



Transcript

The Psychological Cost of War: Tackling Military Mental Health

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Richard Norton-Taylor:

Good evening and welcome. I'm Richard Norton-Taylor from *The Guardian*. It's great to welcome you here with a great team – couldn't be a better team – on such an important subject. Though as a journalist, I should say the subject is regarded as rather a 'soft' one and not consistently treated at all. I would probably dare to say the Ministry of Defence dips in and out of it in a rather erratic way, but I suppose to be fair to them they don't really – they can't have a running commentary on such an important and maybe even a complicated area.

I will now introduce Professor Simon Wesseley, who has been working on this area for years and years and years, and is still working with patients. Your title is director of the King's Centre for Military Health Research, and you will be concentrating, so I'm told, on basically post-conflict mental health and international approaches, or maybe everyone else will want to touch on international comparisons as well.

Dr Suzy Walton now works in post-traumatic stress disorder, is a board member of Combat Stress, but you've been for years in the heart of Whitehall – the Cabinet Office, Prime Minister's Strategy Unit and the Ministry of Defence. Your PhD was on research in the MoD into military suicide.

On my left, David Rutter, who's head of the Military and Veterans' Health Policy Team at the Department of Health, has what I suggested to him earlier was the unenviable task of working in different Whitehall departments, trying to knock their heads together. But he tells me it's getting better.

Patrick Hennessey, I haven't asked him why after leaving Balliol he went into the Army's Grenadier Guards. Now a barrister, author of one bestseller, *The Junior Officers' Reading Club*, and author of probably a second one – it will be in paperback later this month, by Penguin – called *Kandak*, on his experiences in Afghanistan. He's been to Iraq, he's been in various other places – Balkans, Africa, Southeast Asia and the Falklands.

Simon, do you want to start off?

Simon Wesseley:

I thought we could warm up with kind of a panel game. We're going to play a panel game, all of us together. Don't worry, I'm not that kind of psychiatrist, I'm not going to ask you to talk to the person next to you and say – I don't do that kind of stuff. But we *do* do panel games and we're going to play a round of *The Unbelievable Truth*. You know that one with David Webb, on Radio 4?

I'm going to speak for one minute and I'm going to try and slip some truths and lies past you. You've got to guess which are which. There's a prize: the one that gets the right number will get a bottle of champagne from Chatham House. They don't know that, but they will.

I'm going to play against one person so I might as well play against you. So I'm playing you, you're ready? One minute, off we go:

Most servicemen and women who have served in Iraq and Afghanistan come back with mental health problems. We all know the main problem they face is post-traumatic stress disorder. That's what in the First World War we used to call shell shock. Back then, of course, many were shot, but now we don't do that anymore and they all get counselling. But in these wars it's not just PTSD they face. There's a new problem of IEDs and hence, as a consequence, traumatic brain injury, the signature injury of the wars in Iraq and Afghanistan. We know that things get worse the longer you serve, and the risks of getting institutionalized get higher and higher. Those who serve the longest find it particularly difficult to adjust to [civilian life], and when they leave find it most difficult to get jobs.

Many end up homeless: 50 per cent of those on the streets of London are ex-service. If not that, might end up in prison, where ex-servicemen are dramatically overrepresented. Worst of all, of course, is suicide. We know that more Vietnam or Falklands veterans have taken their own lives than were killed in those wars. No wonder then there's a time bomb, or tsunami if you prefer, of veterans' mental health problems coming toward us. If we're going to tackle it, we should at least learn from the Americans and ensure that we routinely screen all those about to deploy, so that we can stop them getting PTSD in advance.

Okay. Sixty seconds up. Richard, what's the score? How many truths did I slip past you?

Richard Norton-Taylor:

Certainly two untruths. The amount of suicide in the Falklands.

Simon Wesseley:

That's good, but do the truths. How many truths were there?

Richard Norton-Taylor:

Probably, I don't know, five or six?

Simon Wesseley:

Five or six?

Richard Norton-Taylor:

The one on the most difficult injury or the worst injury is injury from IEDs.

Simon Wesseley:

Right, that's a lie. Any other bets in the audience? Zero? No, there was one. There was one thing I said that was true. What's the one thing that was true? [audience interjection] No, I thought you were going to get it right. The bit that I said was true is that we don't do that anymore. That we don't, we don't shoot our soldiers anymore. That's good, that's progress. Everything else wasn't true.

That isn't to say that everything's fine, because it isn't. But the first thing we need to get very clear is for the vast majority of people who served in Iraq and Afghanistan, they come back well, they stay well, they leave the military and they have very successful second lives and careers and continue to contribute to society. Perhaps the most worrying thing of all is that 92 per cent of the population in recent surveys don't believe that. They believe that nearly all of those who served in the military come back damaged physically or mentally. So that's not true.

Now we're going to concentrate on those smaller numbers for whom it is true, but everything we're going to say must be set in that context. I think that's probably the single most important fact that I want to get over.

So let's have a look at some of these myths and see what the actual facts are. That's my job. I'm an epidemiologist, a psychiatrist and a researcher. I'm here to play the boring boffin and to give you some boring facts.

First of all, I mentioned PTSD. The rate of PTSD in those who served runs at about three to four per cent. That's dramatically lower than in the US. It's still three to four per cent, it's higher than in the general population and it's associated with being in combat or being a reservist.

But the biggest problem they face is alcohol. The rates of alcohol misuse are much higher than that, about five to six times higher. For regulars, that is in fact the only thing that goes up as a result of deployment. So after they deploy they come back drinking more.

Who's at risk? It isn't those long-serving. There are two groups that are at risk: those in the combat teeth arms, which makes up about a quarter of those in most deployments, and reservists. Reservists have twice the risk of PTSD, but still only from three to six per cent. It's not actually just about seeing bad things. In fact, most of the research suggests that for professional military, the kind of risk factors that work for civilians don't work for the military. For them, much more toxic than seeing bad things is either when the side lets you down, as in incidents like friendly fire – it's completely different psychologically from being shot by the Taliban to being shot by the RAF or the Americans, so completely different things – or when you feel, rightly or wrongly, that you've let the side down. Those are the things that tend to cause PTSD.

What about the groups? Long-serving, no. For every year that you serve, you become progressively more resilient, partly because those who do develop mental health problems are much more likely to leave. So with each increasing deployment the rate of mental health problems actually drops slightly, not because deployment is actually good for you but because those who are deploying twice, three times are being gradually selected towards a more resilient group. The problems are not in those who serve 20–25 years. Obviously I'm talking about statistics here and generalities, and there are going to be exceptions. But in general, those are not the ones we should be worrying about.

The concentration of risk, the bad outcomes, occur in early service leavers, those who serve for less than four years – some of whom have left under a cloud, for disciplinary reasons or mental health issues or whatever, for various reasons. But those who are young, who have left early, maybe have done one deployment or some haven't done a deployment – there you find a concentration of risk: of unemployment, trouble with the law, PTSD, alcohol, mental health problems, homeless, difficult relations, etc. The concentration is in early service leavers.

The time bomb or tsunami – well, I was being slightly economical with the truth there, because it is true but not in this country. It's true in America. In America, after people come back from deployment, then gradually and steadily over the next 12 months, the rates of post-traumatic stress disorder

and other disorders rise, and rise dramatically. So in American reservists, for example, when they come straight back and have demobbed, the rate in the big studies is around seven per cent; goes to 14 per cent at three months; goes to 32 per cent at 12 months. A dramatic increase. But that's not the case for us. In the first year the rates seem to be fairly static and all we can say over the six years that we've been following people up for, there's an increase from about three to four or five per cent. Not a tsunami, not a tidal wave.

Prisons: Overall those who have served in the armed forces are less likely to develop a criminal record than those who haven't, and that's even including the fact that the military over-recruit from those from dodgy backgrounds who are already at risk of getting criminal records. So even when you take that into account, it's still the case that overall, over a lifetime, you're less likely to offend. With one exception though, unfortunately: violent offending is increased and dramatically so. We hear very little about that when we talk about veterans, but post-deployment violence increases and the lifetime risk of violent convictions also increases.

So those are the kind of facts that we've got. So we need to ask ourselves, first of all, why is it different in the US to us? Is it to do with what goes on in the battlefield? I'm going to suggest that that's unlikely: we've been fighting the same war for however many years it is, far longer than our allies in the Second World War. We've had the same proportional casualties since 2006. We face the same risks against the same enemy, using similar tactics, etc. It seems to me inherently implausible that that can account for the dramatic differences that we see in mental health outcomes. I'm going to suggest it's something to do with the organization of medical care in the US and the UK for when people leave the services.

We need to ask ourselves: is our current policy correct? At the moment we give the most to those who we believe deserve the most: those who serve the most, those who have given the most, we give the most in resettlement benefits, pensions, etc. And they probably don't need it the most. Probably those early service leavers, who have sometimes done the least, as it were, in the kind of moral judgment that we use when we determine these things, maybe need it the most. It's not for an academic, a medic, to say what the answer is, but it's just to point out that that's where the need is, in these people who serve for short periods of time.

We need to think about, as we talk about veterans – we're going to hear about veterans' services – but we need to think about what is the problem that we're addressing. Is it specifically an ex-services problem, or is this

actually a problem in our mental healthcare system, where there's a group that we don't treat very well anyway? These are people who are too difficult for GPs but not difficult enough for specialist mental healthcare – not psychosis, not schizophrenia. Is that where the veterans fit or are there actually unique problems that they have that others don't?

We need to think also about reservists. Reservists, in all our studies, remain at greater risk. The most worrying thing we've just shown recently is that increase in PTSD and that increase in family problems is still visible six years after deployment. That is not the case with the regulars. With the increased use of reservists, we need to think about what we're going to do about that. It's not an easy problem.

Let me end up with a last thing, which is this, and I'll repeat the statistic I gave at the beginning: 92 per cent of the population believe that anyone who has served in Afghanistan and Iraq is very likely to be physically or mentally damaged. It isn't true, but it has the potential to become self-fulfilling, as perhaps it might have been in the USA. I think we need overall to move away from the current way we see veterans: either as heroes, which most of course aren't, as I think you'd agree, except for those who have got medals for valour; or alternatively, the exact opposite, as victims to be pitied. Most service personnel are neither. Only when we start to see those who have served for what they are and what they think they are, rather than what we think they are, can we actually help develop proper services and support. Thank you.

Richard Norton-Taylor:

Thank you very much. I'm tempted to ask, as a journalist, how much responsibility lies with the media about perceptions.

Simon Wesseley:

Obviously it's always your fault. You know that. You didn't need to ask. Well, it is partly your fault.

Suzy Walton:

Good evening, ladies and gentlemen. I'm not going to play any games, but Simon set the stall out well there. I'm a board member of Combat Stress, which treats veterans with post-traumatic stress disorder. I have a portfolio of

board roles but I'm talking today with that perspective of mental health for veterans. I'm ex-MoD but civilian, not serving. I want to talk to two broad themes: the toll of conflict on soldiers and what can happen if that toll of conflict is not mitigated.

The case is proven: conflict causes mental wounds. Not all service personnel will develop problems and we can't reliably predict which ones will, but many do. Many go on to develop post-traumatic stress disorder. At Combat Stress we care for such veterans, not during their deployment but on average 10.4 years after their military service – 10.4 years because that's how long it takes the pattern of disordered thinking and behaviour to be identified as PTSD. The average age of people coming to us is 42 years. The average length of service that they had was 10 years. In terms of demographics, 83.7 per cent are ex-Army; the remainder are equally shared between the Royal Navy and the RAF, with a very small number of ex-Merchant Navy seamen. Only 3 per cent are female.

We treat veterans with PTSD in two contexts: either in the community – we have 14 community teams – or as an inpatient. We have three treatment centres, in Surrey, Ayrshire and Shropshire. For our residential treatment, we treat those moderately affected, and that may take a few short stays, or we treat those very seriously affected via a six-week intensive inpatient programme. That's relatively new for us.

People don't have PTSD in isolation: 71 per cent will have or will have had physical illness; 48 per cent will have a physical injury; 69 per cent will have alcohol or drug dependency. So PTSD is a complex condition to treat and that requires, in our view at Combat Stress, systematic and evidence-based treatment.

In terms of numbers, we are in contact with around 5,200 veterans. In the last year we had requests for help from 1,700 people. That's a 6 per cent increase on the previous year. Since 2003 there's been an increase in Iraq and Afghanistan veterans who have been getting in touch with us. We've had 2,004 inquiries, and we have 396 active veterans from Afghanistan, 724 from Iraq. The evidence is that these veterans present sooner than those from earlier conflicts.

Our main elements of our intensive treatment are threefold. We have group education, we have group skills training, and the very important bit of our programme is that we have individual, trauma-focused therapy. We have mainly, but not wholly, imported our methodologies from Australia.

What are our results? The Australian data, which has been based on a dataset of more than 4,000, shows that roughly a third do well, a third get better, and a third don't do so well and need more help. We don't have data on such large numbers because we've only been doing our intensive programme for about a year and a half, but the early results are good. We have very large psychometric datasets so I won't go into all the data that we collect, but the big picture is that 70 per cent of attendees that come to us for the intensive six-week course are much improved. We have dropout rates of only 15 per cent, which is not bad when you consider what's involved in a six-week programme.

How do we see the future? We see a lot of demand, particularly from Iraq and Afghanistan veterans. In the past 12 years, the UK has deployed 211,000 soldiers, sailors and airmen into war zones. If just around four per cent of those – I think Simon said three to four per cent; we work on four per cent – if just around four per cent of them get PTSD, that's around 9,000 individuals. So there are still many people out there that need our help.

So what happens if PTSD isn't mitigated? PTSD isn't always spotted. If it is spotted, it isn't always made better. The best-case scenario is that a severe sufferer usually will lead a difficult and fragmented life; worst-case scenario, quite simply, they won't be here.

My PhD in the late 1990s, which was done from within the MoD, was on suicide in the military. The rates of suicide at the time were above that in the community. Originally my research was classified for 30 years, which I thought was great because I didn't have to talk about it. Then the MoD actually declassified it so I can talk about it now.

There are many factors in my research which clearly correlated with suicide. I personally believe, though I never set out to specifically prove this, that PTSD is clearly a risk factor for suicide. Some of the things in my research that indicated that somebody could be at increased risk were frequent tours in theatre – back-to-back tours – with insufficient rest between tours; access to means – means of committing suicide; and too much time in isolation in certain roles – for example, sentry duty, IED operatives, etc.

I recommended various suicide prevention measures and ministers made most of them operational. We'll never really know how effective they are. You never know what would have happened if they weren't in place.

But I end on this rather sobering note, on the topic of suicide, for I want us not to forget that PTSD is not necessarily the end state from trauma in conflict. At

least PTSD victims are alive. We can, we should and we must treat them. Thank you.

David Rutter:

Being a civil servant, the whole idea of walking, talking and thinking of getting over there is just far too much for me to do, so I'm just going to stay here and talk to you, if that's okay.

I'd like to add to Simon's untruths as well, before I actually start my five minutes or so with you. The other untruth, which perhaps comes from the media and elsewhere, is that nothing is being done for veterans and their mental health. We'll take that as a starting point and I'll lead us through where we are in dealing with veterans' mental health.

By way of opening, I've been doing this work around armed forces health for about six or seven years now, so starting within the previous administration. It's interesting to note that of the many issues that political parties will throw things at each other, this isn't one of them. I get a real sense that whichever side of the political divide you sit, there is a real willingness and a keenness to take this issue on and really grab it by the horns and do something with it. The previous administration produced a command paper – I think it was 2008 – and one of the elements of that which helped to establish, if you like, the baseline was this issue around no disadvantage for those serving personnel and their families. That was then picked up by the current administration, with the Armed Forces Covenant, which is now in place. That really cemented that 'no disadvantage' ethos across government departments, NHS and other services. So that's taking it forward. So I think it's quite interesting that you've got that dynamic politically.

What does the Covenant say? I'll just read this and make sure I get it right. I think the Covenant does summarize the current government thinking around armed forces health. It says: 'Those who serve in the armed forces, whether regular or reserve' – picking up on Simon's point there – 'those who have served in the past, and their families should face no disadvantage compared to other citizens in the provision of public and commercial services. Special consideration is appropriate in some cases, especially for those who have given most, such as the injured and bereaved.' So just in that paragraph I think it actually sets out quite well where the government are coming from, and politicians more generally.

I think it's also a reflection of the way it's played out within the public as well. Again, in my time in dealing with this, I think there's been a sea change in the public appreciation of the armed forces. At one time certainly serving personnel had to be discouraged from wearing their uniform in public. There was a change in that and I think the impact of Help for Heroes shouldn't be underestimated, and the impact they had on the public psyche and the way in which we think about our armed forces. There's a whole host of things coming together over the last six or seven years which I think are leading us to where we are now.

In the context of veterans' mental health, one of the key drivers for that is a report by Dr Andrew Murrison MP. This was before he was made minister for international security in the recent reshuffle. He was asked by the prime minister, shortly after the new administration came into being, to look at access to mental health services for the armed forces and for veterans. I have to say, just briefly because I'm going to put this bit down, but I would say certainly my experience at the MoD is that they've taken that report very seriously. They take the mental health of serving personnel very seriously. I think it's unfair to suggest they dip in and out, but we can discuss that later on. Certainly my experience with the MoD, they have grasped this. My view from the centre, within Whitehall, is that the NHS are grasping this.

So what is it that we've done as a result of Dr Murrison's report? There's a money issue – isn't there always? The government have committed £7.2 million to veterans' mental health services. It doesn't sound much but I think the key element of getting the value from that £7.2 million is actually the way in which we worked with the MoD, the way we worked with the NHS in England, and the way in which we worked with service charities. Certainly when I came into this we didn't have a relationship with Combat Stress; we didn't have a relationship with the Royal British Legion, SSAFA, many of the other service charities that are out there. We needed to change that. We needed to work collaboratively. We needed to understand – we all want to achieve the same thing but how we do it is perhaps different; there is a statutory approach to it and there's a charitable approach to it. We need to understand where we're going to come from. We're definitely not going to agree all the time; the world would be a boring place if we did. But we know that the objective – to help the veteran with a mental health problem – is exactly the same. So how do we come together to produce the best result for that veteran – and for his family, also equally important?

So leading on from Dr Murrison's report, we put in place a number of projects which are now beginning to really get traction. I think there's a long way to go

yet but it's really getting to work. There's an online counselling service that we work with, with an organization called Big White Wall, who in turn work with Tavistock and Portman, providing services for serving armed forces, their families and veterans. That's been taken up very well and has been proven to be very successful. Working with Combat Stress and the mental health charity Rethink, we've imposed a 24-hour helpline, which is now being picked up by Combat Stress and continued funding on that. We've worked with the RCGP to produce a new learning package so that the GPs who are seeing veterans, seeing their families – I would describe it as almost an entry-level approach to armed forces health and healthcare issues.

We're just beginning to work through a process called Veterans Information Service that is intended to contact a veteran a year or so after they've left, so they've gone through a transition process from leaving the military – you've certainly seen this – been fed with all sorts of information, and my guess is they probably walk out the gate and it goes in the bin more often than not. So it contacts a veteran a year or so after service basically to touch base, saying how are you, how are things going. And then the longer-term objective is to link in with the Royal British Legion, the work they're now doing in relation to their services – to link in with that not just so the veteran will have access to charitable services but also will be linked in with statutory services as well. So it covers the ground on that.

So we're putting all those pieces together, they're all in place and up and running. There's Combat Stress, specialist PTSD, which we also fund and are working with – Combat Stress have done a lot for us. More recently there's the Mental Health First Aid project that we're looking to take forward as well. That's within the last month or so. So an awful lot of activity, an awful lot of things happening.

I can see Simon looking at me and I've seen that look before from you. It says: does any of this actually work? That's an absolutely good question that I ask myself. I'm the one that pays for this. I've got a budget and I'm the one that has to oversee how it works. I think that's absolutely right: does any of this work?

So one of the other things we've done is to put in place a national Veterans Mental Health Network. Still early days for it and it needs to settle itself down. But what am I looking for from that network? I'm looking for the clinicians who are delivering many of these services that we put in place to come together as one, so they can actually look to each other and say, 'This is how we do it in the southwest; how do you do it in the northeast? Why do you do it

differently there compared to the northwest? Where is the best practice? How can we actually start getting consistency across a piece?' What works in one area may not work in another area anyway. So we're bringing that together. It's an opportunity for them: people like to inform government, to inform policymakers, what they see as the best way forward in taking it forward. Simon's colleagues are involved in that network, as are the service charities, as are others. As I say, early days for that, but I'm certainly looking.

The question is: what happens next, 2014 and beyond, after the draw down from Afghanistan? What is it we need to do to make this work? What is it that we need to identify to take this forward? I think if there's a challenge for myself and for panel members and for some people I recognize in the audience, it is: how do we go about embedding this within the services that we already provide within the NHS but also within the charity sector as well? It shouldn't be driven by personality; it shouldn't be driven by the media. It shouldn't be driven by the fact that some guys are getting very seriously hurt in Afghanistan. We need it to be driven by the fact that this is the work that services – NHS, charitable – do. It's the daily job. It's business as usual. I think that's the bit we need to get to for 2014, 2015 and beyond. I don't underestimate the challenge in doing that.

Will the political commitment still be there? I think yes. I think the armed forces covenant – there is a requirement there to report back to parliament on an annual basis. Certainly my experience so far within the covenant reference group and the way in which government departments are held to account for the commitments that are in the covenant, that's taken very seriously. I think it would be a very brave government, of whatever colour next time, to walk away from any of that. I just don't see that happening.

So I think the commitment is there. I think the responsibility is on those of us that are doing and providing the policy to pick it up and make sure it's there as business as usual.

Patrick Hennessey:

I was going to presage everything I say by stressing – I think I have to, notwithstanding Richard's very kind introduction – that my experience is all relatively personal and very low-level in comparison to some of the expertise you've got lined up to my right. In fact, the last time I was on a panel where there was such a difference between where I was and where some of the fellow panellists were was when a friend of mine who was working at the BBC asked me to fill in at the last minute with John, now Lord, Hutton, who was

then defence secretary, and Richard, now Lord, Dannatt – my peerage is obviously in the post. I can give you only a very anecdotal account.

But in infantry-speak, I guess I did have the benefit of being at the pointy end of some of what is now being discussed and the effects that are now being felt. I was glad that Simon picked up on some of the myths, because I think there are a lot of myths out there. They are myths that sound very clearly to those of us who served recently and who have been through some of the processes the military tries to implement to deal with that.

One of the interesting ones and one of the ones that I was going to start by highlighting was the Falklands thing. This is close to home for me because I have been one of the people that used the factoid, as it is now shown to be, that more Falklands veterans committed suicide than died in the conflict. Actually I put it in one of my books. The editors, when we were going through it, said: is this actually true? Have you got the statistics? Fortunately, because I'm really lazy, I said no, but I can't be bothered to look it up, so let's just caveat it by saying it's probably not true but everybody always says it. But this obviously got under the Ministry of Defence's skin, because as was referenced they recently commissioned a study and found out that it's not true. So far, so good. That's an unequivocally good thing: 255 people died in the conflict and far fewer have committed suicide since. That must be a good thing.

But what they couldn't resist doing was trying to go a bit further, and I think this throws up some nice microcosm of some of the problems we have when we deal with public discussion of post-traumatic stress disorder. Because they then tried to say, look, actually, by reference to the entire number of people who served in the Falklands conflict, the percentages – you're much healthier if you're in the military and statistically you're much less likely to have committed suicide. Now I am a complete maths idiot – that's why I read English and went into the army and now the bar. Statistics is even more confusing than straight maths.

But the problem, it seemed to me, they had done there is they had said that by reference to the 22,500 people who had been involved in any possible way at all with this vast military operation – certainly vast in comparison to what we could do these days – and that seems to me to be a misleading statistic in itself, because surely the relevant detail – and again, this is something that Simon identified – is that the high-risk areas are the combat teeth arms. The high-risk areas are the ones who are on the interface of what is being done. It's not necessarily, as was said, that it's because you've seen something

nasty, but there is a failure to recognize that there is a vast difference between someone who has served a four-month tour of duty in Camp Bastion and a seven-and-a-half-month tour of duty in a FOB somewhere outside Sangin. The risk factors are going to be different and the percentages are going to be different. So that was the first sort of statistical naughtiness that they couldn't quite resist.

The other thing that they didn't address at all but that I always had been told, and I always thought was more telling – and I kind of hope is true, because it's like one of those old wives' tales that seems to make sense – was that if you drove further down into the statistics, the rates of post-traumatic stress disorder – and possibly as a result of that, the rates of suicide – were higher among those who had been in the airborne brigade than had been in the commando brigade. The reason that was given for this, the non-expert reason, was that the Paras had all flown home and they'd been chucked back out into, probably, Aldershot as it was back then, straight into the bosoms of their families very quickly, whereas the Marines had all come back in the rigs of the boats and had kind of worked through all those initial traumas on that voyage and had got kind of drunk together and beaten each other up and compared war stories, rather than doing it with their families and civilians. I think that's a really pertinent difference.

It seems to me there are three layers of the challenge that we face in dealing with the mental aftermath of conflict. The first is at small-unit level. It's at platoon, company and battalion or battlegroup level. My optimistic takeaway for this evening would be I think what we're doing at that level is quite good, is as good as it can be at the moment. I think there's cause for optimism in how we approach it there. The next level is the institutional level, and it's institutional within the military: possibly more areas for concern there. The third level, and possibly where there's the biggest area of concern because it's the most difficult to police, is the cultural level, the social level. How do we deal with our veterans, who are part of society? This has already been alluded to. This has to be, to use a kind of horrible buzz phrase – you've got to take a holistic approach to this. It's got to be the NHS; it's got to be joined up with how the Ministry of Defence deals with veterans. But it's got to be recognition from the wider public and that's where the media play a part, and that's where we can get into this territory of self-fulfilling prophecies.

Starting at that small level, which is where my experience was, I noticed reference was made to two things: being let down and feeling that you have let the side down. I'd add, purely anecdotally, another risk factor to that, which is feeling you have survivor guilt, which is quite a common thing I think among

soldiers in small units. I had a lance corporal actually, although for completely unrelated reasons we busted him down to a guardsman a bit later, who was the only person on a WMIK, a five-man crew, who didn't get medevaced home quite seriously injured or, in the case of one of them, actually killed. The problem for him was not remotely being let down and actually he was a brilliant soldier. It wasn't the horror of what had happened. It was the confusion for him as to why he had been stood in between one guy and another guy and was completely unscathed, where they had not been.

The approach you have to take to that soldier, and maybe contrast that with the idea of a soldier who'd been let down on the same tour with somebody who had been temporarily posted with another unit we were serving alongside, and felt let down by nothing more than the fact that he was suddenly with a whole bunch of Royal Anglians – and we were going to do it because obviously we're much better soldiers – but no, he was suddenly away from his family. I think the idea of being with your people, with your family, is absolutely fundamental.

How you deal with those two cases in the immediate level, I think it's relatively straightforward. I don't pretend any of this is easy but that just comes down to basic good leadership. If you're a good platoon commander, if you're a good company commander, you know your men and women. You'll be able to see the difference in them between when they're under the normal stress that everyone else is in, because you're working 14 hours a day and you're getting shot at a lot, and actually when they've stopped functioning.

The trauma risk management programme, which is something that the Army has rolled out I think completely across the board but is something that I was doing relatively experimentally with the Grenadiers in 2007, very much centres on early identification up to a sub-unit level, up to a battlegroup level. And you've got to be sensitive. So perhaps the guy on the WMIK, which was attacked by a suicide bomber, actually it was thought the worst thing possible for him would be to be sent back to the secure base location where he would have been even more on his own. He's already lost his fire team, he needed to be with the remainder of his platoon, not being handled with too much kid gloves and getting on with it.

We had another guy in the same platoon who in a different incident very much needed to step back from what was the frontline, so we had to find a relatively sensible excuse – oh, there's a resupply run that needs to be done, you need to go on this run to be in charge of picking up the batteries, and as a happy coincidence you're going to have to spend 72 hours back in a more

secure location with a hot shower and some food and a chance to get a decent night's sleep without worrying about what's going on immediately outside the wire. So that's relatively straightforward.

Where it becomes more difficult is how you coordinate that as you get higher and higher and larger and larger. An example I'd give – and again, this is all about the immediacy – coming back from R&R in the middle of a tour. It's all very well coming back at the end of a tour and getting decompression in Cyprus, you've spent six months, you're together as a unit. But you get shoved out on your R&R for two weeks' holiday – in my case, in London – 37 hours having been pulled off effectively a frontline. I tried to write quite vividly about this because I did find it completely extraordinary to find myself in a nightclub – well, it was fairly extraordinary to be in a nightclub in East London for some people anyway, but the contrast of that to having been in the middle of the Green Zone was probably unhealthy. I can put my hand up, a number of these things that were identified, drinking – I was quite a mess when I came back. It took very good friends of mine to be able to say: you need to sort this out.

Here's where another layer of flexibility is required. We think if we treat things in-house that's going to help. Actually I think you just need to be more sensitive to your people. Most soldiers prefer speaking to other soldiers, and a lot of the guys that I worked with did not like the idea of talking about whatever it was they were going through to civilians. But that doesn't mean it's going to be all – and actually in my case I didn't want to talk to a military doctor, partly because a lot of the reaction I got from them was, 'Oh, were you guys on that tour? Oh, you were there, what was that like?' It's not really why I'm here.

So I was very fortunate. I couldn't possibly be any more kind of hopelessly middle class and I read English, so psychoanalysis and novels is kind of in my DNA. All my parents' friends were like, 'Oh, this is a good therapist, this is a good therapist, this is a good therapist...' I come from that background where that is – I had friends at university who had therapists as accessories. There's no stigma attached to it for me. But again, that is not going to be the case for the vast majority of servicemen and women.

So as we go further up, as you go up from a small unit where you can manage it tightly, as you go up to an institutional level, how does the Army deal with this? How do the armed forces deal with this? It's going to be a question of being flexible. But of course, flexibility and the resources to drive flexibility are things that you just don't necessarily have.

That is writ even larger when we come up to the problem of how does society deal with it. I think there needs to be education, there needs to be awareness, and it needs to be subtle education. It needs to be education that has shades of grey. It can't just be, as we've seen from this horrible statistic that 92 per cent of people think that if you've been to Iraq or Afghanistan you're going to come back damaged – how do you educate the wider public in the idea that that's not true, but because it's not true doesn't mean that there aren't going to be some people that you have to deal with quite carefully?

It's a bit jargonistic, but for those who know about Army 2020 and how the British military is going: it is getting smaller, it is losing resources, and the sort of flexibility to manage its people intelligently I think will be reduced. So it's brilliant that we're doing all this stuff on the one hand to deal with the problem. Could we perhaps save resources by trying to address the problem before it becomes a problem? I wonder if that's something that's been thought about. And again, joined-up thinking between the National Health Service and the Ministry of Defence and I'd also say, crucially, employers. We are moving to a scenario where we have a much bigger reserves and we will depend on them, and if employers don't understand – and as we have seen, reserves are also a real high-risk area.

So as you come up – it was relatively easy for me and I was very fortunate. I was well trained and I was well supported and I had a good bunch of guys. The higher up that spectrum you go, it's more difficult for a lieutenant commander to look after his whole unit than it is for a platoon commander. It's more difficult for the head of the Army to look after the Army. It's going to be very difficult for the secretary of state for defence, the secretary of state for health, to keep tabs on all this.

So I think if you take one thing away, it's that at the lower levels I think we're doing the right things. But how do we carry on going up?