An evaluation of V1P Centres across Scotland

Linda Irvine Fitzpatrick, Susan Prior and Professor Kirsty Forsyth
July 2018

Acknowledgements

We would like to thank all the veterans and staff of V1P Centres who participated in this evaluation and to our wide range of partners across all sectors that made the development of VIP Centres across Scotland possible.

1. Background to V1P Scotland

1.1 Veterans F1rst Point (V1P) Lothian was a service created in 2009 in response to the expressed needs of veterans who had lived experience of mental health problems. It was set up to provide support and services in four main areas:

- Information and Signposting
- Understanding and Listening
- Support and Social Networking
- Health and Wellbeing - including a comprehensive mental health service delivered by a multi-professional team on site

1.2 Funding was secured from the Mental Health and Protection of Rights Division of the Scottish Government (£200,000) and NHS Lothian Strategic Programme Budget for Mental Health and Wellbeing (£60,000).

1.3 The success of V1P Lothian was recognised by the UK Military and Civilian Health Awards:

2011 Mental Health Award, V1P Lothian
2013 Healthcare Civilian of the Year Veterans (Dr Lucy Abraham, V1P Lothian)
2014 Health Improvement and Promotion, V1P Lothian

1.4 A strength and key component of V1P has been the employment of veterans as peer workers. V1P therapists deliver a range of quality evidence-based care, treatment and support to veterans and their families. This includes the delivery of evidence-based therapies including:

- Cognitive Behavioural Therapy
- Eye Movement Desensitisation and Reprocessing Therapy

1.5 The expertise which Lothian V1P accumulated was significant both in terms of creating and sustaining partnership relationships and understanding that until their basic needs are met veterans will not feel or be ready to deal with mental health issues or problems.

1.6 Building on the success of V1P Lothian a comprehensive proposal was submitted to the LIBOR fund in October 2012. The stated objective was to:

"*To work in partnership to deliver high-quality, evidence-based care, treatment and support for veterans and their families across Scotland".*

1.7 Using the knowledge and experience gained to date as an NHS provider, the proposal set out how a hub and spoke mode, supported by a central small development team, would establish a further three centres in Inverness, Dundee and Aberdeen to support all territorial health boards in Scotland. The V1P model In Lothian with the combination of highly skilled mental health professionals and veterans with personal experience of military life, working in partnership with local veterans' agencies and organisations to ensure maximum value, impact and minimum duplication of effort had steadily built up a robust evidence of success demonstrated by:

- Credibility of the model evidenced by over 50% of all referrals to V1P Lothian were self-referrals.
- Positive findings of the Sheffield University independent evaluation (2014)
- Twice awarded Military and Civilian Health Partnership Awards
- Meets the recommendation of the Murison Report (2010): "Follow-up and management should be as close to home as possible."
- Scottish Government and Veterans Scotland advocating the rollout of V1P Lothian

1.8 In addition to the three centres, a national education and training programme delivered by the V1P Scotland team would be developed and would include arranging of training and educational opportunities for the wider community of practice involved in veterans issues.

1.9 The proposal was successful and £2,560,586 was awarded to NHS Lothian to develop and deliver this model.

1.10 The V1P Scotland development surpassed the original intent to develop an additional three centres. Due to the commitment to partnership working and relationship building, a total of eight centres were established supported by a vibrant education and training network led and coordinated by the V1P Scotland team.

1.11 The Network met regularly and provided a forum for continuing professional development and supervision of all staff groups and a place to share learning. Regular progress updates were produced and disseminated to all organisations working with veterans in Scotland. The recently revitalised V1P Scotland website greatly assists with the dissemination of information and provides a valuable resource for veterans, their families and friends and agencies working with veterans across Scotland.

1.12 The eight centres reflected the local needs, priorities, service landscape and partnerships and are therefore quite different in their staff composition, premises and partnership arrangements. However, each of the three principles of the V1P model:

- Credibility
- Accessibility
- Coordination

drove the development of each Centre and underpinned the service model.

1.13 The starting point for each of the Centres was the convening of focus groups with local veterans and facilitated by a V1P Scotland Development Team member. These were invaluable in exploring local issues, challenges and opportunities and to ensure that the subsequent developments were being informed by veterans. Each area then established a V1P Steering Group with leadership and support from the central V1P Scotland team.

1.14 The clinical staff in each V1P Centre were employed by the local NHS Board, peer workers were either employed by the local Board, or key partnership agencies reflecting the best fit for that area.

1.15 Regardless of employer, the teams worked to a single operational policy underpinned by an agreed Memorandum of Understanding with V1P Scotland which clearly set out all partners' key roles and responsibilities, the governance and finance structure.

1.16 All centres received a week-long induction from the V1P Scotland Team and a comprehensive six-month review which highlighted learning and good practice developments.

1.17 Each Centre, in addition to operating welfare and mental health support and interventions to veterans and their families, developed particular approaches or initiatives to meet their clients' needs and reflecting the local geography and infrastructure. The developments, their implementation and leaning are all shared across the partnership areas.

1.18 The V1P Scotland Development team established two successful test of concepts focusing on employability and veterans working with veterans in the criminal justice system. V1P Lothian

delivered both tests of concept. The V1P Team also focussed on strengthening relationships with the Armed Services in order that proactive planning for vulnerable service leavers could commence before discharge.

1.19 **Improving the Offending Pathway**

This Test of Concept aimed to support the Armed Forces Covenant by recognising Veterans whose offending can be identified as connected to disadvantage from their service in the Armed Forces. The project delivered appropriate joint action to address the "root" cause of offending, as part of a Community Payback Order (Supervision Order), thus reducing the likelihood of reoffending. This was delivered as a partnership between Community Justice, City of Edinburgh Council, V1P Lothian and Veterans Scotland. There was an increase in the broad number of referrals to V1P from Criminal Justice Social Work in addition to those being directed by the Courts. The Test of Concept highlighted the necessity of building good and robust working relationships with those working in the criminal and judicial field. All other centres are now building links with local Community Justice and Community Safety Partnerships as part of core business.

1.20 **Individual Placement Support (IPS) Pilot**

The IPS model 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 liaises with local employers on the Veteran's behalf to create sustainable employment opportunities. The IPS team worked as part of the Veterans First Point Clinical and Peer Support Team and provided individually designed support for the Veteran and their future employers.

1.21 **Working with the Armed Services - Proactive and anticipatory planning**

A Partnership arrangement whereby the Clinical Lead and a Veteran Peer Support Worker from regional V1P Teams attend the Personnel Recovery Unit (PRU) discharge meeting of wounded, injured or sick soldiers who are to be discharged to their area has been established. This aims to facilitate access to V1P Centres if required or sought by the soldier and to further effective working relationships with our military partners. V1P Scotland is also a member of the Army Recovery Delivery Group meeting which aims to improve the transition of wounded, injured and sick military personnel.

1.22 **A Memorandum of Understanding between V1P Scotland and the Defence Medical Welfare Service**, a military charity whose aim in Scotland is to support Veterans whilst in hospital and to assist in their discharge, has been agreed.

1.23 Raising Awareness and contributing to the worldwide evidence base

V1P Scotland is committed to ensuring that good practice and evidence-based practice is disseminated across with wider Veterans Community not just in Scotland but across the UK and further afield. The 1st Annual Veterans First Point Scotland Conference was held on Wednesday, 23rd March 2016 at Edinburgh International Conference Centre. The Event was opened by Lord Provost of Edinburgh, Donald Wilson and MSP Keith Brown, Cabinet Secretary and Veterans Minister with a strong endorsement and warm words of congratulations of the progress made towards the establishment of a V1P model across Scotland. Two world-renowned keynote speakers Professor Neil Greenberg and Simon Weston shared their practice, and the workshops and seminars that followed were inspiring to all who attended. The 2nd Conference held on 11 May 2017 focused on Scotland's Armed Services and Veterans health, mental health and citizenship with presentations from each of the V1P Centres highlighting particular features of their local service provision.

2. Methods and Methodology

This section details the methodology used and the dataset.

2.1 The evaluation of V1P Scotland sites was commissioned by V1P Scotland. Queen Margaret University as part of their well-established knowledge transfer programme – The Transformation Station- undertook the evaluation.

2.2 The study design was a quantitative (descriptive) approach.

2.3 The quantitative data analysis was based on secondary data analysis of information which was gathered routinely during contact with veterans in eight national centres.

2.4 The study population comprised veterans using the Veterans First Point Scotland Centres.

2.5 The data set comprised:

Key performance Indicators	**Measure**
Quantifiable improvements in the • physical, • mental and • financial health of veterans and their families who present to V1P Scotland	• **General Health** (inclusive of physical) of **veterans** • Veterans report **SF 12** & **EQ 5D** • **Mental Health** of veterans o Patient Health Questionnaire for Depression **PHQ9**[3] o **Core 10**[4] • **Financial Security** of veterans and their families o Work and Social Adjustment Scale – **WSAS**[5] o Employment status o Employment / education goal o Employment / education outcome o Worker role interview **WRI**[6] ***[Lothian only]***

2.6 National Caldicott Guardian approval was sought alongside local NHS Research and Development approval. Data gathering forms were constructed and distributed for routine use within sites. QMU colleagues supported sites with an orientation to data gathering forms. Hard copies of the data were sent to Team at Queen Margaret University. Data was entered into the electronic system for analysis by Transformation Station Staff. Data had double data entry protocol for 10% of data and correlations were reviewed for quality assurance. A data management protocol was signed off by V1P Scotland leads.

2.7 The eight sites became operational at different times; this is reflected in the data set for the evaluation. Table 1 details the date set.

Table One: Date Set

Centre	Date Service Commenced	V1P Centre Referrals	Included in evaluation	Veterans detained in prison
Lothian	23/04/2009	1,900 (*553 since 2/1/16)	161	18
Tayside	01/09/2015	207	91	0
Fife	18/01/2016	323	101	4
Borders	01/03/2016	112	58	0
Highland	13/06/2016	unknown	86	
Lanarkshire	05/09/2016	289	80	0
Ayrshire and Arran	09/03/2017	301	90	0
Grampian	04/01/2017	unknown	25	
		3,132 (1,785 since 1/2/16)	**692**	22

3. Identifying the needs of veterans

This section focuses on data self-reported measures gathered by peer support workers when veterans initially present to V1P centres.

3.1 EQ-5D™ is a standardised instrument for the measurement of health outcomes (Rabin et al., 2011). The measure is applicable to a wide range of conditions and contains a self-classification scale and a visual analogue scale for self-rated current health.

3.2 The Optum™ SF-12v2® Health Survey is a shorter version of the SF-36v2® Health Survey that uses just 12 questions to measure functional health and well-being from the perspective of the patient or client (Ware et al., 1996).

3.3 At registration veterans are invited by peer support workers to rate their own health status using the EQ5D and the SF12; thereafter Veterans are asked to complete a further EQ5D and SF12 on completion of a clinical intervention and at interim points while attending service.

3.4 Assessments facilitated by Peer Support Workers on the initial presentation by veterans highlighted the following self-reported needs:

3.5 **General Health**

63 was the mean score provided by all Veterans rating their health on a scale of 0-100.
32% of Veterans report poor general health

3.6 **Anxiety and Depression**

The majority of Veterans, 90% report some degree of problem with anxiety or depression. For almost half, 47%, this poses a severe or extreme problem. Around half of Veterans, 49%, report feeling downhearted and blue most or all of the time. When asked about feeling clam and peaceful, over half, 56%, report experiencing this only a little of the time or never. A similar percentage, 53%, report having lots of energy only a little of the time or never.

3.7 **Pain**

Around half of Veterans experience only slight or no pain. However, for 29% of Veterans pain is severe or extreme. When asked about the impact of pain on carrying out activities 68% of Veterans report interference to some degree, while 21% report pain extremely interfered with daily living.

3.8 **Mobility**

Over half, 53%, of Veterans accessing V1P services report some degree of mobility problems. For around one fifth (19%) these are moderate and for a slightly smaller proportion (17%) mobility problems are severe. Around half of the Veterans reported limitations climbing stairs

3.9 Participating in Usual Activities

Over half of veterans (57%) reported accomplishing less due to physical health condition. While the majority (78%) of Veterans accessing V1P Scotland experienced emotional health concerns that resulted in them accomplishing less. Over half (57%) limited the kinds of activities they engaged in, and almost three quarters (72%) found they are less careful in carrying out everyday activities. 70% of veterans report their physical or emotional health interfered with engaging in social activities a good bit, most or all of the time

4.0 Accessibility

This section will consider the data in terms of the accessibility principle of V1P. This includes access, age, gender, ethnicity, and service background

4.1 Referral Route

Veterans are encouraged to self-refer to V1P Scotland. One-third of veterans accessing support from V1P Scotland refer themselves.

V1P Scotland accepts veterans from a wide range of referring routes. The second most common route of accessing V1P Scotland services is through referral by health services which account for 28% of referrals with a further 6% from local authority services. This would appear to reflect recognition among clinicians in mainstream services that specialist Veteran specific services are required to meet the needs of this population.

Graph 1 : Referral to V1P (n-659)

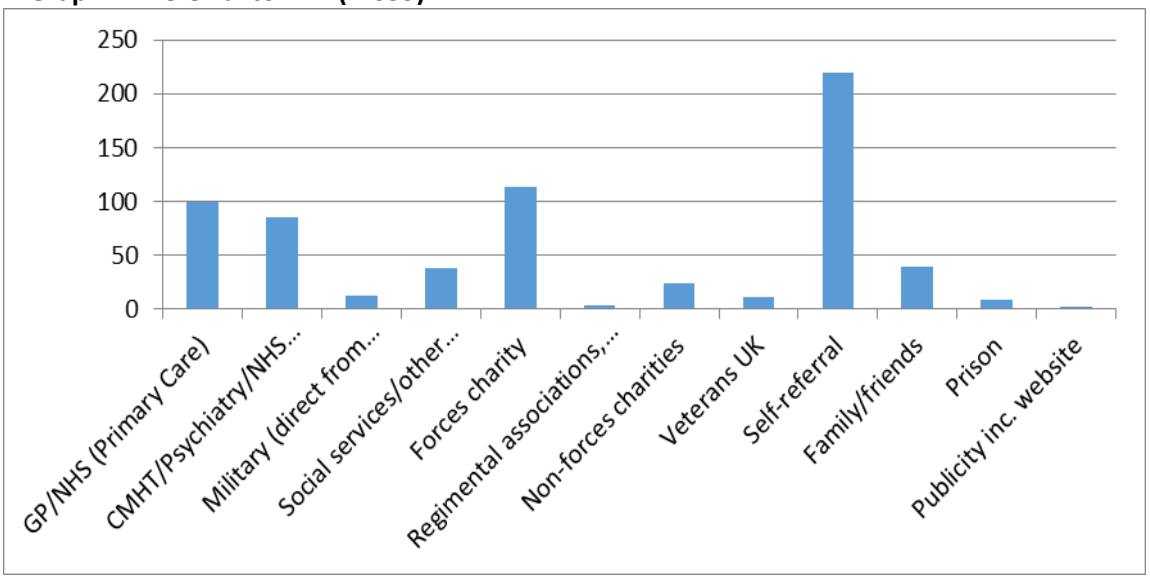


Table 1: Referral to V1P Frequency (n = 659)

	Frequency	**%**
GP/NHS (Primary Care)	99	15%
CMHT/Psychiatry/NHS (secondary care)	85	13%
Military (direct from service)	13	2%
Social services/other local authority service	38	6%
Forces charity	114	17%
Regimental associations, RNA, RAFA, etc.	4	1%
Non-forces charities	24	4%
Veterans UK	12	2%
Self-referral	**219**	**33%**
Family/friends	39	6%
Prison	9	1%
Publicity inc. Website	3	0%

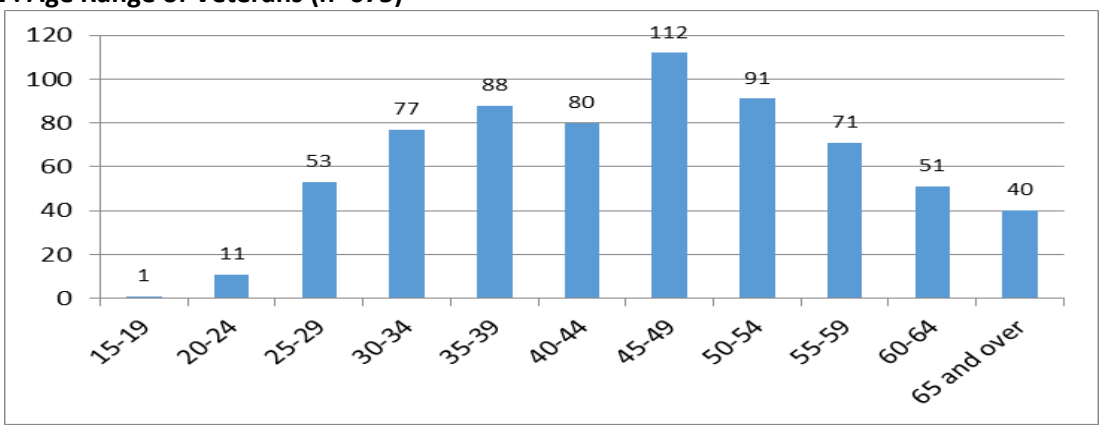
4.2 Veterans Age Range

V1P Scotland are providing services to veterans aged from late teenage years to those over 65. Unlike general mental health services there is no upper age limit. 55% of those veterans accessing support from V1P Scotland are aged between 35 and 55 years. The majority (30%) are aged between 45 and 55 years.

Table Two: Age Range Frequency (n= 675)

Range	Frequency	**%**
15-19	1	0%
20-24	11	2%
25-29	53	8%
30-34	77	11%
35-39	88	13%
40-44	80	12%
45-49	**112**	**17%**
50-54	91	13%
55-59	71	11%
60-64	51	8%
65 and over	40	6%

Graph 2 : Age Range of Veterans (n=675)



4.3 Gender and Ethnicity

The overwhelming majority of veterans are male and white.

Men represent 94% of those accessing V1P services. This is in the context of regular service personnel where the proportions are 89.9% male and 10.1% female (14.1% of reserve forces are female) according to the latest UK Armed Forces Biannual Diversity Statistics Report (MOD 2017).

When asked about ethnicity. 96% of V1P veterans consider themselves White Scottish, British or Irish. The remaining 3% reported a range of other ethnic groups (Pakistani, African, Caribbean, Mixed Ethnicity and Other). This is not reflective of current regular and reserve forces which are increasing in diversity. The latest UK Armed Forces Biannual Diversity Statistics Report states that Black Asian and Minority Ethnics make up 7.5% of regular services and 5.5% of reserve services. These differences between diversity in V1P and current regular and reserve forces may be explained by the time since discharge from service of the veterans accessing V1P Scotland.

4.4 Serving Background

V1P Services are accessed predominately by veterans of regular services (86%), a further 8% have served in both regular and reserve forces. A small proportion have served in reserve forces only.

Table 3: Service type (n-659)

	Frequency	%
Reserve	30	5%
Regular	569	86%
Reserve and Regular	50	8%
Family member (not served)	10	2%

A small component of the service, 2% of the V1P caseload are family members who are supporting veterans.

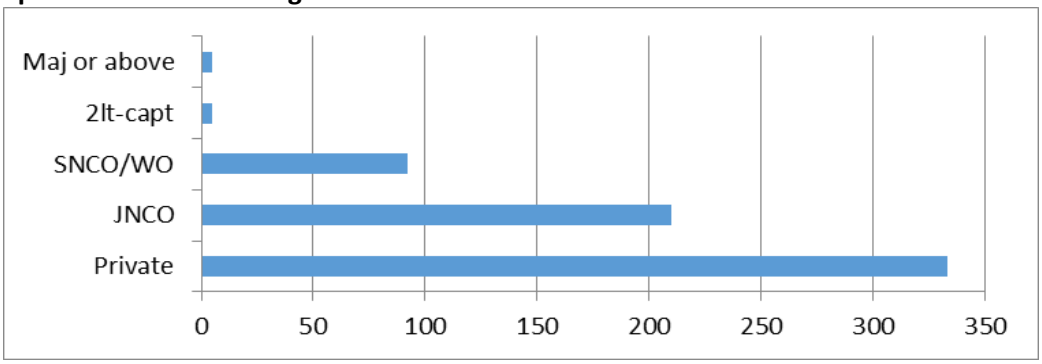
Veterans of the Army represent the majority of the V1P caseload (82%) while other services make up smaller proportions; RAF (8%) Navy (7%) Royal Marines (2%). Veterans of foreign military forces constitute 1% of the caseload.

Table 4: Service arm (n=673)

	Frequency	%
Royal Air Force	54	8%
Royal Navy	50	7%
Army	551	82%
Merchant Navy	1	0%
4= Royal Marines	11	2%
N/A (Family Member)	2	0%
Foreign Military	4	1%

The majority of veterans accessing V1P Scotland were discharged while serving at a rank equivalent to Private (52%). JNCO rank equivalents represent 33% and SNCO/WO 14%. Veterans of more senior ranks equivalent to 2nd Lt-Capt or Major and above represent only 1% each.

Graph 3 : Rank on Discharge



Veterans accessing V1P Scotland do not seem to represent the military population according to figures published by the Ministry of Defence (2014). It is clear that proportionally a greater number of veterans from more junior ranks are accessing support at V1P Scotland.

Table 5: Rank on discharge

Rank Equivalent	V1P Population	Military Population
Private	52%	35%
JNCO	33%	26%
SNCO/WO	14%	22%
2lt-capt	1%	9%
Major and above	1%	8%

The majority of veterans accessing V1P Services had elected to end service. The second highest group were those who were medically discharged.

Table 6: Method of Discharge (n=657)	**Frequency**	**%**
Demob	9	1%
Administrative	29	4%
Elected/daof/End Engagement	**236**	**36%**
Medical	166	25%
Premature Voluntary Release	82	12%
Redundancy	36	5%
Service no Longer Required	69	11%
Other	30	5%

Deployment

A high proportion of veterans accessing V1P Scotland have been deployed to combat zones[1] (78%). The average number of combat zone deployments is two with a range between one and eleven.

4.5 Supporting Early Service Leavers

Eleven percent of those accessing V1P Scotland left service before their initial four years were completed and are defined as early service leavers. A small proportion (1%) left within the first six months of enrolment.

Table 7: Length of Service

	Frequency	%
6 months or less	9	1%
More than 6ths to less than 4yrs	66	10%
More than 4 years to less than 6 years	109	17%

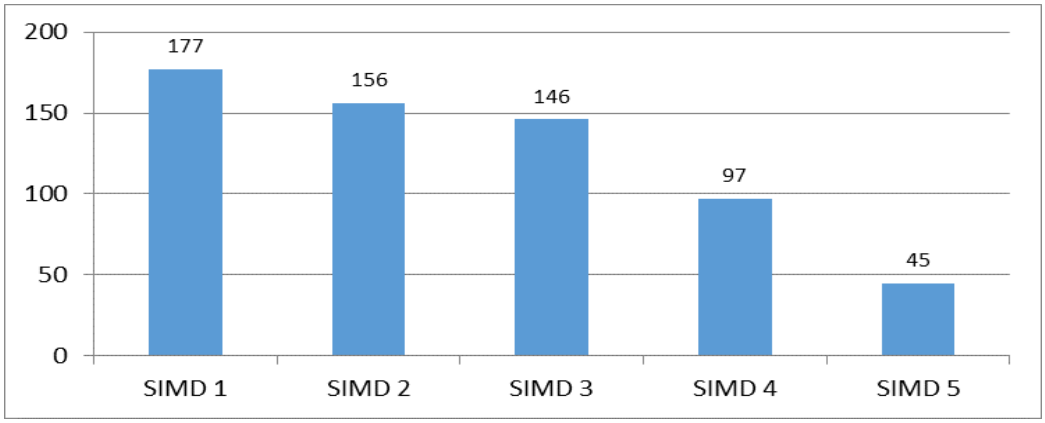
4.6 Veterans' Living Circumstances

V1P Scotland is working with high proportions of veterans living in the most impoverished areas of Scotland as measured by the Scottish Index of Multiple Deprivation. (SIMD) 29% of Veterans reside in locations which are defined as within the quintile of most deprived areas of multiple deprivations, while only 7% live in addresses within the quintile of the least deprived areas.

Table 8 Referrals from SIMD Quintile (n=621)

	Frequency	**%**
SIMD Quintile 1	**177**	**29%**
SIMD Quintile 2	156	25%
SIMD Quintile 3	146	24%
SIMD Quintile 4	97	16%
SIMD Quintile 5	45	7%

Graph 4: Veterans residing in SIMD Quintile (n=612)



[1] This data is vulnerable as Veterans reported the location to which they were deployed and over the timeframe the individual veteran served the location may have been a combat zone. Peer support workers who are themselves veterans assisted in decision regarding which deployments were combat.

5.0 Evaluation Findings: Credibility

This section focuses on the credibility of the services provided in relation to the outcomes experienced by veterans.

5.1 The evaluation used three clinical measures:

- The Work and Social Adjustment Scale (WSAS) (Mundt et al., 2002)
- The Patient Health Questionnaire 9 (Kroenke et al., 2001)
- The CORE 10 (Connell and Barkham, 2007).

5.2 The Work and Social Adjustment Scale (WSAS)

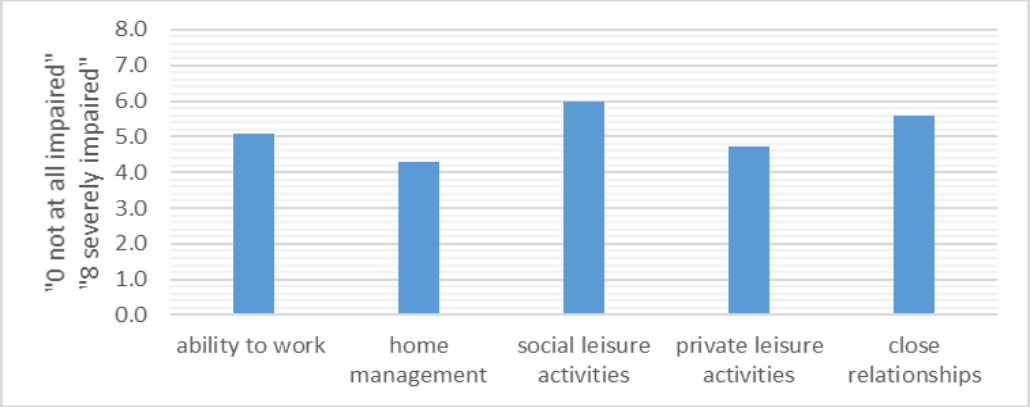
The WSAS measures veterans perceived functional impairment due to health problems. The assessment asks veterans to score (on a scale from 0 to 8) work; home management; social leisure activities; private leisure activities; and relationships with others. Total scores may range from 0 to 40 with lower scores indicating less perceived impairment. According to Mundt et al. (2002), total scores above twenty suggest moderately severe psychopathology, scores between ten and twenty indicate significant functional impairment but less severe clinical symptomatology, and scores below ten are associated with subclinical populations.

The average total score of veterans on commencement of a programme of psychotherapy is 26.1 (n=247 SD=9.2). The mean score is reflective of moderately severe psychopathology. Item scores suggest that social leisure activities followed by close relationships and ability to work are most challenging.

Table 9: WSAS Mean Score

WSAS mean item scores (initial assessment) n=247	
ability to work	5.1
home management	4.3
social leisure activities	6.0
private leisure activities	4.7
close relationships	5.6

Graph 9: WSAS mean item scores (initial assessment) n=247

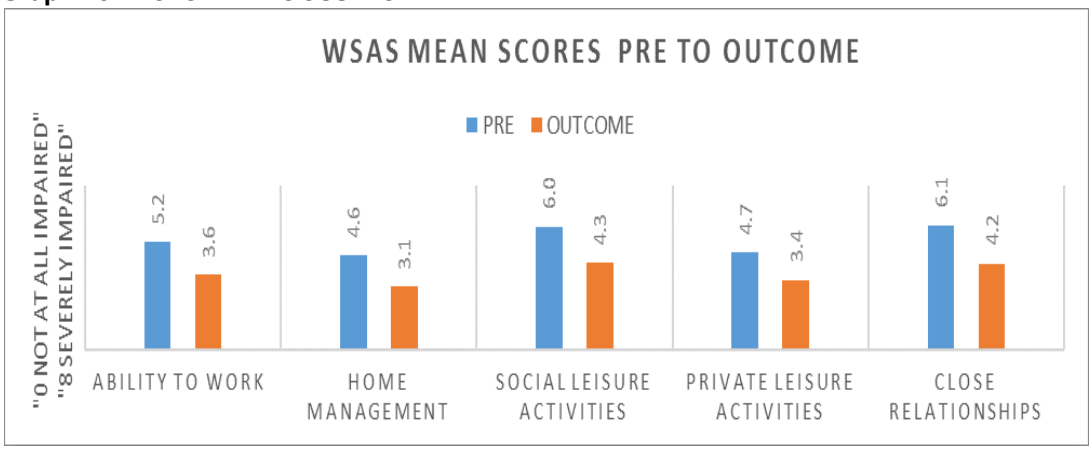


During the evaluation period 50 veterans who engaged in a course of psychotherapy and returned a completed WSAS scored at the end of therapy for comparison. This cohorts' mean initial score was 27 (n=50, SD=8.7) and their mean outcome score was 18 (n=50, SD=11.3).

Veteran's completing a course of psychotherapy with V1P Scotland have an average improved score on the WSAS of 9 points, Zahra et al. (2014) suggest an improvement of 8 points or more can be considered clinically relevant.

These scores suggest an improvement from "moderately severe psychopathology" to "significant functional impairment but less severe clinical symptomatology". The most significant improvement in item scores is in close relationships and social leisure activities - the two items which were most challenging initially.

Graph 10: WSAS MEANS SCORES



5.3 The Patient Health Questionnaire 9 (PHQ-9)

The PHQ–9 is a self-report assessment for depression module which asks veterans to score each of the 9 DSM-IV criteria from "0" (not at all) to "3" (nearly every day). PHQ-9 total scores of 5, 10, 15, and 20 represented mild, moderate, moderately severe, and severe depression, respectively (Kroenke et al. 2001)

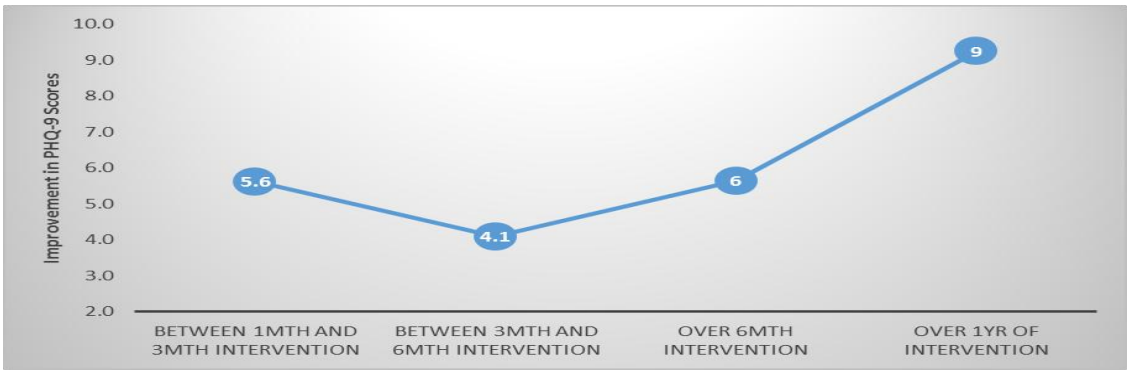
The average total score of veterans on commencement of a programme of psychotherapy is 18 (n=240 SD=5.9). The mean score is reflective of moderately severe depression.

During the evaluation period, forty veterans who engaged in a course of psychotherapy returned a completed PHQ-9 scored at the end of therapy for comparison. The mean initial score for these veterans was 19 (n=40, SD=5.1) and their mean outcome score is 13 (n=40, SD=7.0). These scores suggest an improvement from "moderately severe depression" to "moderate depression". It is also notable that these scores show a continuing improvement over time.

As shown in Graph 11 following an initial average improvement of 5.6 points, improvement increases from 4.1 points (at between three and six months) the longer the veteran remains engaged in psychotherapy. Those who have engaged for twelve months or longer achieve an improvement of 9 points (n=6).

These scores suggest an improvement from "moderately severe depression" to "moderate depression". It is also notable that these scores improve over time. As shown in Graph 11 following an initial average improvement of 5.6 points, improvement increases from 4.1 points (at between three and six months) the longer the veteran remains engaged in psychotherapy. Those who have engaged for twelve months or longer achieve an improvement of 9 points (n=6).

Graph 11: Improvement in PHQ 9 scores Over Time



5.4 The CORE 10

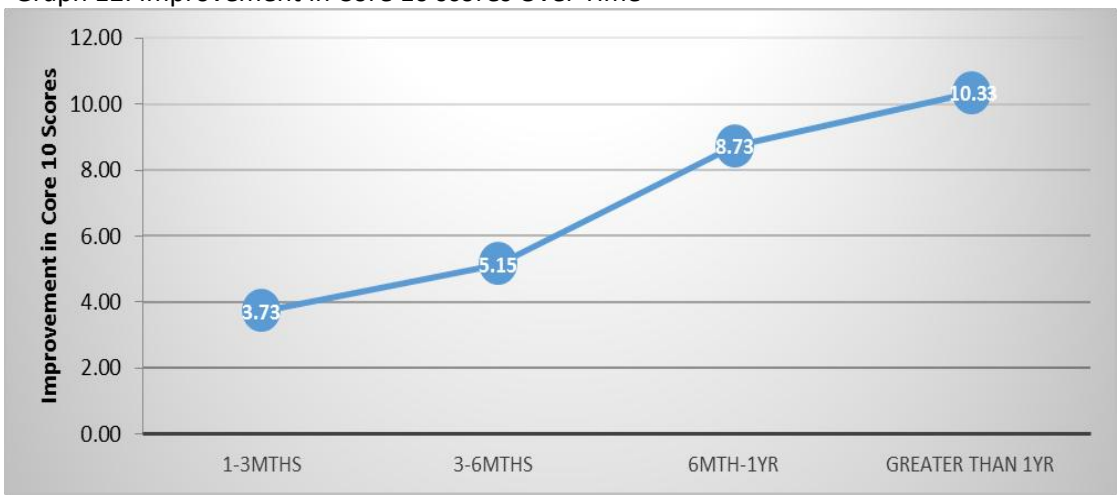
The CORE-10 is a brief self-report assessment of distress. Veterans are asked to rate ten items including commonly experienced symptoms of anxiety and depression and associated aspects of life and social functioning. Total scores above 25 indicate severe distress, 20-24 moderately severe distress, 15-19 moderate distress, 11-14 mild distress and total scores below ten are considered non-clinical (Connell and Barkham 2007).

The average total score of veterans on commencement of a programme of psychotherapy is 24.2 (n=287 SD=7.5). The mean score is reflective of moderately severe distress.

Over the evaluation period, seventy-four veterans who engaged in a course of psychotherapy returned a completed Core 10 scored at the end of therapy for comparison. The mean initial score for these veterans was 25.4 (n=74, SD=6.2) and their mean outcome score was 18.5 (n=74, SD=8.7). The average improvement in scores between initial and outcome assessments is 6.9 (n=74, SD 6.7). Connell and Barkham (2007) suggest that an improvement in scores of 5.9 or greater is reliable.

These scores suggest an improvement from “severe distress” to “moderate distress”. Improvement in scores for the Core 10 are also notable in that the ratings show continuing improvement over time, i.e. sustained benefit. As shown in Graph 12 there is a steady increase in the average improvement between initial and outcome scores over time the longer veterans are engaged in therapy, with the greatest improvement of 10.33 when engaged for twelve months or more (n=9).

Graph 12: Improvement in Core 10 scores Over Time



6.0 Evaluation Findings: Coordination

This section details the social circumstances of veterans, including living arrangements, housing, employment, physical health and time from discharge from armed services to accessing V1P Scotland.

6.1 Living arrangements and housing

The social circumstances experienced by veterans can be challenging, as previously detailed, with significant proportions of veterans live in areas of multiple deprivation. Homelessness and rooflessness are challenges facing Veterans accessing V1P services.

On initial meeting with peer support workers, 2% of veterans describe themselves as, and 38% have experienced homelessness. This is within a national context where 0.6% of the general Scottish population applied to statutory homelessness legislation in the year 2016-17 (SG 2017).

Table 10: History of Homelessness

n= 640

	frequency	**%**
Yes	241	38%
No	399	62%

One percent of the V1P service users use the term roofless to describe their circumstances while national statistics suggest 0.05% of the Scottish population have slept rough within the last three months (Scottish Government, 2017). Additionally, 4% of veterans are living in accommodation for homeless people and a further 3% in homes of multiple occupancy. 37% of veterans accessing support live alone.

Of particular note, 16% of veterans consider their current living situation unstable. It is therefore vital that V1P service continues to build and enhance their coordination with housing services.

Table 11: Living Arrangements

N – 667	Frequency	**%**
Living Alone	249	37%
With Partner/spouse	184	27%
With Children	23	3%
With Partner/spouse and children	125	18%
With Relatives	52	8%
With Friends	14	2%
Homeless	13	2%
House of multiple occupancy	17	3%
Prison	0	0%

Table 12: Living Situation

N = 667	frequency	%
Private Let	130	19%
Supported accommodation	17	3%
Homeless accommodation	24	4%
Privately owned	178	27%
Council house/housing association	259	39%
HMP	1	0%
Mobile home	0	0%
Roofless	7	1%
With relatives	22	3%
Military housing	29	4%

Table 13: Stability of Living Situation

N = 668	frequency	%
Yes	562	84%
No	106	16%

6.2 **Employment**

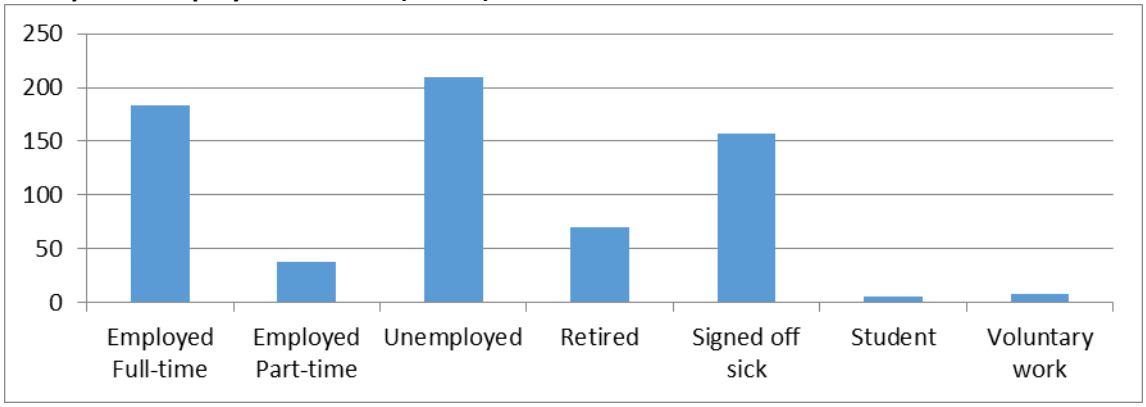
Only 33% of veterans accessing V1P are currently in part or full-time employment, and of great concern, 23% are presently signed off work.

48% are currently seeking employment and a further 8% seeking some form of training or education.

Table 14: **Employment Status**

N = 672	frequency	%
Employed Full-time	183	27%
Employed Part-time	38	6%
Unemployed	210	31%
Retired	70	10%
Signed off sick	157	23%
Student	6	1%
Voluntary work	8	1%

Graph 13: Employment Status (n=672)



6.3 **Financial Welfare**

Financial welfare is discussed with peer support workers on initial contact with services. On commencement with services, 20% of veterans have not applied for service pensions, and 5% have applications in progress. A small percentage (2%) are not entitled to service pensions, and a further 31% are not entitled as yet. 23% of veterans are receiving a War Pension, 21% a Service Pension and 12% a Medical Pension.

66% of veterans are in receipt of some type of state welfare benefit (disability, (un)employment, housing, bonus payment, or grant. Those veterans who are in receipt of welfare support average two benefits (this ranges from 1 to 6 benefit payments). Peer support workers support veterans to access information and appropriate services to address welfare concerns

6.4 **Veterans in the Criminal Justice System**

Veterans who are currently detained in prison represent a small but significant number of the veterans presently accessing support from V1P Scotland. At present, twenty two veterans are supported through co-ordinated in-reach programme.

6.5 **Physical health**

While mental health concerns are the primary focus of interventions provided by the V1P Scotland services co-ordination with physical health services and pain management services are vital.

Just over half of veterans (53%) accessing V1P Scotland report some degree of mobility problems, for 19% these are moderate and for 17% mobility problems are severe. Furthermore, 52% of veterans report limitations in climbing stairs. These mobility challenges reflect needs for services supporting veterans to access appropriate health and housing services.

29% of veterans report severe or extreme pain and 68% of veterans report pain interfered with carrying out daily activities, for 21% this was to an extreme degree.

6.6 **The impact of physical and mental health conditions on participation in daily activities**

Routinely reported by veterans is the impact of physical and mental health conditions on participation in daily activities Less in accomplished due to emotional health concerns for 78% of veterans and due to physical health for 57% of veterans.

Health concerns were a limiting factor in the kinds of activities 57% of veterans pursued, and in particular, 70% of veterans report limitation in engagement in social activities.

6.7 **Seeking help**

It is encouraging to see that a small number of serving personnel are seeking support prior to discharge and 6% are accessing support within one year.

Table 15: Time taken to access V1P Scotland

N – 599	Frequency	%
Still serving	17	3%
within 6 months	16	3%
within 1 year	18	3%
between 1 and 4 years	76	13%
between 4 and 10 years	101	17%
between 10 and 22 years	175	29%
over 22 years	196	33%

7.0 Discussion, Learning Points and Recommendations

This section will discuss the findings of the evaluation and set out clear recommendations.

7.1 Veterans First Point would appear to have established effective links with the military to support Veterans transition out of service. This is demonstrated by the direct referrals from the military and self-refer encouraged by the military; these referrals occur before or rapidly following discharge. These two routes account for 3% of new referrals to V1P service. Strong links with military charities, organisations or agencies have also resulted in direct referrals or self-referrals with support. Referrals from or encouraged by military charities, organisation or agencies account for 29% of referrals to V1P services.

7.2 Over a fifth of veterans access support from V1P Scotland services within 4 years of being discharged from service; 3% are referred while still serving; 6% in the first year following discharge (3% in the first six months) and a further 13% within the four years of leaving services. This demonstrates improved linkages and relationships with military and associated charities, organisation and agencies to support veterans' access support early in their transition out of services.

V1P Centres will:

- Sustain and build up relationships with military charities**,** organisation and agencies who are working veterans in partnership areas.
- Continue to provide inreach to the armed services with a particular focus on potential early leavers
- Provide information on V1P services to serving personnel who finish their service
- Ensure input to the Hard Facts meetings

7.3 Three clinical measures used in the evaluation have all demonstrated improvements over time in depression, distress and functional impairment. Improvements are clinically significant and reliable. The V1P Scotland service is, therefore, a credible provider of psychological therapies to veterans. While these improvements are apparent, it should be noted that Veterans' presentations are complex. Initial assessment scores often meet the severe criteria for clinical assessments at engagement with services. Improvements in veterans' ratings, while significant and reliable, continue to meet the criteria for moderate distress or depression. Veterans are therefore likely to need ongoing support and monitoring. Additionally, it is essential to acknowledge that greater improvements are seen over time, increasing with the duration of engagement with therapy. Veterans seem to be one population group who appear to benefit from intervention of a longer duration.

V1P Centres will:

- Continue to use The Work and Social Adjustment Scale (WSAS), The Patient Health Questionnaire 9 and CORE 10.
- In recognition of the multiplicity and complexity of needs that veterans are presenting with, agree and introduce additional measurement tools including those focusing on PTSD and Substance Misuse.
- Continue to collect the agreed data set with additional items focusing on presenting problems and diagnosis added to the dataset which will add further to the national and international knowledge relating to veterans social and healthcare needs

7.4 In light of both self-reported problems and those identified through the assessment outcome measures which indicated high levels of depression, and anxiety which impacted on functioning, and subsequently quality of life, there needs to be a continued focus on ensuring that V1P staff are trained and supervised to deliver evidence-based therapies for veterans experiencing psychological problems.

7.5 Veterans reported a range of interpersonal problems such as relationship disputes, social isolation, prolonged grief and significant life transitions which all impact on mental health. An A-rated therapy such as Interpersonal Psychotherapy (IPT) aims to reduce depressive symptoms and improve social functioning by focusing on interpersonally relevant issues (Stewart et al., 2014). IPT has been adapted to be appropriate for various populations and for a variety of mental health difficulties ranging in their severity. IPT for depression is recommended by the APA (2010) as a first-line intervention for military service members and veterans suffering from depression (U.S Department of Veterans Affairs and Department of Defence, 2009).

V1P Scotland will:

- Establish a robust training and supervision programme to enable V1P Therapists to be trained (or have skills augmented) to deliver CBT and IPT which are A rated therapies recommended by the Matrix (2017) for the treatment of anxiety and depression.
- Ensure that V1P Staff are trained to deliver Phase based interventions in line with the National Trauma Training Framework (2017).
- Establish a robust training and supervision programme to V1P Peer Workers to be trained and supervised in Interpersonal Psychotherapy Counselling and receive supervision to enable and support delivery.

7.6 V1P Centres are treating veterans with a range of physical and mental health problems which have a significant impact on daily living activities and functioning following the principles of V1P as a "one-stop shop" staff need to developing and implementing pathways of support which responds to both physical and mental health care needs.

V1P Centres will:

- Work with clinician teams and local partners partners/experts to develop care pathways for the care and support of veterans with pain/mobility issues and adopt these pathways into local service provision.

7.7 Veterans identified the impact of their physical and mental health conditions on everyday living activities and interpersonal relationships. High rates of unemployment were striking within the community. Veterans leave the armed services with many transferable skills which would be of great benefit to civilian life. V1P Centres are in a unique position to build partnerships with local business, regeneration programmes and wider civic life would create more opportunities for veterans to contribute to civilian life.

V1P Scotland will:

- Work with the University of Strathcylde to built and test a measure of citizenship for veterans. This will inform future capacity and asset building streams of work within the Centres and across partnership areas.

7.8 It is key that we continue to build our knowledge base of what works for veterans and we maximise the opportunity of the Centres who are now using a standard dataset with routine measures to lead and collaborate on research initiatives nationally and internationally.

.

V1P Scotland will:
Enable Clinical Leads of V1P Centres, through the provision of protected learning time, to participate in research collaborations with higher educational institutes which will enhance the evidence base for responding to veterans' needs.

References

Bowes (2017) Veteran adjustment to civilian life: a research portfolio , Doctorate in Clinical Psychology, University of Edinburgh. https://www.era.lib.ed.ac.uk/handle/1842/22949

Buckman, J E.J., Sundin, J., Greene, T., Fear, N.T., Dandekar, C., Greenberg, N., Wessley, S (2011) The impact of deployment length on the health and well-being of military personnel: a systematic review of the literature, Occupational and Environmental Medicine (2010). doi:10.1136/oem.2009.054692. https://www.kcl.ac.uk/kcmhr/publications/assetfiles/interventions/Buckman2010-impactofdeploymentlength.pdf

Care Quality commission (2016) Community Mental Health Survey https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/568548/MH16_statistical_release.pdf

Coleman, S, J, Stevelink, S.A.M., Hatch, L., Denny, J.A and Greenberg, N (2017) Stigma-related barriers and facilitators to help seeking for mental health issues in the armed forces: a systematic review and thematic synthesis of qualitative literaturure. Psychological medicine, Cambridge University Press https://www.kcl.ac.uk/kcmhr/publications/assetfiles/2017/Coleman2017.pdf

Connell, J. & Barkham, M. (2007). CORE-10 User Manual, Version 1.1. CORE System Trust & CORE Information Management Systems Ltd.

Fear, N.T., Jones, M., Murphy, D., Hull, L., Iversen, A.C., Coker, B., Machell, L., Sundin, J.N., Woodhead, C., Jones, N., Greenberg, N., Landau, S., Dandeker, C., Rona, R.J., Hotopf*, M., Wessely, S (2010) What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. Lancet; 375: 1783–97 https://www.kcl.ac.uk/kcmhr/publications/assetfiles/iraqafghan/Fear2010-consequencesofdeployment.pdf

Goodwin, L., Wessley, S., Hotopf, M., Jones, M., Greenberg, N., Rona, R.J., Hull, L., Fear, N.T (2010) Are common mental disorders more prevalent in the UK serving military compared to the general working population? Psychological Medicine, vol 45, issue 5, https://www.cambridge.org/core/journals/psychological-medicine/article/are-common-mental-disorders-more-prevalent-in-the-uk-serving-military-compared-to-the-general-working-population/B93009A3084218BCDB1D7AD3AAA6B7BF

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment, 36*, 41-54

Gribble, R., Wessley, S., Klein, S., Alexander, D.A., Dandeker, C., Fear, N.T (2014) British Public Opinion after a Decade of War: Attitudes to Iraq and Afghanistan. Political studies association. https://www.kcl.ac.uk/kcmhr/publications/assetfiles/2014/Gribble2014b.pdf

Harvey,S.B., Hatch, S.L., Jones, M., Hull, L., Jones, N., Greenberg, N., Dandekar, C., Fear, N.T., Wessley, S (2011) Coming Home: Social Functioning and Mental Health of UK reservists on return from deployments to Iraq and Afghanistan. Annals of Epidemiology https://www.kcl.ac.uk/kcmhr/publications/assetfiles/iraqafghan/Harvey2011-cominghome.pdf

Jones, N., Campion, B., Keeling, M & Greenberg, N (2016): Cohesion, leadership, mental health stigmatisation and perceived barriers to care in UK military personnel, Journal of Mental Health, DOI: 10.3109/09638237.2016.1139063 http://dx.doi.org/10.3109/09638237.2016.1139063

Kroenke, K., Spitzer, R.L. & Williams, J.B.W. (2001) Journal of General Internal Medicine Vol 16: 606-613

Ministry of Defence (2017) UK armed forces biannual diversity statistics: 2017
https://www.gov.uk/.../statistics/uk-armed-forces-biannual-diversity-statistics-2017

Mundt JC, Marks I.MShear, ., M.K. Greist J.H.,(2002) The Work and Social Adjustment Scale: a simple measure of impairment in functioning, Br. J. Psychiatry Vol.180 461–464.

Murphy, D., Palmer, E., Ashwick, R. Multiple deprivation in help-seeking UK veterans Multiple deprivation. 2017. London, Combat Stress. 2-2-2017.

Scottish Government (2017) Homelessness in Scotland: 2016-17
http://www.gov.scot/Resource/0052/00521186.pdf

Weir, B., Cunningham, M., Abraham, L & Allanson-Oddy, C(2017) Military veteran engagement with mental health and well-being services: a qualitative study of therole of the peer support worker. Journal of Mental Health, https://www.tandfonline.com/doi/pdf/10.1080/09638237.2017.1370640?needAccess=true

Zahra D, Qureshi A. Henley W, Taylor R, Quinn C, Pooler J, Hardy G Newbold A & Byng R (2014) The work and social adjustment scale: Reliability, sensitivity and value, International Journal of Psychiatry in Clinical Practice, 18:2, 131-138.