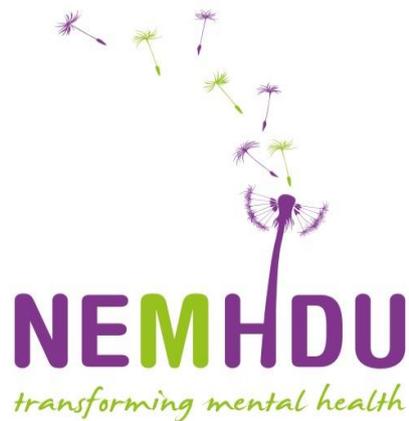


Evaluation of The Big Lottery- funded Veterans Service

Final Report

June 2019



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Evaluation of The Big Lottery-funded Veterans Service

Prepared by the North of England Mental Health Development Unit (NEMHDU) for Finchale Group

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1. INTRODUCTION

The Armed Forces (Army, Royal Navy and Royal Air Force) is a significant employer in the UK (approximately 139,000 people), with numbers of personnel leaving (outflow) per year approximately equivalent to 10% of total strength (16,545 during 2016/17)ⁱ. Services leavers peaked in 2012 (23,520) largely attributable to the 2010 Strategic Defence and Security Review, which has decelerated since 2016 and is expected to stabilise at 14,500 per year in 2020ⁱⁱ. This outflow from the Armed Forces represents approximately 2% of adults seeking employment per year in the UKⁱⁱ.

Ex-service personnel show comparable mental health patterns to the general population, with the most common being alcohol misuse, depression and anxiety disorders. However, those leaving the Armed Forces with psychiatric problems are at increased risk of social exclusion, ongoing poor health and higher rates of unemployment compared with the general population. Therefore, the transition from the Armed Forces to civilian life is critically important for the individual service leaver, their family, their local community and society. As well as a transitional route into the civilian life, it is important to be cognisant that a transition is a 'journey out of the military world' that encompasses a sense of loss.ⁱⁱ

The Forces in Mind Trust define a good transition from the Armed Forces to civilian life as:

“One that enables ex-Service personnel to be sufficiently resilient to adapt successfully to civilian life, both now and in the future. This resilience includes financial, psychological, and emotional resilience, and encompasses the ex-Service person and their immediate families” (p14)ⁱⁱ

The costs of poor transitions are significant. They are projected to increase from £105m in 2017 to £110m in 2020ⁱⁱ. The four areas that account for the largest proportion of costs associated with poor transitions are: family breakdown (27%); mental health disorders (23%); harmful drinking (19%); and unemployment (15%). Mental health disorders are expected to account for highest proportion (28%) of costs associated with poor transitions in 2020; family breakdown is broadly the same, at 26%; while the share of costs accounted for by alcohol misuse and unemployment both fall (to 14% and 10%, respectively).

A recent cross-sectional surveyⁱⁱⁱ indicates discordance between public attitudes of veterans and the actual experiences of veterans. For example, public attitudes include many positive perceptions of veterans – such as loyalty and self-discipline, although negative misunderstandings are pervasive such as armed forces veterans being perceived as more likely to be institutionalised or have mental health issues than the general population.

1.1 Policy initiatives targeting veterans

Since the publication of the Armed Forces Covenant in 2000, government policy has focused increasingly on how to improve the process of transition for service leavers and their families. Alongside growing public interest arising from military conflicts in Iraq and Afghanistan, in 2003 the Ministry of Defence (MOD) published its first *Strategy for Veterans*.^{iv} This outlined a commitment to ensure that ex-service personnel, whether regular or reservist, receive three key standards:

- Excellent preparation for the transition to civilian life following service
- Government and voluntary sector support where required
- Recognition of the contribution of the Armed Forces to society

In 2010 the MOD's *Strategic Defence and Security Review*^v initiated a process of reducing the size of the UK Armed Forces, with a long-term aim to rely more heavily on reservists such as those employed in the Territorial Army and Royal Naval Reserves. Given the subsequent redundancies that have followed, understanding the challenges of transition became more pressing than ever.

In acknowledgement of the growing challenges of resettlement, in 2014 Lord Ashcroft's *Veterans' Transition Review*^{vi} was commissioned. Ashcroft provides a series of practical recommendations across inter-related areas including training, employment, health, housing, welfare and finance. One key overarching recommendation was for the widening of eligibility criteria for full resettlement support, in recognition that the likelihood of poor transition is amplified for Early Service Leavers.

Drawing on existing research findings, Ashcroft paid particular attention to the service leaver's mind-set, and subsequent level of preparation (both practical and psychological), as central influences on individual transition outcomes. The report also highlights the importance of making families a greater part of the transition process, as well as changing public perceptions in order to avoid potentially damaging misconceptions that can serve to restrict opportunities and lower expectations of their capabilities.

In October 2014 the UK government published a response to Lord Ashcroft's review, outlining how the issues raised and recommendations were being addressed.^{vii}

The Defence Secretary commissioned a Veteran's Strategy in April 2018. Over the next decade, the veteran population will experience a dramatic generational shift from the Second World War and conscripted generation to the younger, all professional cohort both with vastly differing needs. The MOD identified several key pinch-points which will be prioritised – debt, housing, social isolation, mental and physical wellbeing, public perception^{viii}.

In November 2018, the 'Strategy for our Veterans'^{ix} was published, which represented the first UK-wide strategy on the delivery of support for veterans, and outlines a new vision:

"Those who have served in the UK Armed Forces, and their families, transition smoothly back into civilian life and contribute fully to a society that understands and values what they have done and what they have to offer" (p7)

The strategy focuses on cross-cutting factors that impact on service provision across six themes identified from research as priority 'pinch points' for support:

1. community and relationships
2. employment and skills
3. health and well-being
4. finance and debt
5. housing
6. contact with the law

The strategy builds on the existing package of cross-government support available to veterans and their families' to facilitate the transition to civilian life (see Box 1).

Box 1 – Package of existing support for veterans^x

Transition to civilian life

- Up to two years before and after leaving service, veterans can access the Career Transition Partnership, which offers one to one guidance and training to those exploring new careers after leaving the military.
- This year, the MOD will launch the new Defence Transition Service – an extra layer of care that will identify and support those most vulnerable as they leave service.
- The Veterans' Gateway was launched in 2017 and acts as the first port of call for ex-service personnel and their families. The MOD has announced that the Gateway's 24/7 helpline will trial a new outreach service where it will proactively call those who have served, to check in on their wellbeing and remind them of where support can be found.

Mental health

- During 2019, the UK Government has doubled its funding of the Armed Forces Covenant Fund Trust, committing a further £10 million to support veterans who may be struggling with their mental health.
- A specialist Veterans Mental Health and Wellbeing Fund has been established to distribute this money, which will provide cash for projects that improve veterans' wellbeing through activities which have been proven to significantly benefit the mental health of individuals.
- Since 2010, the UK Government has also provided an additional £22.5m to the NHS in England to support the mental and physical health needs of both military personnel and veterans, with a further £9m since 2017 to set up the new Transition, Intervention and Liaison Services (TILS), which provides community based support for those personnel approaching discharge.
- In the Budget, the Chancellor announced the UK Government is investing at least £2 billion extra a year in our mental health services by 2023/24, with new mental health crisis centres, support in every major A+E unit in the country and more mental health ambulances.
- NHS England confirmed that every part of the country now has dedicated mental health services up and running for veterans, and announced the first 25 hospitals to become 'Veteran Aware', delivering specialist healthcare support to those who have served.
- The first cross-government strategy to tackle loneliness will allow all GPs in England to refer patients suffering with loneliness to community activities and voluntary services by 2023. This builds on the £20 million dedicated to helping charities and community groups to expand programmes that bring people together.
- Veterans in England, Scotland and Wales benefit from priority access to NHS secondary care for service-related conditions.

Housing and finance

- All veterans have access to housing and financial guidance through the Career Transition Partnership, which ensures they are given the skills to remain self-sufficient in civilian society.
- The UK Government has committed to halve rough sleeping by 2022 and eliminate it altogether by 2027, as part of the Rough Sleeping Strategy launched in 2019.
- The MOD will continue to engage with a wide variety of agencies who assist in homelessness and rough sleeping for veterans

In 2018, the Military Veteran Aware Accreditation was adopted by NHS England and the Royal College of GPs as a nationwide initiative to better identify and treat veterans, ensuring they get access to dedicated care where appropriate^{xi}.

1.2 Evidence-base for the transition interventions

As highlighted in previous literature reviews (NEMH DU, 2013^{xii}) there are few high quality studies that evaluate interventions using robust designs such as randomised controlled trials. Consequently, there is a paucity of robust evidence around the effectiveness of intervention programmes for veterans and their families to facilitate transitioning back into civilian life. Much of the literature is US based prompting questions about the applicability of such data in the UK context. What evidence that does exist is limited in methodological quality and there is a particular dearth of data on health and psychosocial outcomes, including cost-effectiveness of transition programmes, with many studies focusing on presenting descriptive data and analysis of process outcomes such as client satisfaction^{xiii}

See Appendix 1 for an overview of studies identified by the literature search

1.2.1 The previous Joint Transition Service at Finchale Group

Launched in August 2014 (in response to an identified need for greater co-ordination and case management during the transition process for potentially vulnerable service leavers) the Joint Transition Support Service (JTSS^{xiv}) aimed to provide individual, case-managed support to service leavers and family members following discharge on medical grounds. The service was holistic in nature, while holding a strong mental health and emotional well-being focus. The team was made up of a Community Psychiatric Nurse (CPN), an Occupational Therapist and an employment coach, alongside a service coordinator and manager. Common themes identified from service users within previous evaluations of veterans' services were self-management for health and psychological problems, and the provision of information, advice and support for a range of financial, employment and psychosocial challenges. The findings of the service evaluation for the JTSS addressed many of the gaps in the literature. This service evaluation yielded quantitative and qualitative evidence of the value of the JTSS programme for supporting a positive transition and recovery. The JTSS supported 55 over 2 years (average age 30 years, 92% male and 90% White-British). There were statistically significant amelioration of the perceived negative influence of others, stress they were currently experiencing, and the extent that drugs were part of their lives. Powerful narratives around personal transition journeys of clients provided particularly strong evidence that engagement with JTSS impacted positively on their psychosocial wellbeing; family functioning; self-esteem; motivation; and confidence for seeking employment and accessing training.

1.2.2 Recently published evidence for transition interventions

Since the undertaking of the scoping literature review as part of the evaluation of the JTSS (Appendix 1), there has been a paucity of new evidence to inform the design of transitional programs for veterans. Two recent systematic reviews funded by the Forces in Mind Trust are of particular note, one focused on brief alcohol interventions^{xv}, and the second on well-being interventions^{xvi}.

Harmful alcohol consumption is common in the UK armed forces (67% of males compared with 38% in general population), which may impact on the process of, and maintaining a transition to civilian life, for example by contributing to the development of, or worsening existing mental health symptoms^{xvii,xviii,xix,xx}. The first review published in 2016 focused on the effectiveness of brief alcohol interventions (simple structured advice or extended brief intervention which generally involves behaviour change counselling) for active service personnel and veterans, self-administered web-based interventions, involving personalised feedback over a number of sessions, and system-level electronic clinical reminders had mixed evidence for effectiveness. Personalised information within clinician-delivered interventions using motivational interviewing was identified as particularly effective for reducing drinking quantity, frequency, binge drinking days, drinks per drinking occasion, and adverse events in veterans with symptoms consistent of post-traumatic stress disorder (compared to those without).

The second review published in 2018 examined the effectiveness of preventative early interventions to protect the psychological and emotional well-being (and amelioration of pre-clinical distress) of military personnel coping with the pressures of adjusting from military to civilian life, which across the 12 studies reviewed included expressive writing; anger management; cognitive training; psycho-education; and techniques to promote relaxation, connection in relationships, and resilience. Narrative synthesis did not elucidate any reliable evidence for specific interventions. The findings of the individual studies demonstrated some evidence of effectiveness of online expressive writing (thoughts/feelings about transition to civilian life for 20 minutes per day for 4 out of 10 days) compared with factual writing or no writing for protecting the well-being of military personnel adjusting to civilian life^{xxi}. The review sought to exclude studies purposively selecting individuals with clinical diagnoses, such as post-traumatic stress disorder. However, screening utilised in studies often identified participants with clinical diagnoses, and the review authors reported that better effectiveness was demonstrated with veterans with existing mental health symptoms, and those who recruited via clinical services or elected to receive the well-being interventions.

Notwithstanding these important findings from the two recent systematic reviews, both had substantial heterogeneity across studies in terms of research design, recruitment methods, mode, form and content of interventions, outcomes measures, and in particular issues around transferability of findings to the UK (all the studies in both reviews were conducted in the USA). Furthermore, studies reviewed included both active service personnel (during post-deployment periods) and veterans.

Both reviews recommend more research in the UK context to establish the active ingredients of effective brief alcohol and well-being interventions, which could form specific components of more extensive and broader programmes, such as those provided by Finchale Group. With regards to the review of well-being interventions, the authors conclude that a clear conceptualisation of well-being from the perspective of veterans would indicate the optimal selection of outcome measures for preventative interventions, including whether interventions presented as ‘treatment’ would be more acceptable to veterans if they are conceptualised as skills/resilience training.

1.3 Finchale Group

Finchale Group (previously Finchale Training College) was founded in 1943 as a rehabilitation centre for wounded, injured and long-term unwell armed forces personnel returning from service in World War II. Located in the north east of England (serving communities with higher than national average levels of unemployment, health inequalities and deprivation), they provide specialist residential training programmes to over 300 veterans annually.

The Progression Pathways Service supports veterans with employment, housing, finances, physical health, mental health, alcohol and family issues. They also provide specific services focused on the transition to civilian life. These services aim to provide an additional element to the transition pathway by sitting alongside and working with existing providers, particularly the Personnel Recovery Unit at Catterick Garrison. These programmes involve a multi-skilled case worker alongside a service co-ordinator and manager.

Finchale Group hosts the North East Veterans’ Network (forum for statutory and non-statutory organisations involved in supporting veterans). A plethora of external armed forces charities refer their clients to Finchale Group (for example, SSAFA; The Royal British Legion; Help for Heroes) including the NHS, Job Centre Plus and Probation Services. Veterans can also self-refer themselves to Finchale Group.

The Finchale Group team works with each of its clients to establish their aspirations, distance from the labour market, and the level and range of support that they will require to get in to mainstream society and to build their confidence, empowering them to take control of their lives again.

Services and activities that Finchale Group provides (some of which are delivered in collaboration with specialist partner organisations) include:

- Case Management
- Health/mental and physical health, emotional and psychological counselling
- Alcohol/drug misuse
- Occupational Therapy
- Strategies to organise dysfunctional lifestyles
- Debt/benefit/financial advice
- Housing advice/guidance
- Temporary housing/support
- Legal advice/guidance
- Specialist equipment
- Communication problems
- Functional skills development
- Vocational training
- Personal/relationship/social skills
- Employability skills
- Employment preparation
- Job search/work placement/trials
- Monitoring and in-work support for up to 6 months

Finchale Group provides a wide range of facilities/resources/equipment accessible by all clients, including training rooms/accommodation/IT suite. They also have a network of outreach partners and centres across the North East region, where Finchale provides services at the point of need for the client/participant.

All staff are qualified and registered to relevant national standards. Finchale Group holds full accreditation with Awarding Bodies for the delivery of services. Finchale Group has access to an extensive network of organisations/specialists that can provide additional or specialist services when required for clients on any of their programmes. If a client needs a service or support that cannot be provided they would signpost to the appropriate specialist facilities/outreach partners

1.4 The Big Lottery Veterans Service (BLVS) at Finchale Group

Table 1 provides an overview of the scope, structure and referrals process for the BLVS.

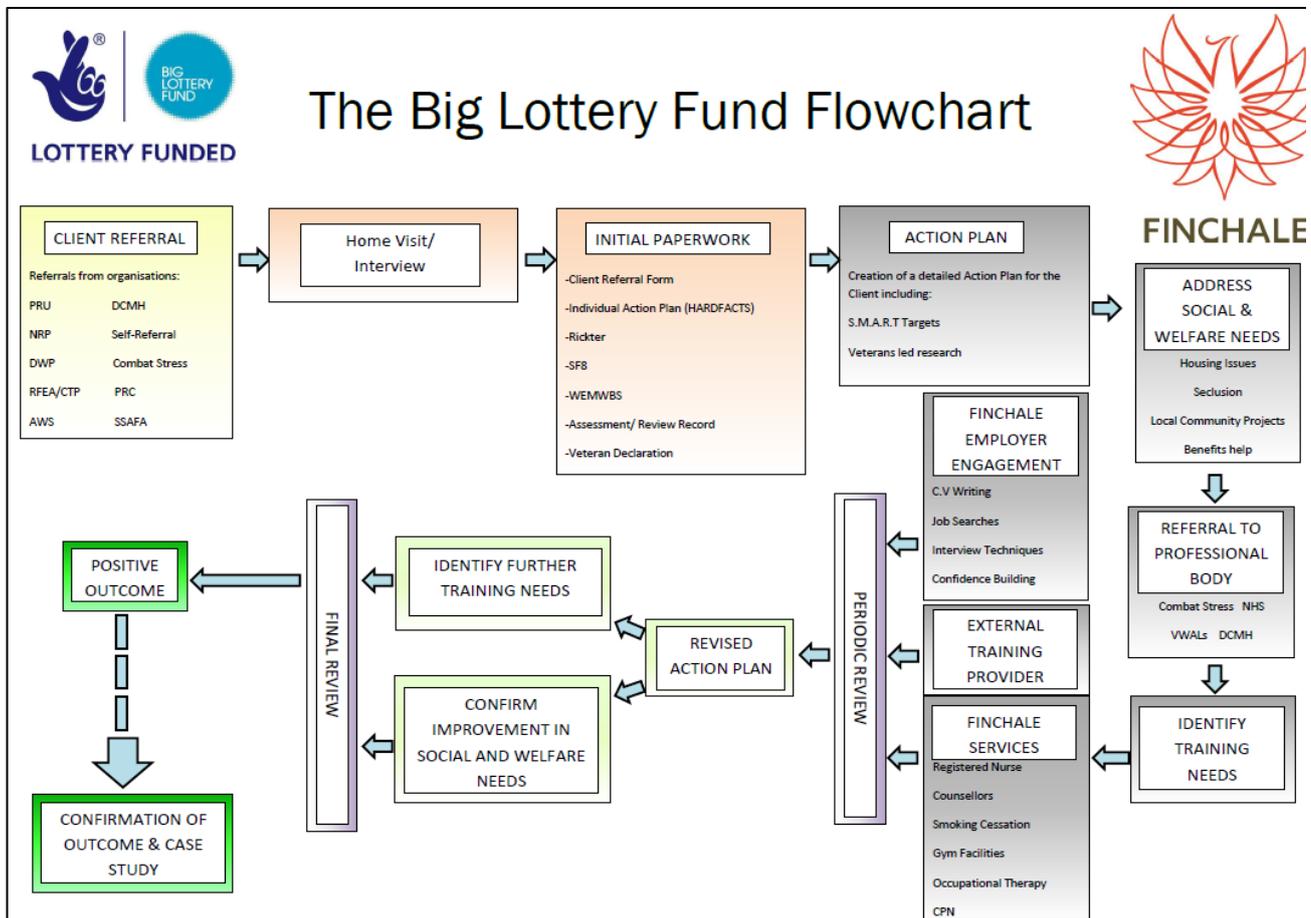
Table 1. Overview of the BLVS

Providing organisation	Finchale Training College (third sector training and veterans' support provider). In December 2018, rebranded as Finchale Group and relocated to purpose-built premises in Belmont Business Park (Richard Annand VC House) - placing Finchale Group at the heart of the community they serve
Funding arrangements	Funded by the Big Lottery
Geographical area covered	North East England

Team set-up	Service co-ordinator (1.0 WTE) plus management oversight
Referrals process	<ul style="list-style-type: none"> • Single point of access (service co-ordinator) • Open to all Armed Forces veterans and their family members. • Main intended referral source: Job Centre Plus. Additional Referral sources: self-referral, family referrals, Armed Forces charities (including SSAFA and Combat Stress), third sector organisations. • Self-referrals accepted by telephone or email (via website and promotional material).
Interventions provided	<p>Assessments undertaken at initial point of contact (face-to-face or telephone). The service provided is based on the client's needs and the support they require following each client's pre-application assessment and individual action plan (IAP). The following services are available for each client and form part of the clients IAP: Care plans developed and worked towards – to include health and wellbeing, housing, employment and training, finances.</p> <p>Signposting and onward referrals. Where a veteran is signposted to relevant supporting agencies they are still case managed and supported by the case manager for a period of 1 year.</p>
Programme timescales	1 st March 2016 to end of Feb 2019

Figure 1 shows a diagrammatic summary of the generic BLVS referral and assessment processes

Figure 1. Referral and assessment process used by the BLVS



1.5 Evaluation of the Big Lottery Veterans Service (BLVS)

In order to provide an independent evaluation, The North of England Mental Health Development Unit (NEMHDU) was commissioned by Finchale Group to provide evaluative input across the timeframe of the Big Lottery Veterans Service. The original aims of the BLVS evaluation were to report on:

1. The sociodemographic profile of clients engaged in the BLVS, including their geographical distribution and origin of referrals
2. The impact of the BLVS on mental well-being, health-related quality of life and Big Lottery Indicators and Outcomes with specified timescales and targets
3. Clients' lived experience of engaging with the BLVS - including what worked well and not so well and why, examples of effective practice and to identify actionable improvements
4. Triangulation of qualitative data from multiple perspectives (referral organisations, veterans and service co-ordinator), in order to provide deeper insights into '*how and why*' the BLVS had an impact on veterans.

However, challenges with recording of routine data arose during the course of the project, for example, resignation of the original service co-ordinator necessitated remedial actions to maintain the quality of front-facing service delivery to clients, and reallocation of resources to provide support to a new service co-ordinator. As a result, a comprehensive quantitative dataset was not available for evaluative purposes. Therefore, the aims of the service evaluation were redefined as follows:

1. Report on selected routinely collected data (e.g., HARDFACTS assessments) and validation forms
2. Explore the active ingredients (what worked well and not so well) and lived experience of the BLVS from the perspective of multiple stakeholders (referral organisations, veterans and service co-ordinator), in order to address key recommendations from a systematic review of well-being interventions for veterans transitioning to civilian life (*qualitative research is needed to explore a conceptualisation of well-being for this group and the acceptability of interventions which may be perceived as treatment*)^{xvi}
3. Utilise the findings of this service evaluation to inform the development of the next phase of veterans programmes at Finchale Group, and the consultation exercise on the Government's Strategy for our Veterans^{xi}.

A detailed description of the original service evaluation methods are presented in an addendum to this report, along with the accompanying analyses of client data provided to the evaluation team.

1.6 The Background and Strategic Objectives of the North of England Mental Health Development Unit (NEMHDU)

NEMHDU operated as a not-for-profit social enterprise based in the North of England until 2017, with a mission to improve the mental health and social wellbeing of local communities by:

- Working alongside statutory and independent organisations to develop their strategic objectives, increase their efficiency and capacity and deliver recovery-focused outcomes
- Working alongside service users and carers to ensure that they are able to play an active role in their own care, as well as the wider development and evaluation of health and social care services

Brand NEMHDU continues under the ownership of Paul Johnson, operating on an Associate model.

2. SERVICE EVALUATION METHODS

Informed by recommendations from a previous evaluation report (Joint Transition Support Service Evaluation) alongside discussions with the project staff (directly and indirectly related to the front-line delivery of the services) and other stakeholders, a mixed methods evaluation strategy was designed to address the aims of this service evaluation.

2.1 Selected routinely collected quantitative data

Box 2 - HARD FACTS

HARDFACTS is a tool for guiding the provision of recovery support and maintaining a case record, which was developed by the Veterans Welfare Service^{xxii} for use by responsible tri-service military personnel or military contractors and partners. The acronym **HARD FACTS** stands for: **H**Health; **A**ccommodation; **R**elocation; **D**rugs and alcohol; **F**inance and benefits; **A**ttitude, **C**hildren and family; **T**raining, education and employment; and **S**upporting agencies. The numerous subsidiary factors within each element which, used together, enable a holistic view of the individual to be developed, and in turn provides a focus for the production of an individualised recovery plan. A blank copy can be found in Appendix 2.

Box 3 - Validation forms

At the end of a client's engagement with the services, they are invited to complete a validation form that consisted of three questions:

1. Are you happy with the support Finchale has given to you? (yes, no and space for free text responses)
2. What support were you given? (brief outline)
3. Do you have any further comments?

2.2 Service review questionnaire

Informed by findings of previous evaluations of services for veterans, a group discussion with senior management, staff responsible for delivery of services and external independent experts (involved in previous evaluations of services provided by Finchale Group) was convened to discuss the methodology for the service review. It was agreed that a survey questionnaire would be the optimal method of data collection for the service review. In order to maximise the response rate it was administered to clients on paper and electronically. The survey consisted of 9 questions and can be found in Appendix 3.

The first part of the survey collected respondent profile data (age category, gender); services they had accessed¹; perceived usefulness of services they has accessed (5-point Likert scale ranging from 1 not at all useful to 5 extremely useful); what they had found useful about Finchale Group's services; and what could be done differently by Finchale Group in the future. These quality monitoring questions enabled veterans to have a say on how useful they found the BLVS that would have a direct influence on the organisations current and future performance, direction and responsiveness.

Given that the area served by Finchale Group comprises of communities with higher than national average levels of unemployment, health inequalities and deprivation, the development of a new mental well-being service was proposed. In order to capture data on client views and preferences on the mode of delivery, content and organisation of a new mental well-being service, the second part of the survey presented the following definition of mental well-being from Mind (2013) – see box 4:^{xxiii}

¹ Only data from respondents with experience of the BLVS were analysed. A full report is available from Finchale Group upon request. Themes in the full report are likely to differ to those reported here.

Box 4 – Mind’s Definition of Mental Well-being

Mental well-being describes your **mental state** – how you are feeling and how well you can cope with day-to-day life. Our mental well-being is **dynamic**. It can change from moment to moment, day to day, month to month or year to year. If you have good mental well-being you are able to:

- feel relatively **confident** in yourself and have positive **self-esteem**
- feel and express a range of emotions
- build and maintain **good relationships** with others
- feel engaged with the world around you
- live and work productively
- **cope** with the stresses of daily life
- adapt and manage in times of change and uncertainty

Clients were then invited to respond to the following free-text questions:

1. What would you like to see included in the well-being service at Finchale Group? This could be specific types of advice, support and activities (and other things you think are important) to help improve well-being.
2. How should we organise and deliver the new well-being service at Finchale Group? For example, group or individual contact sessions (or a combination of both)? Should all activities be based at Finchale Group site or the community (or a combination of both)?

2.3 Qualitative data collection

An interactive group discussion was also undertaken with veterans who were currently engaged with the service to explore their lived experience of receiving support from BLVS (Appendix 4). The dynamic and interactive nature of such workshops encourages creative thought and can quickly yield ideas and solutions.^{xxiv} In this case the aim was to explore their views, experiences and perspectives on the project, including identification of actionable improvements to maximise client engagement and experience.

In striving for 360° evaluative data, in addition to Veterans, agencies and organisations that referred veterans to the BLVS, including the BLVS service-coordinator were also deemed as vital stakeholders and their views and experiences were included in the qualitative evaluation.

High referral agencies and organisations were identified from the routinely collected data and invited to participate in a 2-hour interactive group discussion, which was facilitated by an independent researcher from NEMH DU. High referrers are well-placed to provide feedback on service quality/improvement as they are in possession of sufficient knowledge and close connection with the BLVS. A discussion guide was developed with reference to the aims of the service evaluation (Appendix 5). Several referral agencies/organisations also provided written testimonials on their experience of the BLVS, which were collated and integrated into the dataset.

An Interview was conducted with the BLVS case worker to explore and identify ways of working / approaches / techniques that were utilised to positively engage with clients and active ingredients of the service that were contributing to successful outcomes. The interview guide can be found in Appendix 6.

2.4 Data analysis strategy

Appropriate summary statistics were used to analyse data on HARD FACTS. Data within validation forms were content analysed using manifest content.^{xxv} Summary statistics (frequency and percentage frequency) were calculated for survey questions 1, 2, 3 and 4. Responses to free text questions (5, 6, 7

and 8) from veterans were transcribed verbatim (and anonymised, where applicable) and subjected to thematic analysis (see next paragraph)².

The interview and interactive discussions were audio-recorded with permission and transcribed verbatim. The transcriptions were coded and analysed thematically using an approach described by Ritchie and Spencer (1994)^{xxvi}. This involved a series of processes including familiarisation, indexing, framework development, mapping and interpretation. A combination of *a priori* and emergent coding was applied to indexing of free-text responses into initial codes. Initial codes were then grouped into themes based on similar content, issue or meaning. Pseudonyms and labels such as male veteran or person from referral organisation were used to protect the identity of participants. Direct quotes are used to enhance the credibility of the themes and as a vehicle for the veterans' voices to be heard.

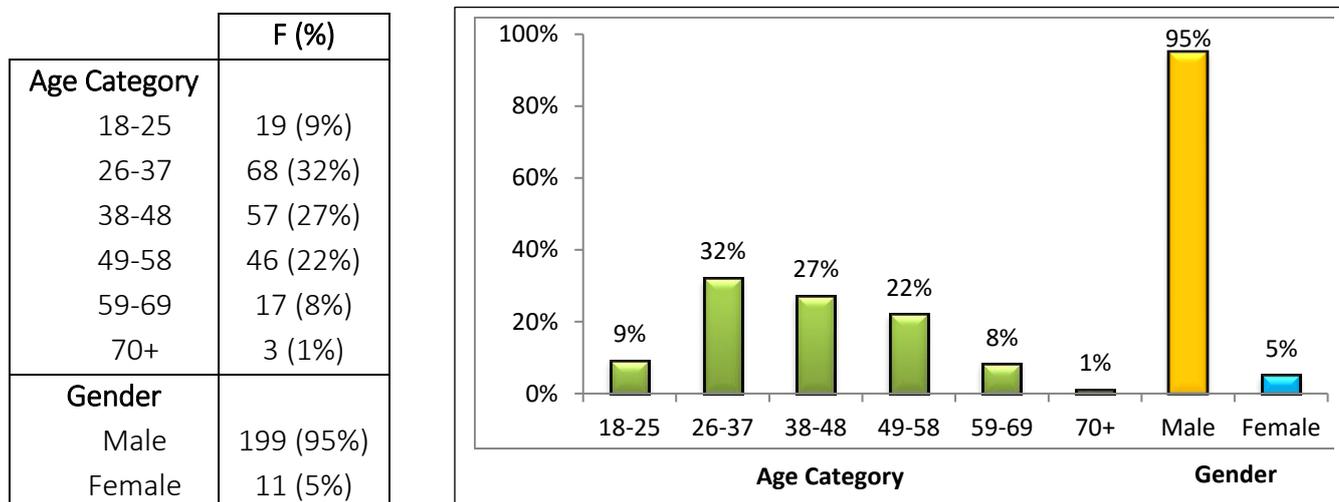
² This represents a comprehensive re-analysis of the service review data obtained from only veteran respondents

3. FINDINGS

3.1 Selected routinely collected data

The BLVS engaged with 210 veterans over the evaluation period 1st March 2016 to end of Feb 2019, which equated to 70 veterans per year receiving support from the Big Lottery Veterans Service (BLVS). Most clients were male and of working age, with relatively few aged > 65 years (Table 2 and Figure 2).

Table 2 and Figure 2. Age and gender profile of the BLVS Clients



3.1.1 HARD FACTS

In descending rank order the Presenting Primary Concerns (HARD FACTS) recorded by the BLVS service co-ordinator is presented in Table 3. As well as the overall number of veterans citing each concern at initial assessments, each domain includes a brief reflective narrative from the service co-ordinator to provide insights into the type of support being provided to BLVS clients.

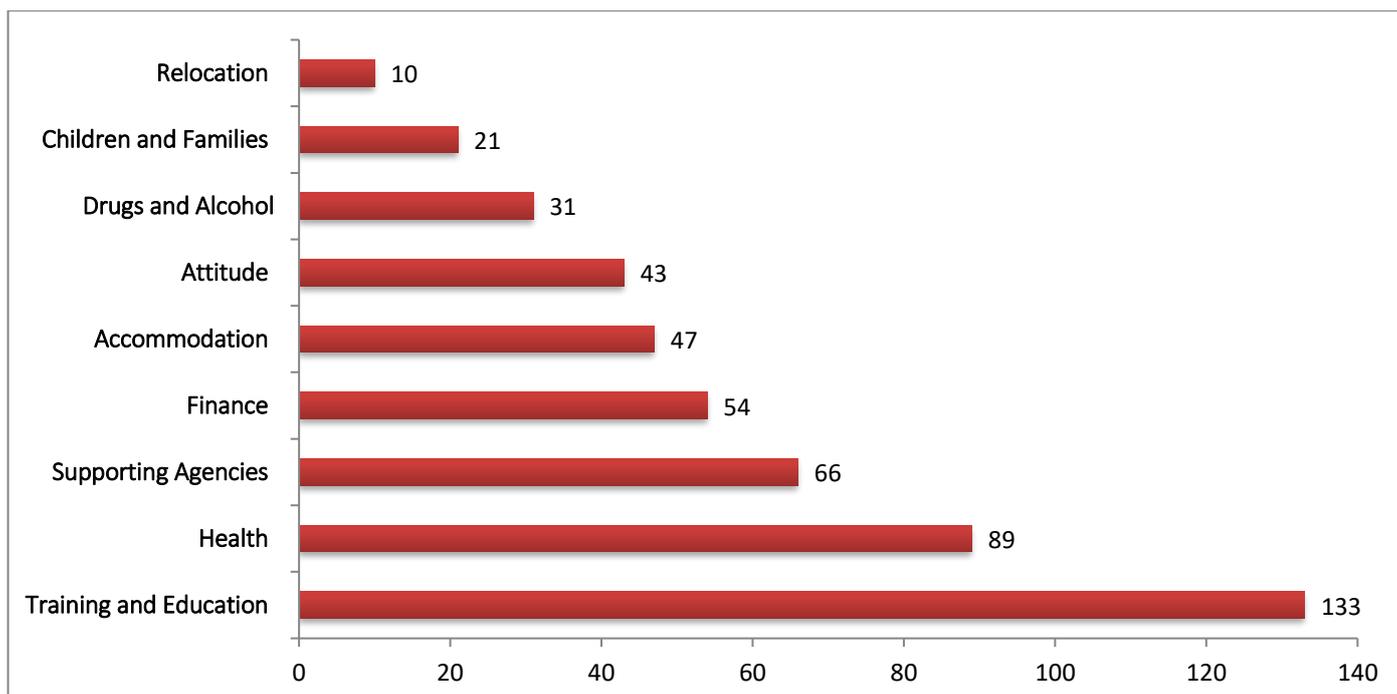
The most prominent issues were training and education with a view to securing employment, health concerns, financial support and advice provided in-house and signposting to external agencies. Substantial support was provided to clients in the domains of accommodation and children/families. Delivery of brief interventions by the service co-ordinator also featured strongly in response to client concerns about Attitude; whereas issues related to drugs and alcohol were exclusively managed by signposting clients to specialist services.

Table 3. Summary of Presenting Primary Concerns (HARD FACTS) of the BLVS Clients

HARD FACTS	Reflections of Service Co-ordinator	Total
Training and Education	This is where veterans require the most support, which ranges from CV building, job applications, confidence skills to applying for funding for training (enhanced learning credits) and entry into employment. The employment relations manager on site and the case manager liaise with suitable potential employees to 'match the Veteran with their preferred potential employers'. Reservists are also supported towards employment, which can ensure the reservist's longer term attendance in the Armed Forces Reserves.	133
Health	General wellbeing physical and mental health, veterans being referred to NHS and various supporting agencies within the local community.	89
Supporting Agencies	There are many areas where a veteran will need financial support. These agencies are primarily third sector military charities: SSAFA, RBL, Help for	66

	Heroes and Military benevolent funds. Local areas of financial support include Greggs Foundation, Elizabeth Finn fund and Durham Community Foundation.	
Finance	A Budget plan is carried out on the initial individual action plan with every veteran. If there are any financial issues a referral is made to turn to our service, citizens' advice or an application can be made to a supporting agency for assistance.	54
Accommodation	Veterans are supported fully through the process, from visiting a potential property to support with the tenancy agreement and thereafter floating support.	47
Attitude	This could range from in-house support (case manager providing some brief techniques for reducing anger and feelings of social isolation) to referral for professional support.	43
Drugs and Alcohol	Veterans are referred to various support agencies for these issues. Worthy of note is the veteran may not connect with the first agency, so they may attend a couple of organisations before they find a one suitable for them.	31
Children and Families	There has been a need for the case manager to support the families of the veterans. This level of support ranges from: <ul style="list-style-type: none"> • Attending school and welfare meetings, acting as a support mechanism for the parents who can become overwhelmed with the possibility of their children being removed from the family home. • Liaising with Police and local authorities to educate and advise on potential family issues; early intervention has resulted in no further action being required • Informing wives/partners on what support they can receive • Support with employment and education 	21
Relocation	Due to veterans serving country wide many veterans from other regions of the UK have relocated to Catterick Garrison, as this was their last posting and their families are settled (schooling and jobs).	10

Figure 3. Frequencies for baseline HARD FACTS assessments



3.1.2 Validation forms

A total of 20 veterans chose to complete validation forms to provide direct feedback on their experience of the BLVS. Content analysis of these qualitative data revealed a range of mutually exclusive themes within each of three questions.

3.1.2.1 Satisfaction with the BLVA

Satisfaction (extent that clients were happy) with the BLVS fell into 7 themes. These are shown in Table 4 alongside exemplar verbatim quotes from the validation forms. The most dominant theme was brief positive remarks about the advice and support that veterans had received from the BLVS, followed by specific extremely positive references to the valued support they received from the service co-ordinator. Other themes that emerged were related to avoidance of adverse outcomes such as homelessness; positive remarks about the quality of interactions with staff; on-going and regular contact via telephone; assistance / support with pensions and compensation schemes; and good organisation of courses at Finchale Group.

Table 4. Satisfaction with the support veterans received from the BLVS

Theme	F	Exemplar quotes
1. Generic, brief positive remarks about the advice and support they received	14 (70%)	<i>"Yes, we are very happy with the support we got"</i> <i>"The help that I was given was excellent"</i> <i>"Yes I am very happy with all the help and advice Finchale has given me over the last year"</i>
2. Positive reference to support provided by service co-ordinator (AK)	3 (15%)	<i>"It has been a life saver. AK has been brilliant, and really made us feel we were not alone. Thank you"</i> <i>"We lived in a bad state of affairs and AK got us back on our feet"</i> <i>"AK is positive and wants to be helpful"</i>
3. Avoidance of adverse outcomes	2 (10%)	<i>"I was in a hole, so it's a great comfort"</i> <i>"Yes, I would still have been living rough"</i>
4. Positive and quality interactions with staff	2 (10%)	<i>"100% amazing staff"</i> <i>"I have found the personnel to be very friendly, polite with their experience and advice being very informative"</i>
5. On-going and regular telephone contact	1 (5%)	<i>"Support is always there when I have needed it. I also receive messages asking how my progress is going"</i>
6. Help with compensation and pensions	1 (5%)	<i>"I am very pleased with the way Finchale has helped me understand my pension scheme and the AFCS" (Armed Forces Compensation Scheme)</i>
7. Course organisation	1 (5%)	<i>"The course was well-organised"</i>

3.1.2.2 Type of support received from the BLVS

Responses to this question were coded into 9 themes (Table 5). Support with employment search and skills development, including accessing training was a dominant theme. Advocacy support provided by the BLVS co-ordinator to liaise with, and access other organisations (where appropriate), in particular practical and emotional support during home visits was a particularly valued type of support for veterans. Support with access to food to address 'food poverty' as well as rudimentary housing needs and financial advice related to pensions, compensation and benefits all featured strongly as themes. Veterans were also supported to identify and prioritise their needs, in order to develop an action plan. Personal well-being support was also provided to veterans, which also included support for their families and children. One veteran referred to support to access medical services.

Table 5. What support were you given?

Theme	F	Exemplar quotes
1. Support with employment search and skills, and/or accessing training	8 (40%)	<i>"Support – CV – letter writing and making it clear to me, and the relevant courses available e.g. SIA course 'passed and license granted"</i> <i>"Job search"</i> <i>"Job advice, about the job's themselves, CVs and interview advice"</i> <i>"Gaining courses such as fork lift / SIT door supervisor/customer services"</i>
2. Advocacy/home visits from service co-ordinator (AK)	7 (35%)	<i>"AK has been a great support to me and has gone out of her way to assist me with food, electric, liaising with RBS and attending my PIP consultation with me"</i> <i>"Initial home visit to discuss a plan around my circumstances"</i> <i>"Liaison with other organisations"</i> <i>"Assisting with processing a successful grant via British Legion for a course"</i>
3. Support with access to food	5 (25%)	<i>"Food bank vouchers"</i> <i>"Food hampers"</i> <i>"Help with food banks"</i>
4. Support with housing, furniture and/or appliances	5 (25%)	<i>"AK helped my partner and I move all of our furniture and household appliances from xxx to xxxx"</i> <i>"We were offered support with moving home and received help with carpets and flooring"</i> <i>"Moving and white goods"</i>
5. Financial advice	5 (25%)	<i>"I was given help with the PIP (Personal Independence Payment) form, and application for veterans badge"</i> <i>"We were given financial support"</i> <i>"Finding out when I can get and how claim for my pension"</i>
6. Guidance / support to identify a priority areas / personal plan of action	4 (20%)	<i>"Showing the right path to take"</i> <i>"Guidance on what help/steps are on offer"</i>
7. Personal well-being support	4 (20%)	<i>"Help with getting some counselling"</i> <i>"Personal support"</i>
8. Support with family and/or children	2 (10%)	<i>"We received support regarding our children, which is ongoing"</i> <i>"Me and my family have been supported on so much. From family problems to personal well-being"</i>
9. Support to access medical care	1 (5%)	<i>"I was given support in medical"</i>

3.1.2.3 Other comments about their experience with the BLVS

Responses to this question were reflective of the initial question on satisfaction with the BLVS with references to staff and generic expressions of gratitude for the advice and support they had received:

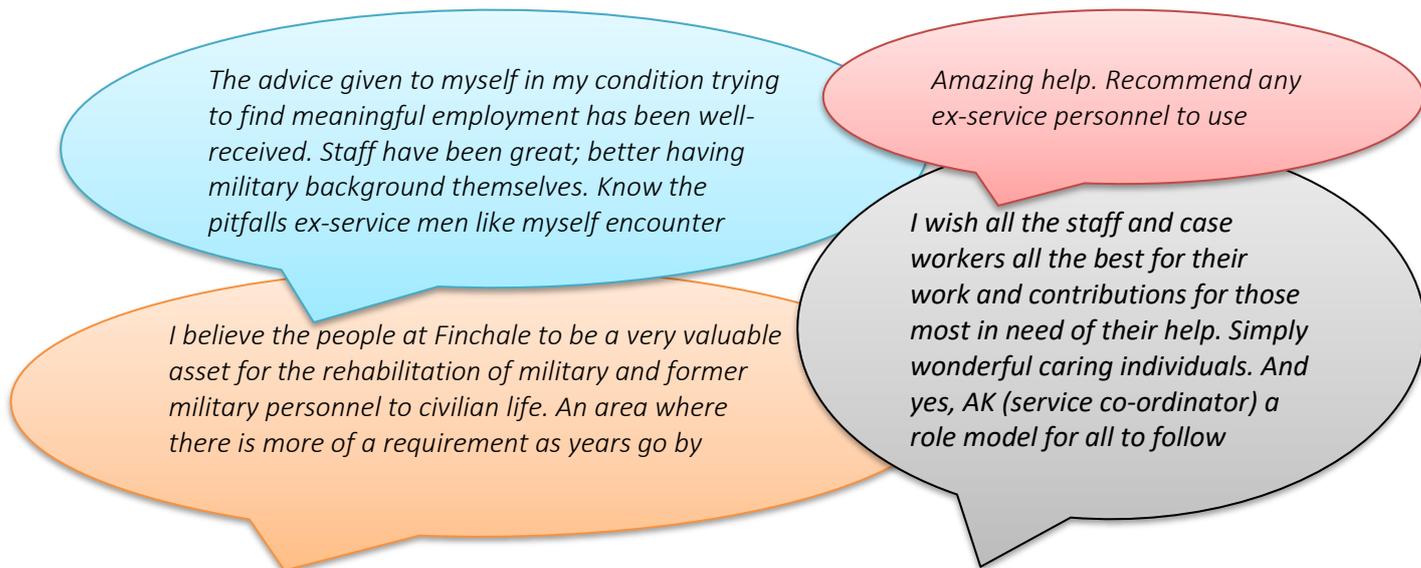
"Awesome staff, really good course would happily attend again"

"I would just like to say a big thank you on behalf of my partner and myself, we really appreciate the help we have received"

Although not themes, four veterans referred to specific active ingredients of the BLVS that underpinned the reasons for their responses in question 1 and question 2. These direct quotes are shown in Figure 4. They specifically highlighted the value of the BLVS being focused on the needs of veterans that change over time. The service co-ordinator (and other staff) also having lived experience of the armed forces

provided veterans with an enhanced sense of their issues being understood; the service co-ordinator was considered to be a role model in this regard.

Figure 4. Other active ingredients of the BLVS reported on validation forms



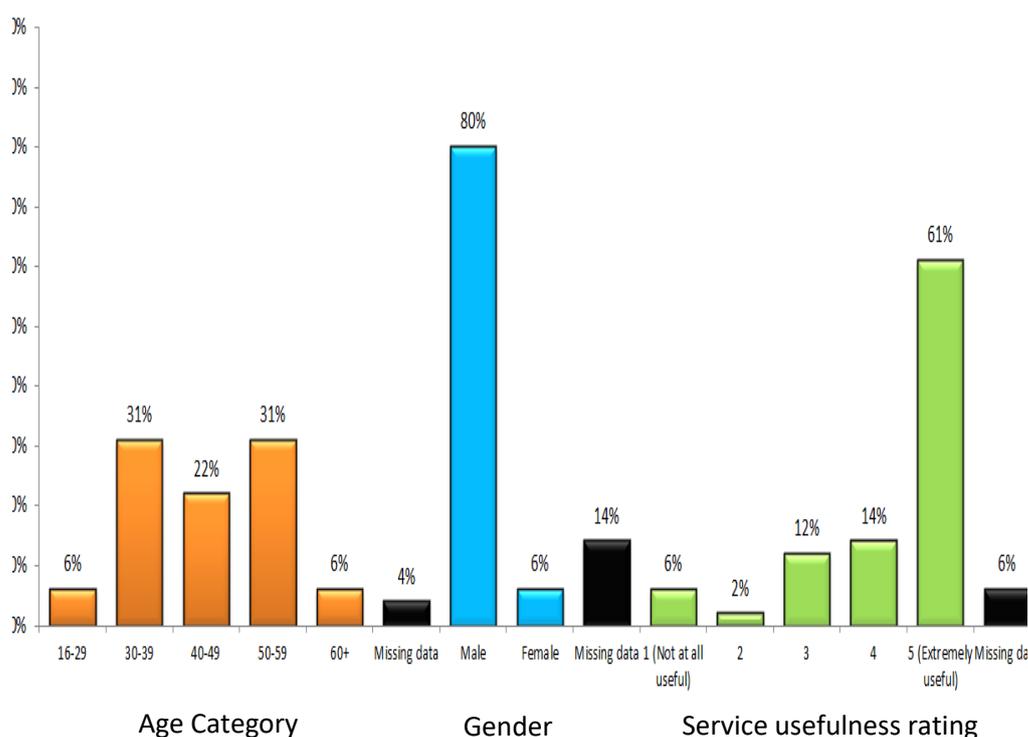
3.2 Service Review Questionnaire

3.2.1 Profile of veteran respondents

In total, 101 responses to the survey were received, of which 51 (45%) were veterans. The profile of the veteran respondents is presented in Table 6 and Figure 5. The majority were aged 30-39 to 50-59 years, with relatively few aged < 30 or > 60 years. The veterans were predominately male (80%). Overall, high 'usefulness' ratings (4 or 5) for the BLVS were reported by 75% (38/51), with a further 12% (n=6) reporting median ratings (score of 3). Low usefulness ratings (score of 1 or 2) were reported by 8% (n=4).

Table 6 and Figure 5. Profile of the Veteran Respondents to the Service Review Questionnaire (N=51)

Age category	F (%)
16-29	3 (6%)
30-39	16 (31%)
40-49	11 (22%)
50-59	16 (31%)
60+	3 (6%)
Missing data	2 (4%)
Gender	
Male	41 (80%)
Female	3 (6%)
Missing data	7 (14%)
Usefulness rating	
1 (Not at all useful)	3 (6%)
2	1 (2%)
3	6 (12%)
4	7 (14%)
5 (Extremely useful)	31 (61%)
Missing data	3 (6%)



3.2.2 Veterans' views and perspectives on what they found useful about the BLVS

Nine themes emerged from analysis of responses from veterans (Table 7). The most dominant theme was 'positive affirmations about support / information that veterans had received from the BLVS or a specific staff member'. This was followed by 'support with employment, training and education', which referred to advice and support with acquisition of employment skills (e.g. CV writing, voluntary work), access to vocational training and academic courses; and business support for self-employment.

The value of information achieved via regular contact with the BLVS staff, follow-up activity and the perceived ease of accessing the BLVS was particularly valued by veterans. One-to-one support (telephone or home) was highlighted by veterans as a very useful aspect of the BLVS. Support with debt, budgeting and a compensation claim was also emphasised. Sign-posting and support with contacting and liaising with external agencies, and advice with regard to housing needs were a further two areas considered by veterans to be useful. Two veterans emphasised receipt of valued 'support with mental health conditions' (specifically PTSD). One veteran referred to social activities as a useful aspect of the BLVS.

Table 7. Themes on what veterans found useful about the BLVS

Theme	F / %	Exemplar quotes
Positive affirmations about support / information received from the BLVS or a specific staff member	19 (37%)	<ul style="list-style-type: none"> • <i>Everything</i> • <i>Fantastic. All the information and support and stuff like that</i> • <i>Friendliness. Help with things that I couldn't do myself</i> • <i>General support from staff and genuine care - amazing!</i> • <i>Excellent case manager; i.e. support</i>
Support with employment, training and education	13 (25%)	<ul style="list-style-type: none"> • Support with CV • <i>Help with courses and help with charity funding to get equipment</i> • <i>Support with funding for training / degree</i> • <i>Support with my needs towards education, employment/voluntary work</i> • <i>Business support</i>
Regular contact, follow-up and accessibility	5 (10%)	<ul style="list-style-type: none"> • Regular contact, 2 weekly phone calls and 4 weekly visits has been really supportive and informative regarding where I am in 'the process' • Being able to ring, email if I need anything, knowing someone is there to listen • Finchale is easy to access • Information and support, regular contact over the phone and in person • Speedy and very helpful / good follow-up
One-to-one support	4 (8%)	<ul style="list-style-type: none"> • Happy to be on board. The 1-2-1 most useful • One to one support / good communication / friendly • 1-2-1 support good understanding of needs
Support with debt, budgeting and compensation	4 (8%)	<ul style="list-style-type: none"> • Debt support • Being able to talk to someone who can help with debt as well • Budgeting • Assistance with compensation claim
Sign-posting and support with liaising with external organisations	3 (6%)	<ul style="list-style-type: none"> • Sign-posting • Help with filling in forms for stuff. Having someone who can ring departments who can ask questions and understand the answers, and explain to me
Housing advice	2 (4%)	<ul style="list-style-type: none"> • Housing knowledge - helped when no one else would • Housing and caring of my dog (took into account for re-housing)
Support with mental health conditions	2 (4%)	<ul style="list-style-type: none"> • Understanding PTSD • Specialist support for PTSD
Social activities	1 (2%)	<ul style="list-style-type: none"> • Allotment, Kielder trip

3.2.3 Veterans' views and perspectives on what the BLVS should do differently

Eight themes emerged from analysis of responses from veterans (Table 8). Reflecting the high satisfaction with the BLVS, the most dominant theme was composed of blank responses, or generic positive affirmations about BLVS and/or staff, but with no specific suggestions for things that should be done differently.

Table 8. Themes related to what the BLVS should do differently

Theme	F / %	Exemplar quotes
No improvements suggested	27 (53%)	<ul style="list-style-type: none"> • Nothing what I've seen so far is brilliant • I couldn't fault your service
Additional services / courses	9 (18%)	<ul style="list-style-type: none"> • I have dyslexia and it would be good to have a service to help people with reading and writing • Prevent me from re-offending. • Work with animals / garden centres • Have a counselling service • No transport. Seaham to Finchale bus laid on to pick up people from the community, for those on the outskirts • Driving courses at the college would have been a big help • Out of hours service/telephone number or signposting to services that can assist • Monthly newsletters (tips and advice) and updates on veteran support • Help with my wife and children
More frequent contact and expeditious follow-up	6 (12%)	<ul style="list-style-type: none"> • More regular contact as there was a big gap between visits • More proactive in contact people regularly • Follow-up on promises. • They should influence other organisations to carry out work faster • Don't make an appointment and not turn up and notify me
More group / peer support	6 (12%)	<ul style="list-style-type: none"> • More groups • More interaction with veterans. • Have groups of vets working together • More time working with, and getting help from wives of veterans
More employment and training support	3 (6%)	<ul style="list-style-type: none"> • More employment trade fairs and help with CVs • I do require appropriate and positive signposting to employers that will understand and utilise the skills I possess • Training opportunities
More support/advice on health	3 (6%)	<ul style="list-style-type: none"> • More support towards my mental health • More specialist support in house (health, transition to civvy street) • Some support to help find causes
More service user involvement	2 (4%)	<ul style="list-style-type: none"> • Feel part of Finchale's organisation and be involved. • A lot seems to happen 'behind closed doors' like funding and training, but don't think I need to be in that process
Continuity / more staff	2 (4%)	<ul style="list-style-type: none"> • Employ more people in other areas, or volunteers • Same case manager

The second most dominant theme related to suggestions about additional services / courses; specifically addressing transport needs (driving courses and for assisted with travel for veterans residing in distal locations from Finchale Group's base), a counselling service; support for dyslexia; support with prevention of re-offending; specific opportunities to work with animals / garden centres; monthly newsletters for veterans; out of hours support service; and help with family and children.

One theme related to requests for increased frequency of contact, better communication and more proactive and expeditious follow-up contact and follow-through on commitments made to veterans. Regarding communication, respondents would have appreciated if they had been informed about any

arrangements in place when staff members leave, and to be contacted, either before or after scheduled appointments have not been attended by staff. Peer-support in the form of group work to enable more interaction with other veterans was also emphasised, including peer-support for spouses of veterans.

Less dominant themes related to suggestions for more training opportunities, assistance with CVs and greater access / contact with employers, either by facilitating contact via job fairs, or the use of appropriate signposting to employers who may be sensitive to a veteran's needs and circumstances. The final three themes were focused on requests for more support and advice on health issues, including mental health and the process of transitioning to Civvy Street; a desire to be more actively involved in the organisation of Finchale Group; and requests for more staff and continuity of staff.

3.2.4 Veterans' views on what should be included in a mental well-being service

Thematic analysis identified 14 themes on what veterans would like to see included within a mental well-being service. Six veterans did not provide any response to the question about the proposed well-being service. The remaining 13 themes provide an insight into how veterans conceptualise mental well-being and what they consider is important for improving and maintaining it (Table 9).

Table 9. Themes on what should be included in a mental well-being service

Theme	F / %	Exemplar quotes
No response / no suggestions given	6 (12%)	<ul style="list-style-type: none"> Nothing comes to mind
Group support and social activities	12 (24%)	<ul style="list-style-type: none"> Group activities Open support groups - share thoughts/advice. Support services/group activities for socialising Group activities, ex squaddie, out of doors activities, camping, organising a community project, things to do to occupy the mind. Outdoor stuff - tidy up poor/deprived areas (gardening). Walking groups. Monthly outings Book club. Indoor caving, wheelchair basketball, inviting veterans to days out Group support and activities Team building activities in groups
Personalised, regular and continuous 1-2-1 support	8 (16%)	<ul style="list-style-type: none"> Tailored advice to my circumstances. Job Centres treat everyone the same. I felt like an individual when you supported me and did my CV Weekly support Individual support Continuity, advice who you deal with and frequency of visits 1-2-1 support/advice More one-to-one consultations and more regular contact Talk to me like a human being, normally,
Information and Advice	7 (14%)	<ul style="list-style-type: none"> Newsletter updates (don't use Facebook or Twitter). Access to advice Advice and support Liaise with smaller local charities On site advice line
Talking therapies for mental health	7 (14%)	<ul style="list-style-type: none"> Basic counselling service Need access to counsellors Counselling for vets Right support for veterans with PTSD before discharge. More agoraphobia help
Peer-support and mentoring	5 (10%)	<ul style="list-style-type: none"> Veterans helping other veterans with group sessions Mixing with other veterans Meeting people who experience my difficulties Somebody who understands ex-services and how they are trying to fit back into the community

Supported self-management for lifestyle/health behaviour change and well-being	5 (10%)	<ul style="list-style-type: none"> • Some form of mindfulness classes, help with sleep patterns! Health and grounding techniques on site • Self-management and recovery. Have a mindfulness worker. Tai chi. Yoga. • Help with my drinking • Maybe group counselling session for dealing with a mix of health • To remain in a good place. A course to allow me to stay focused and not to slip back into ill-health or re-offend or get bored
Confidence-building	5 (10%)	<ul style="list-style-type: none"> • Support with confidence • Confidence-building / self-esteem • Confidence building and supported action to get used to being out and about • Working with life coaches
Benefits, debt management and financial advice	5 (10%)	<ul style="list-style-type: none"> • Debt advice • Someone to support with debt. Have a debt support worker? • I get advice with compensation claims and pension queries - so the same for other veterans would be good • Just discharged with no idea about benefits system • Psychologists for vets to help with war disablement pension claims
Drop in service	4 (8%)	<ul style="list-style-type: none"> • A drop in service or able to see someone at short notice • Drop in centre for veterans • No waiting lists - get seen when needed • Have access to professional help and quickly
Support for carers, families and children	4 (8%)	<ul style="list-style-type: none"> • Possibility of explaining to loved ones about PTSD • I have never experienced anyone who has had PTSD or served in the military. I would like help to understand issues and to be able to stay with my husband • Support for carers (My mam, she can't get any help, not financial, someone to talk to) • Help and support for me in abusive relationships, especially psychological abuse and my kids too
Out of hours support	3 (6%)	<ul style="list-style-type: none"> • 24 hour helpline • 24 access line - someone to talk to • 24 hour helpline - I can then phone when I feel at my worst!!
Support with employment	3 (6%)	<ul style="list-style-type: none"> • A place where I am helped with matters such as voluntary work/employment • Open doors to employment (the covenant is just a word) • A course on interacting in the workplace and to improve my social skills
Support with transport	1 (2%)	<ul style="list-style-type: none"> • Transport to colleges/drop off

The inherent value of the 'power' of groups was recognised by veterans to support mental well-being. A range of group support and social activities were suggested. These included both indoor and outdoor activities that involved collaborative working and connecting socially with people, either for the benefit of the individual veterans, groups of veterans as well as their local community (e.g., gardening in deprived areas). Building on the theme identified in section 3.2.2, 1-2-1 support was also highlighted by veterans as a core component of a well-being service, which should be personalised to be individually-tailored (personalised), occur regularly and received from the same person/people (continuity of support).

The provision of peer-support/mentoring from individuals with similar backgrounds / experiences to veterans also featured strongly in responses, which reflects the comment made by one veteran in section 3.1.2.3, whereby lived experience of the armed forces is important for engagement with the service and feeling that someone understands their needs and situation. Veterans also considered ease of access and crisis support as important for a well-being service, and referred to the need for a drop in service and out of hours telephone support. One veteran emphasised the value of supporting veterans with their transport needs in order to access well-being activities.

Appeals were made for the well-being service to ensure that veterans were aware of the full range of services available at Finchale Group, along with regular updates in the form of newsletters, an on-site advice telephone service and support with accessing advice from internal and external organisations

(liaison support). Support with navigating the benefits system, dealing with debt, and financial advice (compensation claims and pensions advice) was an important specific area of information / advice for inclusion in the proposed mental well-being service.

Employment support was specifically mentioned by veterans to be important for the well-being service, including support with confidence-building for everyday life such as social interaction outside the home. Talking therapy, specifically a counsellor / counselling service for mental health issues such as PTSD and agoraphobia was considered an important feature of a well-being service. Behavioural self-management support for improving both physical health and mental well-being, including specific stress management techniques (mindfulness, Tai Chi, Yoga) were also a feature mentioned by veterans for inclusion in the proposed mental well-being service.

3.2.5 Veterans' views on organisation and delivery of a mental well-being service

A total of 49 out of 51 veterans provided responses that were classified into veterans' preferences on mode of delivery (one-to-one and/or group sessions) and location of mental well-being services.

3.2.5.1 Preferences for mode of well-being service delivery

Mixed preferences were reported for one-to-one or group sessions. On the one hand, reflective of the theme 'Group support and social activities' (section 3.2.4) the inherent 'power' of groups was again emphasised by veterans:

"Days out to bring people together. Stops isolation"

"Group sessions with various help groups"

"Group work"

On the other hand the value 1-2-1 sessions was also deemed important:

"on an individual basis because it is more personal"

"Personally one-to-one more beneficial"

"The 1-2-1 support is best as some people can't cope in groups"

"A lot of people don't like sharing trauma in group settings. Do this 1-2-1"

However, the strongest preference (based on number of instances) was for a combination of 1-2-1 and group activities:

"I think a combination of services would be best as sometimes a group could help someone who is shy come on and develop"

"Individual and group sessions with people with shared goals (e.g., career)"

"I think it's good to have both, individual and group as this gives you different benefits"

"Bit of both. Drop in clinic for people who feel they cannot talk to strangers"

Several veterans also referred to a phased approach to mode of service delivery, commencing with one-to-one sessions, followed by group sessions once individuals were sufficiently comfortable with interacting in a group setting:

"Probably 1-2-1 to start off with don't like change, so start slowly and then introduce group stuff. Location a combination of both for ex-forces/ family day to get to know everyone gradually"

"I prefer to speak privately. Maybe eventually when I got to know them"

"1-2-1 in the community and then as a group once you get used to the people"

3.2.5.2 Preferences for location of well-being service/activities

There was general consensus on preferences for sessions delivered in both the community and at Finchale Group:

"Finchale group. Local community centre".

"I think it should be a mixture of both"

"Group sessions on site and in community"

Salient barriers to accessing services at Finchale Group (not in any way unique to Finchale) were cited by two veterans related to support needs related to travel:

"Community-based activities. Live too far from Finchale

"Finchale group - transport required"

Several respondents indicated a preference for sessions to be based at specific community locations such as community cafes and places of interest in the locality of Durham City:

"Locations in the North East - possibly heritage / National Trust. Finchale in Durham"

"Local community centre"

"Community cafes. Locations of interest in the north east. Durham city"

"Community - activity days out as well"

One veteran expressed a desire for sessions to be conducted in the workplace to enable a greater understanding of veterans' needs by an employer:

"In the workplace so my bosses can understand more"

3.3 Interactive group discussion with veterans

Three veterans (all male, two had served in the RAF and one had served in the Army) with experience of receiving support from the BLVS attended a 78 minute group discussion in a private room at Finchale Group. Two other veterans had agreed to participate, but due to medical and other emergent issues they were unable to attend the group discussion.

Routes into the BLVS were different for each of the veterans: one veteran was homeless when a friend mentioned Finchale Group, and he subsequently made contact by phone; the second veteran was signposted to Finchale by the Royal British Legion; whereas the third veteran had a serendipitous meeting with a job coach (who was covering his regular job coach) at Job Centre Plus who knew about Finchale and encouraged him to make contact. All three veterans described being largely unaware of the availability of the support available for veterans, with one citing that no support at all was available in his local area. The two veterans that had sought support from specific organisations described them, in contrast to the BLVS, as being unresponsive.

Thematic analysis identified two higher-order inter-related themes. The first related to the primary specific areas of support that veterans received advice and support. The second theme related to 'how' this support was provided by the BLVS service co-ordinator in order to gain insights into the active ingredients of the BLVS, and other mechanisms underpinning the positive engagement and outcomes for veterans.

3.3.1 Areas of support received by the veterans

The support that all three veterans received was focused on housing and employment, which represented their priority needs. This required high-intensity cross-Finchale and multi-agency support

from the BLVS service co-ordinator (AK). This is discussed further in Section 3.5 'interactive group discussion with referrers'.

Support with housing was a pressing initial need for two of three veterans, which was not restricted to the individual veteran, but also the veteran's family and children:

"Housing for me. I had a verbal agreement with a landlord but he changed the rent payment schedule that caused me to get into debt. AK is trying to sort this out with the council. The house is a building site and not suitable for my children"

"Housing association refused to move me to a downstairs flat for my medical problem and sleeping pattern – I needed somewhere quiet"

Veterans were encouraged to look beyond the stereotypical civvy street jobs that veterans are often directed towards such as security. Instead employment support was focused on matching the veteran with a job in terms of their skills, experience and aspirations. Moreover, extensive support was provided with the application as well as preparing for interview:

"AK makes you realise there are lots of jobs that are suitable for me and my experience"

"She initially arranged for me to access a Vocational Guidance Service to help write my CV, and gave me details about jobs"

"when AK got involved I felt depressed, and out of the blue here is a job! I decided to go with it and AK motivated me in a step-by-step way. She helped with the application and supported me with offers of interview practice – no one had helped me like this, and I then wanted to apply for more and more jobs!"

Facilitating access to training was a further core aspect of support with employment, which included support to access funding with external agencies for training of high value; for example:

"I'm getting a driving license for HGVs, funded for up to 35 tonnes and covering the payment of medical too" (Army veteran)

3.3.2 How was support provided to veterans? The value of relational support

There was overwhelming praise for the advice, guidance and support they had received from the BLVS, in particular from the BLVS service co-ordinator (AK). The latter coalesced into a central theme of relational support provided by AK that served to develop trust and open up a rapport with veterans. This incorporated emotional social support, and involved a range of person-centred communication skills, principally the effective use of active listening skills:

"She (AK) is always willing to listen and does not interrupt, and makes valid suggestions that are 100% appropriate"

"She is devoted to you and I do not get a sense that she has other people to see – she spends time with you"

"personable and listens with a purpose"

The use of active listening paid dividends for positively engaging with veterans and making suggestions for change and tackling key issues; for example: *“It made 100% sense to me as she had heard the whole problem”*

Other valued forms of relational support included outreach (home visits) and an awareness that AK was available if needed:

“Home visits to talk about what could be done and what I need”

“AK is there on the end of the phone”

Face-to-face contact was most valued relational support mechanism - as one veteran put it: *“I like face to face as on the telephone you don’t have eye contact for example, it helps with sincerity”*

All three veterans remarked on how AK’s experience in the armed forces helped with motivation and engagement:

“She knows how we think”

“its more like a family unit – for me to tell people how I really feel – helped me to trust and open up”

“it is like a family unit – AK is on the same wavelength as me as a vet”

AK’s extensive network and specialist knowledge (in particular on housing due to her membership of the Chartered Institute of Housing) was also instrumental to the provision of effective relational support:

“AK had a high ranking role in HR in the army and this helps her to find the right people to help you”

“AKs worth is what she knows”

“She knows the people to speak to. Next week she is speaking with the British Legion about getting repairs to my central heating”

It was also evident that as part of the positive relational support provided to veterans, AK adopted a non-judgemental and proactive approach. A powerful example of how this avoided a negative outcome was her response to a veteran who had been unable to attend a course due to his mental health:

“I did not attend a course because of anxiety and kept this to myself. AK called me to ask how it went and explained why I didn’t attend. She didn’t have a go at me and she called the course organisers. I don’t know what she said to them, but I was accepted back onto the course”

3.3.3 Building self-esteem and confidence

A core part of the psychological work with veterans was helping them to rebuild their self-esteem, in particular the sense of self-worth, which served as a catalyst for building confidence:

“I’ve always helped family and friends. I am now focused on helping myself too”

“AK helped me to realise I am important and to stop internalising and blaming myself and to remember that I have potential”

This enhanced confidence had a spring-board effect on applying for jobs, social interaction, development of life skills such as DIY, and in one case the confidence to support other veterans:

“The confidence that AK has helped me with has helped me to help others with mental health problems”

This veteran elaborated further on how support with self-esteem and confidence underpinning his motivation to find employment that was right for him:

“She (AK) helped me to understand how I can benefit others, and this was a driving force to me working as a volunteer for the CAB, who are quite good at getting people a paid job in the end”

3.3.4 Veterans’ perceptions of the consequences had the BLVS not been available

One route into assessing the impact of the BLVS was to ask veterans for their thoughts on what the consequences might have been for them personally if the service had not been available. The responses from all three veterans speak for themselves and provide powerful testimony to the value of the BLVS:

“I would be lying in bed looking at four walls”

“Muddling through in financial difficulty”

“on the street”

3.3.5 Suggestions from veterans on improvements to the BLVS

When directly asked about improvements that could be made to the BLVS, the only issue they raised in unison were impassioned pleas for administrative and other support for AK so they (and other veterans) could receive more support, in particular relational one-to-one support:

“AK would benefit from dedicated admin support to help her with case management. She covers everything from top of Northumbria to Hartlepool”

“She is the expert, but she needs support, especially for emergencies such as being asked to leave your property, she has to drop everything to help you”

“Point of contact that is dedicated to what AK does – co-ordinating what she is doing so instead of chasing people on our behalf she can use this time for more face to face work”

3.4 Interview with the BLVS service co-ordinator

The BLVS service co-ordinator (AK) participated in a semi-structured interview (lasting 41 mins) about her experience of delivering support to veterans, and to further explore the active ingredients of the support provided to veterans, in particular the nature of the relational support identified by veterans as being critical to continued engagement with the service.

3.4.1 Development of positive therapeutic alliances with veterans

Engaging clients in a service and fostering the development of positive therapeutic alliances or relationships (the quality of the client – therapist relationship) is the strongest driver of building motivation, autonomy and confidence for change, including positive outcomes for clients irrespective of the type of ‘therapy’ used and the characteristics of the therapist or the client. This was evident in the approach utilised by AK and accounts of veterans in the previous section. AK described the following relational support strategies to augment engagement of veterans in the BLVS as a means of developing effective therapeutic alliances with veterans:

- Active listening – allowing veterans to tell their ‘entire story’ in their own words, often allowing them to express positive and negative emotions, including allowing them to speak in their own terms using the common language of the armed forces as a vehicle to engage with veterans and develop trust, and in the words of AK:

“Allowing things to emerge, and allowing veterans to take their time – avoid over-reaching”

- Emphasising to veterans that the BLVS are ‘friendly-forces’ and are independent from statutory services such as the NHS and Job Centre Plus
- Informing veterans that she had experience of serving in the armed forces – the power of which for engaging with veterans is exemplified by the following quotes from AK:

“I saw the guy last week who served in The Tank Regiment and I served alongside people who worked in the Tank Regiment - now that guy looked at me as if to say how wonderful is this person talking to me. It will help me to get him on side and this way you can build up a rapport with them and this is absolutely unique”

“I think it's important to build a rapport cos it builds trust and it allows the barriers to come slightly come down and theoretically I can empathise with them because I walked in their shoes - you understand you know they're going on a journey and you're with him on the journey. I understand the jargon the banter such as Lance Jack now that's Lance Corporal and you need to have served to understand that”

- Instilling in veterans the need for honesty and adopting buy-in to the philosophy that honesty is a two-way street and that it ‘helps me to help you’
- Explaining and supporting veterans with gaining an understanding of the cultural differences between civvy street and the armed forces to mentally prepare veterans for challenges they will be facing:

“broadly speaking I start by saying that generally civvy street is reactive and the armed forces is proactive – I then move onto explaining how just about everything is different in some way or another”

- Building on the above, AK iterated the importance of recognising that responsibilities and tasks in everyday civvy life can be confusing for veterans who had not had the experiential learning needed to manage them effectively, for example the multi-faceted nature of housing that involves a process of knowledge acquisition, planning and money management skills – to quote AK:

“In the armed forces you always have accommodation (even a tent), but many veterans do not understand about things such as a security deposit, difference between calendar month and monthly payments, gas, electricity, TV license, water rates, council tax, telephone and they are dealt with by different departments”

This often necessitates addressing the issue of self-worth and affirming the rights of veterans (indeed any individual) for ‘good housing’ and ‘meaningful employment’ both of which are recognised as the bedrock of well-being:

“veterans when looking at properties often say well this is good enough for me, even when it is clear to me that the house or flat is clearly not ready and lots of work needs to be done by the landlord”

“explaining that they deserve somewhere nice – they don’t have to accept poor accommodation”

“I always say don’t just take any job. I always ask what type of job would you like to do? Emphasise that it is about fulfilment and not just doing anything”

AK also described a process of self-development to ensure her knowledge was up-to-date. She described how she attended Chartered Institute of Housing meetings and visited local services such as food banks to obtain information on opening times and administrative requirements, as well as meeting with prospective sources of support as part of her promotional work for Finchale Group – the value of this for the BLVS is exemplified by her attitude to self-development:

“There is nothing worse than giving bad advice to veterans”

3.4.2 Supported empowerment

As opposed to doing things for veterans, which would foster dependence on the BLVS, AK provided veterans with ‘supported empowerment’. At its heart this approach was explaining at each step the rationale and actions to be taken, followed by practical hands-on support whilst at the same time actively involving the veteran in the process – in other words she provided vicarious learning experiences so veterans could learn via observation and thus opportunities for development of skills that were transferable to other contexts; for example with reference to supporting a veteran to consider moving into a private property:

“veterans are typically not aware of the need to conduct a thorough inventory of contents and any work that is required for a property to be deemed fit for purpose”

“I will visit a prospective property with a veteran and take a damp detection tool, check the taps are working and a wide range of other tasks on a standard checklist that I give to veterans, and involve the veteran in finding out whether the property has a valid gas safety certificate, when was the boiler last serviced – this gives them the mind and skill set [knowledge and confidence] needed for challenging a private landlord to make the necessary repairs”

3.4.3 Well-being triaging and personalisation

AK described taking a triage approach to the needs of veterans, with supported empowerment initially provided to address immediate primary concerns (HARDFACTS – see section 3.1.1) after engaging veterans in preference-based decisions on their priorities for moving forward.

“I will often say to them, once you have your HQ sorted you can then start looking for jobs – it is essential they get this [accommodation] right!”

“deal with the practical and immediate needs then move onto other stuff”

Empathy was a core part of the engagement work done by AK, and she was acutely aware that anger was a sign of mental health problems and that veterans were often self-medicating with alcohol. Therefore, a preventative focus was also apparent to the work that AK did with veterans, and this triage approach also took into account the individual veteran’s circumstances (personalisation); for example to avoid exacerbating existing mental health problems:

“Where appropriate, and the veteran is happy to do so, I do my level best to try and get them into social or supported housing so they have some support when things go wrong, as opposed to private housing”

Similarly in the case of employment:

“Door supervisors or security guards should not be the default option. I take into account their situation, in particular if they have mental health problems and these jobs are not likely to be a good fit for them”

“I conduct a skills audit so that you can signpost veterans to a variety of jobs not just roles such as security work”

“I sometimes ask them to tell me what they would not like to do for a job”

3.5 Interactive group discussion with referring organisations

Representatives from four organisations that were high volume referrers to veterans’ services at Finchale Group (plus the BLVS service co-ordinator [AK] and the Veterans Service Manager at Finchale Group) attended an interactive group discussion lasting 77 minutes.

All four representatives described how veterans’ services at Finchale Group was a component of their induction training for their respective posts and that they all participated in the Veterans Network Meetings convened at Finchale Group. It was clarified at the meeting that referrals were made into the BLVS at Finchale Group, and that the Veteran’s Service Manager would signpost the veteran to the most appropriate service as there were multiple programmes available.

Three over-arching themes emerged from the analysis:

1. Quality and reliability of services at Finchale

Finchale was described by attendees as a regionally-based team with a huge knowledge base and reliable services with a track record of helping veterans with a variety of issues:

“There are a lot of agencies out there that let veterans down. We need to ensure that we get it right first time for our clients so we can deliver on our promises we are making and we don’t want to let them down” (female referrer representative)

One representative from a veteran’s organisation added to this by stating:

“The network and relationship with Finchale help us to filter out the poor support providers – the shysters who claim to provide a good service when they don’t – we know the people at Finchale Group do” (male referrer representative)

Comments focused on quality of Finchale Group services for veterans (and not throughput) in terms of providing a personalised 1-2-1 service that is sensitive to the transitional support needs of ex-service personnel from early service leavers to those who had longer service records, and had been medically or dishonourably discharged. One female referring agency representative described her reasons for referring veterans to Finchale:

“They use a holistic approach – I can refer for employment, but if there is something else they need support with, Finchale covers a wide range of needs and problems that veteran encounter – they will dig around and look after important needs such as food and housing”

Further positive remarks about Finchale veterans' services were that they had access to funding networks for training, and reflecting themes identified by veterans and the BLVS in the previous sections (3.3 and 3.4), a specific high-value aspect of referring to Finchale was that the staff have an understanding and a connection with veterans:

"A few of my guys said they did not want to explain to NHS people as they don't want to put onto the staff. The veterans want to talk to someone who understands what it is like to be someone from the armed forces"

A reference to active follow-up of veterans and a recognition that they may not attend scheduled appointments for a variety of reasons was also cited as a reason for referring to Finchale:

"They won't give up if somebody does not turn up – the opportunity carries on"

A further comment reflected the personalised approach by AK the BLVS service co-ordinator as a driver of referring to the Finchale Group:

"AK has the time and expertise that I don't have, for example I only deal with support with employment"

2. Finchale Group as a focal point for veterans services

Network of advice and support for veterans and organisations working for veterans and their families. All four representatives knew each other very well and had a good understanding of their respective roles. Veteran's Network Meetings were considered critical for sharing of expertise, knowledge and networking:

"You don't have to attend multiple events so saves you time and you get to know everything you need to know"

There was a sense of collective action for the benefit of veterans, and the referring organisations described a strong collaborative and mutually beneficial relationship with veterans' services at Finchale Group. On the one hand, representatives described how they could not provide services to meet the needs of veterans under their care (e.g., welfare, housing, mental health) without the existence of, and working relationships with Finchale. They described that the capability to provide referrals to Finchale Group enabled them to do the best they could for the veterans, as working with them on their own would be doing the veteran a disservice. All four representatives described having limited resources at their disposal and that they were often 'one person bands' covering large geographical areas. Whereas on the other hand, AK the BLVS service co-ordinator described how the established working relationships with high referring organisations enabled a smooth hand-over of information that was critically important for addressing the needs of veterans.

Having Finchale on their 'doorstep' in regional term was invaluable and one representative commented:

"without veterans support at Finchale I could not help as many people as I do"

One representative described how his role (1 of 10 nationally) was the envy of his counterparts in other parts of the country because he had *"access to Finchale Group!"*

Worthy of note was the referring organisations were not applying a 'fire and forget' referral policy. They remained very much involved in the veteran's case management in collaboration with AK to enable

formal and informal feedback on progress being made and sharing of expertise on how to best support the veteran.

3. Improvements to services at Finchale Group

They all unanimously agreed that the referral process was expeditious and fit for purpose and there was no requirement for improvements or the introduction of unnecessary bureaucracy.

The limited feedback that referring organisations received was emphasised as the only area for improvement. Whilst there was a consensus that the 'end result was most important', there was a desire for feedback that could be used for their own quality monitoring purposes and as evidence to secure continued funding.

“often the feedback is not given to the most appropriate source and it would be helpful to have joint case studies with Finchale”

“you need feedback to be relevant and to attract funding – positive feedback is critical”

“would like more feedback, good or bad, but this is a general issue across veterans’ services that you get cut off and they don’t want to re-engage once they no longer feel they need any help or support”

4. SUMMARY AND RECOMMENDATIONS

The BLVS engaged with 210 veterans over the evaluation period (1st March 2016 to end of Feb 2019). The majority were male (95%) and of working age. A similar demographic profile was also observed for veterans who responded to the service review questionnaire. The age-profile of veterans engaged in the BLVS approximately equates to outflow statistics published by the MOD in December 2018; however, the gender split of the veterans engaged in the BLVS differs to the figures published by the MOD, where 10.5% of armed forces personnel were female^{xxvii}

The HARD FACTS baseline assessment data demonstrated that veterans' primary needs upon entering the BLVS were training and education with a view to securing employment, followed by health concerns and financial support and advice. Substantial support was also provided to veterans with regard to accommodation and their families, including their children. Relational support in the form of 1-2-1 meetings served to develop trust and open up a rapport with veterans. This incorporated emotional, practical and social support, and involved a range of person-centred communication skills and confidence-building to address the most pressing needs of veterans.

The capability of the BLVS to address these needs is multi-faceted. The wider support programs for veterans and staff at Finchale Group are well-established and could be drawn upon by veterans referred to the BLVS. Finchale Group is a trusted and respected organisation, and is viewed as a hub of knowledge and expertise on veterans' services, with excellent mutually beneficial collaborative working relationships with veterans organisations across the region. This is a critically important component of the support infrastructure available to veterans who engage in services, including the BLVS at Finchale Group. The BLVS service co-ordinator has an exemplary toolkit of attitudes, knowledge, skills and experience to deliver a holistic service to veterans that relies heavily on her to approach to fostering positive therapeutic alliances, utilising supported empowerment techniques and triaging of well-being support that are personalised to individual circumstances of veterans.

In combination these elements constituted the active ingredients of the BLVS, and worked symbiotically to provide high-quality services to veterans and their families in the north east of England. Data from a range of different sources (validation forms, service review questionnaire responses, interviews and interactive group discussions) triangulated around specific themes that provided compelling evidence that the BLVS provided veterans, as well as their partners and children with effective advice, emotional and practical support, and confidence to address a wide range of complex socio-economic, psychosocial, health and well-being needs.

4.1 Is the BLVS addressing the pinch points described in the Veterans Strategy?

Themes identified from an analysis of qualitative data closely mapped onto 5 of the 6 themes stated in the Strategy for our Veterans as priority pinch points for support:

1. Community and relationships

A small number of veterans explicitly referred to support with needs in regards to making connections within their community or experiencing loneliness. Nevertheless, the BLVS maintained regular contact with veterans and supported them to access housing, education, training and employment, which invariably provides opportunities for social interaction (within and outwith Finchale Group) and development of relationships within their community.

2. Employment, education and skills

Support with employment search and skills development, including accessing training was a dominant theme identified from analyses of validation forms, service review questionnaire responses, including the

group discussion with veterans. A unique selling point was adopting a personalised approach and steering veterans towards meaningful employment that would boost well-being.

3. Health and well-being

This was a core aspect of the initial HARD FACTS assessment and veterans were signposted to appropriate medical and other health professionals in their local community. With reference to well-being, this was conceptualised in terms of receiving high quality relational support, information and advice on debt and support with employment. It was abundantly clear from different sources of evidence (validation forms, service review questionnaire responses, and interactive discussions) that veterans received well-being support, although there is room for improvement and a bespoke well-being service is discussed further in section 4.4.

4. Finance and debt

A budget plan is part of the initial HARD FACTS assessment process. Financial advice related to pensions, compensation and benefits all featured strongly as themes in validation forms and service review questionnaire responses. Importantly, veterans received support to avoid debt and better manage their finances when receiving support for addressing the challenges associated with the multi-faceted nature of housing that involves a process of knowledge acquisition, planning and money management skills.

5. Making a home in civilian society

This was a cornerstone of support provided to veterans with reference to the challenges of the transition process (i.e., they typically did not have the life experience of dealing with housing) and veterans received personalised support to access housing that was of good quality, fit for purpose and safe.

6. Contact with the law

The majority of veterans do not come into contact with the law. For the minority that do require support with the criminal justice system, there was no evidence identified that the BLVS addressed the needs of veterans in connection with the criminal justice system.

Additional themes were identified as pinch points in the BLVS evaluation, which were related to the issue of finances. There was the need to address food poverty in veterans. Among population subgroups in high-income countries, food insecurity has been shown to be associated with compromised nutrition^{xxviii}, poor general health, and a myriad of chronic physical and mental health conditions^{xxix, xxx}. Food insecurity has also been shown to be a marker of poor mental health, with studies identifying associations with mood and anxiety disorders and suicidal ideation^{xxxi, xxxii}. Veterans were supported with access to food banks via the BLVS, which further demonstrated responsiveness to the changing needs of veterans.

Support for children was also evident in qualitative feedback from veterans, which in one case was *“still ongoing”*. One veteran also raised an unmet need for support with caring responsibilities *“Support for carers (My mam, she can’t get any help, not financial, someone to talk to)”* which suggests a need to develop links with locality carer centres to give direct access to professional carers advice and support; for example in the form of carers assessments.

Worthy of note is that veterans predominately come into contact with BLVS at post-discharge, following a protracted period of sub-optimal support for socio-economic and psychosocial issues leading to compromised mental well-being being a key driver of making contact, or being referred to the BLVS. This strongly indicates that pre-discharge well-being assessment is warranted.

4.2 Relational support underpinning the successful delivery of the BLVS

This evaluation demonstrated that relational support provided by the BLVS service co-ordinator was the lynchpin to addressing the the holistic needs of veterans. Quality interactions with staff, on-going and regular contact via telephone, including emotional and practical support in the form of outreach (home visits), advocacy and signposting to other organisations were all important relational components underpinning the successful delivery of the BLVS. These areas as well as the use of active listening, supported empowerment techniques and personalisation were critically important prerequisites for successfully engaging with veterans, in order to develop a positive rapport, trust and mutual respect. A highly-regarded and dedicated BLVS co-ordinator with lived experience of serving in the armed forces was an attribute that facilitated engagement and fostered a deeper connection with veterans. This relational support was important for the development of positive therapeutic alliances with veterans, which is consistently found by research in a range of therapeutic contexts to be the strongest driver of building motivation, autonomy and confidence for change.

The interview with the BLVS service co-ordinator concurred with the values that veterans placed on relational support, and case management with individual veterans was typically multi-dimensional and involved high-intensity support to resolve complex issues. Veterans received highly effective relational support to apply a triage to their needs, in order to develop an action plan for addressing the most pressing and rudimentary needs such as housing and finances. Well-being needs were prioritised in a collaborative discussion whereby more immediate and basic well-being needs were identified, which if not addressed expeditiously would invariably lead to adverse or catastrophic outcomes for veterans and their families. This triage (similar to battlefield triage and triage systems utilised in hospitals) enables issues with greatest need being addressed first, which typically means addressing housing, food, financial and other basic needs. This serves to provide a sense of stability and control, which frees up the psychological energy required to address secondary (higher level) mental well-being needs such as employment, training and knowledge, skills and confidence to manage their own health and well-being.

The challenge for future service development is to sustain this effective relational model of support with larger numbers of veterans presenting with differential challenges across the life-course. Indeed, a theme identified across multiple sources of data was a need for greater relational support.

4.3 Why focus on mental well-being?

For too long (although this is changing) the concept of mental well-being has been colloquially referred to as a soft outcome, and considered secondary to 'hard outcomes' such as clinically-focused outcomes (reductions in symptom severity and healthcare utilisation). Views are changing however, in particular with evidence from the professional literature consistently showing that improved mental well-being is a critically important moderating variable that is strongly associated with a range of better 'hard' outcomes:

- Increased life expectancy after adjusting for initial health - high levels of subjective well-being can increase life by 4 to 10 years compared to low levels of subjective well-being^{xxxiii}
- protective factor against the onset, and recovery from physical and mental health conditions^{xxxiv,xxxv}
- beneficial health and lifestyle behaviours^{xxxvi}
- improved well-being of others who are emotionally connected with an individual with positive well-being such as friends, neighbours, children and partners – often referred to as the '*emotional contagion*' or '*social distance*' effects^{xxxiv,xxxvii, xxxviii, xxxix}.

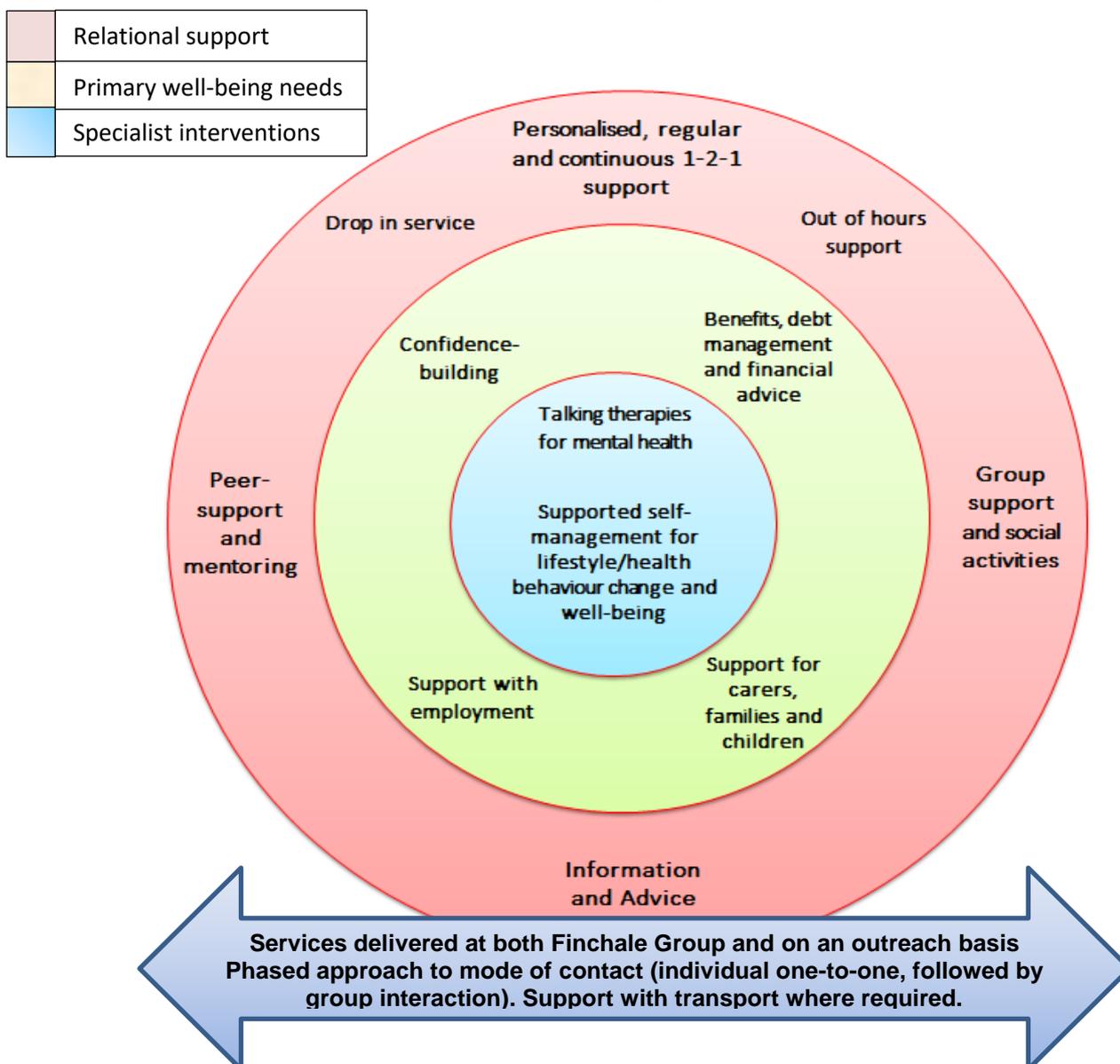
Focusing on well-being is therefore both morally, ethically and scientifically justifiable as the focus of intervention (service structure and content) and evaluation, including better signposting in the form of social prescriptions and establishing stronger links to external services and resources. This could include

both statutory (NHS and social care) and third sector services (e.g. Step Change for debt support after initial discussions with Finchale Staff) to enable facilitated access by veterans at Finchale Group.

4.4 How do veterans conceptualise mental well-being?

Veterans’ conceptualisation of well-being was strongly rooted in the definition of mental well-being as described by Mind. In order to positively engage with the BLVS over time, relational support in the form of four core inter-related components - personalised 1-2-1 support (as well as out of hours support and a drop in facility using the approach and techniques described in section 4.2), provision of advice and information, peer support and mentoring from other veterans, group support and social activities should be the cornerstone of the service. This sets the foundation for engagement in activities to address primary well-being needs related to building confidence, support for employment, benefits, debt and other financial issues, including support for carers, families and children. There was a need identified for ‘treatment’ in the form of specialised services; in particular psychological therapies (primarily counselling) and supported self-management for behaviour change, which suggested that these treatments would be considered acceptable to veterans This conceptualisation of mental well-being from the perspective of veterans is shown graphically in Figure 6.

Figure 6. Veterans’ conceptualisation of mental well-being



It is evident that the BLVS (and veterans services at Finchale Group more widely) is already effectively addressing core concepts of mental well-being from the perspective of veterans. Without compromising the bedrock of effective service delivery and organisation of the BLVS, greater use of signposting and establishing stronger links to existing services and resources outwith Finchale Group would help with issues related to staff capacity and supporting the delivery of specialist services. This is discussed further in the section on recommendations for improvement.

4.5 Recommendations for veterans service development at Finchale Group

Based on the findings of this service evaluation, the following recommendations for development of services for veterans at Finchale Group to augment reach and impact are indicated, which could also inform the consultation exercise on the Government's Strategy for our Veterans.

- Development of closer working relationships with armed forces discharge routes making the offer of contact and the information of what services and support are available from Finchale to service men and women during their discharge planning; thus expediting access to mental well-being support to prevent the emergence and worsening of socio-economic and psychosocial needs.
- Confidence-building could be further enhanced by development of stronger working relationships with Recovery Colleges and cross referral routes.
- *“Support for carers (My mam, she can't get any help, not financial, someone to talk to)”* by developing links with locality cares centres to give direct access to professional cares advice and support, including facilitating access to carers assessments.
- Support for children by developing stronger links, liaising and supporting veterans to access Local Authority support and services for children.
- Development of closer links with Department for Work and Pensions to provide bespoke advice to veterans and access to work payments.
- Development of an engagement strategy targeting female veterans
- Dedicated administrative support for service co-ordinators to enhance communication and free up time for more valued face-to-face interaction with veterans
- Utilisation of person-centred outcomes that capture the core elements of mental well-being (Figure 6) for quality monitoring and evaluation purposes. For example, service users of mental health services and their carer-givers have reported a preference for the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) over other mental health scales^{xi} The 14-item WEMWBS^{xii} was developed to enable the monitoring of mental well-being in the general population and the evaluation of projects, programmes and policies which aim to improve mental well-being. Personalised support was also a core relational support theme. The Patient Activation Measure can also be used as a mechanism to tailor support and specific interventions to veterans in accordance with their level of activation, which can optimise productivity and efficiency by matching the type of support provided to the needs of the individual^{xiii}. Other measures that could be considered include self-efficacy (confidence) for seeking employment and management of finances.
- Collaborative working with local further and higher education institutions, in terms of improved awareness and access to vocational and academic courses for veterans, which would help them to

develop 'softer skills' that are increasingly sought after by employers. Links with educational institutions could also provide training opportunities for their students (under the supervision of senior staff) which would add capacity to BLVS by enabling the provision of low-cost health, social care and well-being services at Finchale Group (and in the community). Staff at Finchale Group could also benefit from evidence-based training on a range of interventions such as alcohol reduction and well-being interventions.

- Better and regular promotion of existing services outwith Finchale Group. With reference to the findings in this report this should include out of hours (telephone) support already provided by several agencies; for example the Mental Health Matters helpline, other Veterans services and NHS Crisis teams. Support for veteran who come into contact with criminal justice system could be addressed by developed links with local probation services.
- Where appropriate, regular promotion of existing services could including sign-posting to reputable digital information and both e-Health and m-Health services to address needs related to specialist information and advice, including supported self-management for health/lifestyle behaviour change to improve mental and physical health. In addition, where appropriate, veterans could be referred to existing charities such as Step Change for debt support after initial discussions with Finchale Staff.

4.6 Conclusions

Finchale Group has a long-standing and positive reputation of providing high-quality needs-led holistic support to veterans and their families that is consistent with the definition of a good transition as defined by the Forces in Mind Trust. The BLVS represents an evolution in addressing the core and changing needs of this population, and offers a replicable and scalable service delivery model that embraces the core priority areas for support described in the Strategy for our Veterans.

This report provides compelling evidence from a triangulation of different data sources that demonstrates the high-value of the BLVS for supporting veterans, as well as their partners and children with effective advice, emotional and practical support, and confidence to address a wide range of complex socio-economic, psychosocial, health and well-being needs.

The report adds to the literature on veterans services by proving a conceptualisation of a service that focuses on mental well-being from their perspective, and provides evidence that services perceived as treatment such as counselling and supported self-managed for health and lifestyle behaviour would be acceptable to veterans (once their initial well-being needs had been addressed). The critical lynchpin to meeting the well-being (and other) needs of veterans is effective relational support to foster the development of therapeutic alliances and provision of personalised support, combined with access to a centralised network of expertise on veterans' services and collaborative mutually beneficial relationships with the wider veterans' support services in the local community.

APPENDICES

Appendix 1: Scoping Literature Review on the Transition from the Armed Forces to Civilian Life

Seventeen papers were found in the academic literature that met the eligibility criteria. Eleven were conducted in the United States, four in the United Kingdom and one each in Canada and Israel. It should be noted that three of the 17 papers located reported on the same study (Anderson and Mason, 2008; Anderson and Mason, 2010; Anderson et al., 2012). Only three of the seventeen articles reported on prospective trials of studies which evaluated interventions, the remainder are cohort studies (n=4), cross-sectional surveys (n=3), case studies (n=6) or qualitative exploratory studies (n=1).

Intervention studies

Systematic searches of the academic literature yielded only one randomised controlled trial (Martens, et al., 2015) of an intervention aimed at veterans during the transition process. This trial was designed to examine the effectiveness of a brief personalised intervention for reducing alcohol consumption in veterans. The authors found that, when compared to educational information only, the personalised intervention had a greater rate of abstinence at 6 months (Martens, et al., 2015). In a qualitative evaluation of a vocational intervention targeted at ex-service men, Warren, Garthwaite and Bamba (2015) found that the case management programme was both viable and valued by clients who reported feeling “listened to” and “valued” and “treated as individuals” by frontline staff. A US study (Johnson and Fogelberg, 2012) of a peer case management service for veterans with traumatic brain injury (TBI) reported that over two years, 143 clients were supported through a range of complex issues including homeless prevention assistance (21%); employment support (27%); 52% mental health issues; 13% substance abuse issues; 41% marital issues; 51% education. A large majority of clients believed that the support they received had improved their lives to some extent (81%).

Challenges to transition and groups at risk

Across the remaining 12 non-intervention studies, there was agreement around the main challenges for veterans making the transition from military to civilian life including mental ill health (PTSD, depression and anxiety disorders), substance abuse, relationship problems, low confidence and self-esteem, shifts in sense of self/identity and social isolation (Anderson and Mason, 2008; Brunger et al., 2013; Johnson and Fogelberg, 2012; Wilcox et al., 2015). Evidence is accumulating to suggest that certain groups are at heightened risk of adverse effects associated with the transition process. These include early service leavers (serving less than four years in the armed forces) and reservists; both of whom suffer a disproportionate burden of ill health following their transition from military to civilian life (Buckman et al., 2013). In particular they are at a greater risk of post-traumatic stress disorder and common mental disorders. Similarly, in a Canadian cross-sectional study of army veterans, MacLean et al., (2014) reported that lower rank and midcareer or involuntary discharge were predictors of a difficult transition to civilian life. Van Staden et al. (2007) found that being disadvantaged after transitioning from army to civilian life was associated with pre-existing mental health problems, receiving an administrative discharge or serving a shorter term in military prison.

Gaps and limitations

A summary of the 17 articles from the academic literature is presented in Table 1. The evidence retrieved is partial in its scope and there are few prospective trials of well-defined interventions. Thus, there is a clear need for well-designed intervention studies to delineate the impact of interventions targeting transition from military to civilian life on veterans’ physical and mental health, including outcomes related to employment/training, family functioning and psychosocial well-being.

Table 1a. Summary of the articles identified from the electronic literature search

Study/Report	Setting	Summary of methods (and intervention)	Key findings	Key recommendations around transition
Gowan et al. (2000) ^{xliii}	USA	The association between self-esteem, self-efficacy and career resilience was examined in the responses of 171 US Army personnel making the transition to civilian jobs.	Only self-esteem and career resilience were related to harm appraisals of the transition. Personality variables were related to use of coping strategies.	Programmes should focus on self-esteem building
Van Staden et al. (2007) ^{xliv}	UK	Participants were interviewed 1 week before leaving armed forces via military prison and 6 months follow-up. Seventy-four were successfully followed up and interviewed 6 months later	Of those followed up 38 (56%) were classed as being disadvantaged after leaving. This was associated with: having pre-discharge mental health problems, receiving an administrative discharge, or a short sentence length.	At the point of discharge, those most at risk of further disadvantage should be targeted for support, specifically those with pre-existing mental health problems, receiving an administrative discharge, or having a short sentence length).
Anderson and Mason (2008). ^{xlv}	USA	Examination of an Intensive Care Coordination provided for veterans with traumatic brain injury (TBI) for up to 2 years. Intensive Care Coordination consists of intake assessment, development of care plan goals, and partnership to develop self-advocacy and goal attainment, transition plans for veterans and families plus minimum once-monthly face-to-face and telephone calls.	Intensive Care Coordination permits veterans to connect with community resources and decreases suicidal ideation, homelessness, substance abuse, social isolation and dependence upon state benefits.	Intensive Care Coordination is a viable option for supporting clients with TBI to provide a sense of inclusion in the community and decreased isolation
Anderson and Mason (2010) ^{xlvi}	USA	Examination of an intensive care coordination programme for veterans (as above)	Intensive Care Coordination reduced the negative effects of Reverse Culture Shock by linking returning veterans to community resources to facilitate positive transitions. Outcomes include a sense of autonomy for veterans and families, feelings of stability, enhanced connections to family and friends and increased hope and sense of purpose.	Partnerships with military, veteran and community organisations achieve positive transition outcomes for veterans and their families.
Anderson et al. (2012). ^{xlvii}	USA	Conference presentation providing anecdotal evidence of intervention outcomes (see above)	Anecdotal evidence from a multifaceted wraparound programme (including Care Coordination and ongoing	Research recommendation was to formally evaluate the programme using

			education) showed increased belongingness (a predictor of health and wellbeing), autonomy and stability, greater social capital and enhanced feelings of purpose and personal value.	robust research design
Mansfield et al. (2011). ^{xlviii}	USA	Path analysis to examine factors associated with suicidal/self-harming ideation among male Navy and Marine Corps personnel transitioning to civilian life	Suicide ideation was reported by approximately 7% of the sample (Sailors = 5.3%, Marines = 9.0%) during the previous 30 days. Combat exposure, substance abuse, and resilience were associated with suicidal ideation/self-harming thoughts (mediated by PTSD symptoms and/or depression symptoms).	Suicidal ideation, substance use and self-harm are important issues to address in support programmes for veterans
Johnson and Fogelberg (2012). ^{xlix}	USA	Evaluation of a military peer case management service for service members with traumatic brain injury (TBI). Peer resource support, links the client to their benefits and other support e.g. homelessness prevention, cognitive strengthening, assistive technology, wrap around family services, and educational and employment support.	The programme supported 143 clients over two years Support was provided for the sample as follows: 21% homeless prevention assistance; 27% employment support 27%; 52% mental health issues; 13% substance abuse issues; 41% marital issues; 51% education. 81% of clients expressed that their lives had improved due to the service.	Recommendation for more traumatic brain injury programs and resources in the USA. More peer support groups are required to assist with the issues of TBI and suicides. General awareness-raising is also necessary.
Baum et al. (2013). ⁱ	Israel	The Peace of Mind program provides support for mental health and normalisation of responses, as well as on the processing of traumatic experiences	The model is described and several vignettes are presented.	
Brunger et al. (2013). ⁱⁱ	UK	Qualitative study with 11 in-depth interviews of ex-servicemen. Data were analysed using interpretative phenomenological analysis (IPA)	Three broad themes were reported: characteristics of a military life; loss as experienced upon return to civilian life; and the attempt to bridge the gap between these two lives. Cutting across these themes was the notion of identity, in which the transition is viewed as a “shift in sense of self from soldier to civilian”.	The military needs to ensure that not only is support provided for all service personnel, but that it goes beyond basic vocational advice.
Buckman et al. (2013). ⁱⁱⁱ	UK	A cross-sectional study used data on ex-Serving UK Armed Forces personnel. ESLs were personnel leaving before completing their 3-4.5 years minimum Service contracts and were compared with	Of 845 Service leavers, 80 (9.5%) were ESLs. ESL status was associated with younger age, female sex, not being in a relationship, lower rank, serving in the army and with a trend of reporting higher levels	Recommendation to target interventions to ESLs on leaving Service to smooth their transition to civilian life and prevent the negative mental health

		non-ESLs	of childhood adversity. Being an ESL was not associated with deployment to Iraq. ESLs were at an increased risk of probable post-traumatic stress disorder (PTSD), common mental disorders, fatigue and multiple physical symptoms, but not alcohol misuse.	outcomes experienced by ESLs in the future.
MacLean et al. (2014). ^{liii}	Canada	Cross-sectional survey of a national sample of 3,154 veterans released from the regular Canadian Forces during 1998 to 2007.	One quarter of the sample experienced difficulties adjusting to civilian life. Lower rank and medical, involuntary, mid-career, and Army release were significantly associated with difficult adjustment, conversely sex, marital status, and number of deployments were not.	Need for collaboration between physical therapists and other service providers to mitigate difficult transition. Future interventions, outreach and screening should be informed by the risk factors identified here.
Misra-Hebert et al. (2014). ^{liv}	USA	Cross-sectional data from focus group plus survey which explores the views and experiences of veterans enrolled on a college course (one time point only).	For participants, the motivation to improve health was viewed as secondary to obtaining housing or work. Concerns about privacy and stigma were perceived barriers to accessing healthcare. In the survey (n=204, 21% response rate) participants reported physical (45%) and emotional (35%) problems which limited their daily activities, and pain interfering with work (42%) plus high levels of self-reported depression and unhealthy behaviours.	The study highlighted how collaboration between primary care, public health and a community college can support veterans with health problems.
Rowland (2014). ^{lv}	USA	Case study of an intervention aimed at transition to bridge the gap between military and civilian life by helping soldiers with their employment needs. The intervention includes use of a design salon environment to create a collaborative, cohort-based learning space, and the adoption of an Entrepreneurial Mindset to successfully execute the required personal and professional transformation.	The article focuses on description of an intervention.	
Martens et al. (2015). ^{lvi}	USA	Randomised controlled trial of brief personalized drinking feedback (PFB) intervention tailored for veterans versus	Those in the PFB group were more likely than those in the EDU group to remain abstaining from alcohol at 6-	The study provides evidence to support the efficacy of a brief, inexpensive

		regular educational information (EDU). The intervention involved personalized information about alcohol use, including social norms comparisons, risks associated with reported drinking levels, and a summary of their alcohol-related problems.	month follow-up	intervention for reducing alcohol misuse In veterans
Milstein et al. (2015). ^{lvii}	USA	Case study of self-guided dialogues to facilitate transition and readjustment. The Warrior Spirit/Mission Homefront (WS/MH) interactive dialogue program was designed to aid veterans to talk about their military experiences with fellow service members or veterans, then with friends and family.	Outcomes discussed include a change in mood from “reticent to vibrant”. The authors report how WS/MH dialogues model how a person can begin to talk about their deployment by telling simple stories, and building on that momentum they can start to share more difficult experiences with their significant others with the overall aim of better connecting with family and community.	
Warren et al. (2015). ^{lviii}	UK	Qualitative evaluation of a vocational case management programme co-funded by the National Health Service (NHS) to prevent ill health among ex-service personnel Semi-structured interviews with ex-service personnel (n=15) and case management staff (n=5).	Clients particularly valued the opportunity afforded by the programme to be listened to, treated as an individual and valued by frontline staff.	The study casts the case management approach as a viable and valued way of supporting ex-service personnel in the transition pathway.
Wilcox et al. (2015). ^{lix}	USA	Cohort study of 126 reservists on their return from a one-year deployment to Iraq, with assessments at baseline, one month and six months post deployment.	Overall, the rates of post-deployment psychological and behavioural problems were elevated upon returning from deployment and remained fairly constant for up to 6 months post-deployment. Reported problems included relationship issues (~30%) and family reintegration issues (>30%).	

Grey literature

Searches of policy and grey literature yielded several reports which examine, to a varying extent, the challenges surrounding the transition from military to civilian life and intervention programmes to address these difficulties. Six of these publications were selected to be included in this scoping review. Much of these data support the academic literature around the greatest challenges facing service leavers during their transition.

Challenges surrounding transition

For many service leavers transitioning from military service to civilian life results in positive outcomes with veterans securing employment and reporting good quality of life, but for a proportion of service leavers the process is more challenging and is associated with outcomes such as mental ill health, alcohol misuse, unemployment, homelessness, involvement in the criminal justice system and social exclusion (Murrison, 2010; Kings Centre for Military Health Research, 2016). The Ashcroft report cites public perception of service leavers as a particularly challenging issue to be addressed as it can result in stigma and reduced expectations for the service leaver (Ashcroft, 2014). A recent report estimates that **66,090** service leavers will require support for physical or mental health problems, although many will be reluctant to seek help. The authors call for further research to establish the specific needs of service leavers in this group and at what time point they are most likely to seek help (Diehle & Greenberg, 2015).

At-risk groups

While the majority of service leavers’ transition to civilian life with positive health, wellbeing and social outcomes, there are certain groups who tend to do less well. These include early service leavers (ESLs), defined as those having served four years or less in the military, and reservists (Ashcroft, 2014, The Futures Company/Forces in Mind Trust, 2013). At present, only service leavers who have served at least six years in the armed forces are eligible for full transition support and less support is available for ESLs and reservists (Ashcroft, 2014). It is speculated that this may account for why ESLs and deployed reservist groups see higher levels of post-traumatic stress disorder and relationship problems (Kings Centre for Military Health Research, 2016)

The role of family in the transition process

It is accepted that the family of the service leaver has a vital role to play in facilitating a successful transition from army to civilian life and this is acknowledged to include parents and siblings as well as spouses and partners (The Futures Company/Forces in Mind Trust, 2013). However, a key gap in the evidence base highlighted by Samele (2013) is around what makes some families more resilient than others against transition risks. Recommendations from the Transitions Mapping Study include ensuring better access to information and entitlement for family members supporting a service leaver as a way of reducing the stigma for the service leaver having to directly seek help themselves (The Futures Company/Forces in Mind Trust, 2013). The authors also recognise the requirement for psychosocial and practical support for family members who may also be transitioning themselves back into civilian life (The Futures Company/Forces in Mind Trust, 2013). A summary of the key findings and recommendations of the grey literature are shown in table 2 below.

Table 2b. Summary of the findings and recommendations in the grey literature

Study/Report	Approach	Key findings	Key recommendations around transition
Ashcroft, 2014 ^{ix}	Review, mixed methods	Support is available for service leavers and most do well, however the needs of early service leavers (those having served four years or less) are often not fully met. Public perception of service leavers as mentally unstable, homeless or unemployed are erroneous and can lead to low expectations and stigma.	Make all service leavers not just those having served at least 6 years eligible for full transition support; introduce personal development plans for service leavers; establish a 24/7 hour contact centre for veteran support; introduce work placement schemes in collaboration with industry; challenge misleading or partial public

			misconceptions of veterans.
Diehle and Greenberg, 2015 ^{lxi}	Secondary data analysis	The report estimates that 66,090 of 757,805 service leavers (serving in the military between 1991 and 2014) will require support for physical or mental health problems. However those most in need are least likely to seek help.	Recommendation for further research to establish the specific needs of service leavers most likely to have physical and mental health problems and at what time point they are most likely to seek help.
Kings Centre for Military Health Research, 2016 ^{lxii}	Briefing to Parliamentary Office of Science and Technology	Signposting of support programmes for service leavers including the Mental Health First Aid scheme which seeks to increase resilience amongst veterans and their families.	
Murrison, 2010 ^{lxi}	Review, mixed methods	Support identified for three key groups: regulars and reservists; service leavers transitioning; existing veterans	Several recommendations including: follow-up approx. 12 months after leaving; deployment of additional community mental health professionals to help veterans' access NHS services.
Samele, 2013 ^{lxiii}	Literature review and stakeholder interviews	Regarding transition, the majority of service leavers have good outcomes in terms of health and psychosocial wellbeing. Reservists however seem to have poorer outcomes, with common mental health problems frequently cited, although these can be transient in some instances.	The authors call for future studies to better understand what makes some families more resilient to better transitioning and resettlement into civilian life.
The Futures Company/ Forces in Mind Trust, 2013 ^{lxiv}	Review, mixed methods	A gap in the knowledge base is highlighted around long term outcomes for service leavers and the inter-relationships between adverse transition outcomes (e.g. alcohol misuse and employment). The report suggests ways to improve transition from the service leavers' perspective which include: (i) early engagement about transition to encourage future-facing attitudes for service leavers; (ii) increase familiarity with civilian life e.g. through workplace; (iii) access to material resources to protect against transition risks; (iv) access to information before leaving the military and afterwards.	Overarching recommendations include: Create transferable skills Create independence Personalise the pathway Engage with the family Track the right outcomes Invest to reduce transition risk

Appendix 2: HARDFACTS assessment tool

Hard Facts	Clients Response
Health (Disabilities, mental, physical and eating habits)	Physical Health Issues: Mental Health Issues:
Accommodation (residency) Social Housing, Private Owned, Home Owned, Supported	Housing Issues:
Relocation (previous addresses since discharge)	
Drugs + Alcohol (Do they have a problem and what assistance do they get if any)	Drug Issues: Alcohol Issues: Cigarettes Smoker Gambling Addictions:
Finance (Income, debt etc.)	Finance/Debt Issues: Is your current economic status stable?
Attitude (Anger issues, social seclusion)	Social Issues: NO How often do you use local amenities, pubs, clubs, restaurants, shops, public transport? Do you currently feel isolated; NO how well do you feel you integrate with the local community
Children + Families (No of dependent children)	Relationship Issues:
Training/ Education/ Employment	Training Needs: Education Needs: Employment Issues: ELC Registered Contact ELC Resettlement Assistance Required Help Needed with CV and or Interview Techniques
Supporting Agencies (e.g. ABF, RBL, SSAFA, HFH etc.)	Are you aware of where to find out information regarding the benefits you may be entitled to and other sources of support?

Appendix 3: Service Review Survey Questionnaire

1. Age Group: 16-29 30-39 40-49 50-59 60+

2. Gender: Male Female

3. Please indicate any services you have accessed at Finchale Group by ticking which of the following applies to you. If you have accessed multiple services, please tick all that apply.
 - Veterans
 - Working Links
 - Remploy
 - Shaw Trust
 - Enterprise support
 - Training

4. How would you rate the services you have accessed on a 1-5 scale (with 1 being not at all useful to 5 extremely useful)?

Not at all useful				Extremely useful
1	2	3	4	5

5. What specifically did you find useful about the services at Finchale Group?

6. What would you like Finchale Group to do differently in the future?

Mental well-being describes your **mental state** – how you are feeling and how well you can cope with day-to-day life. Our mental well-being is **dynamic**. It can change from moment to moment, day to day, month to month or year to year. If you have good mental well-being you are able to:

- feel relatively **confident** in yourself and have positive **self-esteem**
- feel and express a range of emotions
- build and maintain **good relationships** with others
- feel engaged with the world around you
- live and work productively
- **cope** with the stresses of daily life
- adapt and manage in times of change and uncertainty

Source: Mind

After reading the above description of well-being, please answer the following questions:

7. What would you like to see included in the well-being service at Finchale Group? This could be specific types of advice, support and activities (and other things you think are important) to help improve well-being

8. How should we organise and deliver the new well-being service at Finchale Group? For example, group or individual contact sessions (or a combination of both)? Should all activities be based at Finchale Group site or the community (or a combination of both)?

9. If you would like someone from the Office at Finchale Group to contact you by telephone to discuss your feedback, please provide your name and contact details below (along with some convenient times to give you a call)

Appendix 4: Discussion guide for the interactive group discussion with veterans

1. First of all, could you tell me a bit about...

- How you found out about the service
- Reasons why you contacted the service (how long ago?)
- How did you initially make contact – could this process be improved in any way?
- What advice/support did you receive? How did this work for you?
- Current involvement with the service - ongoing?
- Any referral onto other services (using other services currently)?

2. What worked well about the service?

- what worked not so well?
- What could be done differently to improve the service provided?

3. What impact has the service had on you and/or your family?

- Any changes to your disability/mental wellbeing/overall health during the time since your initial contact with the service?
- Any changes specific to emotional health confidence, anxiety, stress levels, sense of control?
- Any changes to wider aspects (e.g. work situation, family relationships, social life, financial situation)?
- Anything you do differently now?
- Any negative impacts?
- Is there any way that the service could be improved in order to make positive changes to you and/or your family?

4. Finally, based on what we have already discussed and your experience of the service, do you have any overall opinions or recommendations that you would like to be taken forward?

- Is there anything that you would recommend to improve the service?
- Is there anything additional you would like to see in future service leavers' support in your local area?

5. What do you think would have been the consequences for you or your family if this service had not been available to you?

6. Is there anything we have not discussed, that you feel is important - related to the service or health/wellbeing support more generally?

Appendix 5: Discussion guide for the interactive group discussion with referring organisations

1. How did you learn about the existence of the service?
2. What were the main reasons for a referral being made and key issues faced by the person referred?
3. What is unique about the service and how does it differ to the NHS and other organisations providing support to veterans and their families?
4. Were there any specific challenges around the referral process?
 - What worked well?
 - What worked not so well?
5. What (if anything) could be done differently to improve the referral process?
6. How could the service be marketed better (ideas to increase awareness and uptake)?
7. What feedback (if any) have you received from clients you have referred to the service?
8. Could you provide some specific examples of how the service has helped clients and their families?
9. What do you think would have been the consequences for clients and their families if the service had not been available?
10. Is there anything that we have not discussed, that you feel is important related to the service?

Appendix 6: Interview guide with BLVS case worker

1. Where did the idea for the project originate?
2. What is unique about the project and how does it differ to the other organisations providing support to veterans (locally, regionally or nationally)?
3. Could you provide some specific examples of how the project has helped clients and their families?
4. How has the service benefited individual clients and their families in terms of physical health/emotional wellbeing/stress levels/confidence/sense of control?
5. Have you observed any tangible changes in the personal circumstances of clients and their families (work situation, family relationships, social life, financial situation)?
6. Could you describe any specific ways of working that are particularly effective; for example for development a positive relationship with clients?
7. What do you think would have been the consequences for some clients and their families if the service **had not** been available?
8. Specifically what is working well with the service?
9. What has not worked not so well? Were there specific challenges around:
 - the referral process;
 - support available for clients and their families;
 - logistical issues;
 - follow-up and maintaining contact with clients;
 - referrals on to other NHS and non-NHS services?
10. Is there anything that we have not discussed, that you feel is important related to the success of the service?

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