is through ongoing assessment or reviews and maybe a yearly review for servicemen. Over in our project, regular reviews are a typical form of patient care.

[200] Treatment cannot be one thing for everyone. Cognitive behaviour therapy is mooted now as the way forward, but it does not work for some people. From our experience with soldiers and as soldiers, going into therapy or having some sort of treatment means that you are given a tag—you are now a patient and you are ill. You will be resistant to that treatment unless you get the right person to treat you. It is about matching skills and matching the right therapist to you. You will be up against a brick wall, so, it is about providing holistic treatment. One cap does not fit all; CBT is not for everybody.

10.10 a.m.

[201] What Hafal is offering across Wales is the opportunity for people with serious mental illnesses to come in—and then I suppose we can talk about PTSD—and have a proper assessment, proper reviews and be offered a menu of options. It has proved effective in our project; we have two ex-servicemen at the moment. The biggest thing we are offering is an element of normality and routine—something that they are used to from being in the forces, which is just getting out of bed and doing the job. Treatment evolves and so we can provide what they need, and, if we cannot, we can signpost them. It is holistic care.

[202] **Veronica German:** Right, okay.

[203] **Darren Millar:** To what extent do volunteers form part of your support services for veterans experiencing PTSD? We have Paul Cleary here today. We are very pleased to have you here, Paul. Is there anything you want to add? What is your role in Hafal?

[204] **Mr Cleary:** I assist John. He is the project guy. I assist him with the running of the building. I suffer from severe depression and there are days when I am not fully up to the mark. John does not know this, but I get flashbacks to the time I was in Northern Ireland, and I often sit there and think about friends who never came back from there and things like that. It is really upsetting, but I will say this: John is very helpful and he listens to you. Hafal is a very good cause and, like John said, we have a couple of ex-soldiers coming in. It has been a big help for them. It is a move forward for them. It has helped me quite a lot, to be honest with you. Like John said, we have one who came back last week. He has not been up to the mark for the past fortnight. I spoke to him yesterday and he is going to try to come back next week because, like me, he wants to try to get back to some normality—the life we used to live. Sometimes, when I go home I have to go upstairs and draw the curtains and be on my own.

[205] **Helen Mary Jones:** To what extent can veterans with post-traumatic stress disorder be treated in general mental health services or do you feel that specialist services targeting people with forces experience are needed? That question is to both witnesses.

[206] **Mr Davies:** It is great if you get the right doctor. Again, for many people it is the first

point of contact. It is sometimes horses for courses. There are some very good GPs, but it is in the name: they are general practitioners. They are not really specialists. We can go down the route of saying we will invest in a specialist service, but we have to ask how much that would cost and who would benefit from it? There are already many services—mental health services, voluntary services and mainstream NHS services. It is really about everyone working together, but each organisation needs recognition and funding for its specialties. If we are talking about general medical services, it may be about prescribing and the CBT routes. If we are talking about voluntary services, it is about the practical and real help people can get day to day.

[207] **Helen Mary Jones:** So, is it about the right services for that person rather than a group of people?

[208] **Mr Davies:** Very much so.

[209] **Ms Turnbull:** The evidence seems to show that it helps if the people providing some of the therapy have an understanding and awareness of that background. However, with regard to developing PTSD services across Wales, it is obviously reasonable and sensible to develop them for the general population, although you would need to have people who have that understanding and experience of dealing specifically with veterans.

[210] **Mr Hulatt:** I think that you are going to hear from Neil Kitchiner who is a nurse specialist in providing treatment for individuals diagnosed with PTSD and is an exemplar of advanced nursing practice. The point to make about general mental health services is that, although an individual may have PTSD, they may have other associated problems and issues, such as those you have alluded to, such as depression, and other coping strategies that can cause problems, such as alcohol use or substance misuse. So, I suppose that PTSD services are needed for that specific issue but there must also be awareness that an individual is much more than that label. So, general mental health services may well be in touch with veterans who have issues of PTSD, but they will be providing services for other areas of that individual's presentation. I know that this is a health issue, but there are obviously implications here for housing, employment and so on. Looking at the whole person, a veteran or someone with PTSD who is one of our nurse members, has a whole range of needs that need to be holistically assessed. It is not just the PTSD; it is the wider needs of the individual as well.

[211] **Helen Mary Jones:** Thank you. You have both touched on this and to an extent, Ian, I think that you have almost answered it. To what extent is it helpful to distinguish post-traumatic stress disorder from other mental health problems experienced by service personnel when we are planning or providing services? We are focusing on post-traumatic stress disorder in this inquiry, but it seems that you are both saying is that it perhaps needs a broader look.

[212] **Mr Hulatt:** Yes. I think that there is a danger of a reductionist approach; so, the individual has PTSD, full stop. No, what we are saying is that an individual has those manifestations of distress known as PTSD but associated needs as well. Now, it may be that other people meet those needs, but I think that we are making an argument—and I am sure that you will want to say more—about seeing the whole person and all their associated needs.

[213] **Mr Davies:** It is about almost targeting our services. So, I suppose that, if we were in a utopia, we would have a service centre, and we would offer a depression service, an anxiety service, and serious mental illness services, so that we were looking at all aspects of mental illness and providing holistic care as and when people needed it.

[214] **Irene James:** An all-Wales veterans' mental health service is currently being

developed using a hub-and-spoke model with six community veteran mental health therapists deployed within the local health boards. Do you believe that this arrangement will meet the needs of veterans with mental health needs and post-traumatic stress disorder in particular?

[215] **Ms Turnbull:** We think that the developments of the Welsh Assembly Government are an excellent way forward. The one point we would probably add is that we feel that there is a lack of professionals who can provide psychological therapies in Wales. That is a point that we have made in other inquiries, such as the previous inquiry into community mental health services. I think that it is appropriate to make it here because this is an area where such professionals would really help. In England, there is a specific initiative—improving access to psychological therapies—to increase the number of healthcare professionals with these skills and, in this case, that initiative is well worth looking at because it could be very beneficial to Wales and to these services in particular.

[216] **Darren Millar:** I concur with that.

[217] **Mr Davies:** I think that therapy works for people who want therapy. Again, from our experience of working with veterans, in a lot of cases, they do not want therapy. Without being sexist, most of the people we see are men, and they are strong men, they are men's men. They see that whole concept of illness, particularly mental illness—whether it is PTSD or any type of mental illness—almost as a woman's thing, and they do not want to be treated that way. So, it may be that going into therapy for a lot of men is a cop out. It needs to be about holistic care and offering real, positive options as and when a person needs them. There is often a journey of about 12 years, from leaving the forces or the experience of trauma to being diagnosed, and that is a very long time and lots of other things are going to happen. To offer a one-size-fits-all approach and say 'You can have your therapy' will not work for a lot of people.

[218] **Darren Millar:** Yes. That is also useful evidence because, of course, the preventive measures to stop people ending up in that 12-year-down-the-line situation are what we are really trying to get at here, to ensure that we tease out what we can do to prevent these problems from occurring and developing.

[219] **Helen Mary Jones:** May I ask a supplementary question? Ian, you touched on this earlier. You talked about the process that people go through when they have come back from a tour of duty and then when they are discharged from the forces. You may not be the right people to ask, but are there other armed forces that do things differently? It seems that there would be one assessment while you were in, say, Cyprus, and, as ex-service people have said to me, they will tell them anything to get home to see their kids, whether they feel great or not, because they just want to get back home.

10.20 a.m.

[220] Are there any other countries that you are aware of that take a different approach to doing that? If there are, Chair, perhaps we can look to see whether those are things that we could suggest?

[221] **Mr Davies:** There are. The Israelis have probably the best army in the world in terms of fighting wars but also for looking after their soldiers. There is a lot of investment in dealing with combat stress and physical injuries as soon as possible. There is not this 12-year wait. There is a real investment in people. We are not just talking about patients and ex-soldiers, but about people who are part of communities. If you are looking at a model of care, look at the Israeli model of care.

[222] **Darren Millar:** Thank you for that. We certainly will glean some evidence from

there to feed into the inquiry. I call on Andrew, then Ann Jones.

[223] **Andrew R.T. Davies:** You used the Israeli model as an exemplar model. Would that be because they have, in effect, national service in Israel? Some of the evidence that we have received is about tagging—which is an awful way of putting it—or identifying, via medical records, that they are from the armed services. Perhaps the model in the whole of society in Israel is far easier to work with because you assume that everyone goes in at 18 years of age or so, or just after they finish university. Perhaps it would be difficult to transfer that model to the United Kingdom, but it would not be difficult to transfer an understanding within the armed services of their responsibility. Perhaps I speak from a degree of personal experience because my wife is a community midwife and she has dealt with quite a few service families. I am going back a bit, but the ear was not always sympathetic, shall we say, when dealing with the army doctor, the RAF doctor or whatever. Is there a need for a change in the mindset of the armed services themselves with regard to their responsibility in relation to this issue?

[224] **Mr Davies:** Very much so. You are talking about the mindset of people joining the forces, who face the reality that they are going to fight a war at some time in their service. The mindset needs to change in how we care for our soldiers. They will not be soldiers for long: they will come out; they then become the patients and become human beings again. They have to be re-socialised from that military mindset. How we care for people needs to change.

[225] **Andrew R.T. Davies:** Really, there is a need to integrate the military health model with the civilian health model so that it is not seen as a case of saying, 'When you are in our silo—that is, when you are enlisted—you are our responsibility, but once you are back in civvy street, you are the civilians' health responsibility'. There needs to be that integration so that people understand their responsibility.

[226] **Mr Davies:** Yes; very much so. Again, it is about that patient journey, is it not? You are a civilian before you join the army, but then you go into military medical services. There needs to be a continuum of care; that is, an interface between a civilian model, a military model and post-military when you go back into normal life, which is where the big let-down seems to be.

[227] **Mr Hulatt:** Something that was raised in the discussions that I have had is the issue of continued interest. If a nurse, such as a territorial army nurse, goes abroad and serves in an area of conflict, comes back and goes back to work, the question is whether there is an interest in that individual. Is there a transfer of interest? Would the occupational health department in that trust take an interest in that nurse coming back? That is why we support the idea of a veterans' champion in local health boards so that there is an awareness of a responsibility, not only to the patients and servicemen who are transferred in their care to civilian services, but also those nurses that are moving between those two areas. There should be an interest in that individual, and there should be continuity.

[228] **Darren Millar:** Okay. I am well aware of the fact that we are running late, so we are up against it. I now call on Ann Jones.

[229] **Ann Jones:** Both of you state in your evidence that there are problems about veterans with more than one diagnosis, where there is a diagnosis of post-traumatic stress disorder and then substance misuse. Do you have any ideas on how we should address those problems? The RCN has said that mental health services may need to develop to consider veterans' needs. Do you have any further views on that?

[230] **Ms Turnbull:** Yes. Again, I will go back to the NICE guidelines because they are a substantive piece of work and research. The guidelines give some clear advice to

professionals on how to deal with this, but that was always going to be a difficult issue for that healthcare professional. However, we do not feel that there are sufficient places available for those suffering from alcohol misuse or substance misuse. There is no sufficient provision of those kinds of services and places in Wales. That will make it very difficult and it will also restrict your choice, because if your healthcare professional asks, 'How shall I deal with this situation and this person's needs?', if you do not have a service, you are forced into a particular route that perhaps you would not otherwise have taken. We do emphasise in our paper that that is an issue that needs addressing. Those services need to be substantially improved for essential places.

[231] **Mr Hulatt:** Also, there are unhelpful boundary issues where someone will say, 'We will work with you on your PTSD, but unfortunately, when it comes to your substance misuse issues, you will go onto another waiting list for another service'. You may argue that that is the reality of health rationing, and I can accept that argument, but also, for the individual receiving that experience, it is very rejecting and it can compound the feelings of alienation, isolation and, frankly, despair and feeling that you are pretty much rejected by the society that you served at great personal cost. I think that we need to think about this idea of seeing these boundaries as being a bit more flexible in meeting individual needs.

[232] **Ann Jones:** I think that Hafal has an idea about having a co-ordinator—someone who will also look at the engagement side of it.

[233] **Mr Davies:** To go back to the substance misuse services first, prior to coming to Hafal I worked for a substance misuse service. Like every other service, they are full. You will then have these complications, either PTSD or mental health problems. For that practitioner it is almost a question of, 'What am I going to treat? Am I going to treat this first? Am I going to treat this?'. In Wales, I think that there is a postcode lottery for services. At present, I think that the better services for substance misuse are probably in Swansea. In the Valleys, there are massively extended waiting lists. As has been said, one aspect might be treated but then they are told, 'Sorry, we will have to put you on this waiting list'. Not only do you alienate people, but the risk then escalates massively.

[234] **Ann Jones:** All right. Thanks, Chair.

[235] **Val Lloyd:** Hafal's written evidence states that the main issue is the unpreparedness of forces personnel for life in the wider community. I think that, as well as it being in the written evidence, you verbalised that earlier on. Bearing that in mind, what do you think the public services in Wales, such as the NHS, local government or any other public service, could do to address the issue?

[236] **Mr Davies:** I suppose that the simple message would be about education, first and foremost. Along with education, there is a need to take away the stigma. It is going to be a growth industry and we have many very young people who will probably be in the services for a very long time with this label. Perhaps it is about challenging the stigma around that and challenging professional stigma where people are presenting with multifaceted needs that may fit that mental health service. It is about accurate assessment, which requires good training for nurses, GPs and any healthcare professional that will be employed in whatever level of service is needed.

[237] **Val Lloyd:** Is there anything that local government could do, do you think, in the arena of housing or any of the services that they provide?

[238] **Mr Davies:** It is a complex problem. It is not just about mental health; it is not just about substance misuse. All of these factors impact on the individual, do they not? So, if you are quite messed up through PTSD you have your first label. Then you are criminalised;

which will be your second label. The knock-on effect is that things become hopeless: you lose your benefits and you are in a cycle of chaos. With any service or any preparation for long-term intervention services, there has to be that need where we will educate every professional. There should then be funds available either to the general medical services or the voluntary services, wherever the expertise is. I suppose that the message that I would like to give is that if you are going to invest in services it has to be a long-term intervention, because that is what the general medical services and the voluntary services are looking to provide. It is not a quick fix.

10.30 a.m.

[239] **Val Lloyd:** No, it is definitely not. My next question is to everyone. What, if any, links exist between the armed forces and mental health services in the community with the aim of ensuring that personnel leaving the services receive support? Is there any signposting or system?

[240] **Mr Davies:** The answer is probably 'no'.

[241] **Val Lloyd:** I gathered that from the silence.

[242] **Mr Hulatt:** When I have discussed this with community psychiatric nurses who work in the armed forces, they have argued that there is a transition and an assessment to ensure that the individual is ready. However, I feel from the previous silence that that is an aspiration. The issue is that individuals leave and are lost. There is a social drift, which has been described, into unemployment, homelessness and overrepresentation in the prison population. There is this issue of an individual being lost. So, from the camaraderie of all that has been enjoyed and endured, they go home to a village or a town where no-one knows about that and, apart from asking how hot it was, might not have a great deal of interest. That is the difficulty; it is the drift of the individual and that transition not being competently made.

[243] **Andrew R.T. Davies:** I am very grateful to you; your evidence is very powerful, because you have such insight. To go back to Val's first point, we have touched on local government, and we have talked about health boards and the army in various pieces of information. Is there good interaction between veterans' organisations, whether they are charitable or not, and the statutory bodies that provide that service, or is the answer 'No, full stop'?

[244] **Mr Davies:** Everyone is fighting for a limited pot of money, are they not? That seems to be the consensus of opinion. You have Help for Heroes, you now have the Gelli Aur project particularly for Wales, and everyone seems to be fighting for the same pot of money.

[245] **Andrew R.T. Davies:** For clarity, even though you are a recognised organisation in the voluntary sector—I will not say that the statutory sector does not recognise you, but that dialogue is exceptionally poor.

[246] **Mr Davies:** It has always been poor. The voluntary sector generally has either been looked at as 'the great unwashed' or as an area in which there is no expertise. However, the expertise is in the voluntary sector, which is working with people directly and the investment should be at ground level.

[247] **Andrew R.T. Davies:** So, the statutory sector does not recognise the voluntary sector? It is the 'great unwashed' I think that you said.

[248] **Mr Davies:** Yes, 'We are doctors, we are nurses, we have the expertise and we will farm out to you'.

[249] **Darren Millar:** I am afraid that we will to have to bring this part of the meeting to an end now. Thank you all for your attendance: John Davies, Paul Cleary, Ian Hulatt and Lisa Turnbull. I also congratulate the RCN on the launch of its 'Nursing Matters' manifesto last night.

*Gohiriwyd y cyfarfod rhwng 10.33 a.m. a 10.36 a.m..*
*The meeting adjourned between 10.33 a.m. and 10.36 a.m..*

## Ymchwiliad i Driniaeth ar gyfer Anhwylder Straen Wedi Trawma i Gyn-filwyr y Lluoedd Arfog—Casglu Tystiolaeth: Grŵp Cymorth Cyn-filwyr y Rhondda a Forces for Good
## Inquiry into Post Traumatic Stress Disorder Treatment for Veterans: Evidence Gathering—Rhondda Veterans Support Group and Forces for Good

[250] **Darren Millar:** We will continue with the inquiry into post-traumatic stress disorder treatment for veterans. I am pleased to welcome to the table Paul Estebanez, who is a Royal Marines veteran and a member of the Rhondda Veterans Support Group; Chris O'Neill from Forces for Good, who is at the other end of the table; and Chris Jones, who is a Royal Air Force veteran and another member of the Rhondda Veterans Support Group. Welcome to you all. I am very grateful to you for taking the time to come and give evidence to this committee inquiry.

[251] Thank you very much for the papers that you sent us, which have been circulated. We will go straight into questions on those papers, if we can. Can you tell us a little more about the Rhondda Veterans Support Group, and what help you give to people who are suffering from PTSD?

[252] **Mr Jones:** The Rhondda Veterans Support Group is supported by an NHS mental health nurse who is also an ex-veteran, which is good for us because we cannot speak to just anyone. It is surprising, but civilians do not understand the forces' attitude. The group was started a while ago by Jim and one of the other veterans. Unfortunately, Jim cannot give us any other support than general mental health support. He cannot give us cognitive behavioural therapy because he is not qualified, so it is basically a self-help group. We meet once a week in Trealaw. I have to admit that it is good. We have a good rapport and more veterans are being referred through Neil Kitchiner on a regular basis.

[253] **Darren Millar:** It is working well. Is that also your experience, Paul? How long have you been a member of the group?

[254] **Mr Estebanez:** I have probably been a member for the least amount of time. For me, it is a place to go. It is a place where there are like-minded people and it is just somewhere where I can talk. However, the support is limited to the point that one of our colleagues who suffers from PTSD is also a facilitator. When you get to that pitch, he is carrying his own baggage, and he is not really in a position to carry our baggage as well.

[255] **Darren Millar:** Is the big, important issue for you having people who have been through it, who know where you are coming from, as opposed to a general mental health support group that might not have anyone there who understands the trauma that you have seen?

[256] **Mr Estebanez:** Very much so. The camaraderie among ex-military personnel is renowned, so there is a lot of support that way.

10.40 a.m.

[257] **Darren Millar:** 'Renowned' is one way to put it. Chris, can you tell us a little bit about Forces for Good and the work that you are doing in north Wales? It is good to have a fellow north Walian come down.

[258] **Mr O'Neill:** Forces for Good is a constituted group registered with the Conwy Voluntary Services Council, but its roots and its origins lie in my own journey and the journeys of a couple of other ex-servicemen, in fighting our way back and making the adjustment to civilian life and everything that goes with that. It is much as these guys have just said; it is about bringing back the bond of forces camaraderie and rekindling it, because it gets lost. You come from an institution, if you want to call it that, and suddenly, in some cases, you are out in a world that you do not understand.

[259] **Darren Millar:** Or rather a world that does not understand you, or perhaps both.

[260] **Mr O'Neill:** Absolutely, it can be both. It is about the self-help and mutual support but, further than that, we do not profess to have any medical knowledge other than our own journeys and the paths that we have taken. However, we operate on the principle that a veteran will talk to a veteran, because one will have been where the other has been. We might not have been to the same places, and we might not have been in the same campaigns, but I have probably had some of the same thoughts and I have certainly travelled some of the same paths. So, I might not know how to treat you or how to deal with you, but I know where you need to go and I might just be able to signpost you and lead you there. That means that we drive you to the appointment and we get you to wherever you need to go. That is how we work.

[261] We are fortunate in that we have managed to build a group in north Wales of all of the agencies, from the police and probation. My interest started with the criminal justice system and the number of guys—sorry, it is a totally different subject—in prison and on probation. That is where my interest was sparked. We will go to court with guys, so that when they attend—because everybody is told to attend at 10.00 a.m.—if they are in trouble, they do not need to sit there for six hours. Their heads will be going, but they will have someone to talk to, so we might just keep them out of more trouble. It is mutual help, self-support, and also campaigning, awareness raising and working with professionals to help them to understand the needs of veterans.

[262] **Darren Millar:** Is it your experience that veterans do not present themselves as being in need of mental health services, and is it easier to get veterans to engage with mental health services when they are encouraged by other veterans?

[263] **Mr O'Neill:** Yes.

[264] **Darren Millar:** Thank you; that is important.

[265] **Ann Jones:** There appears to be little information available to raise the awareness of post-traumatic stress disorder among veterans and their families. How important is raising that awareness, and what would be the best way, do you think, of ensuring that information reaches veterans and their families?

[266] **Mr Jones:** The Rhondda Veterans Support Group has found that GPs have no understanding of veterans who have PTSD. They treat it as depression or anxiety. The Rhondda Veterans Support Group now has its own website. We have gone about and put posters in GPs' surgeries to say, 'If you are a veteran with mental health problems, or you think that you have problems, contact us'. There is a phone number there to contact Jim.

There is also the website address so that they can contact us any time they want. There is no full support within Wales, south Wales at least, and it is crippling us because it is a case of, if you do not have the scars, if you have not lost a limb, there is nothing wrong with you.

[267] I have been diagnosed with chronic PTSD. I have seen Neil Kitchiner. He gave me the diagnosis in 2008. Since then, my GP has treated me, and my consultant has treated me. When I saw the consultant, he said, 'Keep on taking the tablets and I will see you in three months'. The support is not there. The only support that I have is these lads.

[268] **Darren Millar:** It is a medical model of dealing with the mental health issue rather than a recovery model, which the committee has looked at in the past as part of previous inquiries.

[269] **Mr O'Neill:** I would totally agree with everything that has just been said, but the other side of the coin, I believe, is to take it out to the people who are coming across veterans. It is as simple as asking the question. This is why we have no figures, because I do not think that anybody has ever asked the question. Everybody is inducted into some sort of service. At the point of initial contact, a lot of the agencies, such as CAIS, or the drug intervention charity ARCH Initiatives Cymru—even in the arrest referral scheme that we are going to start to pilot in north Wales—do not ask the question, 'Are you this, this, or this? Have you ever served in the armed forces?'. Just making that a standard question would start to identify someone who might have specific needs or issues that require them to go down a different route.

[270] At street level, it comes with advertising, but it also comes with having organisations asking the question. I think that sometimes it is as simple as identifying the people. From there, the GP himself could ask that question. That could trigger a few bells and that could then lead through referral to Combat Stress or whoever, and also to the Army Families Federation, as maybe the wife needs a conversation now and then. All sorts of things can come from just asking that one question right at the beginning of somebody accessing a service.

[271] **Darren Millar:** Andrew, did you want to come in?

[272] **Andrew R.T. Davies:** The evidence you have given us this morning should not, in some respects, be that shocking, because when we looked at community mental health services, a lot of what you are saying was identified in that report, something like 12 to 18 months ago. That is, treatment is on the medical model rather than having the best solution for the individual, namely the holistic model.

[273] Chris, you identified in your earlier presentation cross-working in north Wales involving the police and the health boards. The impression we are getting, certainly in south Wales, is that there does not seem to be much of this cross-working at all. Is there a model in north Wales that works for veterans and could be folded out across the rest of Wales, or is it something that even in north Wales is patchy and really does depend on people like you keeping on pushing at the doors?

[274] **Mr O'Neill:** The beauty of what has happened is that I started banging my drum by campaigning and e-mailing, by being persistent and working what I call my Shawshank theory—the story involved the bloke in the library writing off for the library books, as though to say, 'I'm not going to go away here; I'm going to keep writing and maybe we can get somewhere'—and by finding real life examples, because you always come across them, and we are now getting phone calls from community health teams and from drug and alcohol agencies, simply to go and engage with people they have in their system.

[275] An example would be a phone call I got the other week involving a veteran, who is 24 years of age, who went in at 18 and came out at 22. Prior to going in, he had no criminal convictions whatsoever. He did his four years, but could not take any more, as he tells it, and he wanted to get out. The system is such that that was not an easy ride and he was told it was not an option and that he could not really do it. He was not encouraged to leave, having presented with whatever issues, so he took drugs, because it is a fast route out. In the last two years, that guy has been on all sorts of orders and has 18 convictions for drink and drug-related offences at 24 years of age.

[276] I got a phone call from someone at the agency dealing with him who said 'I've got a lad here, fancy coming in for a chat?'. I cleared it with him, sat there, and said, 'You can do certain things'. He had not signed on. He had no financial backing and he was about to be homeless. Pride held him back—'Why should I sign on? I am not like that'. That is another issue, however. He would not sign on, so I told him that in order to access help, he needed to get down and sign on so that we could get him engaged in some of the various things that would be open to him. He rang me up the same night and said, 'I have been down to an agency. I have utilised my driving licence, and I have a job', and he is working his tail off now. So the pride worked in reverse, but it could be something as simple as that.

[277] He had also been told—there are a lot of myths and misconceptions around—that because of the circumstances surrounding his discharge, call it clerical or service no longer required or whatever expression they use nowadays, he was not entitled to any assistance from ex-forces charities. But he was. He had lived with that for a couple of years.

[278] **Darren Millar**: Is this an issue within the forces themselves, miscommunication, trying to discourage people from leaving, even if they are not suited?

[279] **Mr O'Neill:** Not necessarily. It is peers and other people around you—misconceptions are just part of the general culture. When he came out, he had done his four years and he was proud of what he had done but, because he took drugs to get out, he now feels lower than low and he feels that he is no good now. He totally destroyed himself by doing what he did to come out. His self-esteem had gone, his self-confidence, everything. However, he is fired up and he is back in there and, as I say, he is working his tail off.

10.50 a.m.

[280] **Andrew R.T. Davies:** Could I clarify the point that you raised about the *Shawshank Redemption* film? Of course, once he got out, the prisoners were still left in the prison and they still had their issues. If you took yourself or your team out of the model in north Wales, would the institutional model return so that there would not be this help which we have had evidence of in south Wales?

[281] **Mr O'Neill:** To answer you original question, unfortunately not. What has happened by default is by getting a lot of those agencies together on a bi-monthly basis—the next one is on 1 October—the agencies think, 'Great, they are taking it away from me—it is no longer going to be me e-mailing and saying 'Can we meet up?.' The group is going to give itself terms of reference, part of which is in the report. It will then own it, and that is fantastic because it means that all of those agencies which have been coming to these meetings have subscribed to taking it forward. So, there is a model there that could be followed, used or drawn on.

[282] **Mr Jones:** There is one main problem with regard to other agencies. We have a veteran in our group at the moment who has been kicked off from receiving employment and support allowance with zero points for mental health. He went to a tribunal for it and got 27 points by the tribunal. Three months later he was called back for another assessment, and the

Department of Work and Pensions had him kicked off again with zero points for mental health. He is on £60 a week for him and his wife. They have threatened to take his house from him, although it is rented. There have been letters from Neil Kitchiner, his Member of Parliament, the Soldiers, Sailors, Airmen and Families Association, and so on. He is being totally disregarded.

[283] **Darren Millar:** This is about general awareness among DWP medical assessors because—

[284] **Mr Jones:** Well, so-called medical assessors.

[285] **Darren Millar:** This is a problem at the moment in everybody's constituency, not just with veterans. It is certainly filling my postbag at the moment, and no doubt it is also the case with other Assembly Members.

[286] **Helen Mary Jones:** That is right. It is particularly a problem for veterans because of the pride issue. As with older people, they will not necessarily be honest with the assessors about what they cannot do, and it may be difficult, because of that culture of being independent and being the strong person, it may be harder for people to get that across, even than it is for the general population.

[287] **Darren Millar:** Yes. We have made a note in terms of the DWP assessments and—

[288] **Mr Jones:** We know that the Assembly cannot do anything about it because it is UK law.

[289] **Helen Mary Jones:** We can have an influence, though.

[290] **Mr Jones:** What we need is for the Assembly to lobby the UK Government in regards to this because I am sure to God that there are veterans out there that have committed suicide because of this.

[291] **Darren Millar:** While the benefit system is not devolved, healthcare is, and if Welsh GPs, the Welsh medical system and NHS have specified that someone is experiencing certain illnesses, I cannot see why the DWP ought to disregard that evidence.

[292] **Irene James:** We have received evidence that service personnel are often poorly prepared to return to civilian life. Do you agree with that, and, if so, how do you think that support could be provided to overcome this by the armed forces and the services that are provided in the community?

[293] **Mr Jones**: When I came out of the Royal Air Force, I was entitled to a resettlement course, to work or do whatever I wanted. My PTSD stems from Operation Burberry where I pulled out one of the children who was burnt to death in Birmingham. What should happen is that the Ministry of Defence should give you a mental assessment before leaving. Once you come to civvy street, as Chris was saying, you have to see a GP. One of those questions should be: 'Are you an ex-forces veteran?' If the answer is 'yes', you should have another mental health assessment and be taken all the way through the process for at least 12 months, because the PTSD does not come on overnight.

[294] **Mr Estebanez:** I will give you a rough idea of my job. I left the Marines and got a job on civvy street working for the NHS as a paramedic supervisor, and its counselling service is non-existent. Nothing is given to you, no matter what job you have gone on. It asked, 'Do you want to speak to a higher officer?' What for? He has no counselling skills or debriefing skills. You can go on a job which is the death of a baby, and you are lucky to get a

cup of tea before you go to the next job. That is fact, and that is your ambulance service. People in the ambulance service are stigmatised; they are afraid to say that they are anxious or stressed. It is a major issue. Twenty-six years of building things up and look at the mess that I am in. The military conditioned me to accept everything that is put in front of you, but there comes a point where you cannot do any more. When your current employer is worse than your previous employer, where do you go with it?

[295] **Darren Millar:** In the previous evidence session, it was suggested that a pre-return to civilian life assessment was important. It was also suggested that a 12-monthly assessment after that on an annual basis might help to identify and nip in the bud any problems that might develop post the return to civilian life. Is that something that you think would be helpful?

[296] **Mr Jones:** It would beneficial, but, as Chris said, we cannot talk to anyone. If a veteran is in my group or Chris' group up in north Wales, you pull them aside because veterans speak to veterans. I am sorry, but it is hard to speak to civvies because they do not understand. We have this black humour and people think that we are callous, but within our groups it is not callous—that is surviving and getting you out of the mess that you are in.

[297] **Mr Estebanez:** It is a coping mechanism.

[298] **Mr O'Neill:** An annual assessment is a good idea but, to be honest, all that would probably occur is that, 12 months on, I have to go and sit across a desk to talk to an individual, but I am now a civilian and I am out of that military system. It is just an appointment and I will do it, but I do not believe that you are going to bring out what is really going on in that meeting. With everything, I keep going back to community. My answers lie in the community and my beliefs lie in the community. It is something that I will come on to later, but it is about a veterans' day centre and a veterans' point of contact. Scotland has Veterans' First Point, which is somewhere that ex-service personnel can mix among each other and everything that they need is within the building. The community is there, the bond is still there and they are making the transition, but there are professionals there or the first point of contact is a veteran. Maybe that is another way to go. It would probably cost something.

[299] **Darren Millar:** That is interesting. Irene, the next question has been answered.

[300] **Helen Mary Jones:** I think that you have almost answered my question as well, but I will raise it because it is quite important. In your experience, how effectively are the kind of issues that you experience as veterans, and particularly problems experienced by veterans with PTSD, helped and treated by your GPs? You have touched on some services, such as the consultant dishing out the medication and not dealing with it.

[301] **Mr Jones:** It is not. My GP is our family GP. He has been our GP for donkey's years and I trust him with my life, but he has no experience of PTSD. As far as he is concerned, it is a label that I could do without. I thought that when I got that label, I could get help, but that is not the case. I have been discharged from Neil Kitchiner's active patient list from the veterans' mental health unit in Cardiff. The service is just not there. GPs are not made aware of it.

[302] **Helen Mary Jones:** Do they just not understand?

[303] **Mr Jones:** They do not understand.

[304] **Mr O'Neill:** I have a veteran of 15 years in my group. This is his story and I can only give his side. He went to see his GP. His GP gave him the label and said, 'You suffer from PTSD'; end of story. He has wandered around in the wilderness with this badge and label

since, but nothing has been done about it, but the GP told him what was wrong with him. That is not knocking GPs at all, because the other side of the coin is that the pride thing comes in again. You are in this Catch-22 situation. Most of them are not going to say that there is something wrong with them when they go to their GP. Over the years, I went to see my GP with all sorts of issues, including depression, drink, and through this and the other, but there is no way I that I discussed my military service.

11.00 a.m.

[305] I came out in the mid 1980s and it was only less than two years ago, as a result of doing a six-month rehab for other issues, that I touched on the military stuff and accessed Combat Stress. It was a long time from when I came out to when I touched the military stuff. Now, without dealing with it, I would not have had a chance of going forward. I am glad I did, because otherwise I would not be sat here now talking to you. That is just an example.

[306] The other problem that I find in the groups that I attend is that although there are lists, costs and priorities for everything, the biggest issue—and this is why I get into the community thing—is that somebody has to hold it in there. When somebody is ready to engage with some sort of service, then that is when they are ready to engage. Six months on, 12 months on, they are lost in the wilderness and then they are out there again. Somehow, we—the people, the Assembly, Parliament—need to look at, not a fast-track process exactly, but what we implement in the meantime, while the direct interventions go on. We need to look at how we get people to this stage.

[307] **Darren Millar:** That brings us nicely on to treatment issues. I ask Veronica to ask her question.

[308] **Veronica German:** In your written evidence, Chris, you mentioned the difficulties of accessing services for someone who might have drug or alcohol problems as well. I know this happens in general with people with mental health problems—if you have a drug or alcohol problem then you cannot get the other treatment because you are expected to clear up the drug or alcohol problem first. People are told, 'We cannot treat you for the drug and alcohol problem if you are registered with a mental illness'. There are certain schemes that you cannot do, so you sort of fall into a gap.

[309] This is further compounded, I would imagine, with post-traumatic stress. Have you come across any services that are particularly geared towards people suffering from more than one aspect of these problems? Most people with PTSD, I should imagine, have other related issues to deal with—perhaps other mental health issues, or drug or alcohol problems.

[310] **Mr O'Neill:** Within mainstream officially funded services, 'no' would be my honest answer. There are some charity organisations whose help you can access, but, again, we come up against the question of who is responsible for what, where, and what falls within their remit.

[311] **Veronica German:** Is there no holistic service?

[312] **Mr O'Neill:** I mention Pathways in the paper. Without Pathways in Bangor I would have some guys in serious trouble. On a wing and a prayer, they have taken guys in for me when I have found them. As a result of it, there is one case I can cite. I only went to get my hair cut and I bumped into an ex-squaddie in Colwyn Bay and we started talking. The guy was homeless. He had drink issues. He was on probation. He had another court appearance coming up and, basically, he was a mess. He had done everything over the years: he had done the rehabs, he had done whatever else. Finally, he was ready, albeit when I was having my hair cut, to talk about the forces stuff. I actually said to him, 'If we could do something about

it and if we could get you somewhere now, would you be prepared to look at it?', and he said 'Yes'. So I called his bluff, and the only thing I could do, because I had come into contact with Pathways—this was a Saturday—was ring there. I spoke to Dr Powers and she said, 'Wheel him in'. We took him across on the Monday morning. He was assessed on the Monday morning. I had previously met, as part of the group we were discussing earlier, the chief executive of CAIS, and he had been interested in what we do with these guys with substance misuse issues as well as the mental health side. I called his bluff as well, ringing up and saying, 'You said if I could find a live one, we could test a theory'. So, by the Monday morning we had somebody to assess him and we had placed him in a safe environment. That morning, a worker came out from CAIS, and he is now on the books of a drug and alcohol agency. All of this is unfunded; it is just people wanting to try to make stuff work. Within three weeks, we got the guy into a supported house, so he has been there and done it.

[313] So, it can be done. You just have to be a bit of a maverick and try to buck the system, but you can make it work in a joined-up way again. If people and agencies work together without getting into this business of who gets paid for an outcome, and where, then it is going to be a lot less—

[314] **Veronica German:** That is the issue, is it not? Even with the charities—

[315] **Mr O'Neill:** Absolutely. It always comes down to who gets paid and outcomes and this sort of thing, and that is the crazy bit.

[316] **Mr Jones**: The feeling that we have is charities are always there to help; the NHS and social services are not.

[317] **Mr Estebanez:** It is disappointing at the moment. The CPN who normally takes the group has been off with ill health and nobody has replaced him. We have a member of social services who has cancelled six out of 11 weeks.

[318] **Darren Millar:** We are touching on some community mental health services. We are going to have to move on through these questions now so that we cover all of the area. You have touched on the welfare benefit issues, and you started to touch on the social services and housing there, Chris. Have you got any more information to add on that?

[319] **Mr Jones:** Not really, no.

[320] **Mr Estebanez:** No, I do not really have a lot to do with those services.

[321] **Darren Millar:** Are the same sort of barriers there across the country?

[322] **Mr Jones:** Yes.

[323] **Darren Millar:** Okay.

[324] **Helen Mary Jones:** In your opinion, how effective are mainstream mental health services for veterans—for example, those provided by community mental health teams? I am inferring from what you have said already that the answer is going to be, 'Not very' or, 'Hardly at all'.

[325] **Mr Estebanez:** I cannot say that. My own dealings with them have been fine.

[326] **Helen Mary Jones:** Have you had a good experience?

[327] **Mr Estebanez:** I have had good experiences with my consultants. I am not going to

sit here and say that it is all rubbish. My psychiatrist has been absolutely fine and the support he gives has been fine.

[328] **Mr O'Neill:** It is there, but it is the same as the veterans on that particular issue—they are under the same constraints as anyone else. So, to say that it is bad, it is poor, it does not work and people are no good at it would be wrong, as you say. Again, it comes back to this awareness or having people specifically working with veterans, be that a qualified veteran or whatever—we are back to the veterans theme again.

[329] **Helen Mary Jones:** That leads me into my second question. Obviously, there are good and bad experiences in the mainstream services, and that ties in with what other people have told us, of course. You touched on specialist services for veterans with PTSD—for example, the services provided by the veterans mental health pilot project in Cardiff. Do the specialist services tend to work better or, again, is it down to individuals?

[330] **Mr Jones:** It is down to individuals. As I have said, I went down to see Neil. I was there for about an hour and a half with him and he was a great chap, but I have had a letter now saying I have been discharged from his active patient list. He sees so many people that he does not have time to give the therapy, so I am back in the hands of the mainstream services.

[331] **Mr O'Neill:** The other thing is that we have to get away from this one-size-fits-all model, because there are different degrees and different interventions that we require. Some people will need more intensive therapy than others. As I say, Combat Stress has been great for me, and has helped me get where I am. I believe that it has an agreement or contract within Wales, but the crazy thing is the funding constraint. Any Welsh veteran or any veteran living in Wales would have to leave Wales for a residential treatment. I have to go to Newport in Shropshire and that, to me, seems totally insane. Maybe funding should be looked at to have such a facility here. It is a strange one. Like everything else, it comes down to finance.

[332] **Helen Mary Jones:** It does, but I think, in a sense, that is our problem and the Government's problem. You need to tell us what you need, and then we make recommendations to the Government and it will have to make its priorities. You are right to identify the funding problem, Chris, but to put it crudely, there are real funding issues if these issues are not addressed, given the people who will end up in the criminal justice system, in residential mental health care, or hospitalised. So, in a sense, let us worry about that; let the Government worry about that.

[333] **Mr Jones:** We have been told that there is going to be a hub in south Wales and six therapists going out from there. We have been told this since the beginning of the year. We were told it in the middle of the year. All we are being told is, 'It is coming, it is coming'. We do not need, 'It is coming'. We need to know when it is going to be implemented and who will be providing the treatment in our area. Preferably, those individuals will be veterans, because we are not just going to open up to Joe Bloggs.

11.10 a.m.

[334] **Darren Millar:** You want people who understand where you have come from and some firm timescales pinned to the implementation of that hub-and-spoke model. I will bring you in in a second. Lorraine wanted to come in.

[335] **Lorraine Barrett:** Just briefly, do you feel that there is a case for a specialist service being offered to veterans suffering from post-traumatic stress disorder rather than just a general service? Do you think that the case can be made for having a specialist service just for PTSD?

[336] **Mr Jones:** Yes. What this committee has done now is open up Pandora's box and the only people who will put a lid on it are those in the Government. There are veterans now coming from Afghanistan and you have still have veterans from the Gulf war and from the Falklands. It is opening up such a can of worms that it is unbelievable and we need help. We need a place to go so that a GP can turn around and say, 'I believe you are suffering from PTSD—that is the place to go'. It has to be there.

[337] **Mr O'Neill:** You mentioned previous campaigns, and the other point that I think has, not been forgotten but left behind here is obviously the fact that, given current conflicts, there is a lot of emphasis on Afghanistan and treatment for the guys and girls returning from there, and rightly so. However, we are leaving behind others and we are almost in danger of creating a divided ex-military community because a lot of the things that are being implemented are down to people saying, 'If you served from that date on, then you are eligible for this'. This is happening with all sorts of funding—bits and pieces that I can write to you about. We are leaving behind the guys from Ireland, the Falklands, Sierra Leone, Bosnia and the first Gulf war. They have not been forgotten, but they are being neglected. When it comes to putting anything in place, the qualifications should be the fact that you have served at all and not when you served. That approach is definitely coming into play in a lot of areas and not just in health and wellbeing.

[338] **Mr Jones:** There is a second world war veteran who lives by me. He has nightmares about slitting a German's throat. He has been assessed by Neil Kitchiner as having chronic PTSD. I do not know how many world war two veterans are left now, but they also need to be brought in.

[339] **Mr O'Neill:** With a special case, you could present it on the basis—and I am not a clinician in any way, shape or form—of the fact that there is PTSD and there is combat PTSD. I believe that there is a definite difference and I am sure that people will tell you that as you continue with your inquiry.

[340] **Darren Millar:** There is a distinct difference in terms of how you treat those disorders and that is what we are trying to get to the nub of—whether these should be general services or whether they should be ex-forces-specific services. Val, I think that your question has been covered, has it not? Andrew is next.

[341] **Andrew R.T. Davies:** To build on the evidence that you have just given us and talking about being service-specific, later in evidence that we will take, there will be the issue of funding for the hub-and-spoke model that you have talked about and, in particular, for the specialist teams. It is my understanding from the armed services that there are traditional recruiting grounds, shall we say, where there would tend to be more armed forces personnel than other areas. I would be right in saying that, would I not? Yet, regrettably, the funding model for the hub-and-spoke teams is based on the general population rather than on the ability to analyse and say, 'Well, actually, the bulk of the veterans live in x, y or z local health board'. Looking at the funding, if you take Cwm Taf, for example, which is responsible for the Rhondda, it is the least funded of the LHBs to provide that service. It would seem to me—and I am not sure whether you would agree and I would look for your agreement, if that is not the case—that the analysis for support and resource should be targeted on the density of veterans rather than on the general population. That could almost be correlated with the traditional recruiting grounds of our armed services. Would that be a fair assessment?

[342] **Mr Jones:** I definitely agree with that. It is not a case of population, but of the number of veterans.

[343] **Mr O'Neill:** I had a conversation with someone about these posts, and I think that

they relate to around 1.5 posts across north Wales. I said that they should not be placed in a hospital. I said, 'Create those posts and by all means make them qualified professionals. It would assist if they were veterans—they do not have to be, but they should be placed alongside veterans.' Those posts should be placed in the community in the same way that it is done now. Doing what I am doing now, I have met in the court service or probation service a team of NHS mental health nurses who work purely in the courts. They are taken outside the normal system and they work specifically in courts on pre-sentence reports and initial reports, but they are on the ground. Another point is: do not ask me to come to hospital and attend an appointment when I will get the paranoid phobias and everything else that goes with sitting and waiting and becoming impatient. It is not because I am stubborn, but because in a lot of cases that is the effect that it has on you along the way. I know guys who cannot go shopping or stand in a supermarket for whatever reasons. So, if you were to take those posts, I think that it is brilliant that the funding is there and that it is a start—

[344] **Andrew R.T. Davies:** If you just take Cwm Taf, for example, I think that the funding is only for 0.89 of a position rather than your 1.5. So, really we need a bit more analysis of where we put our valuable resource so that that resource is having the best effect and so that the models that you have talked about can be placed in the communities that need it rather than in the wider community that is not necessarily facing the challenge.

[345] **Val Lloyd:** The problem is that there is no accurate information regarding the number of veterans in each health area so they have just done it on the proportion of population to try to get some clarity. How would we get it? Would we get that information from the Ministry of Defence?

[346] **Darren Millar:** There was a suggestion earlier that perhaps a flag on health records for ex-forces personnel would be a good idea but then, of course, there is the argument that some ex-forces personnel do not want to be labelled as being ex-forces. It is a difficult one, but I think that there is food for thought for the committee in that respect.

[347] **Mr O'Neill:** On the hub-and-spoke pilot in Cardiff, why not place one or two of those positions in areas where veterans are active at present and are engaging? There are two examples there. Maybe look at working something around that sort of scenario where we can see how it works and if it works, before it is laid in stone.

[348] **Mr Estebanez:** To finish, you find that veterans join other services such the police and ambulance service—it is all the same. They carry that burden with them because they feel stigmatised, but the disparity between the different services is massive and no-one looks at that. I could give an example: you could attend a road traffic collision, where five young kids are dead and if you get a cup of tea after the job, you are lucky; otherwise you are back doing whatever you can. You can only take that for so long.

[349] **Darren Millar:** I am afraid that the clock has just about beaten us. We did have a further question on what is going on in Scotland for you, Chris, but if you can give some information directly to the clerk after the meeting that would be great. Thank you very much indeed to Paul Estebanez, Chris Jones and Chris O'Neill for their attendance. We really appreciated your evidence.

[350] The committee is running significantly over time this morning. I think that it is with good reason and I understand that some Assembly Members may need to leave before the end of the meeting. I ask Members who remain to be succinct in asking their questions and I will ask the same of witnesses in their responses.

11.19 a.m.

## Ymchwiliad i Driniaeth ar gyfer Anhwylder Straen Wedi Trawma i Gyn-filwyr y Lluoedd Arfog: Casglu Tystiolaeth
## Inquiry into Post Traumatic Stress Disorder Treatment for Veterans: Evidence Gathering

[351] **Darren Millar:** We will move on to item 5 on our agenda, continuing with our inquiry into PTSD services for veterans. I am delighted to welcome Neil Kitchiner of the UK Psychological Trauma Society, who is also a member of the mental health service for veterans' pilot. I understand that you are the lead on that, Neil, and of course you are a community veterans' mental health therapist. Thank you for your attendance today. I also welcome Dr Steven Hughes from Pathways in north Wales—another person from north Wales; we appreciate you making the journey down.

11.20 a.m.

[352] We have received papers from you both, which we really appreciate. They have been circulated to members and we have read through them. So, we will go straight into questions. Neil, can you give us an overview of the pilot project that is under way in south Wales, including some of the achievements that you think have been realised so far?

[353] **Mr Kitchiner:** As you know, the pilot project was funded by the MOD and the Welsh Assembly Government, for which we are very grateful. It ran for two years and ended in March of this year. The idea was that it would be the only Welsh pilot project; the others were in England and Scotland, and they are all coming to an end. The remit was to set up a service for veterans and try to attract them into NHS mainstream services. I guess that, with just over 200 referrals in two years, we achieved part of that aim at least, and we saw a variety of individuals, from the age of 19 to 88, who were veterans of various conflicts. We were able to give those people a biopsychosocial assessment over an hour and a half to two hours and come up with some sort of plan in most cases, which was probably to link them into existing NHS services, the community mental health teams and drug and alcohol teams. We may have offered some psychological therapy ourselves or referred them back to primary care and the veterans' agencies, and so on.

[354] **Darren Millar:** That seems a remarkable number. What proportion of those 200 would have had a diagnosis of PTSD?

[355] **Mr Kitchiner:** It is just over 50 per cent. As a rough guess I would say that about 52 per cent were diagnosed with a primary diagnosis of chronic post-traumatic stress disorder with co-morbid problems such as depression, anxiety disorders, or problems with alcohol or drugs, and lots of social problems in relation to housing, relationships, unemployment and so on.

[356] **Darren Millar:** We will tease some of those out as we go through the questions. Lorraine Barrett has the next question.

[357] **Lorraine Barrett:** You say that a study on the prevalence of mental health problems among veterans living in Wales will report later this year. In your view, how much unmet need is there among veterans in Wales for mental health support, and in particular for post-traumatic stress disorder?

[358] **Mr Kitchiner:** I am not actively involved in that study; that is a study that Professor Bisson and a few researchers are carrying out. It is looking at probably 200 to 300 veterans who live in Wales. They are accessed by telephone and go through a very structured clinical assessment, which will give us some indication of their mental and psychosocial needs and so

on. The study is ongoing, so it is difficult to give you a definite number. They have telephoned around 200 veterans so far across Wales.

[359] **Lorraine Barrett:** Do you know when we will have that information? When will the report be out?

[360] **Mr Kitchiner:** I think that the report is due in the spring of next year.

[361] **Darren Millar:** Dr Hughes, did you want to come in on this issue of unmet need and the scale of the problem out there?

[362] **Dr Hughes:** It is a very difficult question. We are talking about the tip of an iceberg, and it is a question of how much is above the water and how much is below it. We have been functioning for just over a year, and the referral rate of cases is picking up steadily. We are a UK charity, and are based in Bangor. We have seen 30 clients in the last year, 10 of whom have come from Wales. Over the last few months more self-referrals have come through. Those individuals will, by word of mouth, have heard of someone who has come to Pathways or will have gone on to the website. That applies to the whole of the UK. Recently, serving soldiers have presented on the doorstep who we have had to send back to the military after a brief assessment.

[363] **Darren Millar:** It is interesting that you are getting self-referrals, because an issue that we picked up on before is that ex-service personnel tend not to self-refer without significant encouragement perhaps from other ex-forces service personnel.

[364] **Dr Hughes:** They may also have got good vibes from someone or have been told, 'I have been helped'. The self-referrals either come from the website or those people know someone, in which case they come in and say that they spoke to one of our previous clients.

[365] **Ann Jones:** To what extent is a specialist veterans' mental health service needed?

[366] **Mr Kitchiner:** In the two years that we have been running we have had 200 referrals, some of which were self-referrals. We also have a website and families of veterans or veterans themselves have referred. We have also had quite a good response from veterans who have seen our posters and leaflets in GPs' surgeries and have come through that route. So, there is something in thinking outside the box and trying to get veterans to come into the mainstream, but that is a very difficult thing to do.

[367] I think that we do need a service for veterans. We have had 200 referrals, and the guys—I say 'guys' because most of them are men; we have seen five females so far—present with very complex presentations, involving a very co-morbid mix of problems, not just PTSD but anxiety disorders, depression, problems with alcohol and so on. We need a dedicated service that can have something above the door that says 'veterans' service' that will attract people in. I heard the veterans speak earlier about veterans wanting to speak to veterans. That is an interesting concept, and one that I do not entirely agree with, having seen 200 veterans. I am not a veteran—I am a veteran of the army cadets, but that does not count, I am told. In our research, when we ask veterans whether they would prefer that we had been a veteran, they usually say, 'Not really. As long as you know what you are doing in your particular field, that is great, as long as you are willing to learn about our culture.'

[368] **Darren Millar:** So, it is about the understanding.

[369] **Mr Kitchiner:** Yes.

[370] **Lorraine Barrett:** On something that Neil has just said in relation to a specialist

veterans' mental health service being needed, should there be a role or a responsibility here for the armed forces, or the Ministry of Defence or whatever, to work with the health service? From some of the evidence that we have received, we have heard that there are lots of issues when one minute you are in the armed forces and the next minute you are not; you are in a completely different world. Something should be going on while you are in the armed forces and then when you are in that transition period. Is there a responsibility there for a specialist service that would help the transition?

[371] **Mr Kitchiner:** In the military there are 16 defence community mental health teams—I think that that is what they are called—that have psychiatrists, psychologists and social workers, as you know. Our nearest team is the Donnington barracks service, and we work very closely with it. If it medically discharges someone back to south Wales, two or three months before they are released we will have a meeting, a joint assessment, and start to develop some plans for when that person leaves and becomes a civilian. I think that that could be better, though.

[372] **Ann Jones:** What funding difficulties are experienced by veterans from Wales compared with those from England when they are referred to Pathways?

[373] **Dr Hughes:** The health service in Wales will not fund referrals to Pathways, that is, to Telford House, even with a recommendation from a consultant psychiatrist. I get on the phone to the Army Benevolent Fund or to regimental charities. They are probably the best bet. If I can tie down which regiment an individual belongs to, I can contact the welfare officers and we can bring in funding in that way. It depends on how wealthy that regimental welfare organisation is, but they are usually very accommodating in coming up with some funds.

[374] **Ann Jones:** What funding do you get from England?

[375] **Dr Hughes:** It is sporadic. It depends on geography and postcodes, to be honest. If you come from Scotland, Newcastle or Sunderland, the primary care trusts will virtually always fund patients or clients who are referred to us. There are parts of the country that just do not want to know, where the PCTs do not regard PTSD in veterans as a priority and will not fund it at all.

[376] **Andrew R.T. Davies:** I asked previous witnesses about this. I would assume that that is a good example of a PCT—and Scotland in particular is also a good example of somewhere where this is the case—that understands that maybe it has a high concentration of veterans because it is a traditional recruiting ground. So, maybe it is about the devolution of power and the PCT deciding what its priorities are in that locality. Is part of the issue the fact that we generalise the issue in Wales rather than focusing what resources we have on the more traditional grounds for the military, such as the Valleys for example, and are therefore unable to create the services within those communities?

[377] **Dr Hughes:** Yes, I think so, and that is the case on two levels. There is a greater number of individuals who may be prone to PTSD, but there is also a greater number of families in that population who will be saying, 'We need to have something to be done for our brother or father or whatever'.

11.30 a.m.

[378] So, you have a political background of people saying they need a service. So, a greater concentration means that you have a larger number of people needing secondary services and more people shouting for it.

[379] **Darren Millar:** How many beds are there in Pathways?

[380] **Dr Hughes:** We have six, and we have a seventh bed that we can use for 24 hours to bring somebody in for an assessment. What often happens is that we will bring somebody in for 24 hours and Dr Powers, who is our clinical psychologist, will assess them and make a plan for the treatment they require, and if we the other six beds are occupied, they are given a date to come back. It is important to them that they have a plan. It is part of the veterans' concept: they like to have a plan so that they know what is going to happen and when and they have a rough idea of how long it is going to take.

[381] **Darren Millar:** On what basis is this not being funded by the NHS in Wales when there are referrals from the NHS?

[382] **Dr Hughes:** They are not funded, so we have to rob Peter to pay Paul. If we have five individuals—

[383] **Darren Millar:** What I am trying to get at is why they are saying they will not fund a bed in Pathways.

[384] **Dr Hughes:** I think that that is for the Minister for Health and Social Services to answer.

[385] **Darren Millar:** Okay. Have you had an explanation from the Welsh NHS?

[386] **Dr Hughes:** As far as I understand it, it is because external services to the NHS will not be funded because the NHS in Wales is able to deal with these cases.

[387] **Darren Millar:** Is that your experience, Neil?

[388] **Mr Kitchiner:** My understanding is very similar to that of Dr Hughes. The fact that we have an all-Wales veterans mental health service coming on line means that the line is that the NHS has provision now and Pathways—

[389] **Dr Hughes:** I do not have a copy with me of the letter that the Minister for health wrote to me a few weeks ago, but I think that it is in that letter.

[390] **Lorraine Barrett:** Looking at information and awareness training, in his written evidence, Neil talked about the pilot and the website and ways of getting the message to those who need support. Can you say something generally about how veterans and their families are made aware of the symptoms of post-traumatic stress disorder, the services that are available to treat it, and how they might be improved? How do we make them more aware? How important are voluntary organisations in helping to raise awareness? I know you have done work with the British Legion and other agencies. Could you say something about that?

[391] **Mr Kitchiner:** One of the biggest lessons we have learned has come from a project steering group that has helped to guide this pilot for the last two years or so. It is made up of the British Legion and other veterans' agencies, including the war pensions people, and it has been very helpful in spreading the word that there is a veterans service out there. These people go to people's houses—that is, case workers from British Legion and welfare officers from the Service Personnel and Veterans Agency—they take our information and our leaflets, and they recommend that the veteran self-refers or have them refer on their behalf. So, having people on the ground who already do work with veterans has been of great value.

[392] **Lorraine Barrett:** I am sorry to interrupt. Is there a problem with information sharing? In other inquiries into other issues that has always been a problem. Obviously, there

is the issue of confidentiality, but it is sometimes useful to share information. Do you find that something of an issue in this area?

[393] **Mr Kitchiner:** There is a slight issue to do with electronic information sharing, so we ask the veterans' agencies always to refer someone in writing to us rather than through our e-mail system, because of the confidentiality issue. Once we take a referral from the British Legion we, with the veteran's permission, keep them updated with work in progress and the plan, but it could be better. Information technology makes it easier, but there are problems with IT and confidentiality, as you know.

[394] **Lorraine Barrett:** It is down to resources, probably.

[395] **Helen Mary Jones:** You have touched on this, so your answer will probably be quite brief, but in your opinion, how effective are the current services for veterans suffering from post-traumatic stress disorder in terms of the expertise available and the appropriateness of those services?

[396] **Mr Kitchiner:** The current veteran service is only myself and one other person currently in Abertawe Bro Morgannwg University Local Health Board in Bridgend. The current services for veterans would be through the community mental health team via the GP, and then, if you are fortunate enough to have a good psychologist who is trained in trauma-focused psychological therapy, you might get a good evidence-based treatment. Our understanding from our two years is that there is a lack of clinical psychologists, particularly in Cwm Taf Local Health Board, and those who are there are not always particularly skilled in trauma-focused therapies and they are not always happy to take on veterans.

[397] **Dr Hughes:** The critical thing is that PTSD is a psychological condition not a psychiatric illness. So, formal mental health services are geared to treatments—as you heard, Chris said that the approach was, 'Take the tablets and go away; come back in three months' time'; it does not work that way, as there are not tablets that will necessarily make a difference. They are given antidepressants or something to calm anxiety. So, what you have left means that you have to have a service that is run by psychologists. Our treatment consultant, Dr Power, is a psychologist with a track record of dealing with PTSD.

[398] When you look at mental health services across the UK, rather than singling out Wales, you see that there would not be so many charities interested in these individuals if the mental health services in the NHS were doing a good job.

[399] **Darren Millar:** In terms of the availability of services, because you are based in south Wales, Neil, it is easier for you to focus on that region, but in north Wales, what would typically happen if a veteran were to turn up at a GP's surgery and be diagnosed with PTSD at some point after being referred to a mental health team? Are they just lost to the system, or is there a service specifically for them?

[400] **Dr Hughes:** They will get lost in the system, unless they refer themselves. I do not think that we have had a single referral from a GP in north Wales. We have had two or three referrals from GPs in south Wales who have picked up on people who have referred themselves and then come back. It is done through networking. The guys we treat will go out and spread the word, and they link together. If you talk about electronic transfer, there is a link across the UK, particularly from my battalion, of 2 Para veterans of all types. The ones with PTSD will link together on e-mail. If somebody has a problem, they will get in touch. In fact, before Pathways, for the last 25 to 27 years, about two clients a year from 2 Para have got through to me because somebody else has picked up and contacted me and I have directed them in the right direction.

[401] **Darren Millar:** Are there no ex-forces-specific services for those suffering from PTSD as a result of combat stress?

[402] **Dr Hughes:** No.

[403] **Darren Millar:** Thank you for that.

[404] **Veronica German:** You mentioned earlier, Neil, the links to people who had been identified in-service as they were leaving. What about people who are leaving who have not been identified as having a problem? In your experience, are they given any signposting as they leave the service, in case they do get a problem later on, despite perhaps not having one at the time? We have heard other evidence saying that all they want to do is get home; they will answer all the questions with, 'No, I'm fine', just to get home. Are they given anything at that point telling them, 'If you have a problem, this is what you need to do'?

[405] **Mr Kitchiner:** On the steering group for one of our projects, we have a serving officer from Fifth Division, which covers Wales and the midlands. He is clear that, as service leaders leave now, their pack includes who to go to, including the veterans' agencies. As our pilot in Cardiff was there, we were included in that pack. So, if you are coming to Cardiff and you have mental health problems, it tells you to contact Neil Kitchiner at the UHW. I am sure that it can be improved. It is probably worth looking at.

[406] **Veronica German:** What do they do with the pack, though? Does it not really need to come a few months later?

[407] **Darren Millar:** One of the problems that we heard about earlier, from Hafal, I think, is that it can take up to 12 years for the symptoms to become so distressing and problematic that somebody actually gets a diagnosis and into treatment. Clearly, 12 years on, service configuration is likely to have changed significantly, and if somebody has a 12-year-old pack with Neil Kitchiner's telephone number on it when Neil Kitchiner is elsewhere, they will find the message telling them that the number that they are calling is not available a bit discouraging. What can be done to keep a tab on people to ensure that if problems develop, they are identified early and early intervention can be arranged to prevent them from getting worse?

11.40 a.m.

[408] **Mr Kitchiner:** It was talked about earlier, but on patients seeing new GPs, if the question, 'Have you served?' was asked and the answer placed on their records, that would be extremely helpful. We would know very quickly how many veterans there were in a particular GP's practice or local health board. That is fairly easy to do.

[409] **Dr Hughes:** Under the last Government, about five or six weeks before the election, the Ministry of Defence said that it would notify every GP when a serviceman or servicewoman left the forces. I am not sure whether that disappeared with the change of Government, but that struck me as a very sensible thing to do.

[410] **Darren Millar:** However, we were also told earlier—and you will have to tell us if this is not the case—that if somebody goes overseas for more than three months on a tour of duty or has a posting overseas, they are automatically de-registered with their Welsh GP. Which GP would the military notify?

[411] **Dr Hughes:** They would notify the GP to whom that individual returns if they are discharged from that particular GP's list. Their medical records should theoretically still be within the health service system, so that when they return to the UK and re-register, that

medical folder will find its way to their new GP. The problems arise with those who are not registered.

[412] **Darren Millar:** They would not be able to notify that person in advance, so that if they relocate to another part of the country or, for whatever reason, do not go back to the locality that they left before joining the forces, then there could potentially be a significant issue, could there not?

[413] **Dr Hughes:** Yes. I am not sure how they planned to get around those problems, but it did seem to be a very sensible move. I think that it was geared mainly towards physical injuries rather than psychological injuries. We are now treating those who were in Northern Ireland and the Falkland Islands; PTSD was not an issue that people understood at that time. There has been successively more interest from the media and within the military in the last seven or eight years since Iraq and now Afghanistan. So troops leaving now should have a better understanding of what can happen, but very often the individual deteriorates over a period of time and is not aware of what is going on, unless someone looks objectively at him and says, 'Something has happened to you'. For example, he may have broken up with his girlfriend or his wife and is drinking heavily and has lost his job. So, unless somebody is focusing on that, they will not pick up on the fact that these are the signs of his life disintegrating.

[414] **Darren Millar:** And the spiral of problems gets worse.

[415] **Andrew R.T. Davies:** Could you outline the all-Wales veterans' mental health service, including the rationale for developing the hub-and-spoke model that is currently being unfolded?

[416] **Mr Kitchiner:** The Minister asked Professor Bisson to undertake a task and finish group over six months, which he chaired, and that included representatives from across Wales: from health and social services, veterans' agencies and so on. That model was developed through that group over six months. The hub was deemed to be in Cardiff and then the five spokes, as you said earlier, were costed based on the population of that particular local health board. Just to bring you up to date, we have one person in post currently in the Abertawe Bro Morgannwg University Health Board, namely Margaret Gibbons. She has been in post for two weeks now. The post in Cardiff has not been made substantive yet, but will be. We hope that the LHBs will advertise very soon for their community veterans' therapists, who will be in post before Christmas.

[417] **Andrew R.T. Davies:** What was the timeline for all of this? Forgive me, because I am not too familiar with what the timeline for delivery was. You are giving a picture of quite a patchwork roll-out. For example, ABM university health board already has their person in place. Are things progressing as envisaged or have there been issues with the roll-out resulting in some time being lost?

[418] **Mr Kitchiner:** I think that we are very frustrated, particularly in Cardiff, with our own university health board, where the job descriptions for the administrative post and the veterans' therapist in Cardiff have been slowed down through administration via 'Agenda for Change', banding, scrutiny panels, the senior structure of our—

[419] **Andrew R.T. Davies:** A lack of will, in other words.

[420] **Mr Kitchiner:** I think a lack of prioritisation.

[421] **Andrew R.T. Davies:** A lack of will?

[422] **Mr Kitchiner:** Yes, maybe, but certainly the senior structure in our trust has been disintegrated and rebuilt and that has caused immense problems for everyone. It is in the pipeline somewhere and I keep pushing my bosses to drag it out of the pipeline.

[423] **Andrew R.T. Davies:** There was not a backstop to say that LHBs should have these up and running by 'x' date as such. It was left to each individual LHB to draw the model up for implementation as they saw fit. Would that be right or was there a date where they were—

[424] **Mr Kitchiner:** There is certainly no date that I am aware of. Professor Bisson is chairing this all-Wales veterans' mental health group, which met two weeks ago and is meeting every six weeks. That is one issue that we are trying to push through. The message from the last meeting was that the local health boards should just get on with their advertisements and appoint someone rather than wait for Cardiff.

[425] **Andrew R.T. Davies:** Could you tell me a bit about a specific role that the community veterans' mental health therapist—abbreviated as CVMHT—fulfils within the model?

[426] **Mr Kitchiner:** The community veterans' mental health therapists will be responsible for their local health board region. They will be responsible for accepting referrals, developing pathways with agencies, putting together a steering group that will support them, and then networking and spreading the word and advertising their service and taking referrals, as we do in Cardiff, where we make an assessment, develop the management plan and signpost people to the appropriate treatment and agencies.

[427] **Andrew R.T. Davies:** Do you believe that that role will be of sufficient capacity to deal with the issues that are presented in the LHBs? I touched on the point and you reiterated, Neil, how the funding has come from the general population rather than the veteran population, and obviously some roles are going to be more demanding than others. We understand why that is because there is not enough detailed information to be specific when targeting the funding. Given where we are, will the role be able to meet the demands and the challenges placed on it?

[428] **Mr Kitchiner:** You are asking me to crystal-ball gaze, I am afraid; we will have to see.

[429] **Andrew R.T. Davies:** It is a suck-it-and-see exercise, is it?

[430] **Mr Kitchiner:** Yes, it is.

[431] **Andrew R.T. Davies:** On the point about resources, is it possible to be more targeted in our allocation of resources, given your understanding of how the situation sits in our communities at the moment? Do you support the general principle that they go with funding from the general population?

[432] **Mr Kitchiner:** I think that we have a lack of evidence to say where veterans are. We know we have a large proportion in Aberdare, but we do not know where the rest of the veterans are and, indeed, if we knew where all the veterans were, we would not know how many have a mental health problem that requires treatment. Not all veterans have mental health problems.

[433] **Darren Millar:** Before I ask Helen Mary to ask the final question, can I follow up on this? Obviously, Pathways is not part of the package in terms of the delivery of this particular service that doctors use. Given the increasing number of referrals from Wales and the UK, but specifically Wales, which is what we are really interested in, you have a residential facility

that is helping to meet a need. However, if your service is not going to be funded by the Welsh NHS, and there is clearly a need for a residential service for some veterans, albeit perhaps small numbers, where will we send those veterans to access the services that you provide? Where do you send them at the moment, Neil?

[434] **Mr Kitchiner:** We would send them to the local NHS mental health unit, so if they need in-patient care—

[435] **Darren Millar:** It would be non-specific then to veterans. Is it preferable to you to send them to a veteran-specific unit? Do you think that that is important?

[436] **Mr Kitchiner:** Again, I do not think that we have the evidence to show that residential in-patient units for veterans are required.

[437] **Darren Millar:** For some veterans.

[438] **Mr Kitchiner:** We have gone for an out-patient community model because we feel that that is how to integrate veterans back into civilian life because it is closer to the home. There is no evidence that there is a need for residential in-patient units as far as I am aware.

[439] **Darren Millar:** Do you have anything to say about that, Dr Hughes?

[440] **Dr Hughes:** I do not think that there is published evidence, but certainly the model that works for us is taking an individual in for assessment in order to plan a course of therapy.

11.50 a.m.

[441] They then come into the unit, which is purely residential, and we alternate their psychological treatment with adventure training. We are dealing with ex-servicemen, so they are used to arduous activity. Instead of basket weaving or making Airfix models we take them out and get them physically tired and we build the man back together. They come in dishevelled and unshaven, and they have to be responsible for themselves and their rooms, and that is built up over a period of six weeks. Then they go back to the community and come back at whatever appropriate intervals as outpatients. To get that cohesion and to get them building up with a group works best if you bring them together for a period of time, and then they make the network links so that, even after they are discharged back to the community, they have friends to ring up. If they have a wobbly one night they will ring up somebody who they were in the unit with or they will meet up periodically, so that networking also comes from that.

[442] **Darren Millar:** Thank you for that. Helen Mary has the final question.

[443] **Helen Mary Jones:** We have heard a lot of other evidence, and you have expressed concern in written evidence, about services for veterans with substance misuse problems. Can you tell us a bit more about this and the ways in which the all-Wales service could help to address the needs of veterans who have post-traumatic stress disorder but who have additional problems such as substance misuse?

[444] **Mr Kitchiner:** We are concerned that we have identified individuals with alcohol dependency syndrome as their primary problem and struggled to get those people into NHS services for a detox or home detox and so on, because of waiting lists and priorities. That is an issue, so it would be a helpful way forward to have a system that prioritised veterans or a veteran-specific alcohol detox centre in Wales. Of course, not everybody needs an inpatient detox. We can do it for people as outpatients.

[445] **Helen Mary Jones:** Thank you. That is helpful.

[446] **Darren Millar:** That is a very important message to end on. Thank you very much indeed for the written and oral evidence you have provided. It is greatly appreciated, and I am sure that we will draw on it in making our recommendations as a committee. Thank you.

[447] Briefly, there are some papers to note. I will take it that they are all noted by the Members who are still here, and I am very grateful for your being so patient with our going over time this morning. I know that we are normally right on the button, but I felt that we needed that extra time on the orthodontic issues at the start, so thank you.

[448] **Helen Mary Jones:** We are in a difficult situation because there is so much we want to do. We all know that we are coming to the end of the session, but I suggest that we need to think about the weight of people on agendas. It is a real balancing act. It is not intended as a criticism, but half the Members have not heard the last bit of evidence. I am making a plea, really, to have a look at agendas going forward. There is a balance to be struck between breadth and trying to get as many witnesses as we can, and being able to drill down into some issues. We have needed to go backwards and forwards over some of the issues with some witnesses, and there are certainly supplementary questions that I would have liked to ask, if it were not for time constraints—and I am sure it is the same for other Members. So, it is just a plea to have a think about that; it is a huge job.

[449] **Darren Millar:** Yes, I know. It is a fair point. There is an issue that, even if we had been on time, some Members would not have been here for the end of the meeting anyway because some had to leave early for other purposes. I accept that. It is always particularly difficult on a Wednesday because of Plenary and other appointments and so on, but I take that on board. Also, in order to accommodate discussions on the budget rounds, I will be slotting in an extra meeting. I know that we have the fortnightly cycle, but I will be slotting in an extra meeting in order to accommodate that at some point in future, because we will not have time to do it in the way that we need to otherwise.

[450] **Helen Mary Jones:** I think that is entirely appropriate. Perhaps, Chair, we will have to revisit the idea of the fortnightly cycle, if we cannot get the work done.

[451] **Darren Millar:** We can have a look at that if necessary, yes.

[452] **Helen Mary Jones:** It is very nice to have the fortnightly cycle, because it gives us all a bit of space, but particularly on Wednesdays when people have to be here anyway perhaps it is not such an issue. It is a big deal on Thursday afternoons because people need to get home.

[453] **Darren Millar:** Yes, okay.

*Daeth y cyfarfod i ben am 11.54 a.m.*
*The meeting ended at 11.54 a.m.*