An Evaluation of Veterans First Point Scotland: Scotland's Specialist Mental Health Service for Veterans

Acknowledgements

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1. Introduction

1.1 Veterans First Point (V1P) Scotland is a network of six regional centres across Scotland (see Figure 1), providing a holistic veteran-led mental health and welfare support service for veterans. V1P Scotland aims to maximise engagement with Scottish veterans and support their recovery through provision of a veteran-led service providing welfare and psychological support.

1.2 In 2007 a Veteran Advisory Group, comprising veterans who had first-hand experience of accessing mainstream NHS mental health services, were invited by Dr. Linda Irvine Fitzpatrick and Dr Claire Fyvie to design a new model of service for the veteran population (Abraham & Allanson-Oddy, 2017). The three requirements for a veteran service highlighted by the Veteran Advisory Group were credibility, accessibility and co-ordination. This informed the design and delivery of the first Veterans First Point (V1P) centre, V1P Lothian, and subsequently the development of regional centres based around Scotland.

1.3 An initial evaluation of V1P Scotland was disseminated online in 2018 (Irvine Fitzpatrick *et al,* 2018). This current report is a continuation of the 2018 evaluation which evaluates V1P Scotland against its ethos of providing a credible, accessible and co-ordinated service.

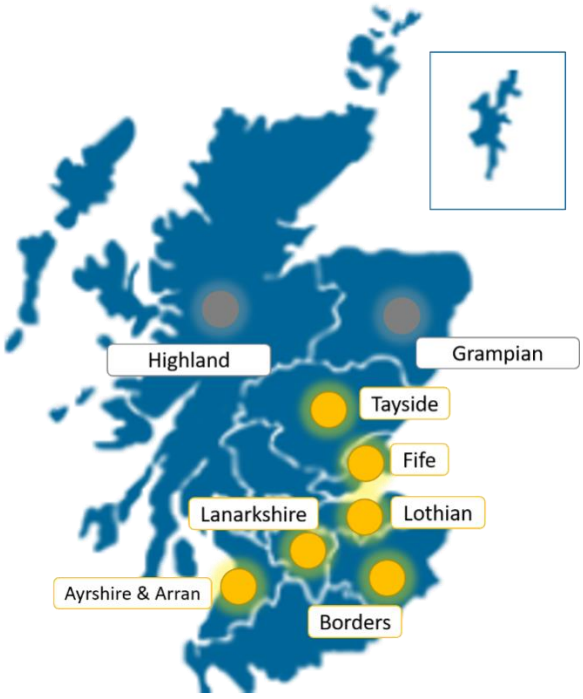


Figure 1
The six regional V1P centres in yellow. Grampian and Highland centres (in grey) were previous delivery sites.

2. What are the needs of Scotland's veterans?

2.1 Veterans are defined by the UK Government as anyone who has served in Her Majesty's Armed Forces for at least one day, or members of the Merchant Navy who served on military operations (Ministry of Defence, 2017).

2.2 As of 2019, there are an estimated 240,000 veterans living in Scotland (Scottish Veterans Commissioner, 2019) and the broader veterans community living in Scotland, including family members and dependents, has been estimated to make up 10% of Scotland's population (Poppy Scotland, 2014). This figure is forecast to fall to around 6% of Scotland's population by the year 2030, and the demographics of Scotland's veterans are increasingly made up of older adults (Punter Southall, as cited by Ashworth et al., 2014). Adapting and catering to the changing needs of veterans and the broader veteran community is therefore an important consideration for Scottish health services.

2.3 The Armed Forces Covenant, the UK's commitment to ensuring that those who have and their families are treated fairly, recognises the exceptional sacrifices made by those who serve in the Armed Forces. It specifies that those who serve and their families should experience no disadvantage in the provision of public services, and special consideration is appropriate for those injured or bereaved (Ministry of Defence, 2016). The Scottish Government have committed to uphold the Covenant in supporting Scottish veterans to access the services they require, and all NHS Scotland health boards have signed the Covenant (Scottish Government, 2016).

2.4 The Scottish Veterans Commissioner, an operationally independent ambassador for veterans appointed by the Scottish government, has recognised the importance of considering Scottish veterans as a unique group who may experience health inequalities when designing and delivering appropriate health services (Scottish Veterans Commissioner, 2018).

2.5 Although the majority of veterans within the UK transition well to civilian life post-discharge, some veterans are at increased risk of experiencing social exclusion and mental health difficulties on leaving the military (Iverson et al., 2005a). These include those who experienced mental health difficulties during service, those of lower rank (Iverson et al., 2005a), early service leavers who leave the armed forces prior to serving their minimum term of contract (Buckman et al., 2012), reservists (Hotopf et al., 2006), those who display psychosocial factors including experiential avoidance and cognitive reappraisal (Bowes et al, 2018), and those who experienced childhood adversity (Murphy and Turgoose, 2019). Often these risk factors are complex and interrelated – for example, early service leavers are more likely to have experienced childhood adversity and served in a lower rank (Buckman et al., 2012).

2.6 Whilst the UK Government definition of veterans is inclusive by international standards (Dandeker, Wessely, Iverson & Ross, 2006), the vulnerability of early service leavers to suffer mental health difficulties or disadvantage is a powerful argument to adopt such an inclusive definition.

2.7 Previous research indicates that V1P Scotland works with a high proportion of veterans who live in Scotland's most deprived areas (as defined by Scottish Index of Multiple Deprivation quintiles), and a high proportion of veterans engaged with the service are unemployed or signed off sick from work at registration (Irvine Fitzpatrick et al., 2018). Veterans engaged with V1P Scotland were also found to present with complex needs at clinical assessment, displaying moderately severe psychological distress, depression and functional impairment (Irvine Fitzpatrick et al., 2018).

2.8 Veterans in the UK experiencing mental health difficulties display relatively low levels of help-seeking and engagement with health services (Iverson et al., 2005b; Iverson et al., 2010). Reluctance to access support for mental health is attributed to perceived stigma and barriers

to care, which are expressed to a higher degree in veterans who are experiencing mental health difficulties, particularly those with probable PTSD (Iverson et al., 2011; Williamson, Greenberg & Stevelink, 2019). Murrison's Fighting Fit report (2010) on mental health planning for veterans in the UK acknowledged stigma as a key deterrent to veterans from engaging with conventional mental health services. Murrison (2010) advised it is therefore necessary to make interventions aimed at veterans acceptable to "a population accustomed to viewing itself as mentally and physically robust". These findings suggest that specialised mental health services such as V1P Scotland, which are veteran-led and designed to meet the specific needs of veterans, are key to engaging with veterans by reducing stigma.

2.9 Other key recommendations for engaging veterans with mental health services are to minimise barriers to care by providing follow-up and management within veterans' local communities, and to provide intervention as early as possible (Murrison, 2010).

3. How does V1P Scotland aim to address the needs of Scotland's veterans?

3.1 V1P Scotland aims to address the needs of Scotland's veterans through provision of a veteran designed service that acknowledges the unique profile and needs of veterans as a group. By basing the V1P Scotland service model on the expressed needs of Scottish veterans who had experience of accessing mainstream mental health services, the network has strived to deliver a service that is acceptable to veterans through being accessible, co-ordinated and credible. The employment of experienced veteran Peer Support Workers across V1P Scotland, who provide essential welfare and life support to service users, ensures the service continues to be veteran-led in its approach.

3.2 Veteran Peer Support Workers at V1P Scotland co-ordinate with partner organisations to provide a broad range of welfare and wellbeing support to veterans engaged with the service. Of key importance is the role that the V1P Scotland's Peer Support Workers play in enhancing veterans' engagement with the service, as their shared understanding of military life enhances their credibility with other veterans (Weir et al, 2019). Peer Support Workers also provide an 'open door' to veterans seeking help, providing an accessible route to engagement and re-engagement with the service (Weir et al., 2019). They enhance the service's ability to engage with veterans by reducing the stigma associated with seeking help, and their facilitation of informal drop-in groups across V1P centres encourage veterans to socialise with their local veteran community and engage positively with their local V1P centre.

3.3 V1P Scotland's model of service can be conceptualised as a stepped care model, whereby registration and engagement with Peer Support Workers is the initial step and accessing clinical support is the second step for those who require it. Engagement with Peer Support Workers at Step 1 links service users to essential welfare support, relating to a broad range of needs including housing, employment, and social activities. The support provided by Peer Support Workers in Step 1 is an important contribution to establishing 'safety and stabilisation' for service users prior to commencing psychological therapy with the clinical team where required

3.4 This is a particularly important consideration for those presenting with Complex PTSD symptoms (NHS Scotland, 2015). Where appropriate, Peer Support Workers refer service users to Step 2 to access psychological assessment and support. V1P Scotland employ Clinical Psychologists, Counselling Psychologists, Psychiatrists and Psychological Therapists who are experienced in working with veterans and trained in a range of evidence-based interventions,

including Cognitive Behavioural Therapy, Interpersonal Therapy, Eye Movement Desensitization and Reprocessing, Cognitive Analytic Therapy, Acceptance and Commitment Therapy, and Cognitive Behavioural Analysis of Systems Psychotherapy.

3.5 Peer Support Workers are also trained in Interpersonal Counselling (IPC), which has been found to be effective in the treatment of mild to moderate depression and may be deemed an appropriate intervention for service users at assessment (Weissman et al., 2014).

3.6 The specialist nature of the V1P Scotland service generally results in shorter waiting times for assessment and treatment compared to mainstream NHS mental health services, which is key to removing barriers to care. Once discharged from psychological therapy, veterans remain registered with the service with easy access to peer support and drop-in groups in order to re-engage with the service as needed. This stepped-care model aims to retain engagement with veterans and supports accessibility through re-engagement with clinical support when appropriate.

3.7 Basing V1P Scotland on an ethos of accessibility, co-ordination and credibility aims to deliver a service in line with both the expressed needs of Scotland's veterans and the evidence base on how best to engage veterans with mental health services.

3.8 Several aspects of V1P Scotland's model are designed to increase accessibility. Firstly, having dedicated community spaces for each of the V1P centres in convenient local locations allows veterans to access care in an accessible space whilst retaining privacy. This is in line with Murrison's (2010) recommendation that treatment should be close to home and the dedication to providing a friendly atmosphere across the V1P Scotland network by offering tea / coffee on arrival sets V1P apart as a safe space for service users.

3.9 V1P Scotland's referral pathway, whereby veterans can self-refer or be referred by a range of other NHS or partner organisations, also contributes to the accessibility of the service. The option to self-refer to V1P Scotland allows veterans to control the timing of their own engagement, which combined with the service model that retains engagement with veterans post treatment could contribute to forming a healthy attachment between veteran and service (Fyvie. et al;, 2019). Research indicates that veteran Peer Support Workers working within mental health services enhances engagement and is associated with positive outcomes for veterans (Weir et al., 2019; Chinman et al., 2015).

3.10 V1P Scotland aims to deliver a co-ordinated service for veterans by working closely with partner organisations. Fostering close links with other NHS and veteran agencies encourages referrals to V1P Scotland from a broad range of organisations. Partnering with other organisations also enables V1P Scotland veteran Peer Support Workers to efficiently access a wide array of support needed by service users. In-house clinics hosted in V1P centres by partner organisations such as the Citizens Advice Bureau, the Armed Services Advice Project and Veterans UK help to reduce barriers for veterans seeking help.

3.11 The Scottish Veterans Commissioner's (2018) recommendations to develop a National Managed Clinical Network (NMCN) for veteran which will advise, influence and monitor the planning and delivery of mainstream and specialist health services for veterans, was a positive development which will allow for continued close partnership working with other veteran organisations.

3.12 V1P Scotland aims to deliver a credible service through employment of experienced veteran Peer Support Workers and clinicians who are highly trained and experienced in working with veterans. Previous research based in the V1P Lothian service found that veteran Peer Support Workers provide a positive first impression to service users due to their credibility, which is associated with their military connections (Weir et al., 2019).

3.13 V1P Scotland ensures credibility of clinicians by ensuring clinicians are highly trained in a range of evidence based interventions (NHS Scotland, 2015) and experienced in working with veterans so that they can provide the best possible care to veterans as a group. The Scottish Veterans Commissioner (2018) voiced an increasing demand for greater focus on healthcare services providing excellent, accessible and sustainable treatment for veterans. By hiring experienced and highly trained clinicians and encouraging veterans to remain engaged with the service, V1P Scotland aims to provide an excellent standard of care and treatment to veterans which will lead to meaningful improved outcomes for veterans.

3.14 The success of the V1P Scotland service model in addressing the needs of Scotland's veterans is reflected by its growth from a single centre to a Scotland-wide network. V1P Lothian served as the initial pilot, and it was widely recognised as a valuable service for supporting Scotland's veterans, attaining awards including the Military and Civilian Health & Partnership's 2011 Mental Health Award and 2013 Healthcare Civilian of the Year Award (awarded to Dr Lucy Abraham, Service Lead), and NHS Lothian's 2014 Health Improvement and Promotion Award. An early evaluation of six UK-wide community-based veteran health pilots also reported promising results regarding V1P Lothian's service model, with V1P Lothian reporting the greatest self-reported improvement of the client's situation across the six community-based pilots and service users reporting that veteran staff helped them feel understood (Dent et al., 2010).

3.15 The recognised success of the V1P model led to an accepted proposal to extend the V1P network across Scotland, with over £2.5 million Libor funding awarded in 2013 to NHS Lothian to facilitate this expansion through a 'hub and spoke' model. Initially planned to create three additional V1P centres, this funding enabled a small V1P Scotland development team (Dr Linda Irvine Fitzpatrick, Dr Lucy Abraham, Dave Carson & Sharon Fegan) to establish regional V1P centres across eight of Scotland's health board and facilitate education, training and network meetings to further development and information sharing across the V1P centres. The eight V1P Scotland centres set up were V1P Lothian, V1P Tayside, V1P Fife, V1P Borders, V1P Lanarkshire, V1P Ayrshire & Arran, V1P Grampian and V1P Highland. All centres worked by the V1P Scotland ethos of accessibility, credibility and co-ordination and signed a Memorandum of Understanding with V1P Scotland to clearly set out key roles and responsibilities.

3.16 The 2018 evaluation of V1P Scotland's eight centres reported positive clinical outcomes for those receiving psychological intervention across a range of measures including the Patient Health Questionnaire 9, the CORE 10 and the Work and Social Adjustment Scale (Irvine Fitzpatrick et al., 2018). Following the initial period funded by Libor funding, funding for V1P Centres relied on a combination of Scottish Government, NHS Health board and health and social care partnership funding. The V1P Grampian and V1P Highland centres unfortunately were unable to obtain the funding required to continue operating and closed in 2017. Whilst this was a disappointment to V1P Scotland staff and service users, the expansion of V1P Scotland was initially planned to involve the set up three regional centres and there continues to be six V1P centres in operation.

3.17 The Scottish Veterans Commissioner (2018) has recognised the importance of specialist services such as V1P Scotland and the impact that insecure funding arrangements can have on V1P Scotland as a specialist service. His recommendations have led to the set-up of a National Managed Care Network for veteran health services.

3.18 The majority of key recommendations resulting from the 2018 evaluation of V1P Scotland have been implemented. These included:

- Sustaining and further developing close relationships with military charities and partner organisations
- Providing in-reach to the Armed Forces to promote engagement with Early Service Leavers
- Continuing to use reliable clinical measures to monitor treatment outcomes and contribute to the evidence base through research
- Establishing a robust training and supervision programme to train clinicians in A-rated psychological interventions and Peer Support Workers in IPC
- Liaising with local health services to support veterans with additional health needs (i.e. pain and mobility, sleep)

3.19 Implementation of several recommendations from the 2018 evaluation are still in progress. These include:

- Introducing additional clinical measures (i.e. measures relating to trauma or alcohol misuse), including information relating to presenting problems or diagnosis within the evaluation dataset to capture the complexity of needs that veterans present with, and
- Building and testing a measure of citizenship for veterans in partnership with the University of Strathclyde to further understanding of alleviating the difficulties that veterans may experience in transitioning to civilian life.

4. Methodology

4.1 The previous 2018 evaluation of V1P Scotland reported on the demographics of veterans engaged with V1P and the outcomes regarding those who engage with psychological therapy across the PHQ-9, Core 10 and Work and Social Adjustment Scale measures (Irvine Fitzpatrick et al., 2018). It also made a series of recommendations based on its findings that will be addressed within this report The results of this evaluation are interpreted and discussed in the context of V1P Scotland's aim to meet the needs of veterans through provision of an accessible, co-ordinated and credible service. Previous evaluation results and recommendations are also addressed (Irvine Fitzpatrick, et al., 2018).

4.2 Design

The evaluation adopted a quantitative design; analysing data gathered routinely during contact with veterans engaged with the V1P Scotland service (see Figure 2).

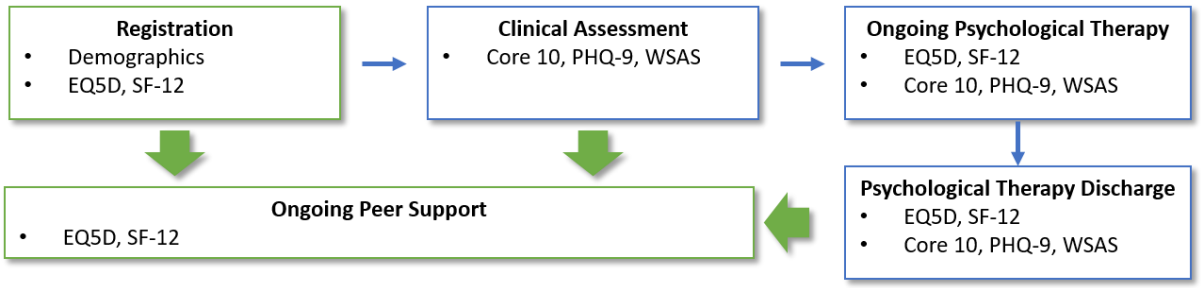


Figure 2
Data routinely gathered during contact with veterans accessing Peer Support (green), and where appropriate Clinical Support (blue).

4.3 Data Sources

4.3.1 Registration Form

Characteristics of veterans engaged with V1P Scotland are collected through completion of a standardised form at registration by Peer Support Workers. Demographic details, referral method and details of service are included in this form.

4.3.2 General Health Measures

SF-12 - The Optum SF-12 Health Survey is a twelve item measure of general health status, adapted from the SF-36 Health Survey. It is used to measure functional health and well-being from the perspective of the service user, across 8 health concepts – physical functioning, role-physical, role-emotional, mental health, bodily pain, general health, vitality and social functioning (Ware, Kosinski & Keller, 1996). The SF-12 is completed by veterans at their initial registration appointment, at follow-up Peer Support appointments, and at ongoing or final Psychological Therapy appointments.

EQ-5D-5L - The EQ-5D-5L is a standardised 5 item instrument measuring health outcomes across 5 dimensions – mobility, self-care, usual activities, pain / discomfort, and anxiety / depression (EuroQol Research Foundation, 2019). The EQ-5D-5L also includes a Visual Analogue Scale item which measures self-rated current overall health. The EQ-5D-5Lis completed by veterans at their initial registration appointment, at follow-up Peer Support appointments, and at ongoing or final Psychological Therapy appointments.

4.3.3 Mental Health Measures

Work and Social Adjustment Scale (WSAS) - The Work and Social Adjustment Scale (WSAS) is a 5item self-report measure of perceived functional impairment due to health problems (Mundt, Marks, Shear & Greist, 2002). Veterans are asked to rate their level of impairment across five items from 0 (not at all) to 8 (very severely), resulting in a total score ranging from 0 to 40 whereby higher scores indicate more perceived impairment. Total scores above twenty indicate moderately severe psychopathology, total scores of 10 to twenty indicate significant functional impairment but less severe clinical symptomatology, and scores below 10 are associated with subclinical populations (Mundt et al., 2002). Total scores were prorated from non-missing items when one item was missing, and cases where more than one item was missing were excluded from analysis (NHS, n.d.). The WSAS is completed by veterans at Clinical Assessment and at ongoing or final Psychological Therapy appointments.

Patient Health Questionnaire 9 (PHQ-9) - The Patient Health Questionnaire 9 (PHQ-9) is a brief9 item measure of depression severity. It is the depression module of the Patient Health Questionnaire, a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders (Kroenke, Spitzer & Williams, 2001). The PHQ-9 items represent the DSM-IV criteria for depression, and symptoms are scored from0 (not at all) to 3 (nearly every day) with total scores ranging from 0 to 27. PHQ-9 scores of 5, 10, 15 and 20 represent mild, moderate, moderately severe and severe depression respectively (Kroenke et al., 2001). A five point decline in total score represents a clinically significant improvement (Kroenke, Spitzer, Williams & Lowe, 2010). In line with guidance, single imputation was used in cases with one missing item and cases with more than one missing item were excluded from analysis (Kroenke et al., 2010). The PHQ-9 is completed by veterans at Clinical Assessment and at ongoing or final Psychological Therapy appointments.

CORE-10 - The CORE-10 is a 10 item self-report assessment of global distress, adapted from the 34 item CORE-OM. Items relating to commonly experienced symptoms of anxiety and depression are rated from 0 (not at all) to 4 (most or all of the time), with total scores ranging from 0 to 40. Total scores above 25 indicate severe distress, scores from 20 to 24 indicate moderately severe distress, scores from 15 to 19 indicate moderate distress, scores from 11 to 14 indicate mild distress and total scores below 10 are considered non-clinical (Connell & Barkham, 2007). In accordance with user manual guidance, single imputation (replacing missing value with average) was used for cases with one missing item, and cases with more than one missing item were excluded from analysis. The CORE-10 is completed by veterans at Clinical Assessment and at ongoing or final Psychological Therapy appointments.

4.4 Procedure

4.4.1 Data Collection

NHs Lothian and Queen Margaret University's Transformation Station conducted the initial evaluation (published 2018), commissioned by V1P Scotland. This evaluation builds upon the 2018 evaluation, with additional data collected and inputted to the database. National Caldicott Guardian approval and local NHS Research and Development approval was granted. Data gathering forms were distributed prior to the initial evaluation for routine use. The study population comprises service users of V1P centres – the overwhelming majority of V1P centres only provide services to veterans, however as some services provide or historically provided services to veterans' family members there are a small proportion of non-veteran family members included in the database.

4.4.2 For the initial 2018 evaluation, Transformation Station staff inputted anonymised data into the electronic database for analysis, with a double data entry protocol for 10% of data followed and reviewed for quality assurance. Data relating to 692 V1P service users were included and analysed in the 2018 evaluation. Additional data inputted to the electronic database for the current report was collected, anonymised and inputted by an Assistant Psychologist (see Table 1 for data breakdown). Data relating to 2,065 veterans engaged with V1P Scotland we reanalysed for the current evaluation report.

Table 1 *Breakdown of data included in database for analysis.*

V1P Centre	Data Included in 2018 Report		New Data Added to Dataset		Total Included for Analysis
	Count	Data Period	Count	Data Period	
Lothian	161	01.02.16 to30.06.17	365	01.07.17 to 21.03.20	522
Tayside	91	01.09.15 to 31.10.17*	115	01.11.17to 21.03.20	206
Fife	101	01.02.16to31.08.17*	227	01.09.17 to21.03.20	328
Borders	58	01.02.16to31.07.17*	86	01.08.17 to21.03.20*	145
Lanarkshire	80	01.09.16 to30.06.17*	83	01.07/17 to21.03.20	164
Ayrshire & Arran	90	01.02.17 to31.07.17*	500	01.08.17 to21.03.200*	590
Grampian	25	01.11.16 to 31.07.17*	NA		25
Highland	86	02.06.16 to 31.07.17*	NA		85
TOTAL					**2,065**

Notes:
Data Period refers to period in which data was initially collected (i.e. appointment dates).
* Does not represent all those registered with the service in this period

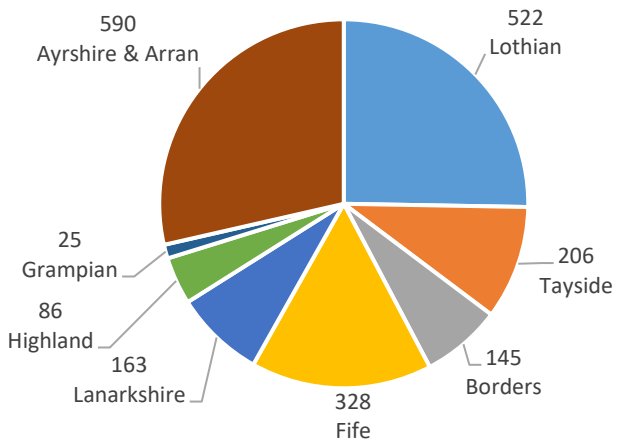
4.4.3 Statistical analyses were conducted using the IBM SPSS Statistics 23 statistical software and the Microsoft Office Excel and PowerPoint packages were used for creation of charts and figures.

Descriptive statistics were used to ascertain veteran characteristics, and inferential statistics were used to compare pre- and post- treatment measures. Parametric assumptions were examined before conducting inferential statistics and non-parametric tests were used where parametric assumptions were not met.

5. Results

5.1 Data relating to **2,065** V1P Scotland service users was collected and analysed for this evaluation (see Figure 3 for centre breakdown).

Figure 3
Breakdown of data included in database by V1P Centre (n = 2065)



5.2 Referral Pathways

5.2.1 Self-referral was the most popular referral method to V1P Scotland, with 41% of veterans referring themselves to the service. Referral from NHS primary or secondary care (i.e. via GP or health services) was the second most popular referral method, with 24% referred in this way. Referral via forces charities (16% of referrals) and family or friends (8% of referrals) were also common methods (Appendix A1).

5.2.2 Self referrals - For those who self-referred to V1P Scotland (Appendix A2) , the most common way of finding out about the V1P Scotland service was through publicity including the V1P Scotland website (48%), NHS primary or secondary care (12%), family or friends (8%) and forces charities (7%).

5.3 Veteran Characteristics

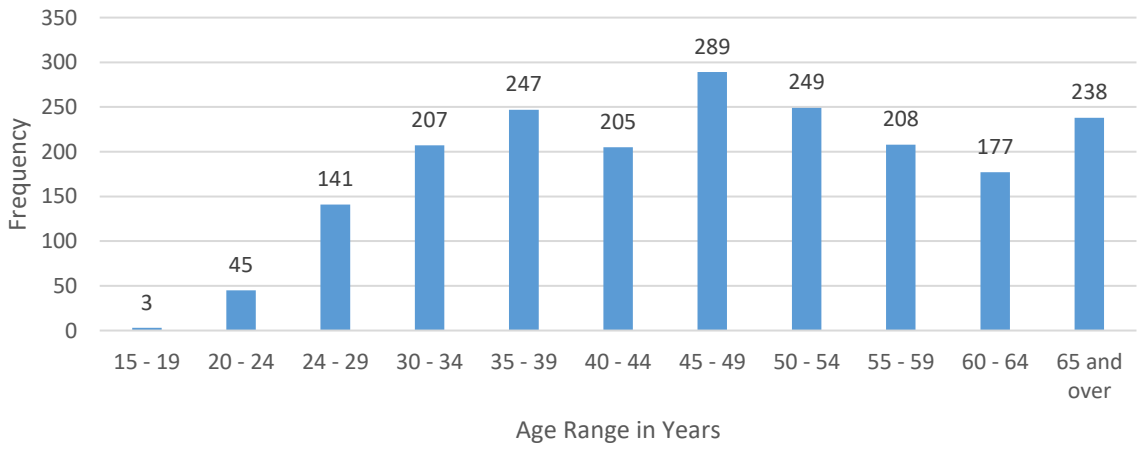
5.3.1 Gender and Ethnicity

The majority of veterans engaged with V1P Scotland were male and white. Men represent 91% of those accessing V1P services. Regarding ethnicity, 92% of veterans engaged with V1P identify as White Scottish, British or Irish, and the remaining 3% of those who listed an ethnicity reported a range of ethnicities including Pakistani, African, Caribbean, mixed ethnicities or other ethnic groups (Appendix A3).

5.3.2 Age

V1P Scotland continues to offer services to those in their late teens to older adults (Figure 4) – unlike mainstream adult mental health teams there is no upper age limit. Over a quarter (27%) of veterans registered with the service are aged between 45 and 55 years, and the majority of veterans (60%) are aged between 30 and 55 years.

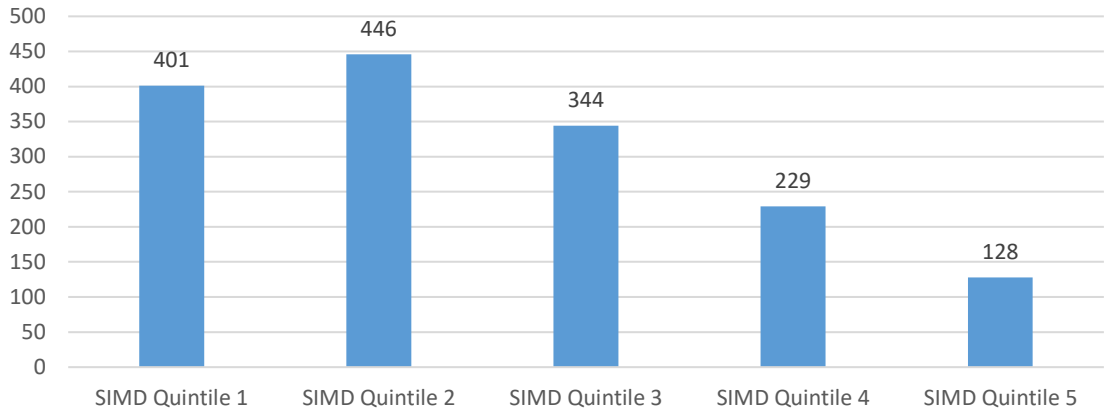
Figure 4.
Age of veterans engaged with V1P Scotland (n = 2,009)



5.3.3 Housing and Living Arrangements

A high proportion of veterans registered with V1P Scotland live in Scotland's most deprived areas (see Figure 5), as measured by the Scottish Index of Multiple Deprivation (SIMD). Over one quarter (26%) of V1P Scotland veterans live in locations within the most deprived SIMD quintile (SIMD Quintile 1), with only 8% of V1P Scotland veterans living in locations within the quintile of least deprivation (SIMD Quintile 5).

Figure 5.
SIMD quintiles of Veterans address (n = 1548)



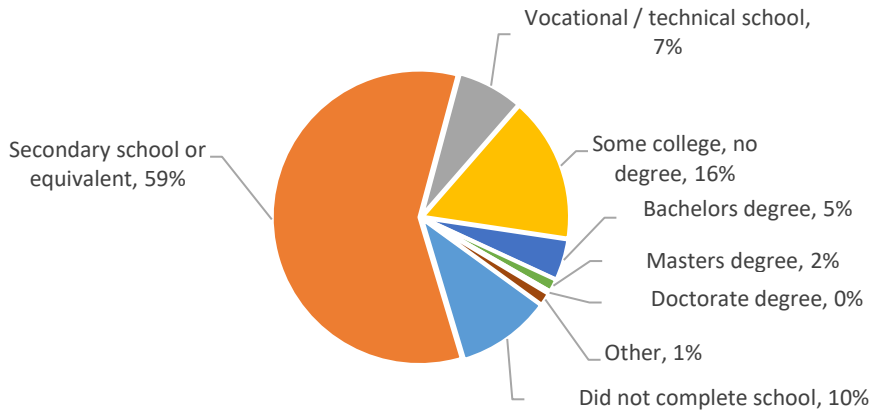
Almost half (49%) of veterans engaged with V1P are married, in a civil partnership or cohabiting, 31% of veterans are single, 18% are separated or divorced, and 2% are widowed (Appendix A4). Over three quarters (77%) of veterans report having children at registration. Just under half of veterans (49%) reported living with a partner or a partner and children whilst31% of veterans reported living alone (Appendix A5).

Homelessness is a particular concern for veterans engaged with the service, with 35% of veterans reporting a history of homelessness (Appendix A6). Whist the majority of veterans reported living in council or housing association (35%), privately owned (33%) or private let (17%) accommodation, reported rates of homelessness were higher than those of Scotland's general population (Appendix A7). In V1P Scotland, 6% of veterans reported living in homeless accommodation and 1% of veterans described their living situation as roofless. Veterans' reported homelessness is high in comparison to figures from Scotland's general population, whereby approximately 1.2% of Scotland's households experienced homelessness in 2017 (Scottish Government, 2018; Shelter Scotland, n.d.). Instability of housing arrangement, which can be considered a risk factor for homelessness, was reported by 14% of veterans.

5.3.4 Employment and Education.

The majority of veterans (59%) engaged with V1P Scotland attained secondary school or equivalent level of education, one third went on to attain some form of further education, whilst 10% did not complete school (Figure 6).

Figure 6.
Educational attainment (n = 1,770)



The overwhelming majority (92%) of veterans report having worked in non-military employment (Appendix A8). However only 36% of veterans are currently in full- or part-time employment, with 29% of veterans unemployed and 20% of veterans signed off sick (Appendix A9).

Almost half (48%) of veterans were currently seeking employment at registration, with 6% seeking education or training, 4% seeking voluntary work, and 42% having no current employment or educational goal (Appendix A10).

5.3.5 **Benefits and Service Pensions**

At time of registration with V1P Scotland, 60% of veterans reported they were in receipt of some form of state welfare benefit (Appendix A11). The mean number of benefits claimed by those in receipt of welfare support was 1 (SD=1), with a range between 1 and 9 claimed.

At registration, 62% of veterans reported not claiming any form of service pension (Appendix A12). There were a variety of reasons behind this - 21% had not applied for a service pension, 4% had an application in progress, 34% were not entitled as yet, and 4% were not entitled to a service pension. At registration 21% of veterans were in receipt of a Service pension, 20% a War pension, 9% a Medical pension and 2% claiming Armed Forces Compensation.

5.3.6 Service Background

Veterans registered with V1P Scotland represent tri-services. The majority of V1P Scotland's caseload served in the Army (81%), with smaller proportions serving in the Royal Navy (8%), the Royal Air Force (8%), the Royal Marines (2%) and the Merchant Navy during defined operations (0.3%) (Appendix A13). Veterans of foreign military forces constitute 0.2% of veterans accessing V1P Scotland, and 1% of the V1P Scotland caseload are veteran family members who did not serve.

Veterans engaged with V1P Scotland predominantly served in Regular forces (86%), with 6% having served in Regular and Reserve forces and 5% serving in the Reserve forces (Appendix A14).

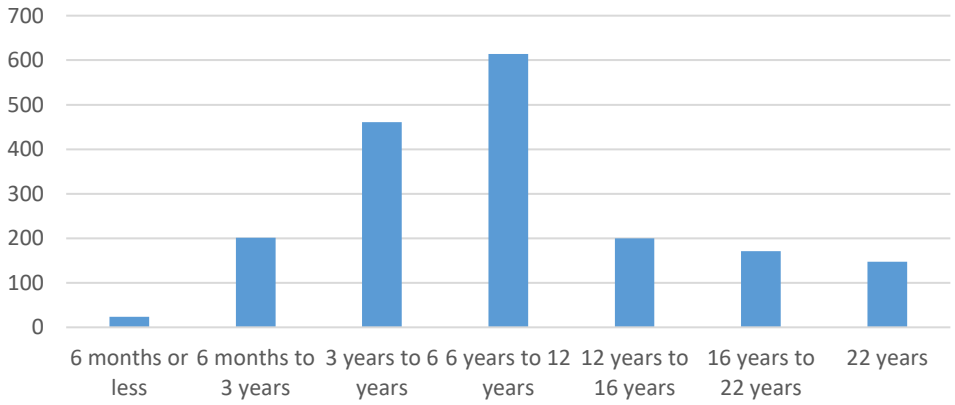
The time served by V1P Scotland veterans' ranges from under 6 months to over 22 years served (Figure 7).

Early Service Leavers, who leave the armed forces prior to completing their minimum term of contract, make up 12% (n=225) of the V1P caseload. This is of note due to findings that Early Service Leavers are at an increased risk of experiencing adverse mental health outcomes once they have left the military (Buckman et al., 2012).

Minimum lengths of contract are at least 4 years, however prior to 1999 the army minimum length of service was 3 years –for purpose of this evaluation a conservative Early Service Leaver definition as someone serving up to 3 years was adopted (ForcesWatch Briefing, 2011).

Figure 7.

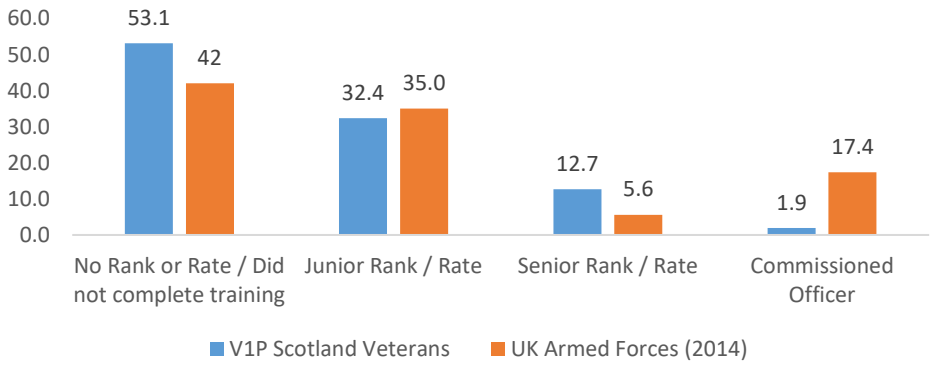
Length of service (n = 1818)



The majority (53%) of veterans engaged with V1P Scotland were discharged whilst serving at no rank / rate (equivalent to rank of Private) or prior to finishing basic training. There are proportionally more veterans from junior ranks accessing support at V1P Scotland as compared to the general military population (see Figure 8).

Figure 8.

Proportion (%) of ranks in V1P veteran sample compared to UK Armed Forces population.



The most common method of discharge from the military among V1P Scotland veterans is elected discharge or end of engagement (36%), followed by administrative or 'service no longer required' discharges (34%), medical discharges (21%) (see Appendix A15). Smaller proportions of those engaged with V1P reported their method of discharge as redundancy (5%), being classed temperamentally unsuited (1%) or other reasons (4%). Time between discharge and registration with V1P Scotland ranged from less than a year to 72 years, with a mean time of 17.4 years (SD=13.6).

A large majority (98%) of veterans reported being deployed during their service, and the mean number of deployments outside of Great Britain was 3 (*SD*=2.6).

5.4 Health of Veterans

5.4.1 Health Status

Veterans engaged with V1P Scotland provided a mean rating of 53 (*SD*=23.98) out of 100 for their average health on day of registration, where 100 represents the best health imaginable and 0 represents worst health imaginable. This is lower than the mean UK population norm health rating of 82.48 (SD=16.96) (Kind, Hardman & Macran, 1993).

A follow up rating of average health was obtained at subsequent peer support or clinical appointments for 289 veterans, and there was a statistically significant improvement in health rating between scores at registration (*M*=49, *SD*=22.13) and follow up (*M*=57.1, *SD*=24.03) for this group, $t(288) = -5.23$, $p = .000$. However, it should be noted that this outcome score is still lower than the mean UK population norm.

The majority of veterans reported their general health as being poor (29%) or fair (32%), with 25% reporting it as good, 11% as very good and 4% as excellent (Appendix B1).

5.4.2 Pain and Mobility

At registration, the majority of veterans (68%) reported feeling some degree of pain or discomfort – 18% to a slight degree, 24% moderately, 18% severely and 9% experiencing extreme pain (Appendix B2). While 35% of veterans reported that pain did not interfere with their normal work (including that outside the home and with housework), 65% reported pain interfering with work and for 17% it interfered extremely (Appendix B3).

Just under half of veterans (49%) reported having no problems in mobility (walking about) at registration, with over one third of veterans reporting moderate to extreme problems (Appendix B4). Similarly, just over half of veterans reported that their health did limited them in climbing several sets of stairs, with 28% reporting they were limited a lot (Appendix B5).

5.4.3 Mental Health

When asked about their experience of anxiety and depression at registration, just 10% of veterans reported **not** feeling anxious or depressed (Appendix B6).

The majority of veterans reported that they were experiencing moderate to extreme difficulties with their mood – 30% reporting they were moderately anxious or depressed, 27% severely and 20% extremely.

Most veterans reported feeling downhearted and blue all of the time, most of the time or a good bit of the time over the past four weeks, with 20% of veterans feeling this way all of the time (Appendix B7). When asked how much of the time during the past 4 weeks were spent feeling calm and peaceful, more than half of veterans reported feeling this way none of the time or a little of the time (Appendix B8). Similarly, the majority of veterans reported rarely or never having a lot of energy over the past 4 weeks (Appendix B9).

5.5.4 Impact of Health on Daily Activities

Just over half of veterans reported that their health limited them in partaking in moderate activities (e.g. vacuuming, playing golf) (Appendix B10). When asked how their physical health impacted their functioning over the past month, 57% of veterans reported that they have

accomplished less than they would have liked (Appendix B11) and 55% reported they were limited in the kind of work and activities they did as a result of their physical health problems (Appendix B12).

A greater majority, 79% of veterans, reported that they accomplished less over the past 4 weeks as a result of their emotional problems (Appendix B13). Emotional problems were also found to impact how carefully work or activities were completed over the past month for 71% of veterans (Appendix B14).

The majority (65%) of veterans reported they had no problems in washing or dressing themselves (Appendix B15). However, some veterans reported problems with washing or dressing themselves –14% of veterans to a moderate extent, 6% to a severe extent and 1% reported they are unable to wash or dress themselves.

Two thirds of veterans reported experiencing problems in partaking in their usual activities (Appendix B16). Just over half (54%) of veterans reported that they felt their physical health or emotional problems interfered with social activities all of the time or most of the time over the past 4 weeks, and 14% reported it interfered a good bit of the time (Appendix B17).

5.5 Mental Health Outcomes for V1P Service Users

5.5.1 Mental Health Status at Clinical Assessment

Mean CORE-10 scores at assessment (n=755) were 23.51 (*SD*=7.62), which indicates moderately severe psychological distress (Connell & Barkham, 2007). See Figure 9 for a breakdown of mean CORE-10 item scores at assessment.

Veterans reported a mean score of 24.17 (*SD*=10.43) on the Work and Social Adjustment Scale (WSAS) at assessment (n=647), indicating moderately severe psychopathology (Mundt et al., 2002). Mean scores for WSAS outcomes are detailed in Figure 10.

A mean score of 17.12 (*SD*=6.39) on the Patient Health Questionnaire (PHQ-9) was reported by 716 veterans at assessment. This indicates moderately severe depression (Kroenke et al., 2001). Mean item scores for the PHQ-9 are detailed in Figure 11.

Figure 9

Core 10 item scores at assessment. Scores range from 0 (not at all) to 4 (most or all of the time)

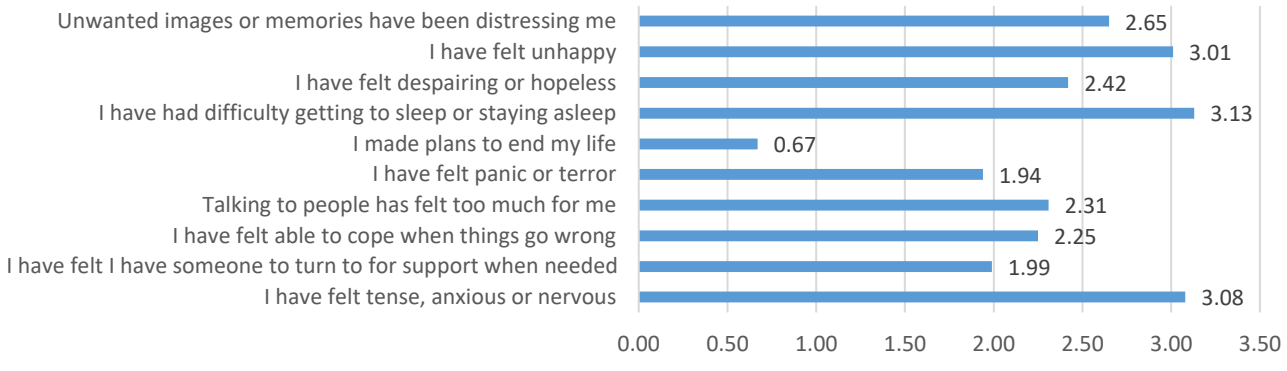


Figure 10.
Work and Social Adjustment item scores at assessment. Scores range from 0 (not at all) to 8 (very severely).

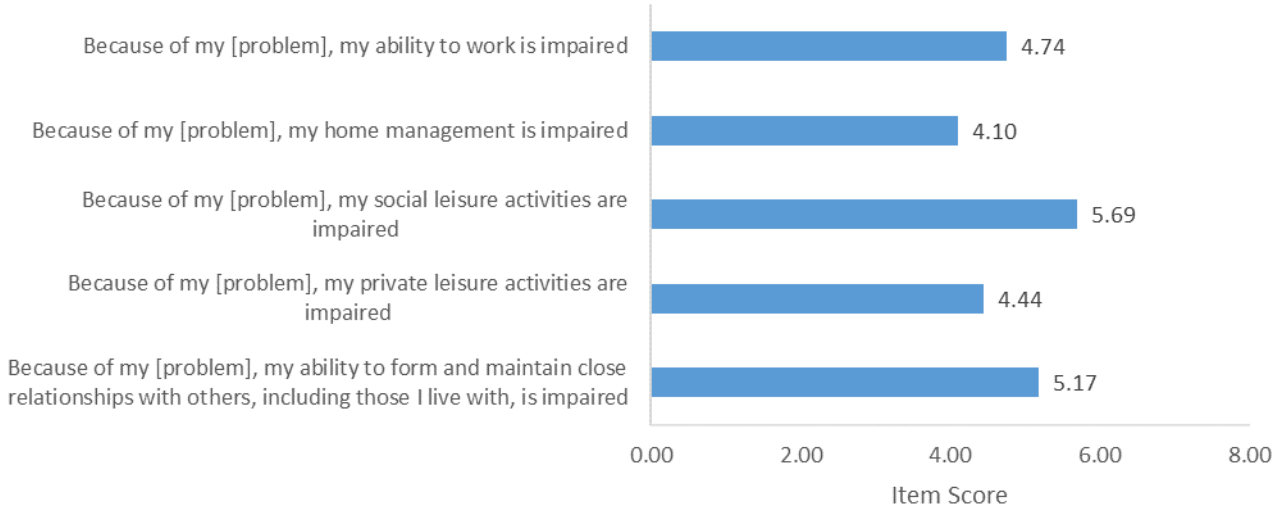
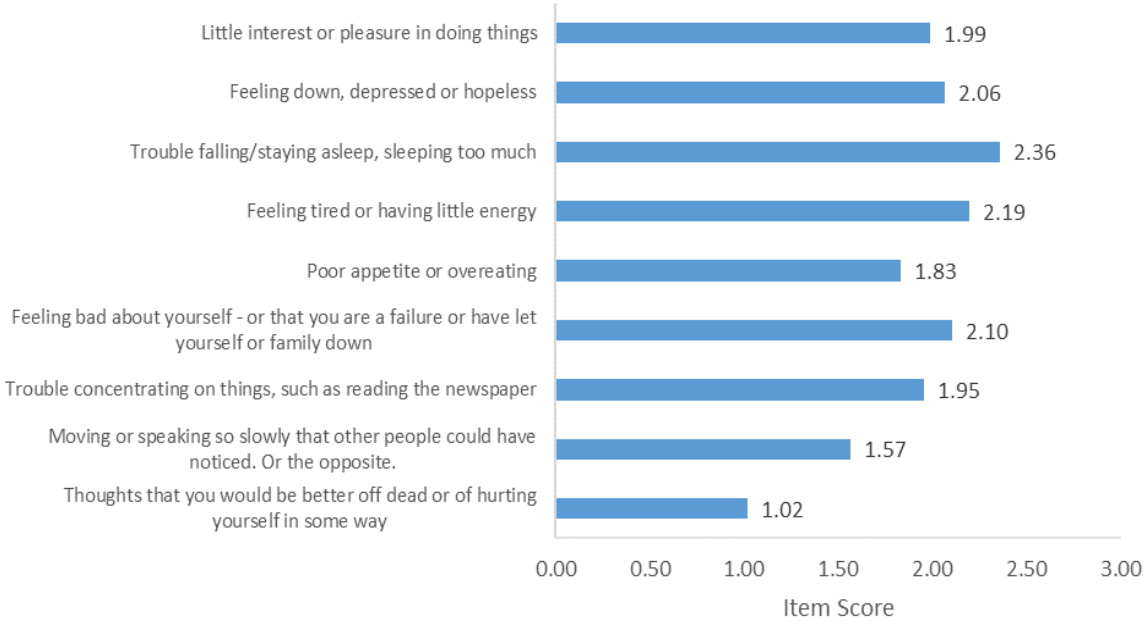


Figure 11.
PHQ-9 item scores at assessment. Scores range from 0 (not at all) to 3 (nearly every day).



5.5.2 Mental Health Outcomes following Psychological Intervention

Outcome measures are sought from veterans who, after assessment, go on to complete a course of psychological therapy in V1P Scotland Centres. For those who have not finished a course of treatment, interim measures are collected and analysed instead.

CORE-10 scores taken at assessment were compared to interim or outcome (Figure 12) scores to investigate whether there was a reduction in psychological distress post treatment.

Median CORE-10 post-test ranks from interim follow up (*Mdn*=25) were found to be significantly lower than median pre-test ranks from assessment (*Mdn*=25), *Z*=-4.480, *p*<.001. However, this difference does not indicate clinically significant improvement as the CORE-10 stipulates that a decrease of 6 points between pre and post measures is required for reliable improvement to be ascertained and the median total interim score remains in the moderately severe distress category.

A statistically significant difference was also found between total CORE-10 assessment and outcome scores, *t*(114) = 12.25, *p*<.001. Mean scores decreased from 22.26 (*SD*=7.63) at assessment to 12.10 (*SD*=8.75) at completion of therapy. This signifies that the12 point decrease in CORE-10 scores from assessment to completion of therapy represent a clinically significant reliable improvement in scores (>6 points), from moderately severe distress to mild distress.

Assessment PHQ-9 scores were compared to interim or outcome scores (Figure 13) to assess whether there was a reduction in depression symptoms post treatment. A statistically significant difference was found between mean total PHQ-9 assessment and interim scores, with a decrease from a mean total score of 18.78 (*SD*=5.74) at assessment to an interim score of 17.15 (*SD*=6.69), *t*(154) = 3.67, *p*<.001. However, this difference in scores is not considered clinically significant, as a five point decrease in scores represents a clinically significant improvement (Kroenke et al., 2010) and the interim score remains in the moderately severe depression category.

A statistically significant difference was also found between assessment total PHQ-9 scores at assessment and outcome scores at completion of therapy, *t*(101) = 11.42, *p*<.001. The decrease in mean total PHQ-9 score from 16.55 (*SD*=5.78) at assessment to 8.76 (*SD*=6.78) at completion of therapy indicates a clinically significant improvement in scores (a difference greater than 5 points) and that depression symptoms have reduced from being moderately severe to mild and considered subclinical.

WSAS scores at assessment were compared to interim and outcome scores (Figure 14) to assess whether there was a reduction in functional impairment post treatment.

A statistically significant difference was found between mean total WSAS assessment and interim scores, *t*(142) = 3.78, *p*<.001. However, this represented a decrease in mean total scores from 26.47 (*SD*=9.46) to 23.93 (*SD*=10.57), which is still associated with moderately severe psychopathology and functional impairment (scores greater than 20).

A statistically significant difference was also found between total WSAS scores at assessment and at completion of therapy, *t(*94) = 9.87, *p*<.001, representing a reduction from a mean score of 24.15 (*SD*=10.01) to 14.18 (*SD*=10.63). This indicates a clinically significant reduction in functional impairment, reducing from a score representing moderately severe

psychopathology to a score still associated with significant functional impairment but with less severe clinical symptomatology (scores below 10 are considered subclinical).

Figure 12.

Comparison of assessment, interim and outcome mean CORE-10 item scores. Scores range from 0 (not at all) to 4 (all or most of the time)

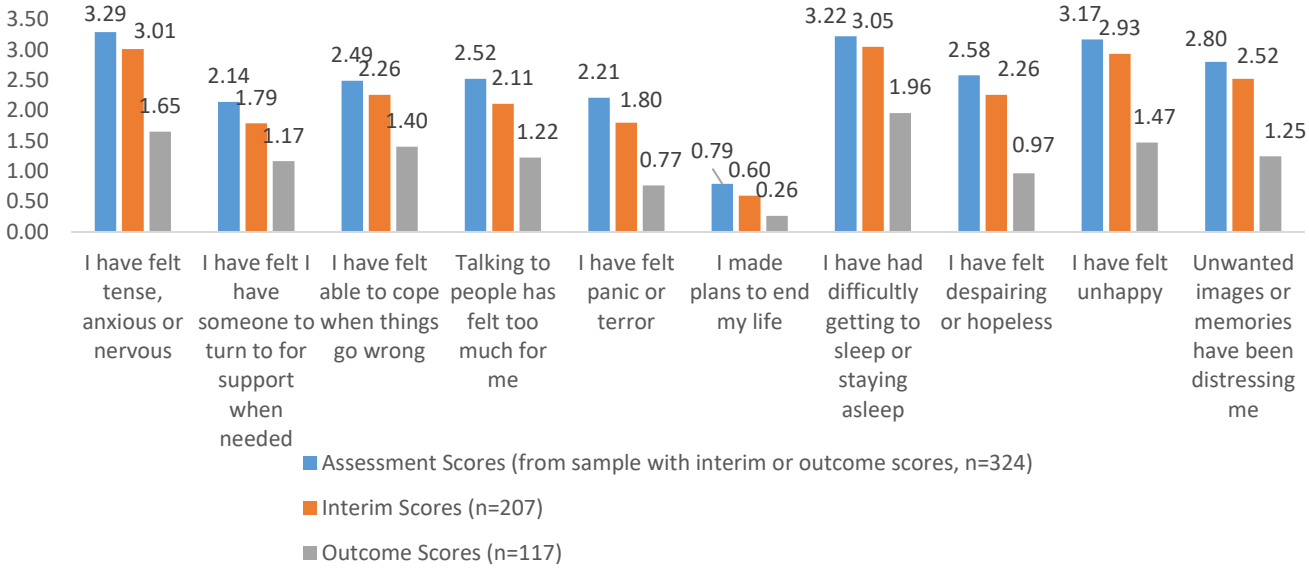


Figure 13.

Comparison of mean assesment, interim and outcome PHQ-9 item scores. Scores range from 0 (not at all) to 3 (nearly every day).

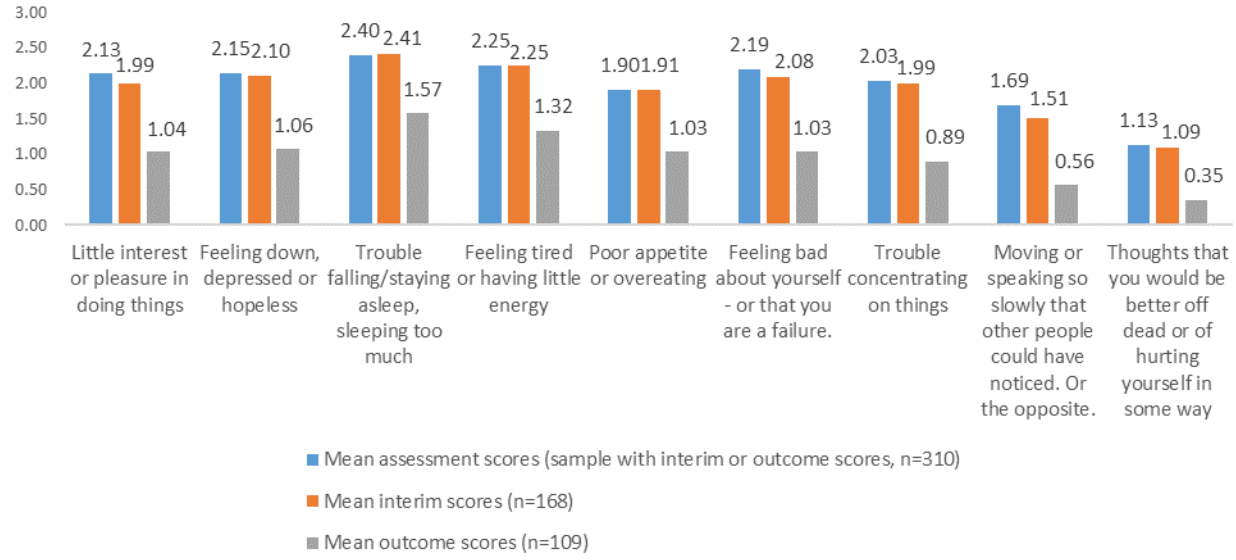
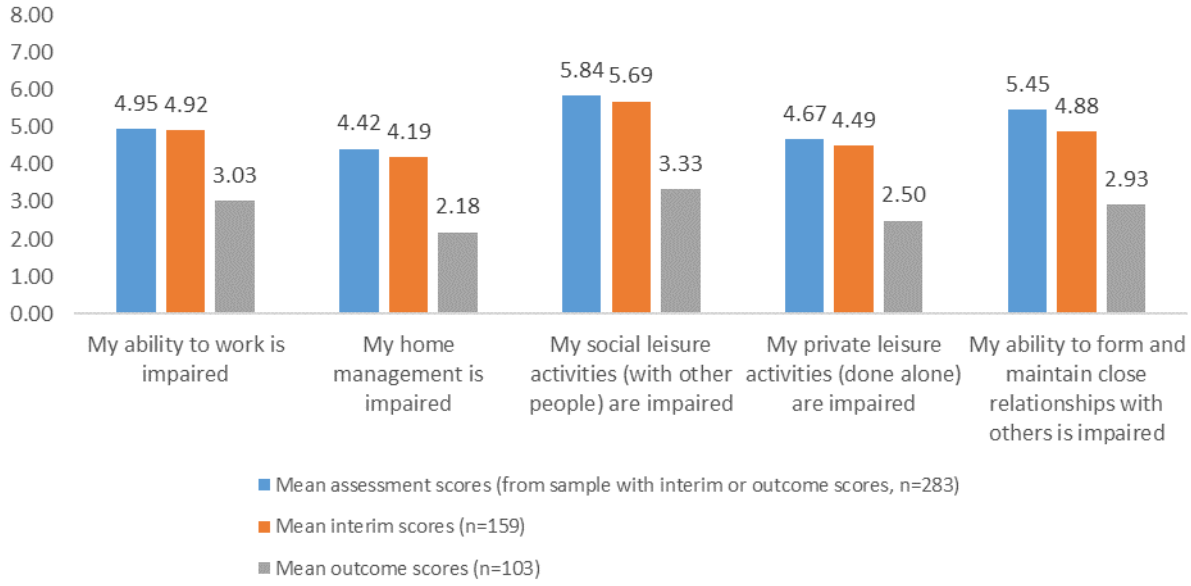


Figure 14.
Comparison of assessment, interim and outcome mean WSAS item scores. Scores range from 0 (not at all) to 8 (very severely).



5.6 Early Service Leavers

5.6.1 Research indicates that early Service leavers (ESLs) who leave the military prior to serving their minimum term, conservatively defined for purposes of evaluation as those who have served up to 3 years, are at increased risk of experiencing disadvantage and adverse mental health outcomes (Buckman et al., 2012). ESLs make up 9% (n=184) of V1P Scotland's caseload.

5.6.2 The age range of V1P Scotland ESLs range from 20 to over 65 years, however a slightly greater proportion are aged under 35 years of age as compared to non-ESLs (see Appendix C1). ESLs are more likely to be female (13% of ESLs) compared to non-ESLs (6% of non-ESLs), and a greater proportion (45%) of ESLs are single compared to 28% of non-ESLs – these findings are consistent with research literature concerning ESLs (Buckman et al., 2012).

5.6.3 ESLs are more likely to live in Scotland's most deprived areas (SIMD Quintile 1) as compared to non-ESLs – 33% of ESLs as compared to 22% of non-ESLs (Appendix C2). There were slight differences between groups regarding current living situation – a slightly larger proportion of ESLs reported being homeless at time of registration as compared to non-ESLs (Appendix C3). The overwhelming majority of ESLs (84%) reported that their living situation was stable, as did 84% of non-ESLs. Over half (55%) of ESLs listed a history of homelessness (Appendix C4), compared to one third of non-ESLs.

5.6.4 Discrepancies were found between ESLs and non-ESLs regarding employment status – just 23% of ESLs are in full or part time employment as compared to 38% of non-ESLs (Appendix C5). Of particular concern, a greater proportion of ESLs are unemployed or signed off sick from work. ESLs were also more likely to be in receipt of at least 1 state welfare benefit – 73% of ESLs in comparison to 51% of non-ESLs.

5.6.5 Both ESLs and non-ESLs represent tri-services with the majority of both groups serving in the Army – 84% of ESLs and 81% of non-ESLs (Appendix C6). A greater proportion of ESLs served only in Reserve Forces (11%) as compared to 4% of non-ESLs (Appendix C7). Regarding

discharge from the Armed Forces, it was more common for ESLs to be discharged for Administrative or Service No Longer Required reasons (39% of ESLs vs. 27% of non-ESLs) or Temperamentally Unsuited (3% of ESLs vs. 0.5% of non-ESLs). Non-ESLs reported higher rates of elected discharge (41% of non-ESLs vs. 22% of ESLs) and redundancy, and medical discharge rates were similar between groups (Appendix C8).

5.6.6. Mean scores on clinical measures – the PHQ-9, CORE-10 and WSAS – were slightly higher for ESLs compared to non-ESLs at assessment, indicating increased levels of depression symptoms, psychological distress and functional impairment. At follow up (clinical interim or outcome), non-ESLs tended to have slightly lower mean scores across the measures (indicating lower levels of psychological distress and functional impairment) and greater improvements in scores (with exception of the CORE-10, see Table 2).

Table 2

Mean clinical scores and improvement in scores of Early Service Leavers and Non-Early Service Leavers at clinical assessment and follow up (clinical interim or outcome scores).

Measure	Score at Clinical Assessment		Score at Follow Up		Improvement in Scores	
	ESL(n=68)	Non-ESL(n=619)	ESL(n=27)	Non-ESL(n=288)	ESL	Non-ESL
PHQ-9	17.24 (6.12)	17.04 (6.44)	13.85 (6.94)	13.77 (7.87)	-3.72 (6.6)	**-4.07*** (6.82)
WSAS	25.08 (10.37)	24.08 (10.47)	23.26 (11.27)	20.59 (12.07)	-4.45 (8.05)	**-5.51*** (9.73)
CORE-10	24.07 (8.38)	23.41 (7.57)	19.63 (9.65)	18.84 (10.29)	**-5.54*** (8.01)	-5.34 (8.93)

Note. Values are Mean (SD). Negative values for Improvement in Scores represent a decrease in scores between clinical assessment and follow up – greater decreases represent a greater improvement in scores across measures.
* Mean improvement scores marked with an asterix indicate the greater improvement in scores.

6. Discussion

The results of this evaluation are discussed in relation to V1P Scotland's ethos of delivering an accessible, co-ordinated and credible service for veterans. Findings are also discussed with reference to the results and recommendations of the previous 2018 V1P Scotland evaluation.

6.1 Accessibility

V1P Scotland aims to deliver an accessible service. This is a particularly important consideration for mental health services engaging with veterans, as research indicates that perceived stigma and barriers to care amongst veterans with mental health problems negatively impact help-seeking and engagement with services (Iverson et al., 2011). Accessibility is evaluated through exploration of V1P Scotland's engagement with veterans.

6.1.1 Veterans engaged with V1P Scotland are overwhelmingly male (91% of veterans) and white Scottish; British or Irish (92% of veterans). The sample of veterans engaged with V1P Scotland is therefore slightly more male dominated than serving personnel, where 89.5% of UK Regular Forces are male.

6.1.2 There is a larger proportion of Black, Asian and Minority Ethnic (BAME) representation within serving UK Regular Forces (Ministry of Defence, 2018). These differences in diversity between serving personnel and veterans registered with V1P Scotland can be understood to represent a time lag between the increasing diversity of the military and veterans' discharge from the military.

6.1.3 Veterans accessing support at V1P Scotland represent a wide age range, from under 20 years of age to over 65 years of age. V1P Scotland continues to offer services to those in their late teens to older adults, and unlike many mainstream mental health teams there is no upper age limit. This inclusivity regarding age range of service users is particularly important in providing an accessible service to veterans, as the demographics of Scotland's veterans are increasingly made up of older adults (Ashworth et al., 2014).

6.1.4 The high rates of self-referral (37% of referrals) to V1P Scotland suggests it is perceived as an accessible service by veterans.

6.1.5 V1P Scotland works with veterans who represent tri-services, with the majority of veterans (81%) serving in the Army. Junior ranks or rates were over-represented in the V1P Scotland caseload, with the majority of veterans engaged with the service of junior rank or rate at discharge. There were proportionally less Commissioned Officers registered with V1P Scotland comprising 2% of the V1P caseload, as compared to those serving in the armed forces which comprises 17.4% of those serving. (Ministry of Defence, 2014).

6.1.6 The success of V1P Scotland at engaging with veterans of lower ranks or rates is an important finding, as veterans of lower rank are at increased risk of experiencing adversity and adverse mental health outcomes (Iverson et al., 2005a). The under-representation of Commissioned Officers within V1P Scotland may reflect the finding that lower rank is associated with increased needs regarding mental health among veterans (Iverson et al., 2005a). However, it could also suggest that distinct barriers to care exist for more senior veterans when engaging with mental health services and these should be considered when considering accessibility of the service.

6.1.7 A high proportion of veterans engaged with V1P Scotland live in Scotland's most deprived areas, with 26% of veterans living in the most deprived Scottish Index of Multiple Deprivation (SIMD) quintile and just 8% living in the least deprived SIMD quintile. Disadvantage regarding housing and financial stability is also a concern for those engaged with the service.

6.1.8 Reported homelessness is high in comparison to Scottish population figures, with 7% of veterans reporting being roofless or living in homeless accommodation at registration as compared to approximately 1.2% of Scotland's households experiencing homelessness in 2017 (Scottish Government, 2018; Shelter Scotland).

6.1.9 Only a minority of veterans are in full or part time employment at registration with the service, with 28% of veterans unemployed and 22% of veterans signed off sick from work. The unemployment rate of veterans engaged with V1P Scotland is considerably higher than the Scottish average figures of 3.6% (Scottish Government, 2019). The high proportion of veterans signed off sick from work is concerning, and overall self-reported health ratings from veterans engaged with the service were lower than the mean UK population norm.

6.1.10 Veterans engaged with V1P Scotland reported a mean health score of 53 out of 100 (where 100 represents best health imaginable) compared to the mean UK population norm of 82.48 out of 100 (Kind et al., 1993). The majority (65%) of veterans reported that pain interfered with work and for 17% it interfered to an extreme extent.

6.1.11 These findings highlight the complexities of how health, functional impairment and disadvantage can be intertwined. By engaging with veterans with a complex presentation of

welfare and health needs, V1P Scotland is successfully delivering an accessible service to those who may be most at risk of disadvantage.

6.2 Co-ordination

6.2.1 One of the key aims of V1P Scotland is to deliver a co-ordinated service. In a landscape where there are a large amount of services and organisations supporting veterans in Scotland, co-ordination with partner agencies is key. Providing a co-ordinated service allows V1P Scotland to work efficiently to deliver early intervention by identifying at discharge those who may be at risk, to receive referrals from the wide range of veteran organisations in Scotland, and to signpost veterans to welfare supports offered by partner organisations.

6.2.2 A further strength is as an NHS Scotland service, V1P works closely with mainstream NHS services and General Practitioners to provide a holistic service to veterans and ensure continuity of care. Co-ordination is evaluated through exploration of referral pathways to V1P Scotland and engagement across tri-services.

6.2.3 After self-referral, the most popular referral methods to V1P Scotland were from NHS primary or secondary care services (27% of referrals) or from Armed Forces charities (16% of referrals). This suggests that there are high levels of awareness of V1P Scotland as a service amongst other NHS services and partner organisations, and that V1P Scotland has a proven track record of providing a high quality service to veterans. Whilst a lower proportion of referrals came through the military (2% of referrals), this can partly be explained by the time lag between veterans being discharged from the military and setup of V1P Scotland.

6.2.3 Early Service Leavers (ESLs) comprise 12% of V1P Scotland's caseload, which indicates that V1P Scotland's efforts to provide in-reach to the Armed Forces to engage those most at risk are proving a success. The representation of tri-services across the V1P Scotland caseload also indicates V1P Scotland is effectively engaging with veterans across service branches.

6.2.4 These results suggest that V1P Scotland is successfully implementing the key recommendations from the previous V1P Scotland evaluation to sustain and build strong relationships with military charities, organisations and agencies working with veterans and continuing to provide in reach to the Armed Forces with a particular focus on ESLs.

6.3 Credibility

6.3.1 A key aim of V1P Scotland is to deliver a credible service to veterans. Credibility is of particular importance for engaging veterans with mental health services, as research findings suggest that UK veterans can feel alienated from civilian mental health services and therefore they may not be acceptable to a population used to viewing itself as robust (Brewin, et al., 2011; Murrison, 2010).

6.3.2 Following recommendations from the previous evaluation of V1P Scotland, the service has continued using reliable measures to further the evidence base relating to veterans social and health need.

6.3.4 A robust training and supervision programme to train V1P therapists in evidence based psychological therapies and V1P Peer Support Workers in Interpersonal Counselling (IPC) has been established. The expertise of V1P Scotland Peer Support Workers and clinicians in delivering evidence based interventions and understanding the veteran population as a group

contributes to V1P Scotland's credibility as a service. Credibility of the service is therefore evaluated through analysis of mental health treatment outcomes.

6.3.5 Veterans who engage with V1P Scotland experience a range of physical and mental health needs. At registration the majority of veterans report their health as poor or fair, and just 10% of veterans report that they do not feel anxious or depressed (Appendix B6). Similarly, a range of adverse mental health outcomes are reported by veterans at clinical assessment.

6.3.6 Mean CORE-10, WSAS and PHQ-9 scores indicate that veterans experience moderately severe psychological distress, moderately severe psychopathology regarding functional impairment and moderately severe depression at clinical assessment.

6.3.7 Mean total scores across the three measures were slightly higher for Early Service Leavers (indicating slightly higher levels of psychopathology), but this difference was not clinically significant.

6.3.8 Disturbed sleep was a particular issue highlighted at assessment, with CORE-10 and PHQ-9 items referencing sleep issues obtaining the highest scores (indicating greater problems).

6.3.9 Impairment of engaging with social leisure activities and maintaining close relationships were highlighted as particular issues at assessment by the WSAS. Presentation at assessment of V1P Scotland service users is therefore relatively complex and wide-ranging.

6.3.10 To assess mental health outcomes as a result of psychological intervention, assessment scores were compared to interim scores (latest available measures when psychological treatment was not completed) or outcome scores (measures taken on completion of psychological therapy). Whilst statistically significant differences were found between assessment and interim CORE-10, PHQ-9 and WSAS scores, indicating improvements in reported symptoms pertaining to psychological distress, functional impairment and depression, these improvements were not clinically significant and did not indicate a reliable change in scores.

6.3.11 Greater improvements were found between assessment and outcome CORE-10, PHQ-9 and WSAS scores, indicating both statistically and clinically significant improvements in psychological distress, functional impairment and depression after completion of psychological therapy.

6.3.12 Mean outcome scores following psychological therapy indicated mild psychological distress, mild depression and significant functional impairment but with less severe clinical symptomatology.

6.3.13 These findings indicate that mental health outcomes are significantly improved across a range of measures, representing reliable clinical change, following psychological treatment at V1P Scotland.

6.3.14 The finding that interim measures do not represent clinically significant improvements is interesting, and could partly be accounted for by decreased time in treatment and the complex presentation of V1P Scotland service users at assessment. This supports findings from the 2018 evaluation of V1P Scotland that suggested longer time in treatment is associated with improved outcomes for veterans within the service.

6.3.15 These results support V1P Scotland's credibility as a service improving mental health outcomes for veterans.

7. Recommendations and Future Direction

7.1 The results of this evaluation indicate that V1P Scotland is continuing to effectively deliver against its ethos to provide an accessible, co-ordinated and credible service for veterans. The evaluation has also highlighted a number of areas where further improvements and enhancement should be made. These are set out below:

7.2 Accessibility

Recommendation One
V1P will see to understand if there are any distinct barriers for higher ranking veterans when engaging with mental health services through discussion with the Armed Services and with clients of higher ranking who have accessed V1P support.

Recommendations Two
V1P will work with key partners including the National Veterans Care Network, the Armed Services and the Veterans Scotland Health and Wellbeing Pillar to promote the services and support provided by V1P centres.

7.3 Coordination

Recommendation Three
V1P will continue to foster close relationships with the Armed Services Vulnerable leavers and Firm Base programme to ensure that connections are made Early Service Leavers who display increased risk of adverse psychological outcomes and disadvantage to discharge.

Recommendation Four
V1P will continue to work with local veterans' agencies and statutory and 3rd sector providers to ensure that pathways and networks of support for all aspects of a veterans' care and support needs are coordinated and maximised. This "more than a sum of our parts" approach builds on the collaboration and partnership working which has been developed over a number of years in each of the localities serviced by V1P Centres.

7.4 Creditability

Recommendation Five
Continue to offer a "safe secure base" for veterans with complex needs where they can access help, support and psychological interventions at a time and phase which suits their needs. This phase based approach recognises that until welfare concerns are addressed a veteran will not be able to fully engage or make best use of formal psychological therapies.

Recommendation Six
Continue to pursue funding opportunities for the "Veterans as Citizen" programme which recognises the social and relational difficulties that veterans experience in readjusting back to civilian live and seeks to maximise the assets that veterans can offer to their local communities.

Recommendation Seven
Accelerate work with key NHS and 3rd Sector partners to improve service response for veterans with chronic pain and depression.

Recommendation Eight
Ensure that the learning and experiences gained by V1P Scotland over the last ten years is shared with key partners across Scotland and wider afield. The newly established Veterans Care Network will be a key conduit for this.

Recommendation Nine
Ensure that research and evaluation which contributes to the evidence base on mental health and social care needs of veterans remain a priority for V1P Scotland.

7.5 Data collection for this evaluation ended on 21 March 2020. This cut-off date was selected as it marked the beginning of the Scottish Government's regulations and advice in the light of the Covid19 pandemic. The authors and the V1P Clinical Leads deemed it appropriate and timely to add an additional section to this report on responses and initial reflections from V1P to the pandemic. This update is included in section 8. In reviewing the impact of Covid 19 to date (as detailed in section 8.2) on the veterans community a further recommendation is made

7.6 During the pandemic period to date an increasing number of veterans are presenting with employment issues, Higher employment rates resulting in more isolation, increase financial related stress and a lack of meaningful occupation leads to poorer mental health. V1P Lothian previously piloted the Individual Placement Support model which is internationally recognised as a model of best practice which supports people to achieve and sustain employment. The model aims to find jobs consistent with Veterans preferences and liaise with local employers on the Veteran's behalf to create sustainable employment opportunities.

Recommendation 10
Evidence based developments focused on employability are accelerated in order to address the impact of Covid 19.

7.7 Future direction

Since the cessation of the LIBOR funding V1PS Centres have been funded in part by the Scottish Government and by Health Boards/ Integrated Joint Boards on a year by year basis. This has caused concern and disruption to V1P users and staff. It is hoped that the commitment to develop a national Mental Health Action Plan with clear outcomes responding to policy and Covenant commitments will also seek to address the funding issue, establishing V1P Centres on a firm base to consolidate and build further on Scotland's distinctive approach to improving the health and wellbeing of all our veterans.

8. Postscript: V1P and Covid19

Data collection for this evaluation ended on 21 March 2020. This cut-off date was selected as it marked the beginning of the Scottish Government's regulations and advice in the light of the Covid19 pandemic. The authors and the V1P Clinical Leads deemed it appropriate and timely to add an additional section to this report on responses and initial reflections from V1P to the pandemic.

8.1 Changing Service Provision

Across the Network, Veterans First Point has continued to accept referrals and provide support during lockdown, albeit it largely virtual on telephone or using Near Me. Remote options have increased overtime and limited face to face (F2F) services have gradually been introduced for those most in need. This is prioritised based on clinical need and socio economic situation.

The table below sets out how the six V1P centres have adapted and responded to the pandemic.

V1P Lothian
Telephone support 0131 220 9920
Email support : veterans.Enquiries@nhslothian.scot.nhs.uk
Weekdays 09:00 - 17:00
All appointments continue to be offered over the telephone and 'near me' once available.

- All active PSW cases given rag rating, red, amber and green.
- Urgent cases prioritised and given telephone support (video once available) and/or referral onto emergency and high intensity home treatment services
- Drop-ins and social groups cancelled
- No face to face consultation
- Referrals continue to be taken by normal methods telephone, email or post
- Registrations and assessments adapted for over the telephone
- Those awaiting psychological therapy have been written to offering a range of online therapies, and email therapy IESO
- All veterans sent a **V1P resilience pack** developed by the Lothian team for support during COVID
- Citizen advice Bureau and Veterans UK continue to offer clinics by telephone for V1P veterans
- All Veterans sent an e-activity calendar of courses, podcasts and wellbeing classes to stay well during Covid
- Clinicians with capacity are telephoning veterans as they reach the top of the psychological wait list and conducting a new triage specifically for their appropriateness for online therapy course, IESO email therapy or telephone therapy. Some are opting to wait for face to face and are recorded as a COVID cancellation on TRAK to be offered later.
- Two therapists have been deployed part time to offer sessional support on the staff COVID support line
- An administrator has been deployed part time to assist with recruitment and testing of staff at occupational health.

V1P Fife Helpline Monday, Tuesday, Thursday and Friday, 09:00 - 17:00 07976739583
• Since August 2020 - V1P has remobilised (following staff redeployment into emergency mental health and staff support services) to offer peer support and psychological therapy to veterans. • At the present time this contact is being offered remotely by telephone or video conference. • Funding has also been confirmed for a dedicated Veterans Centre in Lochore in the old Rosewell library and, at the time of writing, refurbishment work is about to start. • It has been possible to recruit to 2 peer support worker posts with these workers due to start by December 2020. • Planning is underway to develop and deliver an online programme of veteran wellbeing sessions and we are presently working to establish a forum for active service user involvement and consultation.
V1P Tayside Helpline or Near Me videoconferencing. 'Virtual drop in' on a Friday morning. 01382 424029 or 07811 471443(Monday-Friday 9am-5pm) vfp.tayside@nhs.net
• During the initial lockdown, the team quickly transitioned to telephone contact for the first couple of weeks and risk assessed all veterans on our caseload (using a red, amber and green alert system) and prioritised contact and support based on need. • Pre-Covid work in developing the NHS video consultation system – "Near Me" enabled V1PT to offer video consultations to veterans from early April 2020. A system was devised to ascertain preference in appointment delivery, e.g., by telephone, Near Me or those wishing to wait until face-to-face appointments resumed. We produced a step by step guide, test calls prior to appointments and trouble-shooting support on the day of the appointment. • Face-to-face Drop Ins were replaced by Virtual Drop Ins. These have been well attended and by request we developed a virtual Evening Drop In for those veterans who are working and/or expressed an interest in attending and maintaining social and emotional support with other veterans and our peer support workers. • Peer support and specialist mental health assessment and support, including the delivery of psychological therapy, as continued. • In the temperate climate of late spring and summer, some physically distanced appointments where conducted outside, for example, in the V1P Tayside garden area. Such appointments were offered by both peer workers and team clinicians to support veterans who required enhanced support. • In line with national and local guidance, some face-to-face appointments resumed in August 2020. Appointment numbers and timings were carefully managed to ensure adherence with physical distancing guidance and manage footfall. Stringent hygiene measures were put in place to maintain the safety of veterans and team members, including the use of PPE. We offered 50 face-to-face appointments in August 2020 and this has been building gradually since then. • We have maintained contact with veterans and partner agencies in a range of ways. Those not already mentioned include regular emails; a peer support text message system, and our regular newsletter.

• Team governance has been sustained, including: referral meetings; business meetings, and clinical and managerial supervision either in person or via Microsoft Teams. Staff recruitment progressed during the pandemic, enabling the service to appoint a new peer support worker and psychological therapist.
V1P Borders Tel: 01896 668551 Email: V1P@borders.scot.nhs.uk https://www.veteransfirstpoint.org.uk/drop-center/borders Making contact: Call and leave a message, send an email or contact via the website and the team will respond.
• Over the course of the lockdown, NHS Borders were able to offer continued contact with veterans and their families requiring support from the service. • The majority of this contact has been via telephone and email with additional regular updates by post including a Resilience pack. • Veterans new to the service have still been able to register and receive support. • The needs of veterans requiring crisis support and/or psychological therapies were met as far as was possible. • A waiting list has developed for individuals who could not access mainstream NHS services for psychological therapies. • "Near Me" video consultation appointments have recently become available for veterans who are willing and able to access the service via this online system. Staff are able to offer support to veterans in accessing and using this service including an easy read guide. Inroads to re-establishing some limited face to face sessions for psychological therapy and initial assessment are being made, however no firm date can be set at this time. This is in part due to ongoing consultation with the other services that share the premises. Full risk assessments are being undertaken with a view to commencing with these activities as soon as is possible. • The team are hoping to take forward some of the 'virtual' developments made across the wider V1P network in the coming weeks.
V1P Ayrshire and Arran Monday – Friday; 10am – 4pm Telephone 01294 310400 email aa-uhb.veteranfirstpoint@nhs.net
• V1P Ayrshire & Arran has remained open and running the service throughout lockdown (with the exception of drop ins). • A risk assessment was carried out of the premises early on in lockdown to ensure both staff and patient safety regarding COVID-19. Floor markings, hand sanitiser PPE supply and room number restrictions were introduced. • Patients have been offered either telephone or Attend Anywhere video appointments, although more recently, face to face appointments have been offered to those registering with the service for the first time, those requiring Psychological/Psychiatric assessment appointments or to patients presenting in crisis. • Peer support workers have been working from our offices every day, taking phone calls and offering peer support remotely. They have also continued close partnership working with fellow veteran organisations to meet the needs of veterans.

• More recently, where Scottish Government guidance has permitted, Peer Support workers have visited vulnerable patients at home and offered more isolated patients face to face appointments in outdoor areas. • Office doors do remain closed but patients can access support by appointment or via telephone/video/email. • Consideration was given to offering virtual drop ins, however those veterans who previously attended the centre for drop in indicated that they would prefer to meet up in person and have already made arrangements independently of the centre which they are keen to continue with. • Visits by our Peer Support Worker to the local Prisons have recently resumed (September 2020)
V1P Lanarkshire Get in touch: Weekdays 9:00 – 17:00 0300 303 3051 and leave a message. Complete the online enquiry form at veteransfirstpoint.org.uk
• V1P Lanarkshire have remained accessible our registered veterans throughout lockdown and continue to expand the ways in which we provide support. • Telephone support maintained to all vulnerable veterans during early stages of C19 lockdown and leaflets with resources sent to all on the mailing list. • Remote working established for all staff within the first weeks of lockdown and remote support options made available to all active cases within two months. • Partnership working in the community to increase access to food parcels for those shielding and to increase access to technology to those living in technology poverty. • By May 2020, staff resumed engagement with new veterans and established telephone screening for all new enquiries to assess for risk, vulnerability, and access to technology. • September 2020, staff resumed F2F appointments with vulnerable veterans meeting specific criteria either in the local community (walk and talk) and shortly after in clinic spaces. • October 2020, PSWs established the first of our remote Access Points (drop ins) and these now run weekly. • November 2020, plans are in place for small, controlled, F2F Access Points for vulnerable veterans unable to access technology and following strict protocol. • Plans to expand remote options for other supports and resources e.g. groups and workshops are in place for 2021.

This provision may change due to local and national restrictions.

8.2 Changing Needs

Include below are some early observations from the VIP Lothian team regarding clients presenting needs.

8.2.1. V1P Lothian staff have during COVID observed that some veterans thrived during lockdown. For other this period has resulted in a rapid deterioration in their mental health. Initial sampling of data indicates that suicidal ideation has increased to 68% of all veterans who registered during lockdown in comparison to 51% of veterans during the same time period in 2019.

There has also been an increase in risk to others, in the past month 50% of referrals reported that they are violent/aggressive with or without provocation at the time of registration.

Veterans during lockdown are also displaying an intensity in their symptomology with higher average scores on item 5 (panic/terror) and item 10 (unwanted images) during lockdown. As a consequence, overall risks and the intensity of clinical work has increased.

8.2.2. The complexity of referrals and clinical presentation has increased during lockdown. In the past month, employment has been a presenting problem for 45.5% of referrals and 30% have reported being unemployed at the time of registration. This is significantly higher compared to the figures for 2019, where 35.5% of referrals indicated employment as a presenting problem and 24.8% were unemployed. Higher employment rates resulting in more isolation, increase financial related stress and a lack of meaningful occupation. This leads to poorer mental health.

8.2.3. Many veterans are feeling isolated and unsupported as a result of measures in place at partner organisations and are therefore turning to V1P for assistance. As a consequence of our continued operation during the pandemic, our flexibility to new ways of working and the reputation for Veterans First Point, we are now seeing more referrals of a complex nature. The increased volume and intensity of our work has also increased meaning that we are often speaking to the most at risk individuals on almost a daily basis.

8.3 V1P Centres remain committed to collecting and analysing data in order to ensure that we capture the changing experiences of veterans during these unpredictable and unsettling times.

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Appendices

Appendix A – Supporting Data Tables - Demographics

Figure A1.
Referral Method to V1P Scotland – frequencies and percentage breakdown.

Referral Method	Percent	Valid Percent	Frequency
GP/NHS (PrImary Care)	12.5	13.6	258
CMHT/NHS (Secondary Care)	9.1	9.9	187
Military	1.9	2.1	39
Social Services / local authority services	3.9	4.2	80
Forces Charities	14.2	15.5	293
Regimental associations, RNA, RAFA etc.	0.3	0.4	7
Non-forces Charities	2.9	3.1	59
Veterans UK	1.0	1.1	20
Self-referral	37.5	41.0	75
Family or Friends	7.2	7.8	148
Prison	1.1	1.2	22
Publicity incl. website	0.2	0.2	4
Valid total	91.6	100.0	1892
Missing	8.4		173
Total	100		2066

Figure A2.
Self referral to V1P Scotland – frequencies and percentage breakdown.

Referral Method	Percent	Valid Percent	Frequency
GP/NHS (PrImary Care)	4.3	8.7	89
CMHT/NHS (Secondary Care)	1.4	2.8	29
Military	.8	1.7	17
Social Services / local authority services	1.1	2.2	23
Forces Charities	3.6	7.3	75
Regimental associations, RNA, RAFA etc.	.2	.4	4
Non-forces Charities	.7	1.4	14
SPVA	.2	.4	4
Family or Friends	8.7	17.5	179
Prison	3.7	7.5	77
Publicity incl. website	1.1	2.1	22
Valid total	49.6	100.0	1024
Missing	50.4		1042
Total	100		2066

Figure A3.
Reported ethnicity – frequencies and percentage breakdown.

Reported Ethnicity	Percent	Valid Percent	Frequency
White Scottish	64.3	70.8	1328
White Other British	18.6	20.5	384
White Irish	.6	.7	13
Other white ethnic group	.3	.3	6
Mixed or multiple ethnic group	.0	.1	1
Pakistani, Pakistani Scottish or Pakistani British	.1	.2	3
African, African Scottish or African British	.5	.6	11
Other African	.1	.2	3
Caribbean, Caribbean Scottish or Caribbean British	.3	.3	6
Black, Black Scottish or Black British	.1	.1	2
Other Caribbean or black	.1	.1	2
Other Ethnic Group	.5	.5	10
Prefer not to say	.2	.2	4
Not known	4.9	5.4	102
Valid total	90.8	100.0	1875
Missing	9.2		191
Total	100.0		2066

Figure A4.
Marital status – frequencies and percentage breakdown.

Status	Percent	Valid Percent	Frequency
Single	27.9	30.8	576
Married / Civil Partnership	34.8	38.5	720
Co-habiting	9.2	10.2	191
Divorced	9.3	10.3	193
Separated	7.1	7.9	147
Widowed	2.1	2.3	43
Valid total	90.5	100.0	1870
Missing	9.4		196
Total	100.0		2066

Figure A5.
Living arrangement – frequencies and percentage breakdown.

Living Arrangement	Percent	Valid Percent	Frequency
Living Alone	28.3	31.4	584
With Partner / Spouse	25.7	28.5	531
With Children	3.6	4.0	74
With Partner / Spouse & Children	18.6	20.7	385
With Relatives	6.4	7.1	132
With Friends	1.5	1.7	31
Homeless	4.6	5.2	96
Houses of multiple occupancy	1.0	1.1	21
Prison	.4	.4	8

Valid total	90.1	100.0	1862
Missing	9.8		204
Total	100.0		2066

Figure A6.
History of homelessness – frequencies and percentage breakdown.

History of Homelessness	Percent	Valid Percent	Frequency
Yes	29.7	34.8	613
No	55.7	65.2	1151
Valid total	95.4	100.0	1764
Missing	14.6		302
Total	100.0		2066

Figure A7.
Living situation – frequencies and percentage breakdown.

Living Situation	Percent	Valid Percent	Frequency
Private Let	15.0	16.8	309
Supported Accommodation	1.6	1.8	34
Homeless Accommodation	5.0	5.7	104
Privately Owned	29.0	32.6	600
Council House / Housing Association	30.9	34.7	639
HMP	.4	.4	8
Mobile Home	.0	.1	1
Roofless	.8	.9	16
With Relatives	2.8	3.1	57
Military Housing	3.4	3.9	71
Valid total	89.1	100.0	1839
Missing	10.9		227
Total	100.0		2066

Figure A8.
History of non-military employment – frequencies and percentage breakdown.

History of Non-Military Employment	Percent	Valid Percent	Frequency
Yes	71.8	91.7	1483
No	6.5	8.3	135
Valid total	78.3	100.0	1618
Missing	21.6		447
Total	100.0		2066

Figure A9.
Current employment status – frequencies and percentage breakdown.

Employment Status	Percent	Valid Percent	Frequency
Employed full time	27.5	31.1	568
Employed part time	4.5	5.1	94
Unemployed	25.8	29.1	532
Retired	11.7	13.2	241

Signed off sick	17.6	19.9	364
Student	.7	.8	15
Voluntary work	.6	.7	12
Valid total	88.4	100.0	1826
Missing	11.6		240
Total	100.0		2066

Figure A10.
Employment & educational goals – frequencies and percentage breakdown.

Goal	Percent	Valid Percent	Frequency
Employment full time	30.4	42.1	629
Employment part time	4.2	5.8	87
Education / Training	4.2	5.8	87
Voluntary Work	3.2	4.4	66
No current employment / educational goal	30.3	41.8	625
Valid total	72.3	100.0	1494
Missing	27.7		572
Total	100.0		2066

Figure A11.
Veterans in receipt of benefits – frequencies and percentage breakdown.

Receipt of Benefits	Percent	Valid Percent	Frequency
No benefits	33.0	40.3	681
Receiving benefits	48.7	59.7	1007
Valid total	81.7	100.0	1688
Missing	18.2		378
Total	100.0		2066

Figure A12.
Veterans in receipt of service pensions – frequencies and percentage breakdown.

Service Pension Count	Percent	Valid Percent	Frequency
4 Pensions	0.1	0.1	2
3 Pensions	0.7	0.7	14
2 Pensions	7.2	7.8	148
1 Pension	26.7	29.0	551
0 Pensions	57.5	62.4	1187
Valid total	92.1	100.0	1903
Missing	7.9		163
Total	100.0		2066

Figure A13.
Service arm – frequencies and percentage breakdown.

Service Arm	Percent	Valid Percent	Frequency
RAF	7.0	7.5	145
Royal Navy	7.7	8.3	160
Army	75.5	80.8	1560
Merchant Navy	.2	.3	5
Royal Marines	1.5	1.7	32

N/A (Family Member)	1.2	1.2	24
Foreign Military	.2	.2	4
Valid total	93.4	100.0	1930
Missing	6.6		136
Total	100.0		2066

Figure A14.
Service type – frequencies and percentage breakdown.

Service Type	Percent	Valid Percent	Frequency
Reserve	4.5	4.9	93
Regular	79.2	85.9	1636
Family member (not served)	2.6	2.8	53
Reserve & Regular	5.9	6.4	122
Valid total	92.2	100.0	1904
Missing	7.8		162
Total	100.0		2066

Figure A15.
Discharge method – frequencies and percentage breakdown.

Discharge Method	Percent	Valid Percent	Frequency
Administrative / SNLR	29.5	33.8	609
Temperamentally Unsuited	.7	.8	14
Elected / End Engagement / PVR	31.3	35.8	646
Medical	18.2	20.8	375
Redundancy	3.9	4.5	81
Other	3.7	4.3	77
Valid total	87.2	100.0	1802
Missing	12.7		264
Total	100.0		2066

Appendix B – Supporting Data Tables – Health Measures

Figure B1.
SF-12 Q1. In general, would you say your health is:

Answer	Percent	Valid Percent	Frequency
Excellent	2.7	3.6	55
Very Good	7.8	10.6	161
Good	18.2	24.7	375
Fair	23.7	32.1	489
Poor	21.3	29.0	441
Valid total	73.6	100.0	1521
Missing	26.3		545
Total	100.0		2066
Note: Measure taken at registration appointment			

Figure B2.
EQ-5D-5L Q4. Pain / Discomfort

Answer	Percent	Valid Percent	Frequency
I have no pain or discomfort	23.1	31.6	478
I have slight pain or discomfort	13.2	18.0	272
I have moderate pain or discomfort	17.5	23.9	362
I have severe pain or discomfort	13.2	18.0	273
I have extreme pain or discomfort	6.2	8.5	129
Valid total	73.3	100.0	1514
Missing	26.7		552
Total	100.0		2066
Note: Measure taken at registration appointment			

Figure B3.
SF-12 Q8. During the past 4 weeks, how much did pain interfere with your normal work (including work outside the home and housework)?

Answer	Percent	Valid Percent	Frequency
Not at all	25.5	34.6	527
A little bit	11.4	15.5	236
Moderately	10.0	13.6	207
Quite a bit	14.0	19.1	290
Extremely	12.7	17.2	262
Valid total	73.7	100.0	1522
Missing	26.2		544
Total	100.0		2066
Note: Measure taken at registration appointment			

Figure B4.
EQ-5D-5L Q1. Mobility

Answer	Percent	Valid Percent	Frequency
I have no problems in walking about	35.8	48.6	739
I have slight problems in walking about	11.8	16.0	244
I have moderate problems in walking about	12.9	17.5	267
I have severe problems in walking about	12.2	16.6	252
I am unable to walk about	1.0	1.3	20

Valid total	73.7	100.0	1522
Missing	26.3		544
Total	100.0		2066
Note: Measure taken at registration appointment			

Figure B5.
SF-12 Q3. Does your health today limit you in climbing several flights of stairs? If so, how much?

Answer	Percent	Valid Percent	Frequency
Yes, limited a lot	20.6	28.0	425
Yes, limited a little	16.8	22.9	348
No, not limited at all	36.1	49.1	746
Valid total	73.5	100.0	1519
Missing	26.5		547
Total	100.0		2066
Note: Measure taken at registration appointment			

Figure B6.
EQ-5D-5L Q6. Anxiety / Depression

Answer	Percent	Valid Percent	Frequency
I am not anxious or depressed	7.6	10.3	156
I am slightly anxious or depressed	9.2	12.6	190
I am moderately anxious or depressed	22.2	30.4	458
I am severely anxious or depressed	19.6	26.8	404
I am extremely anxious or depressed	14.6	19.9	301
Valid total	73.0	100.0	1509
Missing	27.0		557
Total	100.0		2066
Note: Measure taken at registration appointment			

Figure B7.
SF-12 Q11. How much of the time during the past 4 weeks, have you felt downhearted and blue?

Answer	Percent	Valid Percent	Frequency
All of the time	14.0	20.1	289
Most of the time	19.3	27.7	398
A good bit of the time	12.3	17.8	255
Some of the time	12.9	18.6	267
A little of the time	6.6	9.5	137
None of the time	4.3	6.2	89
Valid total	69.5	100.0	1435
Missing	30.5		631
Total	100.0		2066
Note: Measure taken at registration appointment			

Figure B8.
SF-12 Q9. How much of the time during the past 4 weeks, have you calm and peaceful?

Answer	Percent	Valid Percent	Frequency
All of the time	3.9	5.4	81
Most of the time	7.4	10.1	152
A good bit of the time	4.3	5.9	89

Some of the time	16.4	22.6	339
A little of the time	23.3	32.2	482
None of the time	17.2	23.7	355
Valid total	72.5	100.0	1498
Missing	27.5		568
Total	100.0		2066
Note: Measure taken at registration appointment			

Figure B9.
SF-12 Q10. How much of the time during the past 4 weeks, did you have a lot of energy?

Answer	Percent	Valid Percent	Frequency
All of the time	4.8	6.7	99
Most of the time	7.8	10.9	162
A good bit of the time	5.8	8.0	119
Some of the time	16.0	22.2	330
A little of the time	20.8	28.9	429
None of the time	16.7	23.2	345
Valid total	71.8	100.0	1484
Missing	28.1		582
Total	100.0		2066
Note: Measure taken at registration appointment			

Figure B10.
SF-12 Q2. Does your health today limit you in moderate activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf? If so, how much?

Answer	Percent	Valid Percent	Frequency
Yes, limited a lot	20.9	28.1	431
Yes, limited a little	19.1	25.7	394
No, not limited at all	34.2	46.1	707
Valid total	74.2	100.0	1532
Missing	25.8		534
Total	100.0		2066
Note: Measure taken at registration appointment			

Figure B11.
SF-12 Q4. During the past 4 weeks, have you accomplished less than you would like as a result of your physical health problems?

Answer	Percent	Valid Percent	Frequency
Yes	41.6	56.8	859
No	31.7	43.2	654
Valid total	73.5	100.0	1513
Missing	26.5		547
Total	100.0		2066
Note: Measure taken at registration appointment			

Figure B12.
SF-12 Q5. During the past 4 weeks, were you limited in the kind of work and other activities as a result of your physical health problems?

Answer	Percent	Valid Percent	Frequency
Yes	39.9	55.2	825
No	32.4	44.8	669

Valid total	72.3	100.0	1494
Missing	27.7		572
Total	100.0		2066
Note: Measure taken at registration appointment			

Figure B13.
SF-12 Q6. During the past 4 weeks, have you accomplished less than you would like as a result of any emotional problems?

Answer	Percent	Valid Percent	Frequency
Yes	71.9	79.3	1208
No	18.8	20.7	316
Valid total	90.8	100.0	1524
Missing	9.2		155
Total	100.0		1679
Note: Measure taken at registration appointment			

Figure B14.
SF-12 Q7. During the past 4 weeks, did you do work or activities less carefully than usual as a result of any emotional problems?

Answer	Percent	Valid Percent	Frequency
Yes	58.5	70.7	1208
No	15.3	29.3	316
Valid total	73.8	100.0	1524
Missing	26.2		542
Total	100.0		2066
Note: Measure taken at registration appointment			

Figure B15.
EQ-5D-5L Q2. Self-Care

Answer	Percent	Valid Percent	Frequency
I have no problems in washing or dressing myself	48.0	65.2	992
I have slight problems in washing or dressing myself	10.5	14.2	216
I have moderate problems in washing or dressing myself	10.0	13.6	207
I have severe problems washing or dressing myself	4.4	6.0	91
I am unable to wash or dress myself	.7	1.0	15
Valid total	73.6	100.0	1521
Missing	26.3		545
Total	100.0		2066
Note: Measure taken at registration appointment			

Figure B16.
EQ-5D-5L Q3. Usual Activities

Answer	Percent	Valid Percent	Frequency
I have no problems doing my usual activities	24.4	33.4	505
I have slight problems doing my usual activities	13.6	18.6	282
I have moderate problems doing my usual activities	18.6	25.4	384

I have severe problems doing my usual activities	12.0	16.4	248
I am unable to do my usual activities	4.6	6.3	95
Valid total	73.3	100.0	1514
Missing	26.7		552
Total	100.0		2066

Note: Measure taken at registration appointment

Figure B17.
SF-12 Q12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (visiting friends, relatives)?

Answer	Percent	Valid Percent	Frequency
All of the time	21.0	29.1	434
Most of the time	17.8	24.7	368
A good bit of the time	9.9	13.7	204
Some of the time	10.2	14.2	211
A little of the time	5.7	7.9	117
None of the time	7.5	10.4	155
Valid total	72.1	100.0	1489
Missing	27.9		577
Total	100.0		2066

Note: Measure taken at registration appointment

Appendix C - SupportingData Tables - Early Service Leavers

Figure C1.
Age ranges of Early Service Leavers (ESLs) as compared to non ESLs.

Age Range	Percent	Valid Percent	Frequency
Early Service Leavers			
20 – 24	7.1	7.2	13
24 – 29	6.5	6.6	12
30 – 34	8.2	8.3	15
35 – 39	10.3	10.5	19
40 - 44	11.4	11.6	21
45 - 49	13.6	13.8	25
50 - 54	10.3	10.5	19
55 - 59	13.0	13.3	24
60 - 64	7.1	7.2	13
65 and over	10.9	11.0	20
Valid total	98.4	100.0	181
Missing	1.6		3
Total	100.0		185
Non Early Service Leavers			
15 - 19	.1	.1	1
20 - 24	1.4	1.4	20
24 - 29	6.3	6.3	88
30 - 34	11.5	11.5	161
35 - 39	13.5	13.5	189
40 - 44	10.6	10.7	149
45 - 49	15.5	15.6	218
50 - 54	13.6	13.7	191
55 - 59	10.3	10.3	144
60 - 64	9.2	9.2	129
65 and over	7.5	7.6	106
Valid total	99.4	100.0	1396
Missing	0.6		8
Total	100.0		1404
Note: Total frequencies do not total 2066 due to missing data			

Figure C2.
SIMD Quintiles of Early Service Leavers (ESLs) as compared to non ESLs.

SIMD Quintile	Percent	Valid Percent	Frequency
Early Service Leavers			
SIMD Quintile 1	33.2	35.5	61
SIMD Quintile 2	22.8	24.4	42
SIMD Quintile 3	19.0	20.3	35
SIMD Quintile 4	11.4	12.2	21
SIMD Quintile 5	7.1	7.6	13
Valid total	93.5	100.0	172
Missing	6.5		12
Total	100.0		184
Non Early Service Leavers			
SIMD Quintile 1	22.3	24.2	313
SIMD Quintile 2	27.4	29.8	385
SIMD Quintile 3	20.5	22.3	288
SIMD Quintile 4	14.0	15.2	197
SIMD Quintile 5	7.9	8.6	111
Valid total	92.2	100.0	1294
Missing	7.8		110

Total	100.0	1404
Note: Total frequencies do not total 2066 due to missing data		

Figure C3.
Living arrangements of Early Service Leavers (ESLs) as compared to non ESLs.

Living Arrangement	Percent	Valid Percent	Frequency
Early Service Leavers			
Living Alone	39.7	40.1	73
With Partner / Spouse	22.3	22.5	41
With Children	3.8	3.8	7
With Partner / Spouse & Children	14.1	14.3	26
With Relatives	6.5	6.6	12
With Friends	1.6	1.6	3
Homeless	8.2	8.2	15
Houses of multiple occupancy	1.6	1.6	3
Prison	1.1	1.1	2
Valid total	98.9	100.0	182
Missing	1.1		2
Total	100.0		184
Non Early Service Leavers			
Living Alone	30.5	30.1	422
With Partner / Spouse	28.2	27.8	390
With Children	4.2	4.1	58
With Partner / Spouse & Children	22.1	21.8	306
With Relatives	6.7	6.6	93
With Friends	1.7	1.6	23
Homeless	5.2	5.1	72
Houses of multiple occupancy	1.3	1.3	18
Prison	.1	.1	2
Valid total	98.6	100.0	1384
Missing	1.4		20
Total	100.0		1404
Note: Total frequencies do not total 2066 due to missing data			

Figure C4.
History of homelessness of Early Service Leavers (ESLs) as compared to non ESLs.

History of Homelessness	Percent	Valid Percent	Frequency
Early Service Leavers			
Yes	54.9	57.1	101
No	41.63	42.9	76
Valid total	96.2	100.0	177
Missing	3.8		7
Total	100.0		184
Non Early Service Leavers			
Yes	31.0	32.5	435
No	64.3	67.5	903
Valid total	95.3	100.0	1338
Missing	4.7		66
Total	100.0		1404
Note: Total frequencies do not total 2066 due to missing data			

Figure C5.
Employment Status of Early Service Leavers (ESLs) as compared to non ESLs.

Employment Status	Percent	Valid Percent	Frequency
Early Service Leavers			
Employed full time	15.8	16.2	29

Employed part time	7.1	7.3	13
Unemployed	32.6	33.5	60
Retired	13.6	14.0	25
Signed off sick	27.7	28.5	51
Student	.5	0.6	1
Valid total	97.3	100.0	179
Missing	2.7		5
Total	100.0		184
Non Early Service Leavers			
Employed full time	33.3	34.2	468
Employed part time	4.5	4.6	63
Unemployed	25.9	26.6	363
Retired	11.8	12.1	166
Signed off sick	20.4	20.8	286
Student	.9	0.9	12
Voluntary work	.8	0.8	11
Valid total	97.5	100.0	1369
Missing	2.5		35
Total	100.0		1404
Note: Total frequencies do not total 2066 due to missing data			

Figure C6.
Service Arm - Early Service Leavers (ESLs) as compared to non ESLs.

Service Arm	Percent	Valid Percent	Frequency
Early Service Leavers			
RAF	7.6	7.6	14
Royal Navy	7.1	7.0	13
Army	83.7	83.8	154
Royal Marines	1.1	1.1	2
Foreign Military	0.5	0.5	1
Valid total	100.0	100.0	184
Missing			
Total	100.0		185
Non Early Service Leavers			
RAF	8.2	8.2	115
Royal Navy	8.5	8.5	120
Army	80.8	81.0	1135
Merchant Navy	0.2	0.2	3
Royal Marines	1.8	1.8	25
Foreign Military	0.2	0.2	3
Valid total	99.9	100.0	1402
Missing	0.1		2
Total	100.0		1404
Note: Total frequencies do not total 2066 due to missing data			

Figure C7.
Service Type - Early Service Leavers (ESLs) as compared to non ESLs.

Service Type	Percent	Valid Percent	Frequency
Early Service Leavers			
Reserve	10.9	11.5	20
Regular	82.1	83.0	151
Reserve & Regular	5.4	5.5	10
Valid total	98.4	100.0	181
Missing	1.6		3
Total	100.0		184
Non Early Service Leavers			

Reserve	3.6	3.6	50
Regular	87.3	88.7	1225
Reserve & Regular	.1	7.5	104
Valid total	1.6		1381
Missing	100.0		23
Total	1.6		1404
Note: Total frequencies do not total 2066 due to missing data			

Figure C8.
Reason for Discharge - Early Service Leavers (ESLs) as compared to non ESLs.

Service Type	Percent	Valid Percent	Frequency
Early Service Leavers			
Adminstrative or Service No Longer Required	39.1	40.2	72
Tempermentally Unsuited	2.7	2.8	5
Elected / DAOF / End Engagement / Premature Voluntary Release	21.7	22.9	40
Medical	23.9	24.6	44
Redundancy	.5	0.6	1
Other	8.7	8.9	16
Valid total	96.7	100.0	178
Missing	3.3		6
Total	100.0		184
Non Early Service Leavers			
Adminstrative or Service No Longer Required	26.6	27.3	374
Tempermentally Unsuited	.5	0.5	7
Elected / DAOF / End Engagement / Premature Voluntary Release	41.0	41.8	576
Medical	20.7	21.1	291
Redundancy	5.3	5.4	74
Other	3.8	3.9	54
Valid total	98.0	100.0	1376
Missing	2.0		28
Total	100.0		1404
Note: Total frequencies do not total 2066 due to missing data			