Written evidence submitted by Trixie Foster

Introduction

Over the last decade, it has become apparent that the Armed Forces and Veterans mental health programme has been misguided. This has been due to indecisions by the authorities who are making the call. Medical advisors to the MoD are not open to accepting the academic, and medical evidence from other professionals, both national and international. They are also not listening or do not want to hear what serving personnel and Veterans are telling them.

1. Background

Historically, military medical records have been incomplete. Therefore, numbers can only be an estimate. The MoD medical branch, their psychiatrists and the politicians (this includes civil servants) will not and do not wish to recognise the additional importance of neurotoxicity so there will never be accurate statistics.

The MoD, especially the Surgeon General and their advisors wish to keep the mental health issues of the Armed Forces and Veterans under the umbrella of PTSD mental health and alcohol. Many Military personnel and Veterans may be misdiagnosed with PTSD when they could have mefloquine toxicity.

Military personnel (including Veterans when serving) may have been given the neurotoxic antimalarial mefloquine, experience a trauma, mTBI and they will have symptoms that they and their medical advisors will associate with the trauma and not the anti-malarial. Mefloquine symptoms mirror PTSD symptoms – e.g. depression, anxiety, and insomnia. They could be prescribed an anti-depressant and other drugs which, if it is mefloquine toxicity may exacerbate the symptoms, causing an adverse event.

In 2013 the FDA and the United States military recognised the danger of mefloquine and ordered the special forces command to stop prescribing the drug thus within the last five years protecting many military personnel from suffering neurotoxicity.1 (NB please look at this evidence). UK experts (psychiatrists), who advise the MoD on Veterans Mental Health, tell us that unless there is evidence-based data on mefloquine toxicity then they will not recognise this being of concern. There are papers from the US written by internationally renowned experts on mefloquine.2 It is of concern how the academic papers written for the MoD identify evidence on PTSD and alcohol from the US when it is advantageous to do so. However the evidence coming from the US on mefloquine toxicity and other neurotoxicity issues are being avoided34

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1 https://info.publicintelligence.net/USASFC-Mefloquine.pdf
2 http://www.remingtonnevin.com/home/publications.html
3 https://vestibular.org/educational-resources/types-vestibular-disorders/neurotoxic-vestibulopathy
4 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5005770/
In July 2017, the UK Veterans Mental Health & Wellbeing 5 year Strategy Report 2017-2022 was published. Having read the report it was evident that neurotoxicity was not included. The report was highlighted at a meeting with CDS PEOPLE Lt Gen Richard Nugee, Helen Helliwell Head Service Personnel Support MoD and Kate Davies NHS Director Veterans. We queried the exclusion of neurotoxicity. They said they would look into it, but this did not occur. General Nugee informed me, any further medical queries should be directed wholly to the Surgeon General.

FOIs were requested but we have received inadequate responses. The Countess of Mar has tabled questions in the House of Lords and received similar answers. (All FOIs available on request)

**2. The US Department of Defence & Veteran affairs.**

The US Department of Defence has been concerned about the Mental Health & Wellbeing of their serving personnel and Veterans for many years. They have, of course, the advantage that the military hospitals on their bases also permit Veterans to have treatment so that they can monitor personnel as ongoing. They also understand that they have to address the situation at source and encourage senior officers in command to promote that there is no stigma in recognising that you need help. They use public media and Forces media giving military personnel the confidence to talk and seek help. Interviewees include senior commanding officers, officers, NCOs and soldiers from the parent regiments that the men can relate with. The main message is no soldier will lose their job for asking for help.

US Brigadier General (retired) Don Bolduc, Commander of the US Special Operations Forces AFRICOM from 2015-2017 had served in Iraq and Afghanistan and recognised he had PTSD, mTBI and mefloquine toxicity. He only asked for counselling after 6 years. He put a programme together for serving personnel under his command and their families in Stuttgart so that all his soldiers and families were aware of what was in place for them. This included awareness talks, brochures handed out to all personnel, and experts in the different fields available to all troops. To carry this out while the personnel are serving is very important.

**3. Is this the right approach?**

One of the most important statements was to inform serving personnel they would not lose their jobs because they asked for help.

In the past sadly, and this is apparent in the UK military, many were asked to leave the forces due to their mental state without receiving the correct treatment.

An example of this was on Radio 5 Live 25th February 2018, Stephen Nolan Show. A Veteran stated that a friend of his, a serving NCO, asked for help from his Regiment, was sent home on home leave without any help and has to leave the military in March. Not acceptable.

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5 http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Lords/2018-01-17/HL4829/
The US personnel are informed that they could have been misdiagnosed due to neurotoxicity including mefloquine toxicity and they can ask to be reassessed and re-diagnosed.

Over the years that I have been aware of the misguidance of Serving Personnel and Veterans Mental Health we have seen the promotion of new projects, new guidelines, new ventures which turned out to be more expensive international conferences with the same senior commanders and advisors promoting the same lines of research.\(^6\)\(^7\) The formation of the five Armed Forces charities including Combat Stress, Help for Heroes, RBL, The Royal Foundation, MoD and NHS are strongly promoting and forming what they believe are the answers to the future of Armed Forces and Veterans Mental Health. The issue is the same advisors are at the helm steering the future. The people who are the CEOs of these charities and members of the Royal Family involved with the Royal Foundation will only be told selective information and if the right questions are not asked they will presume that this is the correct way forward. As long as it appears that they are doing something or anything then, with good publicity they can get away with not doing the most important thing and look after the serving personnel and Veterans with the correct treatments, which includes addressing the correct management structure.

It takes a courageous serving officer like General Bolduc, to make a public statement and say we must address the complete challenge of mental health, which includes the neurotoxicity issue now before any more men and women are facing a dark future. However, as we know, what serving officer wants to be intimidated and lose promotion, lose the job he loves and find he will have to resign?

4. Research

The correct experts in the UK must approach all in depth programmes with open minds and not with a prejudicial remit prior to their investigations. The UK could have saved a great deal of funds from the LIBOR fund and the MoD budget by taking on US research. So much research is replicated. UK advisors keep on stating that the US military statistics on military health is different from the UK. One of the reasons is that the US include neurotoxicity. The information on the Gulf War Syndrome must be included in research as this is part of the neurotoxicity picture. The experience of neurotoxicity covers all conflicts, and serving personnel and Veterans are experiencing miserable outcomes due to neurotoxins.

Millions of pounds of the MoD, the NHS, and taxpayers’ money could be saved, and funding could be channelled into the correct research. At present, articles appear to being published monthly highlighting PTSD and alcohol. The authors repeatedly suggest more research needs to be completed. References in these papers on research are from the same authors thus repeating research already carried out. It appears they are not publishing any new data.

5. LFOS ORDER 3209 Land post-operational Stress Management 2014\(^8\)

\(^6\) https://obamawhitehouse.archives.gov/the-press-office/2012/03/14/joint-fact-sheet-us-and-uk-defense-cooperation

\(^7\)https://www.gov.uk/government/news/joint-communique-on-international-ministerial-5-eyes-conference-on-veterans-issues

When troops, both regular and reservists return from a war zone, they have R & R including decompression. This has occurred in Cyprus when the men and women have returned from Iraq and Afghanistan. The document is commendable. However, the reality of the situations and due to the complexity of some of the personnel’s mental and physical injuries, assessments cannot be comprehensive. Most of the personnel come out of these tours of duty unscathed and the PSOM is acceptable. The paragraph called ‘Normalisation’ is a sobering word to apply to this programme. How can you ‘normalise’ personnel in 2 – 5 days?

In Order 3209 there is no reference at all to neurotoxicity. Therefore, as it is not flagged up at all, the medical staff, TRiM practitioners, command, chaplains and others are not alerted to look out for neurotoxicity. The questionnaires that the personnel have to answer will not be complete.

6. TRIM (Trauma risk Management)

TRiM is now part of this process. Professor Neil Greenberg, a psychiatrist and one of the chosen advisors for the MoD wrote a paper in 2008 where he says ‘Trauma Risk Management (TRiM) is a novel system of post incident management which intend to allow commanders to provide appropriate support to their subordinates in the aftermath of traumatic events’.

The onus is always on the commanders to make sure their men receive TRiM. Serving personnel and Veterans are amongst the people trained to become TRiM practitioners. These are 2 – 5 days of training, mostly by the Training Company March on Stress. The directors of this company are Professor Greenberg and his wife Dr Karla Greenberg.

These TRiM practitioners are not qualified to identify mefloquine toxicity or other neurotoxicity. Thus, the symptoms brought on by mefloquine toxicity, such as depression, anxiety, insomnia and other symptoms can be misdiagnosed at this point as PTSD, and drugs can be prescribed (e.g. anti-depressants) which, on a mefloquine damaged brain, may make the serving personnel experience an even more dangerous event.

7. The Media

Over the last five years, comments from the MoD and NHS medical advisors promote the notion that the public are now aware of neurotoxicity through the media, press and other channels and, because of this they imply the Veterans may ‘decide’ that they have been misdiagnosed. They believe they are being misinformed and in light of this, the MoD should listen to the advisors and adhere to the line that serving personnel and Veterans can only suffer from PTSD and alcohol.

However, it is interesting that these MoD advisors appear to recognise that there is mefloquine toxicity

At the February 2017 meeting of the Medical Advisory Committee (MAC), British Members Council of the World Veterans Federation, Dr Walter Busuttil, psychiatrist and Medical Director of Combat Stress comments that he had a discussion with Professor Sir Simon
Wessely, MoD advisor and Trustee of Combat Stress regarding mefloquine. Here is a quote from the Minutes:

1. Any other business

- On behalf of MLS (Marie Louise Sharp Royal British Legion) (in her absence), DC asked the MAC to give their thoughts on Larium (Lariam) Toxicity following recent requests for the Legion to look in to this in further detail. WB (Walter Busuttil) noted his recent meeting with Prof Sir Simon Wessely on the topic where they discussed that studies had not been carried out in to Larium Toxicity. WB said that Combat Stress had not been seeing significant numbers of veterans presenting with Larium Toxicity, but when they have, they have referred them on to Neuro Psychiatrists.

- DC asked that if any members had further information to contact MLS.

- Action point nine: Members of MAC with any information on Larium Toxicity to contact MLS at the Legion.

From this one would surmise that neurotoxicity has been recognised, mefloquine toxicity being one of them. It could also be accepted that Combat Stress recognise that they may not be qualified to treat mefloquine toxicity.

I have written to Dr Busuttil and am waiting for a response. They also say there have been no studies carried out in to Lariam’ I refer, again, to one of the studies on mefloquine, the Walter Reed study ‘Prolonged Neuropsychiatric Symptoms in a Military Service Member Exposed to Mefloquine’ 2016. More papers can be submitted on request.

8. Combat Stress

It has been apparent for some time that the MoD (and the NHS) has funded charities to carry out the Veterans mental health & Wellbeing, one of the charities being Combat Stress. They are now relying on Combat Stress to deal with a 24/7 Veterans’ helpline. Combat Stress have received from MoD another £50K to operate this. In 2107 Combat Stress lost its NHS funding. However, it acquired £3M MoD funding. The MoD also funded the Veterans Gateway Call centre Contact with £2M.

The issue that was made apparent to the Chair of the Defence Select Committee, Dr Julian Lewis at the Armed Forces Covenant Annual Report 2017 Meeting 20th February 2018 when a Veteran uses the Veteran helpline the experts needed at 2a.m. for the distressed Veterans are not available. Mr Tobias Ellwood MP Minister for Defence People and Veterans responded by saying the police or Samaritans are the contacts. It should not be the police’s responsibility to deal with the MoD’s shortfalls. We have covered this scenario many times. A Veteran will have almost certainly been through the process many times – police, hospital, discharge, back to despair and an available bridge.

Therefore, it appears that Combat Stress have not the facilities and relevant experience to deal with complex conditions and Veterans fall through the cracks.

7. Funding

The NHS is also involved with Veterans Mental Health, and they have spent millions of pounds to appear to be doing ‘something’. There are four NHS Regions, which are addressing Veterans mental health. After the ‘Gate to Gate’ Report 2016, the regions were asked to write a report to see what the situation was at present, what they would have to put in place in their regions and how they see the future with Veterans Mental Health. It is believed they were all given each £80K to write a report. One invoice for a report was £19K. What has happened to the remaining £61K? There has been a suggestion funds for Veterans mental health may have been diverted to be used elsewhere, for instance, on IT equipment. Unless money allocated for service personnel and Veterans, whether from LIBOR, MoD budget or the NHS is ring-fenced this will continue to happen. Sadly, this is ‘built’ into the British culture, unlike the US military where even taking a pencil from a military base is called theft. Cynically, one would say, if this money is ring-fenced then the people responsible will make sure that all the money is seen to be ‘used’ on mental health prior to the end of the financial year by submitting more expensive invoices to empty the accounts. This insidious culture has to be scrutinised. It is fraud. We all know that come the end of the financial year budgets are expended as the money cannot be taken over into the next financial year. Fraud is not an easy subject to address.

8. Regiments

All Regiments should take more responsibility for their soldiers and families who are leaving the army to become Regimental Veterans. The Regiment should be an enduring lifeline. There should be a duty of care in place. This should be part of the Armed Forces Covenant.

Prior to leaving the army the soldier’s (or family’s) future address could be obtained by the Family Office, a Regimental Veteran living in the relevant area contacted and correspondence between the two put in place. Therefore, on leaving, the Military Gate is not firmly closed but a welcoming fellow Regimental colleague can help with this challenging transition. This can be daunting, frightening and lonely time for the new Veteran. A simple system put in place by the Regiment would be cost effective and appreciated. In the months to come this soldier will become a Regimental Friend helping to establish a nationwide network of kindred Veterans.

For this to work it will have to come from the top and carried out in every Regiment as an order. Otherwise it will not be carried out and seen as more paperwork. Data Protection may be questioned but should not hinder the outcome. An ‘opt out’ could be possible. Meeting the Regimental Veteran prior to leaving the Forces should alleviate any concerns.

Simple and positive.

9. Conclusion

- The MoD are advised incorrectly not to recognise neurotoxicity
• MoD are concerned over litigation. This is ongoing. Unlike the US Department of Defence, the MoD is not exempt from being legally pursued.
• US Veterans compensation package is much more realistic and cost effective ultimately.
• Armed Forces and Veterans Mental Health cannot be wholly successful until neurotoxicity is recognised.
• Funding from the MoD, LIBOR, NHS and Armed Forces charities must be strictly monitored. Although it is not the Charity Commission’s job to audit charities it is useful for the public to scrutinise their accounts.
• Certain charities could possibly lose credibility
• Certain medical opinions could possibly lose credibility.
• Regiments need to take more responsibility of their Regimental Veterans. In the 1970’s and 1980’s the Regimental family welfare system was the central hub of support. This is now fractured.
• The MoD and charities can all take advantage of asking an impartial and an experienced ‘soldier’s soldier’ who has successfully put in place a very intensive, comprehensive programme within the US Military system for advice. General Bolduc is the soldier to give this advice. His programme has been proven, and could be adjusted for the British Military.
  His promise of no stigma for any soldier, officer, commander who asks for help will not lose their job is a promise indeed.

**Trixie Foster**

Trixie Foster was married to an army officer. Some of their postings included Germany, Northern Ireland (2 years accompanied in the 1980s pre-the Agreement) and the USA (2 years) thus experiencing the US military life.

Over the past 6 years Trixie has been involved campaigning to have Lariam (Mefloquine) stopped from being prescribed to the UK Armed Forces. This has included contacting Veterans, retired military personnel, liaising with Members of Parliament and members of the House of Lords, Government, the Ministry of Defence and the NHS and making sure the media and press are involved in the campaign.

She was a witness at the Defence Select Committee Inquiry: An acceptable risk? The use of Lariam for military personnel. The Report published in May 2016 resulted in the MoD having to reform their views on Lariam. During 2016 / 2017 she attended meetings which included Roche UK, the MHRA (Medicines and Health Products Regulatory Agency), CD PEOPLE and the NHS (Director of Veterans) With other colleagues she continues to lobby to ensure that the Veterans will receive the correct treatment.

*2 March 2018*