The Finchale Joint Transition Support Service (JTSS) Evaluation Study

Final Report – April 2016

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The Finchale Joint Transition Support Service (JTSS) Evaluation Study: Final Report

Prepared by the North of England Mental Health Development Unit (NEMHDU) for Finchale and the Forces in Mind Trust

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Executive Summary

This report describes the findings of an evaluation of the Finchale College's Joint Transition Support Service (JTSS) undertaken by North of England Mental Health Development Unit (NEMHDU) over an 18-month period from July 2014 to Dec 2015.

1. Background and Aims

Each year around 20,000 UK Armed Forces personnel begin the transition back to civilian life. While most transitions are successful, the cost of poor transition to the UK economy is estimated to be around £100 million per year in direct costs alone. This is due to the financial burden created by issues such as alcohol misuse, mental ill health, unemployment, family breakdown, homelessness and criminal offending.

Since the publication of the Armed Forces Covenant in 2000, government policy has focused increasingly on how to improve the process of transition for service leavers and their families. In 2010 the MoD's *Strategic Defence and Security Review* initiated a process of reducing the size of the UK Armed Forces, with a long term aim to rely more heavily on reservists such as those employed in the Territorial Army and Royal Naval Reserves. Given the subsequent redundancies that have followed, understanding the challenges of transition is more necessary than ever.

In acknowledgement of the growing challenges of resettlement, in 2014 Lord Ashcroft's *Veterans' Transition Review* was commissioned to examine existing support structures and key issues faced by service leavers. Ashcroft provides a series of practical recommendations across inter-related areas including training, employment, health, housing, welfare and finance. One key over-arching recommendation, which echoes findings from the Forces in Mind Trust (FiMT) 2013 Transition Mapping Study, argues for the widening of eligibility criteria for full resettlement support (currently available to those with over six years' service), in recognition that the likelihood of poor transition appears to be amplified for Early Service Leavers.

In response to an identified need for greater co-ordination and case management during the transition process for potentially vulnerable service leavers, in April 2014 Finchale Training College was commissioned by the FiMT to pilot and evaluate a 2-year programme designed to support service leavers and their families during the transition to civilian life. Launched in August 2014, the Joint Transition Support Service (JTSS) aims to provide individual, case-managed support to service leavers and family members following discharge on medical grounds. The service was designed to be holistic in nature, while holding a strong mental health and emotional wellbeing focus. The team is made up of a Community Psychiatric Nurse, an Occupational Therapist and an employment coach, alongside a service coordinator and manager. Building upon existing relationships within the sector, the service aims to provide an additional element to the transition pathway by working with existing providers, particularly the Personnel Recovery Unit at Catterick Garrison.

In order to provide an independent element to the evaluation of JTSS, the North of England Mental Health Development Unit (NEMHDU) was commissioned by Finchale Training College to provide evaluative input across the service's 2-year timeframe.

The aims of the evaluation study were to explore:

- The sociodemographic and service profile of JTSS clients
- Veterans' and their families' experience of the JTSS - including satisfaction levels, examples of effective practice and areas for improvement
- Health, well-being and wider outcomes for those who participated in JTSS and their families

2. Service Evaluation Methods

Informed by discussions with the JTSS staff and other stakeholders, a mixed methods evaluation strategy was designed to address the aims of this service evaluation.

- A scoping review of the academic, policy and 'grey' literature on transition, including its associated challenges and the outcomes of any existing support programmes for service leavers and their families. Eleven bibliographic databases were searched using a structured search strategy. Eligible articles were reviews, primary research papers (quantitative, qualitative or mixed methods) and discussion articles focused on support programmes for armed forces transitioning to civilian life delivered in the primary care / community setting. Articles focused on post-deployment reintegration programs (i.e. armed service personnel returning from operations who remain enlisted in the armed forces) and PhD theses were excluded.

- An Excel-based data recording system was designed to capture data on numbers of referrals, sources of referral and geographical location of clients referred to the JTSS, including data on the sociodemographic and service profile (veterans) of JTSS clients; primary presenting concerns; onward referral destinations; and assessment of health and well-being outcomes at the initial, interim and final appointments using the Rickter Scale and SF-8.

- Qualitative semi-structured interviews with a purposive sample of JTSS clients (veterans and family members) and JTSS staff, including other stakeholders such as referring organisations.

- A self-report questionnaire survey to examine client satisfaction with the JTSS and to explore any long-term impact on health, wellbeing or wider outcomes.

3. Findings: Scoping Literature Review

The grey literature and search of 11 electronic databases yielded 470 hits, of which 23 (17 from the academic literature and 6 papers from the grey literature) fulfilled the eligibility criteria and were included in the scoping review

Evidence was found for brief personalised interventions targeting alcohol use in veterans, and the value of case management and wrap-around services for veterans and their families. Few studies that formally evaluated interventions used robust designs such as randomised controlled trials. Consequently, there is a paucity of robust evidence around the effectiveness of intervention programmes for service leavers and

their families to facilitate transitioning back into civilian life. Much of the literature is US based prompting questions about the applicability of such data in the UK context. What evidence that does exist is limited in methodological quality and there is a particular dearth of robust data on health and psychosocial outcomes, including cost-effectiveness of transition programmes, with many studies focusing on presenting descriptive data and analysis of process outcomes such as client satisfaction.

4. Findings: Routinely Collected Data

The JTSS received 55 'appropriate' referrals during the evaluation period (July 2014 to Dec 2015), which equated to a median of 3 (IQR = 3) referrals per month. In addition to the 55 clients who were appropriately referred to the JTSS service, there were 25 inappropriate referrals received during the evaluation period. Inappropriate referrals were those that fell outside the JTSS eligibility criteria.

JTSS clients were primarily clustered around the population centres of Newcastle-upon-Tyne, Sunderland Durham and Teesside, with smaller numbers located at Blyth, Preston and Harrogate.

Source of referrals to the JTSS

The JTSS received referrals from 12 different sources. The Personnel Recovery Unit (PRU) at Catterick Garrison was the modal referral source (29%). Approximately a quarter of clients were referred to the JTSS by family members (26%). The Jobcentre Plus referred 7 (13%) clients, with 4 (7%) clients referred internally via Finchale College's Progression Pathways Service. Only two clients (4%) referred themselves to the JTSS. The remaining clients were referred via military organisations/charities (Combat Stress, Army Welfare Service, SSAFA and Future Horizons), the Department of Community Mental Health, Durham Police or the Recovery Career Service in collaboration with PRU.

Sociodemographic Profile of JTSS Clients

The majority of the 55 JTSS clients were veterans (n=39, 71%). The remaining 16 (29%) were family members of veterans (spouses/partners (n=9), children (n=3) and other family members (n=4).

Veterans were on average aged 29.5 years (SD=7, min/max = 19/48), and the majority were male (n=36, 92%) and White-British (n=35, 90%). Equal numbers of veterans were single (n=16, 41%) or married/with a partner (n=16, 41%); relatively few were divorced or separated (n=5, 13%).

Family members were on average 5 years older than veterans (mean = 35 years, SD=12, min/max = 17-54) and the majority were female (n=12, 75%), White-British (15, 94%) and had a spouse / partner (n=11, 76%). Veterans and family members both had on average one child in their household.

Armed Forces Profile of Veterans

Veterans had served on average 9 years (SD = 6.7, min/max = 1/29) in the armed forces. The majority of veterans had been medically discharged (94%), were previously army regulars (85%) and had held the rank of private (64%).

Presenting Primary Concerns of JTSS Clients

On average, veterans presented with 4 primary concerns (min/max = 1/9). Issues related to employment, mental health, physical health, PTSD and housing were the primary concerns. This pattern was similar for family members who presented with on average 2 primary concerns (min/max = 1/4). Relationship issues were primary concerns for approximately a third of family members and veterans. More family members than veterans were primarily concerned with debt issues. A substantial proportion of veterans (54%) and family members (31%) cited 'other' primary concerns such as claims for compensation, issues with benefits and gambling problems.

Timeframes for Discharge from the Armed Forces to Referral to the JTSS and Subsequent Discharge from the Service

In three cases, no date of discharge from the armed forces was available. The majority of the remaining 36 veterans were referred to the JTSS after discharge from the armed forces (26, 72%); with over one quarter (n=10, 28%) of referrals to the JTSS received prior to veterans being discharged from the armed forces.

On average, the length of time between a veteran's discharge date from the armed forces and receipt of a referral to the JTSS was 86 days/~3 months (pre-discharge from armed forces) and 155 days / ~5.2 months (post-discharge from armed forces).

Overall, once a referral to the JTSS had been received, on average, the length of time a client received support from the JTSS before being discharged from the service was 165 days (~5.5 months). For veterans the average timescale was shorter 138 days (~4.6 months) than family members (260 days/~8.7 months).

Reasons for Discharge from the JTSS and Onward Referrals

Out of the veterans discharged from the JTSS (21 out of 39, 54%) during the evaluation period, the majority were discharged for positive reasons (n=19, 91%). Nine (43%) had completed action plans or found employment, with a further 4 (19%) stating they had no further support needs. Approximately one third of veterans were discharged (29%) from the JTSS due to not fully engaging with the full range of programme activities. Two (10%) were discharged from the JTSS for negative reasons (in custody).

Six of 16 (38%) of the family members had been discharged from the JTSS during the evaluation period. Family members were discharged for positive reasons - completion of action plans (n=2) or completion of action plans and in a full-time employment (n=1) or caring role (n=1). A further 2 of the 6 family members were discharged from the JTSS due to not fully engaging with the full range of programme activities.

Four clients were subsequently referred to other agencies/organisations following discharge from the JTSS. In 9 cases there was no identified need for a subsequent referral following discharge from the service. In one case a suitable onward referral destination could not be identified. There were no data available for onward referral of family members discharged from the JTSS during the evaluation period.

Rickter Scale Assessments

Average time between initial and interim assessments of Rickter scales was 120 days/~4 months (SD=76, min/max=42/321). Except for accommodation, veterans showed improvements in the remaining 9 Ricketer domains between the initial and interim assessments. There were statistically significant improved mean Rickter scores for veterans between the initial and interim assessment period for Influences, Stress and Drugs

With the exception of accommodation and stress, family members' scores on the remaining 8 Rickter domains improved between the initial and interim assessment period. The largest improvements (>1 point) were observed (in rank order) for drugs, happiness, influences, money and employment/training/education.

SF-8 Assessments

Average time between initial and interim SF-8 assessments was 116 days/~3.9 months (SD=76, min/max=42/321). There were small improvements (>1 point) for veterans on mental health and vitality domains, whereas, the domains general health perception and role functioning-physical showed small decreases. However, none of these differences for veterans were statistically significant.

With the exception of vitality and bodily pain (that showed small decreases), family members showed improved scores (>1 point) on mental health, role functioning-emotional, social functioning, general health perception and physical functioning; although inferential statistical tests of differences were precluded due to the small sample size.

For both veterans and family members, Mental Component Summary (MCS) and Physical Component Summary (PCS) scores were below 50 at initial and interim assessment periods (below national norms) However, there were no statistically significant improvements between the initial and interim assessment periods for veterans

5. Findings: Qualitative Interviews

Sixteen semi-structured interviews were conducted with service leavers, family members, JTSS staff and stakeholders from referral organisations. Of the 16 interviews, eight were conducted in person and the remainder were conducted by telephone. Analysis of the interview data revealed high levels of satisfaction with the service. Particular strengths of the JTSS included the holistic family centred approach, knowledgeable and empathic frontline staff, sustained personal contact over time and the long term perspective underpinning by the service. Challenges were highlighted around defining meaningful measures of success, improving awareness and better publicising the service and increasing resources to provide a sustainable service into the future. Clients reported many positive outcomes ranging from impacts on psychosocial wellbeing, including increased self-esteem, motivation and confidence, for service leavers to impacts on employability including completion of training courses and, for a small

number of clients who were more job ready, actually securing employment. Family members also benefitted from the support provided by frontline staff and reported valuing the opportunity to have someone independent from the family unit to talk with. Finally, a key asset of the JTSS, and Finchale College as a whole, is the opportunity it affords for veterans to interact with others with similar experiences and challenges thereby acting as an informal peer support network.

6. Findings: Post-support questionnaire survey

The response rate to the post-support questionnaire survey was extremely low (n=2), which precluded analysis of these data.

7. Discussion and Recommendations

Over the 18 month evaluation period, the JTSS engaged with 55 clients who were referred by 12 different sources (most frequently from The Personnel Recovery Unit at Catterick Garrison). Once a referral had been received, engagement with staff at the JTSS was typically a few days, which is extremely favourable compared to NHS primary care services such as Improving Access to Psychological Services. Primary issues that clients presented with were related to employment, mental health, physical health, PTSD, housing and relationships. Family members reported being more concerned about debt issues than veterans. Issues such as claims for compensation, issues with state benefits and gambling problems were other common concerns of JTSS clients.

Analysis of Rickter scores for veterans identified evidence for a statistically significant amelioration of the perceived negative influence of others, how much stress they are currently experiencing and the extent that drugs are part of their lives. No objective evidence for any tangible impact on health outcomes was assessed with the SF-8. Engagement with the JTSS was excellent. During the evaluation period, 27 clients were discharged from the JTSS, with the substantial majority of these clients (n=25, 93%) fully-engaging with all JTSS services.

Qualitative interview analysis provided compelling evidence that the JTSS had a range of psychosocial benefits for veterans and families during a challenging period of their lives. These data revealed multiple effects of the JTSS on indicators of a positive transition and recovery from mental health problems, including family functioning, and generic health and well-being. Strong evidence was also found that engagement with JTSS was attributable to the prevention of negative / adverse outcomes, which are likely to have yielded significant 'offset effects' in terms of cost savings to NHS and Social Care services (e.g. reduced visits to primary care). Interviews with JTSS staff and other stakeholders supported the findings from interviews with veterans and family members in terms of perceived psychosocial benefits, but also provided insights into the mechanisms underpinning them. The value of face-to-face contact combined with a holistic person/family-based approach to working with clients was instrumental for building motivation, autonomy and confidence. The benefit of personal contact and continued relationships with clients was viewed as critically important for development of positive therapeutic alliances, which are strong indicators of positive outcomes in mental healthcare.

Challenges

Approximately 30% of the total referrals to the JTSS during the evaluation period were inappropriate; although, all these individuals received support in the form of signposting / referral to a range of other services/programmes that are available at Finchale. Nevertheless, the rate of inappropriate referrals impacted negatively on service capacity and could be reduced by regular communication/engagement with referral organisations to ensure understanding of the remit and eligibility boundaries of the JTSS; and/or expansion of eligibility boundaries. This requires regular and sustained engagement with referral organisations/agencies to be effective, which represents a considerable investment of staff time that is currently allocated to supporting clients.

Defining a 'successful' outcome for clients with multiple and complex needs was considered a key challenge. Key stakeholders stated it was erroneous to employ a 'one size fits all' model to assessing outcomes in terms of recovery and improved health and well-being - a more fitting approach would be the personalisation of desired outcomes for individual clients at the outset.

Recommendations for programme development

There is a need for regular and sustained social marketing/publicity of JTSS with the NHS, social care, third sector/voluntary mental health charities, including other organisations such as the Job Centre Plus and police forces to increase the number of 'appropriate' referrals. Social marketing activity could also target the community directly to increase awareness of the JTSS, in order to yield a concomitant increase in rates of both self- and family referral to the programme.

While the qualitative data from this evaluation demonstrated high levels of client satisfaction with the JTSS, there were concerns expressed from all stakeholders about the need for additional resources to accommodate more clients and also to maintain quality and satisfaction with the service. These concerns could be mitigated with more trained staff. One suggestion might be to supplement the core team of specialist case workers with volunteers to undertake 'lower intensity' work with clients, including peer support from previous JTSS clients. Future services might consider augmenting the core team with an expert in health behaviour change to support clients to make positive changes to health and lifestyle behaviours such as smoking cessation, engagement in physical activity/exercise and reducing alcohol consumption that can impact positively on both physical health and mental wellbeing.

Strategies to reduce time to first contact with the JTSS would benefit clients in order to prevent the appearance, or worsening, of mental health symptoms and other related issues. The pathway could be strengthened and streamlined by enabling opportunities for more engagement with eligible service leavers and their families before discharge from military service. Other possible improvements to the support pathway include making more onward referrals and additional signposting for longer-term healthcare needs, especially for clients with more complex needs.

Recommendations for future service evaluation

The poor response rate from the postal survey strongly indicates that this was a sub-optimal method for post-support service evaluation. Alternatives should be considered such as brief interviews or surveys at the time of, or proximal to, a client's final discharge contact with JTSS staff.

The periods between assessments of quantitative outcomes (Rickter and SF-8) were variable, which combined with missing data at follow-up assessment periods, impacted negatively on the ability to more definitively attribute any improvements in clients' disposition to the support they received from the JTSS. Future service evaluation should adhere to a protocol for standardisation of assessment periods (e.g., once every 3 months) with strategies to reduce any missing data, which would permit a more robust assessment of changes in outcomes over time. There was also a need to assess a broader range of outcomes related to recovery and improved health and well-being. In addition to Rickter and SF-8 assessments, future service evaluation should employ The Warwick-Edinburgh Mental Well-being Scale (WEMWBS), a validated scale of 14 positively worded items for assessing mental well-being.

The JTTS programme is likely to have yielded 'offset effects' in terms of cost savings for NHS and Social Care services. Even if only modest offset effects resulted from the JTTS programme, they would translate into significant cost-savings for NHS and social care services (excluding any offset effects on voluntary / third sector services, the Police Force and other organisations), which are likely to exceed the amount of funding allocated to the JTTS programme. Definite data to inform a robust assessment of cost-effectiveness to support this assertion would provide a compelling argument for the sustainability and further development of the JTSS programme. Therefore to provide an accurate assessment of offset effects, future service evaluation should capture data on rates of involuntary hospitalisation, use of health and social care services and resources at the initial, interim and discharge periods, including changes in un/employment rates and contact with the judicial system.

Conclusions

This service evaluation has yielded quantitative and qualitative evidence of the value of the JTSS programme for supporting a positive transition and recovery from mental health problems. Powerful narratives around personal transition journeys of clients provided particularly strong evidence that engagement with JTSS impacted positively on their psychosocial wellbeing; family functioning; self-esteem, motivation and confidence for seeking employment and training.

Recommendations around improved social marketing of the JTSS programme, increased resources to provide additional capacity, consideration of what constitutes a successful outcomes and assessing additional outcomes related to offset costs would serve to maintain the quality of service delivery, demonstrate cost-effectiveness and enhance outcomes.

Building on the reputation of the JTSS programme and the reputation of Finchale more broadly, consideration of the recommendations suggested here would improve future service provision to veterans in need of timely and effective support to make a successful transition to civilian life.

1. Introduction and Policy Context

1.1 The military transition to civilian life

1.1.1 Armed Forces transitions

Each year around 20,000 UK Armed Forces personnel begin the transition back to civilian life. While most transitions are successful, the cost of poor transition to the UK economy is estimated to be around £100 million per year in direct costs alone. This is due to the financial burden created by issues such as alcohol misuse, mental health, unemployment, family breakdown, homelessness and criminal offending.[i]

A good transition is defined by the Forces in Mind Trust in the following way:

> *'A good transition is one that enables ex-Service personnel to be sufficiently resilient to adapt successfully to civilian life, both now and in the future. This resilience includes financial, psychological and emotional resilience, and encompasses the ex-service person and their immediate families.'* (2013: 6)

A 2014 household survey of the ex-service community carried out by the Royal British Legion (RBL) reported that 10% of those aged 16-44 reported difficulty integrating into society; a statistic which rises to 16% for those discharged from the Forces within the last five years. Once back in civilian life, working age veterans have lower employment rates, are more likely to report a long-term illness such as depression, hearing loss or musculo-skeletal problems, and are considerably more likely to have unpaid caring responsibilities than the general population. In addition, while the reporting of mental health problems had doubled since RBL's 2005 survey, only 16% of those experiencing psychological difficulties reported that they had sought help.[ii]

1.1.2 Transition and the policy context

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

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

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

1.1.3 The 2014 Veterans' Transition Review

In acknowledgement of the growing challenges of resettlement, in 2014 Lord Ashcroft's *Veterans' Transition Review*[vi] was commissioned to examine existing support structures and key issues faced by service leavers. Whilst asserting that poor transitions are experienced by a relatively small number of people, the report highlights some of the cultural, financial and psychological challenges of resettlement. In response to the identified challenges, Ashcroft provides a series of practical recommendations across inter-related areas including training, employment, health, housing, welfare and finance. One key over-arching recommendation, which echoes findings from the FiMT's 2013 Transition Mapping Study,[vii] argues for the widening of eligibility criteria for full resettlement support (currently available to those with over six years' service), in recognition that the likelihood of poor transition appears to be amplified for Early Service Leavers.

Drawing on existing research findings, Ashcroft pays particular attention to the service leaver's mind-set, and subsequent level of preparation (both practical and psychological), as central influences on individual transition outcomes. The report also highlights the importance of making families a greater part of the transition process, as well as changing public perceptions in order to avoid potentially damaging misconceptions that those leaving the Armed Forces are likely to experience physical, mental or emotional ill health upon returning home. This public belief is described as an 'unnecessary hurdle' for service leavers that can serve to restrict opportunities and lower expectations of their capabilities.

In October 2014 the UK government published a response to Lord Ashcroft's review, outlining how the issues raised and recommendations are being addressed.[viii]

1.2 Mental health and wellbeing of the ex-service community

1.2.1 Research focus on military mental health

Prior to Lord Ashcroft's 2014 transition review, the mental health and emotional wellbeing of serving and ex-service personnel had already been positioned in the policy and research spotlight. A growing body of research led by the Kings Centre for Military Health Research (KCMHR) has examined the prevalence of specific mental health conditions and identified particular 'at risk' groups (including Early Service Leavers and reservists) that display increased risk of negative consequences post-service. While post-traumatic stress disorder (PTSD) is the highest profile mental health impact of war, findings have shown that ex-service personnel show comparable mental health patterns to the general population, with alcohol misuse, depression and anxiety disorders as the most commonly experienced issues. However, those leaving the Forces with psychiatric problems appear to be at increased risk of social exclusion, ongoing ill health and other negative outcomes compared to the general population.[ix]

1.2.2 'Fighting Fit': The Murrison report

In response to the growing evidence base, and building on the 2009 national mental health strategy *New Horizons*,[x] in 2010 the coalition government commissioned the Murrison report, *'Fighting Fit: A mental health plan for servicemen and veterans.'*[xi] Considering existing veterans to present a significant challenge

to mental health services, a number of recommendations were made specific to those undertaking the transition to civilian life. Recommendations that have now been implemented included:

- The development of a Veterans' Information Service (VIS) which seeks to contact regulars and reservists 12 months after leaving the Armed Forces
- The development of a post-traumatic stress disorder (PTSD) screening tool
- Improved information and online resources aimed at service leavers, including a 24-hour information helpline (now established as a partnership between the Department of Health and Combat Stress)

Following publication of the Murrison report, each Strategic Health Authority was allocated investment of £600,000 over a four year period (2011-2015) in order to improve the support available to the Armed Forces community. The needs of ex-service personnel were also highlighted in mainstream health policy, including the public health strategy '*Healthy lives, Healthy People'* (2010)[xii] and mental health strategy '*No Health without Mental Health'* (2011)[xiii]. The latter outlined a number of additional funding commitments including the appointment of Veteran Therapist posts in NHS Trusts, training for GPs and other frontline staff, and an increase in the number of IAPT sites providing tailored services to ex-service personnel.

Ashcroft's 2014 transition review states that the implementation of recommendations since Murrison's 2010 report has led to 'a tangible enhancement of provision' (p 113) in mental health, including improved access and awareness amongst both providers and the ex-service community. Nevertheless, evidence suggests that for some service leavers and their families the transition to civilian life continues to pose significant cultural, psychological and financial challenges.

1.3 The Joint Transition Support Service (JTSS)

1.3.1 Service background

In response to an identified need for greater co-ordination and case management during the transition process for potentially vulnerable service leavers, in April 2014 Finchale Training College was commissioned by the Forces in Mind Trust (FiMT) to pilot and evaluate a 2-year programme designed to support service leavers and their families during the transition to civilian life.

Launched in August 2014, the Joint Transition Support Service (JTSS) aims to provide individual, case-managed support to service leavers and family members following discharge on medical grounds. The service was designed to be holistic in nature, while holding a strong mental health and emotional wellbeing focus. The team is made up of a Community Psychiatric Nurse (CPN), an Occupational Therapist and an employment coach, alongside a service coordinator and manager. Building upon existing relationships within the sector, the service aims to provide an additional element to the transition pathway by sitting alongside and working with existing providers, particularly the Personnel Recovery Unit (PRU) at Catterick Garrison. A leaflet advertising the JTSS can be found in Appendix A.

1.4 Overview of the Joint Transition Support Service (JTSS)

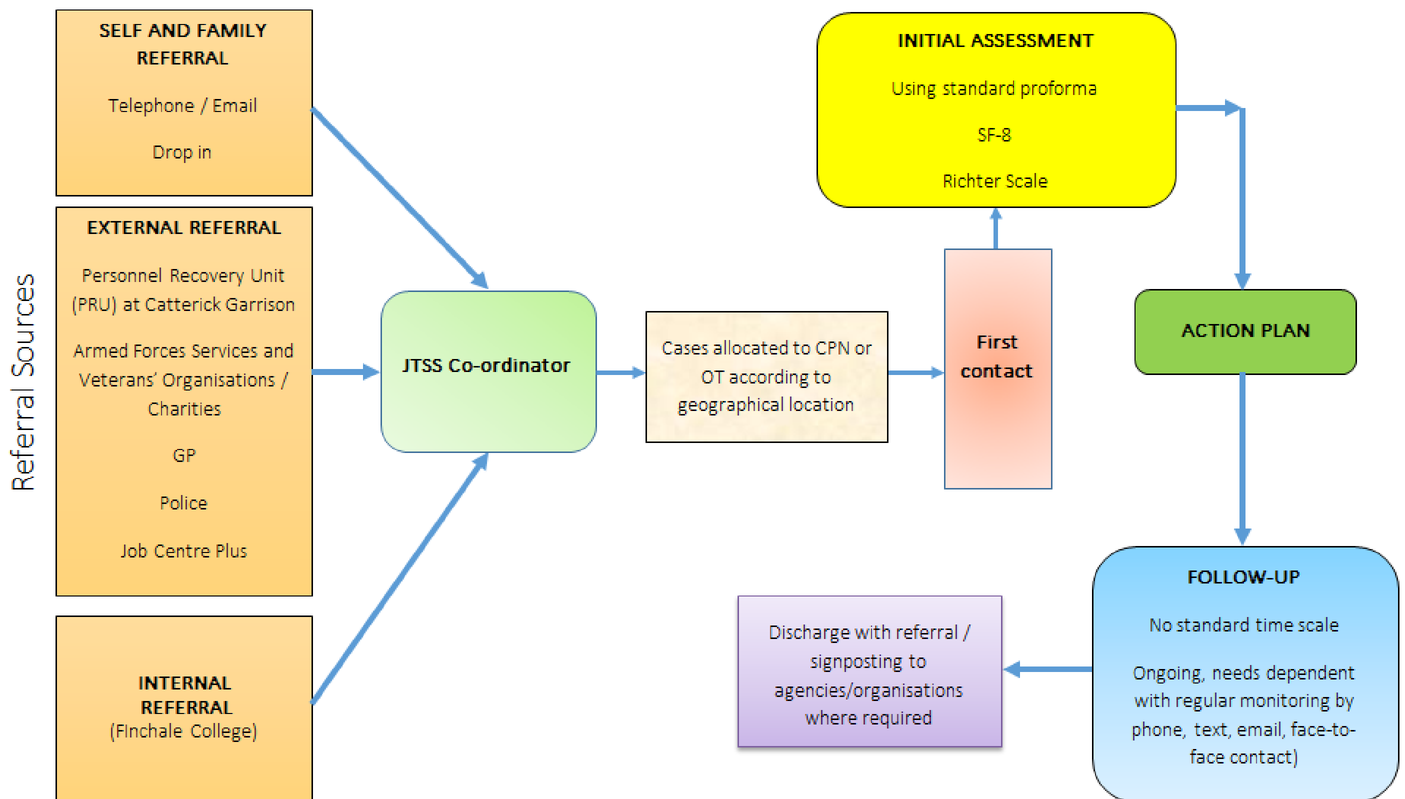
Table 1 provides an overview of the scope, structure and referrals process of the JTSS.

Table 1. Structure of the JTSS

	JTSS Profile
Providing organisation	Finchale Training College (third sector training and veterans' support provider)
Funding arrangements	Funded by the Forces in Mind Trust (FiMT); £383,198 funding over two years
Geographical area covered	North East England
Team set-up	• Community Psychiatric Nurse (1.0 WTE) • Occupational Therapist (1.0 WTE) • Employment coach (0.2 WTE) • Service co-ordinator (1.0 WTE) plus management oversight
Referrals process	• Open to current or recent medically discharged service leavers and their family members (up to 12 months post-discharge) • Main intended referral source: Catterick Garrison Personnel Recovery Unit • Additional referral sources: Self-referral, family referrals, Jobcentre Plus, Armed Forces services (including DCMH and AWS), third sector organisations (including SSAFA and Combat Stress) • Self-referrals accepted by telephone or email (via promotional leaflets) • Single point of access (service co-ordinator)
Interventions provided	• Assessments undertaken at initial point of contact (face-to-face or telephone) by mental health practitioners. • Care plans developed and worked towards – to include health and wellbeing, housing, employment and training, finances. • Signposting and onward referrals
Programme timescales	1st August 2014 – 1st August 2016

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

Figure 1. JTSS - Referral and Assessment Process



1.4.1 JTSS service evaluation

In order to provide an independent element to the pilot programme's evaluation, the North of England Mental Health Development Unit (NEMHDU) was commissioned by Finchale Training College to provide evaluative input across the pilot service's 2-year timeframe.

The aims of the evaluation study were to explore:

- The sociodemographic and service profile of JTSS clients
- Veterans' and their family experience of the JTSS - including satisfaction levels, examples of effective practice and areas for improvement
- Health, well-being and wider outcomes for those who have participated in JTSS and their families

1.4.2 Finchale Training College

Finchale Training College was founded in 1943 as a rehabilitation centre for wounded, injured and long-term sick personnel returning from service in the Second World War. Located in the north east of

England, the college provides a range of specialist residential training programmes to over 300 ex-service personnel each year. In addition, the Progression Pathways service supports veterans in areas including employment, housing, finances, physical and mental health, alcohol and addictions. The College also hosts the North East Veterans' Network, which provides a forum for statutory and non-statutory organisations involved in supporting veterans.

1.4.3 The background and strategic objectives of the NEMHDU

NEMHDU is a not-for-profit social enterprise based in the North of England. NEMHDU's mission is to improve the mental health and social wellbeing of local communities by:

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

2. Service Evaluation Methods

Informed by discussions with the JTSS staff and other stakeholders, a mixed methods evaluation strategy was designed to address the aims of this service evaluation study.

2.1 Scoping literature review on transition from the armed forces to civilian life

A scoping review was undertaken of the academic, policy and 'grey' literature on transition, including its associated challenges and the outcomes of any existing support programmes for service leavers and their families. The following 11 bibliographic databases were searched:

- Ovid MEDLINE(R) 1946 to January Week 2 2016
- Embase 1980 to 2016 Week 03
- EBM Reviews - Cochrane Database of Systematic Reviews 2005 to January 20, 2016
- EBM Reviews - ACP Journal Club 1991 to December 2015
- EBM Reviews - Database of Abstracts of Reviews of Effects 2nd Quarter 2015
- EBM Reviews - Cochrane Central Register of Controlled Trials December 2015
- EBM Reviews - Cochrane Methodology Register 3rd Quarter 2012
- EBM Reviews - Health Technology Assessment 4th Quarter 2015
- EBM Reviews - NHS Economic Evaluation Database 2nd Quarter 2015
- HMIC Health Management Information Consortium 1979 to November 2015
- PsycINFO 1967 to January Week 3 2016

A structured search strategy was applied to the above databases:

#	Search terms
1	armed force or army or navy or air force or ex-service personnel or service leaver
2	transition or transitioning or transitions
3	1 and 2
4	Remove duplicates from 3

Eligible articles had to focus on the following key areas of interest:

- Current knowledge around the military transition to civilian life, including the challenges it may hold for ex-service personnel and their families
- Studies of existing transition support programmes, including evidence of any impact on health, wellbeing or wider social outcomes

Eligible articles were reviews, primary research papers (quantitative, qualitative or mixed methods) and discussion articles focused on support programmes for armed forces transitioning to civilian life delivered in the primary care / community setting. Articles focused on post-deployment reintegration programs (i.e. armed service personnel returning from operations who remain enlisted in the armed forces) and PhD theses were excluded.

Grey literature was identified by Internet searching, reviewing previous reports of transition programmes conducted by NEMHDU and discussions with the team at Finchale. The findings of the scoping literature review are presented in Chapter 3.

2.2 Analysis of routinely collected data

An Excel-based recording system was designed to capture data on numbers of referrals, sources of referral and geographical location of clients referred to the JTSS. The system also captured data on the sociodemographic and service profile (veterans) of JTSS clients, including details on primary presenting concerns and any onward referral destinations. Assessment of health and well-being outcomes were also recorded at the initial, interim and final appointments with the JTSS using the Rickter Scale[xiv] and SF-8[xv].

Rickter Scale

The Rickter Scale was originally designed for work with young offenders, but has been adapted to a wide range of uses. Intended as a practical tool to measure distance travelled and focus the support provided to individual clients, it involves a 'sliding scale' controlled by the client in ten outcome areas: employment/training and education, accommodation, money, relationships, influences, stress, alcohol, drugs, health and happiness.[xvi] Scores are recorded on a scale of 1-10; most commonly where 1 is 'not at all happy' and 10 is 'completely happy'.

SF-8 Health Survey

The Short Form (8) Health Survey (or SF-8) forms a shortened, 8-item version of the widely used SF-36 health survey. It includes individual items on eight domains using a 4 week recall period: general health; physical functioning; role limitations due to physical functioning; role limitations due to emotional problems; social functioning; mental health; vitality; and bodily pain. Each item has 5-6 response options (with higher scores reflecting better functioning) Summary scores for physical and mental aspects of health can then be calculated with reference to a norm-based scoring method.[xvii] The physical component summary (PCS) and the mental component summary (MCS) dimensions are scored on a scale of 0 to 100, with 100 representing the highest level of functioning possible.

Summary descriptive statistics and where appropriate inferential statistical tests of differences (repeated measures t tests) were conducted on the routinely collected data using the statistical package IBM SPSS Statistics Version 22. Findings of these analyses are presented in Chapter 4.

2.3 Qualitative interviews with JTSS clients and staff, including other stakeholders

Qualitative semi-structured interviews were conducted with a purposive sample of JTSS clients (veterans and their family members) and JTSS staff, including other stakeholders such as referring organisations. A 'maximum variation' sampling approach was used to facilitate the inclusion of interviewees with a diverse

a range of perspectives and experiences. Interviews continued until theoretical saturation was reached and no new themes were identified from the data collected.

Interview guides were developed with reference to the aims of the service evaluation, relevant literature and discussions with JTSS staff. Interview guides can be found in Appendices B (JTSS clients), C (JTSS Staff) and D (other stakeholders).

Interviews were audio-recorded with the participant's permission. Where respondents did not wish to be recorded, detailed field notes were taken by interviewer. Recorded interviews were transcribed verbatim, and along with field notes were coded and analysed thematically using an approach described by Ritchie and Spencer (1994)[xviii]. This involved a series of processes including familiarisation, indexing, framework development, mapping and interpretation.

Findings from the interviews are presented in Chapter 5.

2.4 Post-support questionnaire survey of JTSS clients

A self-report questionnaire survey was designed to examine client satisfaction with the JTSS and to explore any long-term impact on health, wellbeing or wider outcomes. The questionnaire used a combination of closed (based on commonly used assessment tools including items from the SF-36 health questionnaire and Quality of Life scales) and open-ended questions for qualitative responses.

A 'cognitive pre-test' of a draft questionnaire survey took place during June-July 2014. This involved a small panel (including ex-service personnel, support workers and mental health professionals) completing the questionnaire while providing verbal feedback on length, visual impact and language used in the questionnaire. Following this, a number of revisions were made to the questionnaire's layout and content.

Prior to mailing of the final version of the questionnaire (Appendix E), a flyer and verbal explanation of the rationale for the post-support questionnaire was given to each client during their final discharge meeting. The final version of the questionnaire was administered by post to JTSS clients approximately 4 weeks after being discharged from the service, along with a covering letter and optional follow-up contact details form. A reminder letter featuring a link to an electronic version of the post-support questionnaire was subsequently mailed to non-respondents when 2 weeks had elapsed since the initial mailing of the paper-version of the questionnaire.

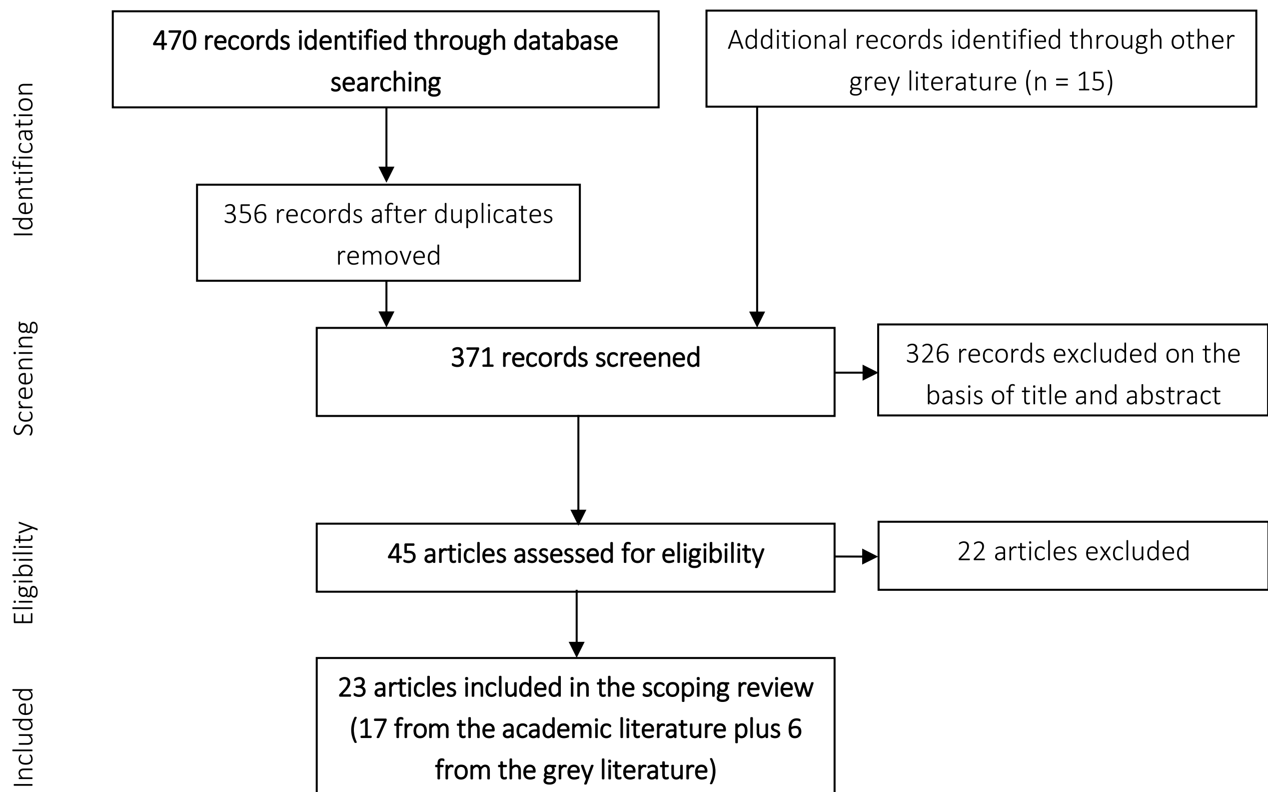
Findings of the analyses of responses to the post-support questionnaire are presented in Chapter 6.

3. Scoping Literature Review on the Transition from the Armed Forces to Civilian Life

3.1 Results of electronic literature search

Searches of the grey literature and 11 electronic databases yielded 470 hits, of which 23 fulfilled the eligibility criteria and were included in the scoping review (Figure 2).

Figure 2. Process used to identify articles for the scoping review



3.2 Academic literature

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

Intervention studies

Systematic searches of the academic literature yielded only one randomised controlled trial (Martens, et

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

Challenges to transition and groups at risk

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

Gaps and limitations

A summary of the 17 articles from the academic literature is presented in Table 2. The evidence retrieved is partial in its scope and there are few prospective trials of well-defined interventions. Thus, there is a clear need for well-designed intervention studies to delineate the impact of interventions targeting transition from military to civilian life on veterans' physical and mental health, including outcomes related to employment/training, family functioning and psychosocial well-being.

Table 2. Summary of the articles identified from the electronic literature search

Study/Report	Setting	Summary of methods (and intervention)	Key findings	Key recommendations around transition
Gowan et al.	USA	The association between	Only self-esteem and career	Programmes should

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

al. (2012).[xxiii]		providing anecdotal evidence of intervention outcomes (see above)	multifaceted wraparound programme (including Care Coordination and ongoing education) showed increased belongingness (a predictor of health and wellbeing), autonomy and stability, greater social capital and enhanced feelings of purpose and personal value.	recommendation was to formally evaluate the programme using robust research design
Mansfield et al. (2011).[xxiv]	USA	Path analysis to examine factors associated with suicidal/self-harming ideation among male Navy and Marine Corps personnel transitioning to civilian life	Suicide ideation was reported by approximately 7% of the sample (Sailors = 5.3%, Marines = 9.0%) during the previous 30 days. Combat exposure, substance abuse, and resilience were associated with suicidal ideation/self-harming thoughts (mediated by PTSD symptoms and/or depression symptoms).	Suicidal ideation, substance use and self-harm are important issues to address in support programmes for veterans
Johnson and Fogelberg (2012).[xxv]	USA	Evaluation of a military peer case management service for service members with traumatic brain injury (TBI). Peer resource support, links the client to their benefits and other support e.g. homelessness prevention, cognitive strengthening, assistive technology, wrap around family services, and educational and employment support.	The programme supported 143 clients over two years Support was provided for the sample as follows: 21% homeless prevention assistance; 27% employment support 27%; 52% mental health issues; 13% substance abuse issues; 41% marital issues; 51% education. 81% of clients expressed that their lives had improved due to the service.	Recommendation for more traumatic brain injury programs and resources in the USA. More peer support groups are required to assist with the issues of TBI and suicides. General awareness-raising is also necessary.
Baum et al. (2013).[xxvi]	Israel	The Peace of Mind program provides support for mental health and normalisation of responses, as well as on the processing of traumatic experiences	The model is described and several vignettes are presented.	
Brunger et al. (2013).[xxvii]	UK	Qualitative study with 11 in-depth interviews of ex-servicemen. Data were analysed using interpretative	Three broad themes were reported: characteristics of a military life; loss as experienced upon return to civilian life; and the attempt	The military needs to ensure that not only is support provided for all service personnel, but that it goes

		phenomenological analysis (IPA)	to bridge the gap between these two lives. Cutting across these themes was the notion of identity, in which the transition is viewed as a "shift in sense of self from soldier to civilian".	beyond basic vocational advice.
Buckman et al. (2013).[xxviii]	UK	A cross-sectional study used data on ex-Serving UK Armed Forces personnel. ESLs were personnel leaving before completing their 3-4.5 years minimum Service contracts and were compared with non-ESLs	Of 845 Service leavers, 80 (9.5%) were ESLs. ESL status was associated with younger age, female sex, not being in a relationship, lower rank, serving in the army and with a trend of reporting higher levels of childhood adversity. Being an ESL was not associated with deployment to Iraq. ESLs were at an increased risk of probable post-traumatic stress disorder (PTSD), common mental disorders, fatigue and multiple physical symptoms, but not alcohol misuse.	Recommendation to target interventions to ESLs on leaving Service to smooth their transition to civilian life and prevent the negative mental health outcomes experienced by ESLs in the future.
MacLean et al. (2014).[xxix]	Canada	Cross-sectional survey of a national sample of 3,154 veterans released from the regular Canadian Forces during 1998 to 2007.	One quarter of the sample experienced difficulties adjusting to civilian life. Lower rank and medical, involuntary, mid-career, and Army release were significantly associated with difficult adjustment, conversely sex, marital status, and number of deployments were not.	Need for collaboration between physical therapists and other service providers to mitigate difficult transition. Future interventions, outreach and screening should be informed by the risk factors identified here.
Misra-Hebert et al. (2014).[xxx]	USA	Cross-sectional data from focus group plus survey which explores the views and experiences of veterans enrolled on a college course (one time point only).	For participants, the motivation to improve health was viewed as secondary to obtaining housing or work. Concerns about privacy and stigma were perceived barriers to accessing healthcare. In the survey (n=204, 21% response rate) participants	The study highlighted how collaboration between primary care, public health and a community college can support veterans with health problems.

			reported physical (45%) and emotional (35%) problems which limited their daily activities, and pain interfering with work (42%) plus high levels of self-reported depression and unhealthy behaviours.	
Rowland (2014).[xxxi]	USA	Case study of an intervention aimed at transition to bridge the gap between military and civilian life by helping soldiers with their employment needs. The intervention includes use of a design salon environment to create a collaborative, cohort-based learning space, and the adoption of an Entrepreneurial Mindset to successfully execute the required personal and professional transformation.	The article focuses on description of an intervention.	
Martens et al. (2015).[xxxii]	USA	Randomised controlled trial of brief personalized drinking feedback (PFB) intervention tailored for veterans versus regular educational information (EDU). The intervention involved personalized information about alcohol use, including social norms comparisons, risks associated with reported drinking levels, and a summary of their alcohol-related problems.	Those in the PFB group were more likely than those in the EDU group to remain abstaining from alcohol at 6-month follow-up	The study provides evidence to support the efficacy of a brief, inexpensive intervention for reducing alcohol misuse In veterans
Milstein et al. (2015).[xxxiii]	USA	Case study of self-guided dialogues to facilitate transition and readjustment. The Warrior Spirit/Mission Homefront (WS/MH) interactive dialogue program was designed to aid veterans to talk about their military	Outcomes discussed include a change in mood from "reticent to vibrant". The authors report how WS/MH dialogues model how a person can begin to talk about their deployment by telling simple stories, and building on that momentum	

		experiences with fellow service members or veterans, then with friends and family.	they can start to share more difficult experiences with their significant others with the overall aim of better connecting with family and community.	
Warren et al. (2015).[xxxiv]	UK	Qualitative evaluation of a vocational case management programme co-funded by the National Health Service (NHS) to prevent ill health among ex-service personnel Semi-structured interviews with ex-service personnel (n=15) and case management staff (n=5).	Clients particularly valued the opportunity afforded by the programme to be listened to, treated as an individual and valued by frontline staff.	The study casts the case management approach as a viable and valued way of supporting ex-service personnel in the transition pathway.
Wilcox et al. (2015).[xxxv]	USA	Cohort study of 126 reservists on their return from a one-year deployment to Iraq, with assessments at baseline, one month and six months post deployment.	Overall, the rates of post-deployment psychological and behavioural problems were elevated upon returning from deployment and remained fairly constant for up to 6 months post-deployment. Reported problems included relationship issues (~30%) and family reintegration issues (>30%).	

3.3 Grey literature

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

3.3.1 Challenges surrounding transition

For many service leavers transitioning from military service to civilian life results in positive outcomes with veterans securing employment and reporting good quality of life, but for a proportion of service leavers the process is more challenging and is associated with outcomes such as mental ill health, alcohol misuse, unemployment, homelessness, involvement in the criminal justice system and social exclusion (Murrison, 2010; Kings Centre for Military Health Research, 2016). The Ashcroft report cites public perception of service leavers as a particularly challenging issue to be addressed as it can result in stigma and reduced expectations for the service leaver (Ashcroft, 2014). A recent report estimates that 66,090

service leavers will require support for physical or mental health problems, although many will be reluctant to seek help. The authors call for further research to establish the specific needs of service leavers in this group and at what time point they are most likely to seek help (Diehle & Greenberg, 2015).

3.3.2 At-risk groups

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

3.3.3 The role of family in the transition process

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

A summary of the key findings and recommendations of the grey literature are shown in table 3 below.

Table 3. Summary of the findings and recommendations in the grey literature

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

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

3.4 Limitations/knowledge gaps in the literature

As highlighted in previous literature reviews (NEMHDU, 2013[xli]) there are few studies that formally evaluate interventions using robust designs such as randomised controlled trials. Consequently, there is a paucity of robust evidence around the effectiveness of intervention programmes for service leavers and their families to facilitate transitioning back into civilian life. Much of the literature is US based prompting questions about the applicability of such data in the UK context. What evidence that does exist is limited in methodological quality and there is a particular dearth of data on health and psychosocial outcomes, including cost-effectiveness of transition programmes, with many studies focusing on presenting descriptive data and analysis of process outcomes such as client satisfaction (Kehle et al., 2011[xlii]).

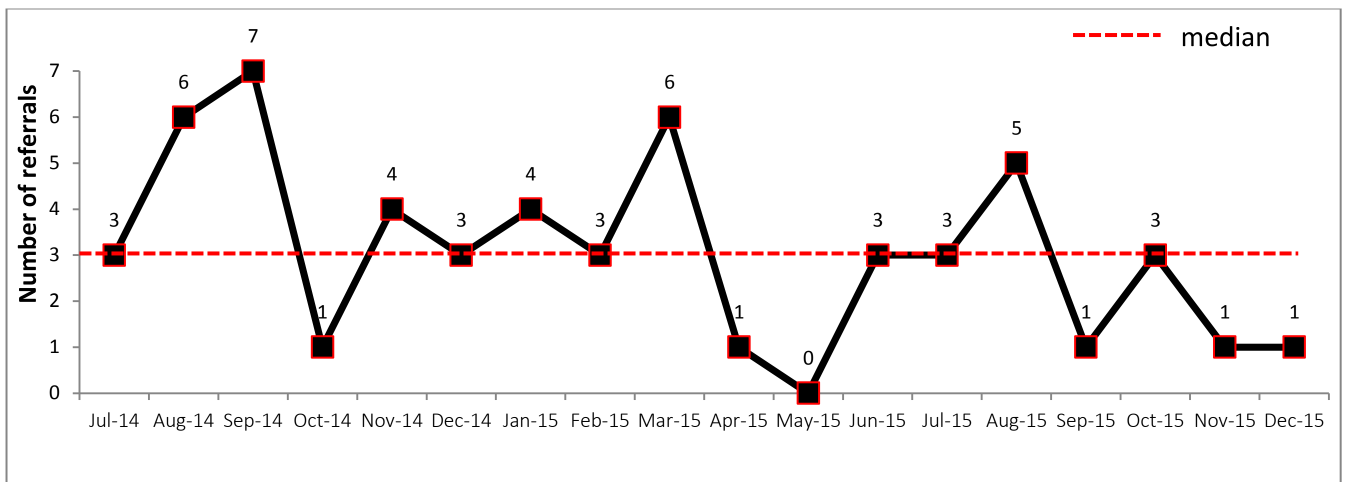
4. Findings: Analysis of routinely collected data

This section reports on the analysis of the routinely collected data from 55 clients referred to the JTSS over an 18-month period from July 2014 to Dec 2015.

4.1 Numbers, geographical location and source of referrals to the JTSS

The JTSS received 55 ‘appropriate’ referrals during the evaluation period (July 2014 to Dec 2015), which equated to a median of 3 (IQR = 3) referrals per month (Figure 3).

Figure 3. Frequency of appropriate referrals to JTSS over the evaluation period (N = 55)



The mapping of postcodes for JTSS clients (Figure 4) showed they were primarily clustered around population centres of Newcastle-upon-Tyne, Sunderland Durham and Teesside, with smaller numbers located at Blyth, Preston and Harrogate.

Figure 4. Geographical distribution of JTSS clients

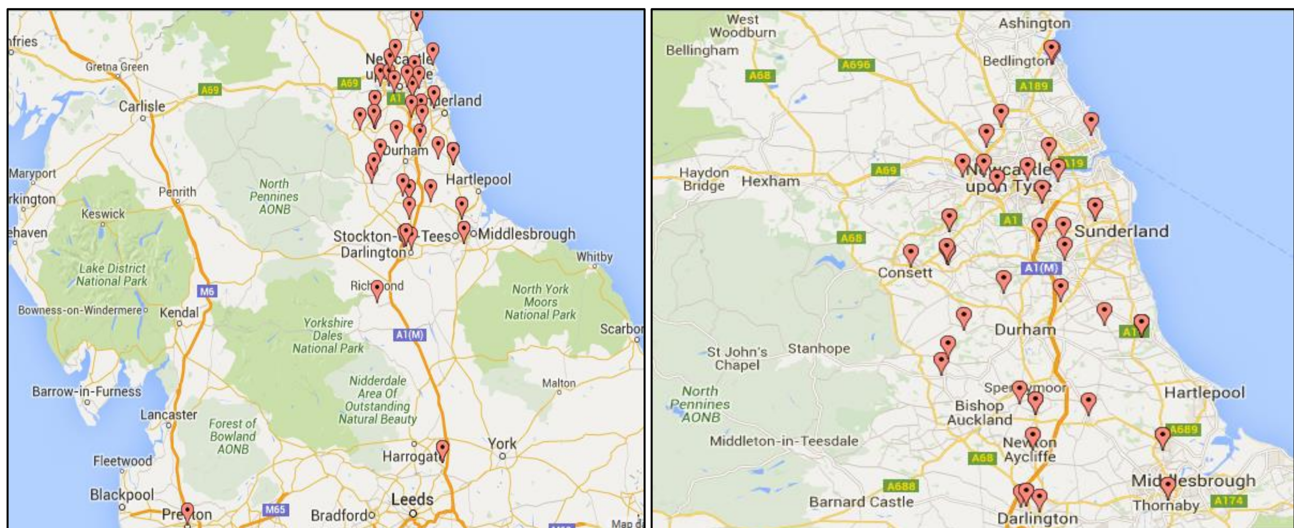


Table 4 shows the 12 different referral sources for the 55 JTSS clients. The Personnel Recovery Unit at Catterick Garrison was the modal referral source (29%). Approximately a quarter of clients were referred to the JTSS by family members (26%). The Jobcentre Plus referred seven (13%), with 4 (7%) clients referred internally via Finchale College's Progression Pathways Service. Two clients (4%) referred themselves to the JTSS. The remainder were referred via military charities (Combat Stress, Army Welfare Service, SSAFA and Future Horizons), the Department of Community Mental Health, Durham Police or the Recovery Career Service in collaboration with PRU.

Table 4. Referral sources of JTSS clients (N=55)

Referral Source	n (%)
1. Personnel Recovery Unit (PRU)	16 (29%)
2. Family-referral	14 (26%)
3. Job Centre Plus	7 (13%)
4. Progression Pathways Service (Finchale College)	4 (7%)
5. Combat Stress	3 (6%)
6. Career Transition Partnership (CTP) Future Horizons	3 (6%)
7. SSAFA	2 (4%)
8. Self-referral	2 (4%)
9. Army Welfare Service (AWS)	1 (2%)
10. Department of Community Mental Health (DCMH)	1 (2%)
11. Durham Police	1 (2%)
12. Recovery Career Service and PRU	1 (2%)

4.2 Sociodemographic Profile of JTSS Clients

The sociodemographic profile of the 55 clients is shown in Table 5. The majority of the 55 JTSS clients were veterans (n=39, 71%). The remaining 16 (29%) were family members of veterans. The latter consisted of spouses/partners of veterans (n=9), children of veterans (n=3) and other family members (n=4). Veterans were on average aged 29.5 years (SD=7, min/max = 19/48), and the majority were male (n=36, 92%) and White-British (n=35, 90%). Equal numbers of veterans were single (n=16, 41%) or married/with a partner (n=16, 41%); relatively few were divorced or separated (n=5, 13%). Family members were on average 5 years older than veterans (mean = 35 years, SD=12, min/max = 17-54) and the majority were female (n=12, 75%), White-British (15, 94%) and had a spouse / partner (n=11, 76%). Veterans and family members both had on average one child (SD=1) in their household.

Table 5. Sociodemographic profile of the clients (N=55)

	Veterans N (%)	Family Members N (%)
Gender		
Male	36 (92%)	4 (25%)
Female	3 (8%)	12 (75%)
Ethnicity		
White-British	35 (90%)	15 (94%)
Black-Other	3 (8%)	1 (6%)
Black-Caribbean	1 (3%)	0 (0%)
Marital status		
Married/partner	16 (41%)	11 (79%)
Single	16 (41%)	2 (13%)
Divorced/separated	5 (13%)	2 (13%)

NB: Percentages may not equal 100 due to rounding or missing data

Most veterans (29 out of 39, 74%) and 3 out of 16 (19%) family members had previous contact with support services (Table 6).

Table 6. Previous Service Contact of the JTSS clients (N=55)

Previous Service Contact	n (%)
Veterans	
Personnel Recovery Unit (PRU)	11 (28%)
Career Transition Partnership (CTP) Future Horizons	3 (8%)
Army Benevolent Fund: The Soldiers' Charity	2 (5%)
Army Welfare Service (AWS)	1 (2.5%)
Combat Stress	1 (2.5%)
Family Members	
Army Benevolent Fund: The Soldiers' Charity	1 (6%)
Personnel Recovery Unit (PRU)	1 (6%)
Family referral	1 (6%)

4.3 Armed Forces Profile of Veterans

Veterans had served on average 9 years (SD = 6.7, min/max = 1/29) in the armed forces. Table 7 shows reasons for leaving the armed forces and other service characteristics of veterans. The majority had been medically discharged (94%), were previously army regulars (85%) and had held the rank of private (64%).

Table 7. Service profile of the veteran clients (N=39)

	n (%)
Reason for leaving forces	
Medical Discharge	37 (94%)
Administrative Discharge	1 (3%)
Force Served	
Army-regular	33 (85%)
Navy-regular	3 (8%)
RAF regular	1 (3%)
Rank	
Private	25 (64%)
Lance Corporal	5 (13%)
Corporal	4 (10%)
Able Seaman (AB1)	2 (5%)
Sergeant	1 (3%)
Warrant Officer Class 1	1 (3%)
Warrant Officer Class 2	1 (3%)

NB: Percentages may not equal 100 due to rounding or missing data

In three cases, no date of discharge from the armed forces was available.

The majority of the remaining 36 veterans were referred to the JTSS after discharge from the armed forces (n=26, 72%); with over one quarter (n=10, 28%) of referrals to the JTSS were received prior to veterans being discharged from the armed forces.

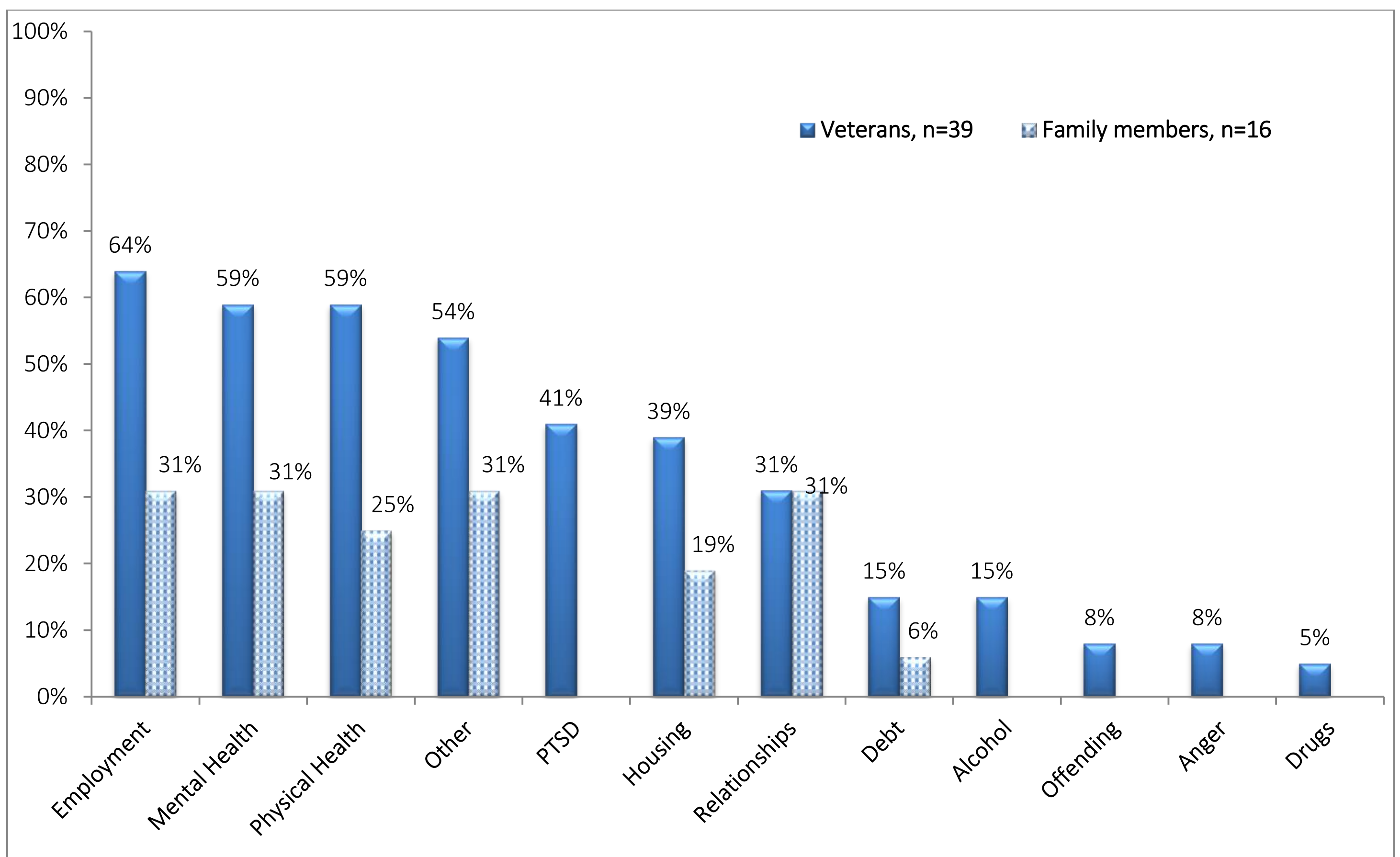
4.4 Presenting Primary Concerns of JTSS Clients

The presenting primary concerns of the 55 clients are shown in Figure 5. Detailed summary statistics can be found in Appendix F.

On average, veterans presented with 4 primary concerns (min/max = 1/9). Issues related to employment, mental health, physical health, PTSD and housing were the primary concerns that veterans presented with at initial assessments with the JTSS. This pattern was similar for family members who presented with on average 2 primary concerns (min/max = 1/4). Relationship issues were primary concerns for approximately a third of family members and veterans. A larger proportion of family members than veterans were primarily concerned with debt issues. Relatively few veterans were primarily concerned about issues related to substance misuse (drugs and alcohol), offending or anger. The latter issues were not primary concerns for family members.

A substantial proportion of veterans (54%) and family members (31%) cited 'other' primary concerns such as claims for compensation, issues with benefits and gambling problems.

Figure 5. Primary Concerns of JTSS Clients (N=55)



4.5 Timeframes for Discharge from the Armed Forces to Referral to the JTSS and Subsequent Discharge from the Service

On average, the length of time between a veteran's discharge date from the armed forces and receipt of a referral to the JTSS (Table 8) was 86 days/~3 months (pre-discharge from armed forces) and 155 days / ~5.2 months (post-discharge from armed forces). Variation for discharged from the armed forces and referral to the JTSS was greater for veterans referred at post-discharge from the armed forces.

Overall, once a referral to the JTSS had been received, on average, the length of time a client received support from the JTSS before being discharged from the service was 165 days (~5.5 months). For veterans, the average timescale was shorter 138 days (~4.6 months) than family members who were on average discharged from the JTSS after 260 days (~8.7 months).

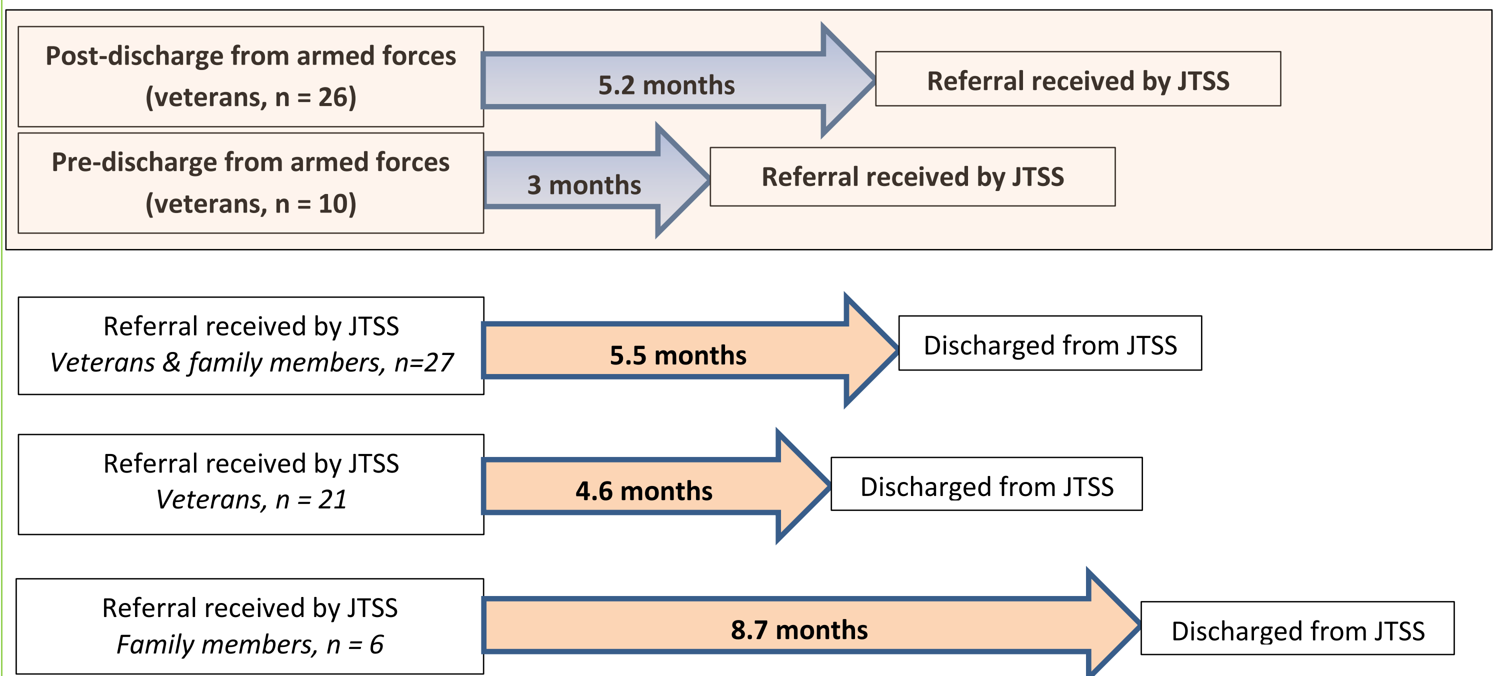
Table 8. Timescales for discharge from armed forces to referral and subsequent discharge from the JTSS

	n (%)	Min / Max	Mean (SD)
Post-discharge from armed forces to referral to JTSS	26 (67%)	4 / 436	155 (135)
Pre-discharge from armed forces to referral to JTSS	10 (26%)	31 / 247	86 (69)
Time from referral to discharge from JTSS in days			
Overall (veterans and family members)	27 (49%)	8 / 440	165 (111)
Veterans	21 (54%)	8 / 260	138 (76)
Family members	6 (38%)	46 / 440	260 (163)

NB: Percentages may not equal 100 due to rounding or missing data

A graphical representation of the timescales in Table 6 is shown in Figure 6.

Figure 6. Average time from discharge to referral and subsequent discharge from the JTSS



4.6 Discharge Profile of JTSS clients and Onward Referrals

Within the evaluation period, 27 of the 55 clients (49%) were discharged from the JTSS. Overall, 21 of the 39 veterans (54%) were discharged from the JTSS. During the same period, 6 out of the 16 family members (38%) were discharged from the service. Reasons for discharge from the JTSS and information about onward referrals to other organisations during the evaluation period are shown in Table 9.

The majority of 21 veterans were discharged (n=19, 91%) from the JTSS for positive reasons. Nine (43%) of the 21 veterans discharged had completed action plans or found employment, with a further 4 (19%) stating they had no further support needs. Approximately one third of veterans were discharged (29%) from the JTSS due to not fully engaging with the full range of programme activities. Two (10%) veterans were discharged from the JTSS for negative reasons (in custody).

Six of 16 (38%) of the family members had been discharged from the JTSS during the evaluation period. Family members were discharged for positive reasons - completion of action plans (n=2) or completion of action plans and in a full-time employment (n=1) or caring role (n=1). A further 2 of the 6 family members were discharged from the JTSS due to not fully engaging with the full range of programme activities.

Four clients were subsequently referred to other agencies/organisations. In 9 cases there was no identified need for an onward referral. In one case a suitable onward referral destination could not be identified. There were no data available for any onward referral of family members.

Table 9. Discharge profile of the JTSS clients

	n (%)
Reason for discharge from JTSS (veterans, n=21)	
Not fully engaging with the full range of programme of activities	6 (29%)
Completed action plan	5 (24%)
In employment	4 (19%)
Support no longer required/no further needs	4 (19%)
Imprisonment / In custody	2 (10%)
Onward Referral from JTSS (veterans, n=14)	
None / none needed	9 (62%)
Citizens Advice Bureau (CAB)	1 (8%)
Help for Heroes (HFH)	1 (8%)
Veterans in custody support officers (VICSO), North East Council on Addictions (NECA), Gamblers Anonymous, CAB and probation	1 8%)
Veterans' Wellbeing Assessment and Liaison Service & Combat Stress	1 (8%)
None suitable	1 (8%)

NB: Percentages may not equal 100 due to rounding

4.7 Inappropriate referrals to the JTSS

In addition to the 55 clients who were appropriately referred to the JTSS service, there were 25 inappropriate referrals received during the evaluation period. Inappropriate referrals were those that fell outside the JTSS eligibility criteria such as veterans not being medically discharged, not having completed their basic training or being discharged > 12 months prior to their referral. All inappropriate referrals were directed into the Finchale College's Progression Pathways Service, which provided support to veterans on a range of issues including employment, housing, finances and wellbeing.

4.8 Rickter Scale Assessments

Detailed summary statistics for Rickter scale responses for veterans and family members can be found in Appendix G. In order to enable meaningful comparisons, data are included only for clients with Rickter scores recorded at initial and interim assessment periods. Insufficient data were available for analysis of Rickter scale assessments across the initial, interim and final assessment periods. Average time between initial and interim assessments of Rickter scales was 120 days/~4 months (SD=76, min/max=42/321).

Mean scores for the 10 Rickter scale domains at the initial and interim assessment periods for veterans are shown in Figure 7, next page). There were statistically significant improved mean Rickter scores for veterans between the initial and interim assessment period for Influences ($t = -2.49$, 95% Confidence Intervals = -0.3 to 2.9, $p = 0.022$), Stress ($t = 2.53$, 95% Confidence Intervals = 0.3 to 2.8, $p = 0.021$) and Drugs ($t = 2.29$, 95% Confidence Intervals = 0.2 to 3.4, $p = 0.034$).

With the exception of accommodation (that showed a negligible decrease) and stress (that showed a negligible increase), family members' scores on the remaining 8 Rickter domains improved between the initial and interim assessment period (Figure 8, next page). Improvements (>1 point) were observed (in rank order) for drugs, happiness, influences, money and employment/training/education. Inferential statistical tests were prohibited due to the small amount of data (n=7).

4.9 SF-8 Assessments

Detailed summary statistics for SF-8 scores for veterans and family members can be found in Appendix H. In order to enable meaningful comparisons, data are included only for clients with SF-8 scores recorded at both the initial and interim assessment. Insufficient data were available for analysis of SF-8 assessments across the initial, interim and final assessment periods. Average time between initial and interim SF-8 assessments was 116 days/~3.9 months (SD=76, min/max=42/321). Mean scores for SF-8 domains at the initial and interim assessment periods for veterans and family members are shown in Figures 9 and 10 respectively (see page 34).

There were small improvements (>1 point) for veterans on mental health and vitality domains, whereas, the domains general health perception and role functioning-physical showed small decreases. However, none of these differences for veterans were statistically significant. With the exception of vitality and bodily pain (that showed small decreases), family members showed improved scores (>1 point) on mental health, role functioning-emotional, social functioning, general health perception and physical functioning; although inferential statistical tests of differences were prohibited due to the small sample size.

For both veterans and family members, Mental Component Summary (MCS) and Physical Component Summary (PCS) scores were below 50 at initial and interim assessment periods (below national norms) There were small improvements in MCS scores for veterans and family members, with small decrements in PCS scores for both groups across the same assessment period Figures 11 and 12, (see page 35). However, these differences in MCS and PCS scores were not statistically significant.

Figure 7. Average Rickter scores across each of 10 domains for Veterans (N = 20, pairwise data)

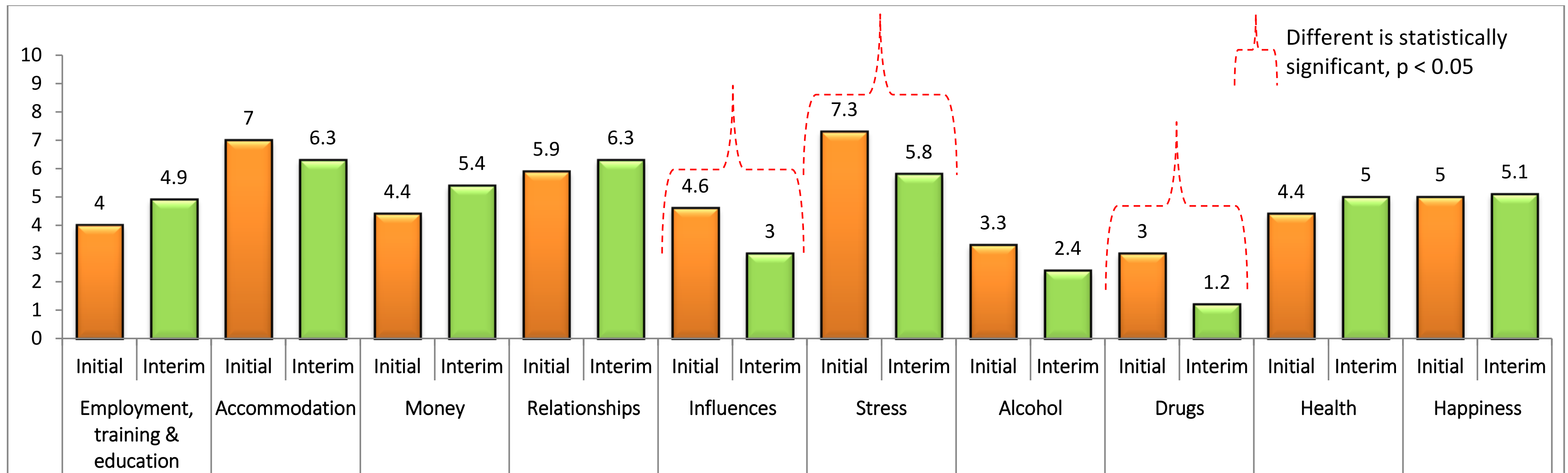


Figure 8. Average Rickter scores across each of 10 domains for Family Members (N = 7, pairwise data)

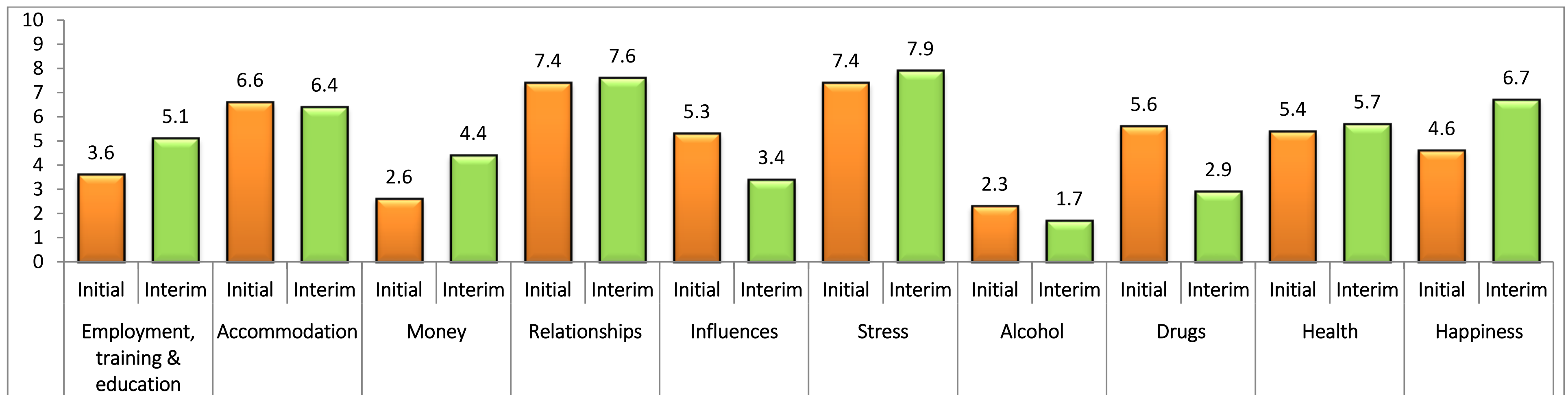


Figure 9. Average SF-8 domain scores at initial and interim assessment periods for veterans (N=18, pairwise data)

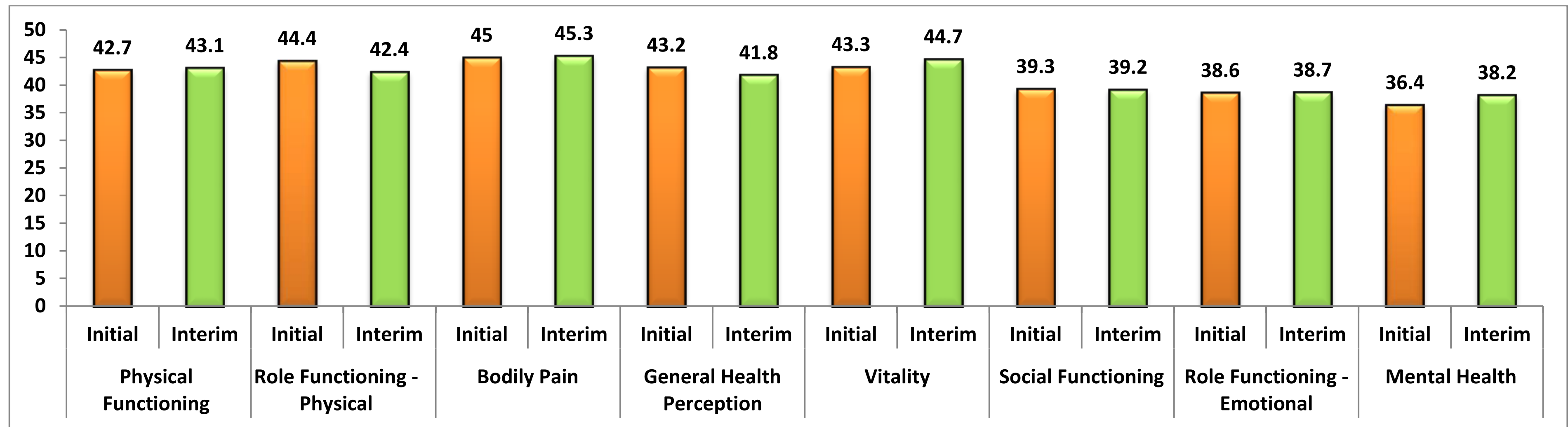


Figure 10. Average SF-8 domain scores at initial and interim assessment periods for family members (N=7, pairwise data)

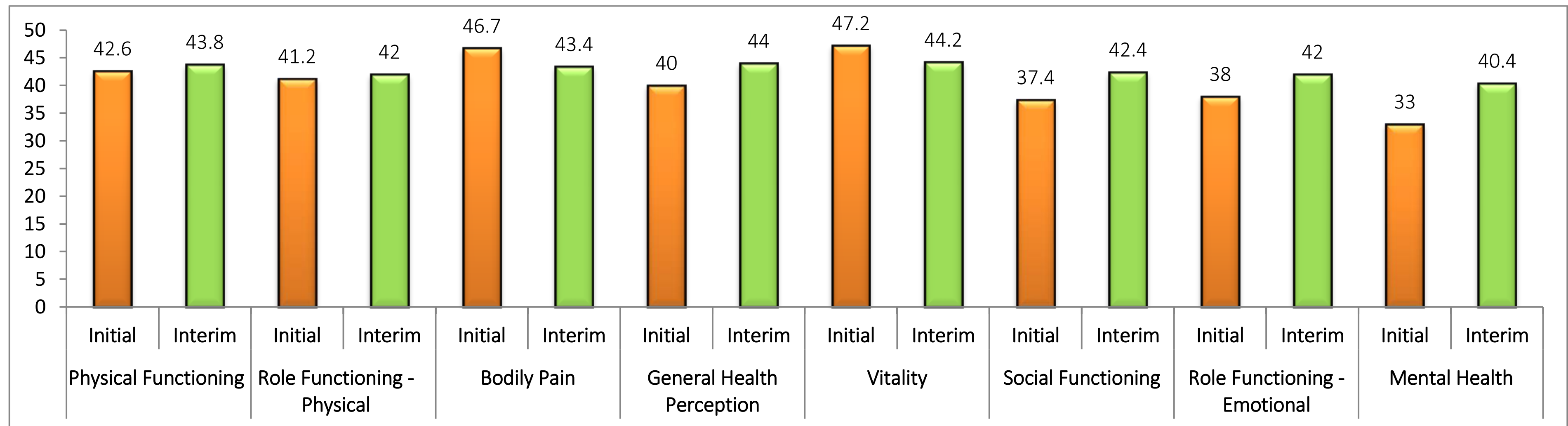


Figure 11. Average Mental & Physical Summary Component Scores (SF-8) at initial and interim assessment periods for veterans (N=19, pairwise data)

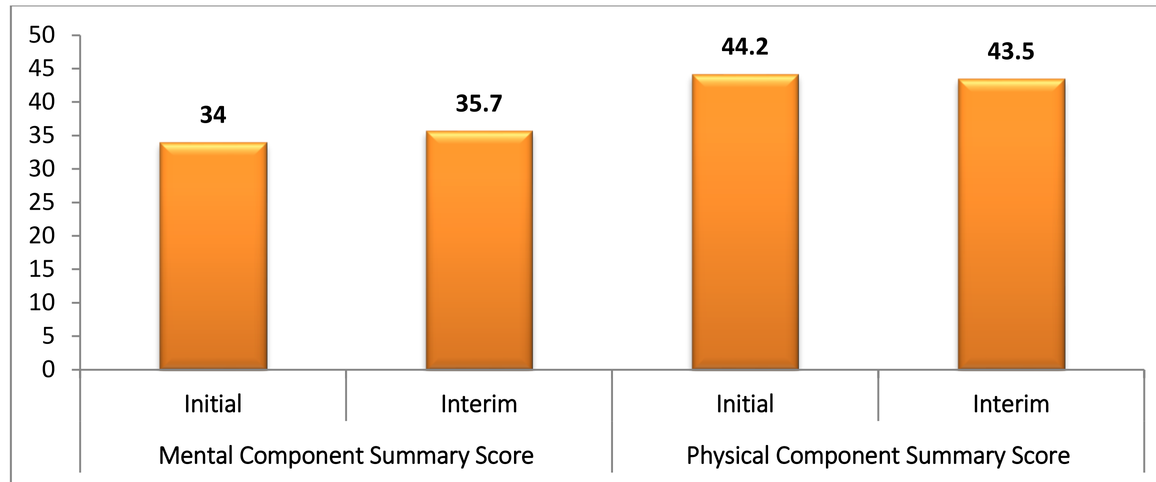
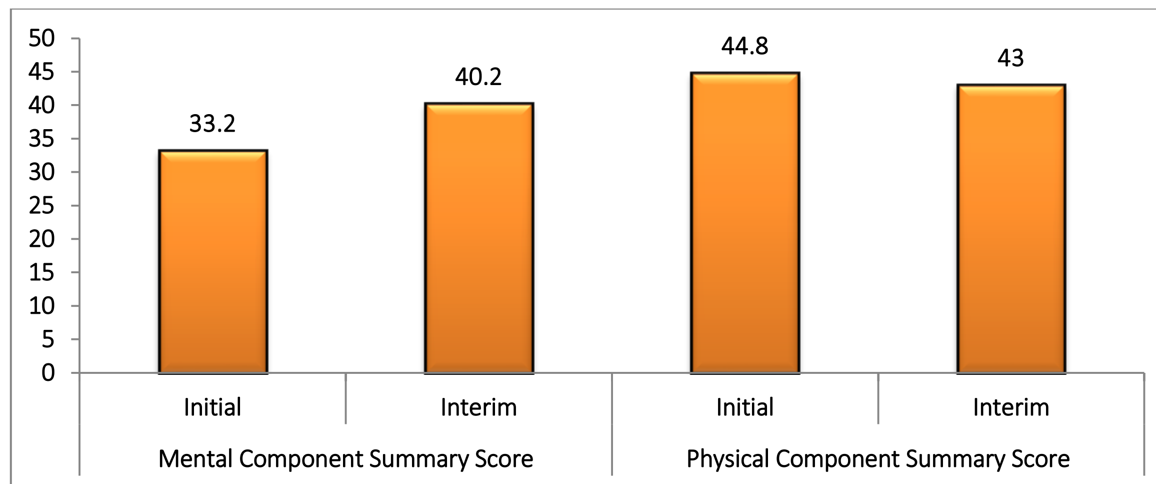


Figure 12. Average Mental & Physical Summary Component Scores (SF-8) at initial and interim assessment periods for family members (N=7, pairwise data)



5. Findings: Qualitative Interviews

Interviews were conducted with clients (including veterans and family members), JTSS staff and other stakeholders involved in the referral process. Together these provide an account of how the JTSS was viewed and experienced by clients, providers and referrers. First we discuss the referral approach and how, to date, this has been enacted, we discuss clients' satisfaction levels and then chart examples of effective practice by mapping out the key characteristics of the programme. We go on to provide evidence for the impact of the service by drawing on experiential data from clients as well as those providing the service and those making referrals into it. This section concludes by drawing on clients thoughts on personal consequences if the JTSS had not been in existence along with stakeholders' suggestions for how the service could be improved. It is important to note that 'clients' are anyone who accessed support from JTSS, which includes family members as well as veterans.

Sixteen people were interviewed including eight veterans, three family members, four staff members of the JTSS programme and one stakeholder from a referring organisation. Half of the interviews were conducted in person and half were conducted by telephone, based on the participant's preference. The interviews lasted from 19 minutes to 1 hour 14 minutes (average = 43 minutes). According to case support workers, 19 clients (veterans and family members) met the eligibility criteria for participation. Of the 19, seven did not respond after three attempts to make contact either by phone or text message. Quotations from interviewees are included to demonstrate salient themes and are anonymised using pseudonyms. A summary of the interviewees is shown in table 10.

Table 10: Summary of interviews with veterans, family members, JTSS staff and other stakeholders

Participants	Telephone or face to face	Pseudonym
1	Telephone interview	Oliver
2	Telephone interview	Edwin
3, 4	Face to face interview	Joe and Maria
5	Telephone interview	Felix
6	Telephone interview	Oscar
7	Telephone interview	Martha (mother of veteran)
8, 9	Face to face interview	Leo and Grace
10	Telephone interview	Claude
11	Telephone interview	George
12	Telephone interview	Ivan
13	Telephone interview	Referral Organisation
14	Face to face (JTSS)	Service provider, A
15	Face to face (JTSS)	Service provider, B
16	Face to face (JTSS)	Service provider, C
17	Face to face (JTSS)	Service provider, D

5.1 Referral process

Interviews with veterans and family members illustrated the range of routes to accessing JTSS. As an opening question clients were asked how they first heard about the service and how they were able to access support. Routes into the programme were varied with referrals from well-known organisations such as Combat Stress. Conversely, for some individuals, and in particular family members looking for support on behalf of a loved one, the referral route was more ad hoc and serendipitous. For example, one mother described trawling the internet looking for avenues of potential support for her son and happening upon information about Finchale College by chance:

> "*As I say he was medically discharged and he was angry all the time and he couldn't find work. I was looking online and I found Finchale College for ex-army, ex-forces. I saw that and I basically nagged him because he had got into a slump and he had to be pushed and nagged. He got into contact with Finchale and he didn't look back. They were absolutely tremendous*" (Grace, wife of veteran).

Another veteran described how a friend, with whom he served, made contact with Finchale College on his behalf to initiate access to support:

> "*Basically, my friend who was out in Afghanistan with me got in touch with Finchale because he thought I was showing symptoms of posttraumatic stress disorder. So he put them onto me. Well there was kinda a mixture, because I got in touch through my friend and through Combat Stress as well*" (Felix, veteran).

Others heard about the programme when they were undertaking training courses at Finchale:

> "*We were approached and asked if we were interested in the service. I think on my course I was the only person who said yes*" (Edwin, veteran).

For some clients, the JTSS was the only avenue of support available due to the eligibility criteria imposed by other organisations. One mother described her gratitude to the JTSS programme for offering an avenue for support where other organisations had failed:

> *"Combat Stress had said, because my son was, how can I say, using alcohol as medication, Combat Stress weren't able to actually do anything for him unless he actually reduced his alcohol, which we were working on at the time but at the same time we needed the help and support there. […] We were thinking well we know he has to curb his alcohol ways but we need more help to help him with that"* (Martha, mother of veteran).

As alluded to in the interview extracts above, entry into the JTSS was ad hoc with some clients arriving in the service purely by chance.

5.2 Satisfaction levels with the JTSS

Without exception, clients' satisfaction with the JTSS was overwhelmingly high. Many described how the service helped in multiple and varied ways. By way of illustration clients received advice and support on a range of important aspects of the transition from army to civilian life:

> *"I received a lot of advice and support about different courses, who I should speak to about my finances, my health and wellbeing, if I'm doing okay, if I'm getting jobs, help with my interviews, stuff with my applications, stuff with my resume, just really helpful"* (Claude, veteran).

The challenges of the transition from army to civilian life were well documented by interviewees, as shown in the following two quotations which both point to the importance of the JTSS in supporting individuals to navigate the unfamiliar civilian world and in providing a source of emotional as well as practical support. When asked if the JTSS had helped with the transition process, one veteran said:

> *"Massively, because if I'd just walked into the outside world, you know just going from the military to nothing, I think I would have got lost, you know like a lost sheep"* (Ivan, veteran).

> *"I think it was the fact that having spent so long in an institution that effectively dresses you, feeds you, all that sort of stuff, nobody is your friend when you're back on the bottom of the pecking order. […] Ex-forces people they've served in Iraq, Afghanistan, the Balkans, first world war, second world war, so there's a better understanding of what we've been through. So organisations are better equipped to understand what our needs are, to be that shoulder to lean on or that ear to listen or that person to talk to. Just talking to someone can help. […] For me, every soldier leaving the army having served in an operational environment, he or she may say 'nah I'm tough as old boots I don't need any support'. Somewhere deep inside something happens, something eats away at you and you need to speak with somebody like [case support worker] and these various different organisations can help. Just sitting down and having a chat might be all that's required, someone just to say "hi, how you're doing, everything okay?" We built up a rapport and just chatted like old mates. That rapport, that interaction, taking me out of the learning environment into a helping environment"* (Edwin, veteran).

The veteran quoted above highlights the importance of simply having someone to speak with about the issues that mattered most to him. This was an aspect of the service that was universally valued by all veterans and family members interviewed. Other important elements of the JTSS will now be discussed in example of effective practice.

5.3 Examples of effective practice

One to one, personalised approach

One of the key strengths of the programme was perceived by many interviewees to be the individualised, one to one support provided. As the following quotation demonstrates the JTSS adapted its approach to the needs of the individual client:

> "*Finchale is normally retraining for veterans and veterans' welfare, where mine was more about mental health and I was still experiencing problems with mental health. And they put me in touch with* [support worker] *who is a mental health nurse and we went on the route of getting me sorted, taking me to the doctors, getting bloods done and then it was going through processes like vWALs, getting the right help*" (Felix, veteran).

An ingredient felt to be key to the success of the JTSS was that the support and advice delivered was in person rather than by telephone/internet. As shown in the following interview extract, the support worker was able to be responsive to the needs of the family and visited more often when those needs escalated or in times of crisis:

> *"She rings us, she helps us, she supports us. Other places, you just do telephone conversations, it's no good, they need the one-to-one, they need face-to-face, one to one, and that's what works with it. As far as I'm aware there's nowhere else that actually does this. Yeah, Combat Stress you go see them once a month or whatever, but that's just not good enough, you need to have that contact where you know, how can I say, if you ring them you know they are going to be there. The structure is really good. We were seeing [case support worker] twice a week and if there was any chaos going off, she would try and come and visit. If she knew there was something really kicking off and yeah we've had a few of them, she would be there you could guarantee. And I would say to her, it's okay, we've done this and that but she would still come. That is the major thing, how can I say, you just know someone is there for you. You can ring a phoneline but there is no one there to give you that hug that you need"* (Martha, mother of veteran).

For many people who had experienced other difficult life events coinciding with their transition from army to civilian life, the fact that they had someone to rely on or to lean on was hugely comforting. For example, the following interviewee describes their support worker as a shoulder to lean on and how the support from the JTSS programme catalysed their successful transition into civilian life:

> *"As I said you know my army life had pretty much ended, I left the army, was medically discharged, my family had fallen to pieces etcetera. So I was in a deep dark place, so she [support worker] was that light at the end of the tunnel. So for my mental health having the knowledge that someone was there, not at my beck and call but that was there to just point me in the right direction. She was my shoulder to lean on, that metaphorical shoulder, so yeah she was able to pull me out of a deep, dark place. I think without her I*

would eventually have got to where I am now but the process I think would be a lot harder" (Edwin, veteran).

Holistic, family-centric approach

One of the key strengths of the JTSS is the provision of a service that adopts a whole person approach rather than compartmentalising an individual into issues to be dealt with. Indeed, the JTSS does not stop at the individual and considers the perspective and needs of the whole family unit:

> "*the wide range of skills that we've got, knowledge that we've got it's not just about sorting out one issue at the time, it's about seeing the person at home, it's something that you have to deal with the individual circumstances, seeing what they are trying to deal with, the issues about that person's family*" (Service provider, D).

> *"It's not just the person you are looking at, look at the house, look at the children, take notice of the wife and then say in three months' time, is that the same family, because you are starting to become immersed and is it cleaner, has she got the nails polished, has she been to the hairdresser, is there now a different dynamic in the house, is it happier for instance, are the children more settled, does it feel relaxed, is there more smiles perhaps? That is unique, that is taking people on a journey to self-sustainment again and to contribute back to society, which is exactly what we want"* (Service provider, C).

This family-centric approach was well articulated by the team providing the service and was captured in interviews with staff members. These data are triangulated by clients' accounts of the support they received in the following interview extract:

> *Just the personal level because she came across she met me, she met my family, she interacted with my children. And my children were shy initially but grew to like her, which was nice, because it's that safe feeling, the fact that you've got somebody here who is more concerned about your own wellbeing rather than just trying to get ticks in the box, you know trying to get their stats up. So the fact that she was here to make sure I was okay and she was ready to help with any needs that I required"* (Ivan, veteran).

Importantly the JTSS saw clients in their own homes and were able to build up relationships of trust with the individual but also their family unit including spouses, children and members of the wider family. Although the support provided was time intensive from the provider's perspective, this was felt by clients to be crucial to the success of the programme in order to build trust and rapport over time. As the quotation above illustrates, the approach which centred on the needs of the individual and their family made clients feel cared for and not just part of the system.

Knowledge and advice

The support received through the JTSS programme was varied and included emotional support providing a listening ear as illustrated in the interview extracts above, as well as practical knowledge and advice, for example help to access benefits for both veterans and family members:

> *"She turned around and said are you on disability living or anything like that and we said no and she said well you're entitled to it cause I was MD'd as well with a back problem and they said I was entitled to it. […] She got all the paper work and she helped us fill it all in"* (Leo, veteran).

> "*It was help with my benefits things like that and just getting on with civilian life because I'd never been jobless. So I didn't know what the benefit system was, what I was entitled to*" (George, veteran).

> *"A lot of it wasn't straight forward but [case support worker] with her background understood it. And when I had to go for the interview she came with me"* (Grace, wife of veteran).

Several veterans also described being advised by their case support worker to register with the GP surgery as a veteran in order to be prioritised for appointments. This was something that many veterans and family members reported not being aware of prior to contact with the JTSS and a valuable piece of information:

> *"Another thing [case support worker] did was ask does your surgery know that you are both veterans (Leo and his son). So we went down and they said have you got any proof you are veterans and I said yeah I've got all my medical records and they went on and said yeah. Now because we're veterans we're prioritised and we didn't know anything about that and that came from [case support worker]"* (Leo, veteran).

Case support workers also made referrals onto other services to provide more specialist advice or to line up additional support into the future:

> "*My first referral was onto VWALS which is the veterans' welfare and liaison service, to deal mostly with posttraumatic stress disorder. She also put in place JSA and PIP, the PIP is still on the go. She also sorted out medications to make me more stable and basically helped me through the harder parts of getting me into the right people*" (Felix, veteran).

> *"She put us in touch with the Carer's Association and we were able to get a wheelchair through the Red Cross so we could go out and stuff like that and all that came through from [case support worker]" (Grace, wife of veteran).*

As illuminated in the data extracts above, the breadth and depth of case support workers knowledge was perceived to be a particular strength of the JTSS.

Importance of trust

When trying to unpack the active ingredients to success of the programme, there was consensus that it was the one to one, personalised approach that was most important. Many participants voiced that being able to phone someone whenever they felt it was necessary or to have weekly or sometimes twice weekly in person visits was crucial to their progress. Some compared JTSS with other less personal, larger

organisations and felt that this one to one, face to face, time intensive approach was absolutely vital to their feeling that they had someone to "lean on" and someone they could trust. The importance of this time and resource commitment should not be underestimated as it was the trust and rapport established through these relationships that made the support so successful. As the following quotations allude to (the first from a client, the second from a frontline worker) it was important for the support worker to establish a relationship over time to garner trust, particularly as the experiences of some veterans may have caused them to become cynical or distrusting of certain organisations and people in general:

> *"It helps take somebody's guard down because there will be people with a lot more issues than myself, so to be able to break that down and get to know the person and then get to understand what that person wants and needs is key I think for helping anyone" (Ivan, veteran).*
>
> *"I think the main one is personal contact, they actually put a face to the person and we don't have what one client called it a conveyor belt to put one person on at one end and out at the other end. Another comment has been that they feel in control of this, whatever their journey is and with some there may be no end to their journey, how can you put a time on it"* (Service provider, B).

Long-term perspective

Rather than fire-fighting the support workers encouraged clients to think long term and equipped them with the skills to become self-sufficient:

> *"It was more setting me up for a long period, more a sort of lifetime approach, rather than let's just get you over the next hurdle"* (Ivan, veteran).

The above client data are triangulated by extracts from interviews with frontline staff providing the service, who were cognisant of the need to balance support for individuals with encouraging independence:

> *"Obviously it's trying to give them autonomy with the decisions but there's some things that even myself and others find very complex to deal with, so how can parents or partners deal with these things when there's not a co-ordinating person there to co-ordinate all of these different avenues of support that they need"* (Service provider, B).

Comradery/peer support

Finally, a key asset of the JTSS, and Finchale College as a whole, is the opportunity it affords for veterans to meet with others with equivocal past experiences and facing similar challenges. Clients, referral organisations and service providers alike recognised this to be a positive opportunity for social interaction, building friendships and informal peer support:

> "*The other thing is your employment prospects and how to write your CV and how to get on. Finchale is quite adept at this. Talking about strengths, meeting other service people there or ex-service people. There's a lot of comradery there. […] Building friendships, it's*

really a morale boost for our clients. They're so chirpy after leaving a course having been on it. I suppose the only drawback is when they've finished you can't really keep sending them back to Finchale!" (Referral Organisation).

"Being on the college course, there was three or four soldiers knocking around who I could associate with and have some squadie banter and I got the realisation that there are other people out there the same as you are suffering the same way as you" (Edwin, veteran).

5.4 Outcomes and impact of the JTSS

Mental well-being

When asked about whether they perceived any changes in their sense of wellbeing following support from the JTSS, several respondents felt that their mental health had improved and they were beginning to feel more independent, motivated and self-confident:

"It's a lot better, tomorrow I'm actually viewing a veterans flat. So I'm getting back to the point where I can start being independent again. We're still at the part where I'm not quite stable enough to go back to me old job and things like that, cause the stress could bring stuff out but all the pathways are now covered and I'm just going through my treatment and once that gets me more stable we'll look at getting me resettled, basically onto resettlement courses that I can do through Finchale" (Felix, veteran).

"She helped me become more independent, more comfortable with myself, more positive" (Oliver, veteran).

"Just giving us motivation you know" (George, veteran).

For one individual, in particular, being able to better manage his condition meant that he felt a stronger sense of control:

"Because of the support I've received so far, it's put me into a position where I can start to be independent again. I'm not in that position where I had no appetite, I was drinking constantly, I shut myself away from people etcetera. Now I can walk in a shop and I'll still be a bit panicky stuff like that and if it's crowded I can kinda just deal with it and do what I need to do and get out. Originally that would have been impossible for me" (Felix, veteran)

Impacts on employability

Examples of impact on employability were cited by clients, frontline staff and referral organisations and included completion of training courses and, for a small number of clients who were more job ready, actually securing employment:

"*I've been in full employment three months ago and training was two and a half months so roughly five months in total, three months on the job itself*" (Claude, veteran).

"*She helped me finish my Horticulture course*" (Oliver, veteran).

"*I'll give you an example, one of our chaps we weren't able to help with his employment prospects but we were able to get him out of debt and get him up to Finchale and he learnt new skills. One of them was forklift truck driving, and he was able to get various licenses in it, he's got all of his licenses via Finchale's arrangements. So he's great and he's happy, before that he saw no hope at all*" (Referral organisation).

Reduced hospital admissions

Two staff members talked about an example of a client who, before contact with JTSS, had numerous hospital admissions but after working with a case support worker his condition had improved such that since initiating contact with JTSS he had yet to relapse:

"The most obvious one I know is a guy who's had five hospital admissions before he came to us and he came to us four months ago and he hasn't had a hospital admission since. Those kind of things are the most obvious differences that we make to people (Service Provider, D).

Wider impacts of the JTSS

The approach adopted by the JTSS was intended to reach out to the family unit as demonstrated in the quotation below:

"I think you've got to give the family back perhaps sometimes, not just independence, but their own identity and to give them the worth sometimes, because they spiral away, I don't feel worthy of this, I'm not communicating with anyone and social isolation can be in a crowd so we've got to work hard to give them wings and to give them confidence to talk to one another and also to move out into the community much more" (Service provider, C).

When asked to talk about an example of how the JTSS had wider impacts another staff member explained how helping a family to access benefits, they were unknowingly entitled to, offset a range of distal effects such as getting out of the house more, socialising and engaging in community life. In this way, alleviating tensions around the household income, allowed the family to focus on activities to promote overall quality of life:

"There's one family in particular who didn't realise they were entitled to certain tax credits, we said have you had a look at this, have you considered this, put them in the right direction, got them in touch with people who could sort out these things, they ended up few hundred pounds better off a month, it's a huge amount of money for them. But it's not just about the money, now they take the kids to the local café, they go to local events they wouldn't have gone before, they now bought a car to take the kids

around, so they are socialising a bit more that has made life a little bit more comfortable for them as well, so instead of worrying about what do we need at the end of the month before we're getting paid, they can relax about those things, they don't have to worry, the stress level goes down, the anxiety level goes down, they've got other things to deal with, that gives them more time and space to deal with other things that are more important rather than worrying about what seems small things" (Service provider, D).

The interviews with clients revealed that the impacts of the programme were experienced not only by the veteran but also by their family. The examples included below illuminate a range of impacts including reducing social isolation, providing an opportunity to chat and talk through difficult issues and improving understanding of mental health conditions, in particular PTSD, amongst family members:

"As for my family, my family got ultimate support. [Case worker] came out to start seeing my mother, taking her out. And they would go out and have a chat and coffee. So [case worker] wasn't just there to support me, she was also there to support my family" (Felix, veteran).

"I think on my wife's behalf, they did have a positive effect [on mental wellbeing] they were able to talk her through things and to assist in matters where obviously I couldn't. For myself, I know pretty much how to deal with myself" (Ivan, veteran).

"The support's there for the family as well. Saying that, [case worker] has even seen my Mam and Dad to tell them how the illness is and how it affects him. She explained that it's not actually him, trying to explain to them he's actually unwell rather than him just being bad" (Martha, mother of veteran).

Consequences if the JTSS had not been available

All participants in the interviews agreed that the support received from the JTSS had enormous impacts on their lives. Given the difficulties in charting clients' journeys and assessing impact, one route into measuring success was to ask clients for their thoughts on what the consequences may have been for them personally if the service had not been available. The responses to this question cast light on how important clients perceived the JTSS to be in their transition process.

As the following interview extracts demonstrate the perceived consequences for some veterans were dire, with interviewees sharing some distressing and poignant scenarios of what might have happened if they had not been involved in the JTSS programme:

"*would have ended up in jail on an assault charge, I was that angry. I'm not an angry little man anymore.* […] *Without the help of [caseworker] I don't know where we'd be. We've got each other, a roof over our head, food in the cupboard and beer in the fridge. It's been life saving"* [Joe, veteran].

"There would have been two things that would have happened. One I would never have left the house ever again and two I would probably have been dead from alcohol

poisoning or three I would have been in prison because I'd have killed somebody" (Felix, veteran).

"I wouldn't be sat here now. I was in a pretty bad way I was working with, I had a psychiatrist and a social worker and all that sort of stuff and I'd not long been out of hospital. I was in a bit of a bad way, I was a bit of a liability to send on college courses (Edwin, veteran).

For family members too, the possible consequences of not receiving support from the JTSS were significant with the wife of a veteran who, alongside her husband, received support from the service speculated about the couple losing their home and the possible breakdown of their marriage:

"*homeless, we wouldn't have got support to go to meetings and we would have got kicked out. It [the support from JTSS] saved our marriage and gave us the strength to continue and not just give up"* [Maria, wife of veteran].

Another veteran described how the transition from army to civilian life can be quite sharp and the transitions programme provided an element of support to aid/catalyse that transition:

"I think there would have been a lot of stumbling in the dark, not knowing what to do. And the fact that you feel quite lonely and in a dark place if you didn't have someone to talk to and someone who knows what you go through, they've dealt with it before, They know somebody to help you. Because when I left the military it was like they'd cut my umbilical cord and see you later and I was like whoa what just happened there. So to go from that environment to nothing it can be quite daunting for some folk I think" (Ivan, veteran).

Similarly, another veteran talked about the difficulties navigating the "new" civilian world and suggested that without the help of the JTSS it would have been difficult for him to complete his college training:

"*Like I said I probably wouldn't have finished college. It would have been a big problem. Because I was in the army it was all, everything is completely new to me and without this support I probably wouldn't have managed. Now I am doing a part time job and this is all because of their support" (Oliver, veteran).*

5.5 Suggested Recommendations

Awareness raising and inter-agency collaboration

Several interviewees mentioned the need for better publicity and marketing of the service to improve awareness across potential referring agencies as well as amongst veterans and their families. In fact this was the most frequently cited recommendation when interviewees were asked to comment on weaknesses of the service and their ideas for improving the JTSS:

"That's what they do need more publicity because I'm not being funny but it's not like they get any trade from people driving by cause you can't see the place. It was only by luck that [wife] found the place online. What needs to happen, there's a lot of military establishments in the UK now, so it would be great if they could get some pamphlets in their hives, either in the hive or the families office. [Leo, veteran]

Similarly, there was a suggestion from clients that the JTSS could better collaborate with other organisations not only for awareness raising but also to foster joint working with organisations such as the NHS and JobCentre Plus to address the employability needs of clients and to work towards more positive treatment outcomes for those clients with PTSD or other mental health issues.

"I tell you somewhere else they could do with information, DWP. When Leo had to go and sign on they'd heard of Finchale but they aren't knowledgeable about Finchale" [Grace, wife of veteran].

Personalised outcomes – no one size fits all

There was recognition across frontline staff of the need for more nuanced and personalised outcomes to measure the impacts of the programme. There was a cognisance about the difficulties in measuring realistic, meaningful outcomes across the heterogeneous client group, all of whom have different starting points and complex and varied needs. As the following data extract alludes to, for some individuals with PTSD for example, being able to manage their condition on a daily basis and being able to reduce the number of times they present to their GP or to secondary services would be a strong outcome of success whereas for others with less complex needs securing employment may actually be a realistic prospect.

"*Everyone is interested in an outcome and that outcome has to be a certain thing, which ticks a box and that's achieved. But I think for some people those outcomes are set too high and for people who are quite unwell an outcome for them is simply to manage their health condition, perhaps to reduce the number of times they have to access their GP or secondary services and if they can function reasonably independently in the world at large that is for many, and for a certain number, the only outcome they can achieve if they are really unwell. But that isn't an outcome that's being measured. And organisations need a tick in the box that so many people have done this but that is something that can become lost, the individual in the whole process. […] You can't measure what might have happened if you hadn't been there. Some things aren't measurable, perhaps this might have happened had I not been there*" (Service provider, A).

This indicates a need for personalised outcomes with the recognition that a broad brush, one size fits all approach is unlikely to capture meaningful data.

Resources

Several clients expressed a desire for the service to be extended and expanded, with specific suggestions around resources, more trained staff and cover when staff members are on leave:

"I think, like, more trained staff because people are in terrible situations and they might need an extra hand. I don't think they have enough people that's what I think" (Claude, veteran).

*"I suppose for now, the representative is sick and I've got no one to take his place when he is sick. He comes with me to appointments (*Oliver, veteran).

In sum, these data provide insights into the strengths and weaknesses of the JTSS while also outlining various challenges to address in future service development and evaluation.

6. Findings: Post-support questionnaire survey

The response rate to the post-support questionnaire survey was extremely low (n=2). Despite implementation of remedial strategies to increase response rate over the course of the evaluation period, only two questionnaires were returned by clients, which precluded analysis of these data.

This low response rate is consistent with surveys conducted in a range of settings and sample populations. Reasons for the low response rate encountered in this study were likely to be due to the high rate of positive engagement with the JTSS. The majority of clients were discharged from the JTSS for positive reasons such as completing their action plans, finding employment of stating they no longer required support, which may have resulted in clients positively dis-engaging with the service and not responding to a request for additional information on their disposition.

7. Discussion and Recommendations

7.1 Summary of key findings

Over the 18 month evaluation period, the JTSS engaged with 55 clients who were referred by 12 different sources (most frequently from The Personnel Recovery Unit at Catterick Garrison). JTSS clients were primarily clustered around the population centres of Newcastle-upon-Tyne, Sunderland Durham and Teesside. During this time frame there were also 25 inappropriate referrals.

The majority of the JTSS clients (n=39, 71%) were veterans (referred to the JTSS after they had been formally medically discharged from the armed forces), male, in their mid-30s, white British, married/partnered and previously served in the army at the rank of private, with on average 9 years of military service. Female veterans and those from ethnic minorities were few in number, although they were commensurate with proportions enlisted within the armed forces.

Once a referral had been received, engagement with staff at the JTSS was typically a few days, which is extremely favourable compared to NHS primary care services such as Improving Access to Psychological Services. Time from date of discharge from the armed forces to ‘first contact’ with JTSS for veterans was approximately five months. This period was closer to three months for those who had yet to be formally discharged (approximately 3 months). On average, clients engaged with, and received support from the JTSS for a period of five and a half months.

Primary issues that clients presented with were primarily related to employment, mental health, physical health, PTSD, housing and relationships. Family members reported being more concerned about debt issues than veterans. Issues such as claims for compensation, issues with state benefits and gambling problems were other commonly reported concerns of JTSS clients.

Analysis of Rickter scores for veterans identified evidence for a statistically significant amelioration of the perceived negative influence of others, how much stress they are currently experiencing and the extent that drugs are part of their lives. No objective evidence for any tangible impact on health outcomes was assessed with the SF-8.

Engagement with the JTSS was excellent. During the evaluation period, 27 clients were discharged from the JTSS, with the substantial majority of these clients (n=25, 93%) fully-engaging with all JTSS services. Eight clients (30%) were discharged from the JTSS as they ‘partially’ engaged (i.e., did not engage with all the services discussed); although this partial engagement was underpinned by positive outcomes (e.g. finding employment or training).

Analysis of interview data provided compelling evidence that the JTSS had a range of psychosocial benefits for veterans and families during a challenging period of their lives. These data revealed multiple impactful effects of the JTSS on indicators of a positive transition and recovery from mental health problems, including family functioning, and generic health and well-being. Strong evidence was also found that engagement with JTSS was attributable to the prevention of negative / adverse outcomes, which are likely to have yielded significant ‘offset effects’ in terms of cost savings to NHS and Social Care

services (specifically due to prevention of homelessness, disengagement from college/training, visits to primary care, involuntary hospitalisation, unemployment, incarceration and relationship breakdown).

Interviews with JTSS staff and other stakeholders supported (triangulated) the findings from interviews with veterans and family members in terms of psychosocial benefits, but also provided insights into the mechanisms underpinning them. The value of face-to-face contact combined with a holistic person/family-based approach to working with clients was instrumental for building motivation, autonomy and confidence. The benefit of personal contact and continued relationships with clients was viewed as critically important for development of positive therapeutic alliances, which are strong indicators of positive outcomes in mental healthcare. JTSS staff also reported a high level of job satisfaction. Interviews also provided valuable data on how to tackle challenges experienced by the JTSS as well as further development of the programme. These are discussed in the following sections.

7.2 Challenges

7.2.1 Meeting referral targets

Annual leave entitlements of the small number of JTSS staff, including sickness absence are invariably a challenge for maintaining full service readiness to accept referrals throughout the year.

Approximately 30% of the total referrals to the JTSS during the evaluation period were inappropriate; although, all these individuals received support in the form of signposting / referral to a range of other services/programmes that are available at Finchale. Nevertheless, the rate of inappropriate referrals impacted negatively on service capacity and could be reduced by regular communication/engagement with referrer organisations to ensure understanding of the remit and eligibility boundaries of the JTSS; and/or expansion of eligibility boundaries. This requires regular and sustained engagement with referral organisations/agencies to be effective, which represents a considerable investment of staff time that is currently allocated to supporting clients and responding expeditiously to new referrals.

Strategies to mitigate the impact of annual leave/sickness absence of JTSS staff, as well as time to engage more regularly and widely with referral sources are discussed in section 7.3.

7.2.2 What constitutes a successful outcome?

A further key challenge was in defining a ‘successful’ outcome for clients, an issue that has been well rehearsed in the literature around evaluating complex interventions. As discussed in the qualitative interviews many of the clients in the service had multiple and complex needs, and were not beginning their transition journey from a common starting point. As such, key stakeholders implored that it would be erroneous to employ a ‘one size fits all’ approach to assessing outcomes in terms of recovery and improved health and well-being. To paraphrase one member of staff, a positive outcome for individuals with chronic mental health problems might simply be to manage their condition, in order to reduce the number of times they present to primary or secondary care. For others, it might be to feel confident and motivated enough to go for a walk, or to begin to socialise with friends or family. These might be viewed as “soft” outcomes, but from the client’s perspective these are things that matter and make a real difference in terms of quality of life and sense of personal well-being.

7.3 Recommendations for programme development

There is a need for regular and sustained social marketing/publicity of JTSS with the NHS, social care, third sector/voluntary mental health charities, including other organisations such as the Job Centre Plus and police forces to increase the numbers of 'appropriate' referrals. Social marketing activity could also target the community directly to increase awareness of the JTSS, in order to yield a concomitant increase in rates of both self- and family referral to the programme. Furthermore, social marketing could employ a range of media such as the Internet, social media channels, TV, print and radio). The latter would be augmented by the inclusion of personal narratives and testimonials of past and current clients (with appropriate permissions sought for their use from clients), including testimonials from referring organisations. Regarding technology, email and SMS texts could be used to remind clients about meetings, as well as provide further avenues of support and advice to clients.

While the qualitative data from this evaluation demonstrated high levels of client satisfaction with the JTSS, there were concerns expressed from all stakeholders about the need for additional resources to accommodate more clients, and also to maintain quality and satisfaction with the service. These concerns could be mitigated with more trained staff to add capacity and capability of the service to accommodate an increased case load. From interviews with clients it was clear that one of the key ingredients of success for the programme was the time that case support workers could provide to each client which served to build trust, rapport and a strong therapeutic relationship. It is crucial, therefore, that this successful approach is not undermined by increasing the caseload at the expense of a quality personalised service. An acceptable approach would be to augment the core team. Given omnipresent budget constraints, supplementing the core team of specialist case workers with trained volunteers to undertake 'lower intensity' work with clients is one viable option to adding capacity to the JTSS programme. This could also take the form of training former clients (veterans and/or family members) who have successfully transitioned into civilian life who are willing to share their stories and provide peer support. This peer support worker role has been successfully introduced into NHS services for mental health.

Another approach might be to supplement the core team with attaché staff from local NHS or social care services, who are available to meet with clients at Finchale for specialist advice or support. One key gap in the skillset of the core support team is around health and lifestyle behaviour change, which are of equal importance for mental and physical health. Future services might consider augmenting the core team with psychological support, in particular an expert in health and lifestyle behaviour change. It is well established that positive changes in health and lifestyle behaviours such as smoking cessation, engagement in physical activity/exercise, and reducing alcohol consumption can positively impact on mental wellbeing, as well as help people to prevent and self-manage physical health problems such as Type 2 diabetes and obesity. Supplementing the skillset of the core JTSS team with a behavioural expert would be in keeping with the holistic paradigm underpinning the JTSS, highly likely to be valued by future clients and lead to improved outcomes.

Only four (11%) of JTSS clients previously served with the Royal Navy or the Royal Air Force. However, these small numbers demonstrate proof of concept for a full tri-service programme. Future development

of a tri-service programme would benefit from developing and strengthening existing relationships with agencies representing veterans from the Royal Navy and Royal Air Force, in order to facilitate referrals, as well as to ensure the service is sensitive to the needs and experiences of veterans from all armed forces.

Strategies to reduce time to first contact with the JTSS would benefit clients in order to prevent the appearance, or worsening, of mental health symptoms and other related issues. The pathway could be strengthened and streamlined by enabling opportunities for more engagement with eligible service leavers and their families before discharge from service. Other possible improvements to the support pathway include making more onward referrals and additional signposting for longer-term healthcare needs, especially for clients with more complex needs.

7.4 Recommendations for future service evaluation

The very poor response rate to the postal survey strongly indicates that this was a sub-optimal method for post-support service evaluation. Alternatives should be considered such as brief interviews or surveys at the time of, or proximal to, a client's final discharge contact with JTSS staff.

The periods between assessments of quantitative outcomes (Rickter and SF-8) were variable, which combined with missing data at follow-up assessment periods, impacts negatively on the ability to more definitively attribute any improvements in clients' disposition to the support they received from the JTSS. Future service evaluation should adhere to a protocol for standardisation of assessment periods (e.g., once every 3 months) with strategies to reduce any missing data, which would permit a more robust assessment of changes over time.

In accordance with findings from interviews, there is a need to assess quantitatively a broader range of positive outcomes related to recovery and improved health and well-being. Therefore, in addition to Rickter and SF-8 assessments, future service evaluation should employ The Warwick-Edinburgh Mental Well-being Scale (WEMWBS), a validated measurement scale of 14 positively worded items for assessing mental well-being.

The JTTS programme is likely to have yielded 'offset effects' in terms of cost savings for NHS and Social Care services. Below are some selected average unit costs of health and social published by the Personal Social Services Unit (2014)[xliii]:

- Local authority social services day care for people with mental health problems (£35 per client attendance / £8.60 per client hour / £30 per client session lasting 3.5 hours)
- Local authority care homes for people with mental health problems (£1,062 per resident per week)
- Counselling services in primary medical care (£50 per hour)
- Alcohol services – admitted (per bed day) and community (per care contact) = £353 and £120 respectively
- A&E mental health liaison services = £206 (per care contact)
- Secure mental health services (per bed day) = £537

Even if only modest offset effects resulted from the JTTS programme, they would translate into significant cost-savings for NHS and social care services (excluding any offset effects on voluntary / third sector services, the Police Force and other organisations), which are likely to exceed the amount of funding allocated for the JTTS programme. Definite data to inform a robust assessment of cost-effectiveness to support this assertion would provide a compelling argument for the sustainability and further development of the JTSS programme. Therefore to provide an accurate assessment of offset effects, future service evaluation should capture data on rates of involuntary hospitalisation, use of health and social care services and resources at the initial, interim and discharge periods, including changes in un/employment rates and contact with the judicial system.

7.5 Conclusions

This service evaluation has provided quantitative and qualitative evidence of the JTSS programme for supporting a positive transition and recovery from mental health problems. Powerful narratives around personal transition journeys of clients provided particularly strong evidence that engagement with JTSS impacted positively on their psychosocial wellbeing; family functioning; self-esteem, motivation and confidence for seeking employment and training.

Recommendations around improved social marketing of the JTSS programme, increased resources to provide additional capacity possibly in the form of attaché staff from NHS and social care or peer support volunteers, consideration of what constitutes successful outcomes and assessing additional outcomes related to offset costs (involuntary hospitalisation, use of health and social care services/resources, un/employment rates and contact with the judicial system) would serve to maintain the quality of service delivery, demonstrate cost-effectiveness and enhance outcomes.

Building on the reputation of the JTSS programme and the reputation of Finchale more broadly, consideration of the recommendations suggested here would improve future service provision to veterans in need of timely and effective support to make a successful transition to civilian life.

Appendices

Appendix A

Leaflet advertising the JTSS

FiMT
forces in mind trust
SUCCESSFUL SUSTAINABLE TRANSITION

Joint Transition Support Service (JTSS)

(Funded by Forces In Mind Trust)

We are offering medically discharged personnel, an opportunity to join this unique, tailored and professional service that is designed to provide assistance, support and advice for you and/or your family. Helping you overcome difficulties and settle into your new lives in the North East.

The team:

- Mel Pears - Manager
- Andy Wildish - Co-ordinator
- Avril Clark - Mental Health Support
- Julie Goldsmith - OT Support
- Alison Golsworthy-Miller - Employment Coach

History

Finchale is located just North of Durham and was founded in 1943 to support the wounded, injured and long term sick veterans returning from the Second World War.

Our aims are to support you with:

- Family needs
- Form filling
- Assisting individuals and families
- Schools and childcare
- Health, mental health and wellbeing
- Advice
- Benefit claims
- Employment needs
- Housing
- Debt
- Training needs

Background

We are offering a unique, family orientated, holistic support programme which is designed, and delivered, by local professionals to supplement any ongoing support from the point of discharge.

We offer a team of case workers, from your local area, who have access to information and resources which can help you, and your family, to successfully make the transition into civilian life. Each case worker has many years of experience and can help, advise and guide you, through those awkward times following discharge. They can also assist your smooth transition into your new lives by helping you make contact with local organisations and agencies such as banks, councils, GPs, dentists, housing providers, schools and community groups.

For referrals, please contact Andy at:

E-Mail: andy.wildish@finchalecollege.co.uk

Telephone: 0191 386 2634 Ext: 361

By Post – Send section below to Andy at:
Joint Transition Support Service
Finchale College
Durham, DH1 5RX

First name: ________________________________

Surname: ________________________________

Contact address: ________________________________

____

____

Home telephone: ________________________________

Mobile telephone: ________________________________

Email address: ________________________________

Current support (AWS, Support Hub, PRC, PRU, Combat Stress, DCMH...)

____

North of England
Mental Health Development Unit

Appendix B

JTSS client interview topic guide (telephone or face-to-face)

Introduction

- I/we work as a researcher for NEMHDU (North of England Mental Health Development Unit). We are a not-for-profit organisation based in the North East, interested in improving health care services for people in the region. We have been asked by Finchale College to gather feedback about the transitions service from people who have used it. The project was funded by the Forces in Mind Trust. We will be using the findings to write a report to summarise peoples' opinions of the service and any recommendations for how it could be developed in the future. The interview discussion is very informal and will take around 30 minutes.
- Your participation is **completely voluntary** and you are free to end the interview at any time, or move on to a different question or discussion topic. Taking part is entirely up to you.
- This discussion is **confidential** and no names or personal details will be included in the report, or passed on to anyone outside our research team.
- Are you happy for me to **record our discussion**? We record interviews only for the purposes of note taking; you will not be personally identified in any report and the recording will not be listened to by anyone outside of the research team.

Interview Prompts

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

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

3. Now I would like to ask about any impact that the service may have had on you or your family.
   - Any changes to your health during the time since your initial contact with the service? (disability/mental wellbeing/overall health?) If no change, why do you think that is?

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

4. Finally, based on what we have already discussed and your experience of the service, do you have any overall opinions or recommendations that you would like to be taken forward?
    - Is there anything that you would recommend to improve the service?
    - Is there anything additional you would like to see in future service leavers' support in your local area?
5. **What do you think would have been the consequences for you or your family if this service had not been available to you?**

Anything we have not discussed, that you feel is important - related to JTSS service or health/wellbeing support more generally?

What next?

We will be writing a report based on the views and recommendations gathered through the questionnaire and interviews. Finchale College and the Forces in Mind Trust will use the report to help inform how the service develops in the future - so your input is very valuable.

Any views or comments included in the report will be anonymous and no names will appear anywhere. Do you have any further questions?

Would like a summary of study findings sent to you in the post or email? Yes / No

Happy to be contacted in the future in relation to this study? Yes/ No

Appendix C

JTSS staff interview topic guide

1. Where did the idea for the JTSS originate?

2. What is unique about the JTSS and how does it differ to the other organisations providing support to veterans and their families?

3. Could you provide some specific examples of how the JTSS has helped clients and their families?

4. How has the JTSS programme benefited individual clients and their families in terms of physical health/emotional wellbeing/stress levels/confidence/sense of control?

5. Did you observe any tangible changes in the personal circumstances of clients and their families (work situation, family relationships, social life, financial situation)?

6. What do you think would have been the consequences for some clients and their families if the JTSS <u>had not</u> been available?

7. Specifically what worked well about the service?

8. What worked not so well?

9. Were there specific challenges around:

   - the referral process;
   - support available for clients and their families;
   - logistical issues;
   - follow-up and maintaining contact with clients;
   - referrals on to other NHS and non-NHS services?

10. What could be done differently to improve how the service is delivered?

11. What additional support in your local area is needed for veterans and their families (any other recommendations)?

12. Is there anything that we have not discussed, that you feel is important related to JTSS?

Appendix D

Other stakeholder interview topic guide

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

Appendix E

Post-support questionnaire survey

North of England
Mental Health Development Unit

REF: ____________
(OFFICE USE ONLY)

The Joint Transition Support Service (JTSS):

Tell us your views!

This questionnaire is designed to help us understand your views about the Finchale College Joint Transition Support Service (JTSS). It should take around 20 minutes to complete.

If you have any queries, or would like help to complete the questionnaire, please contact us on **07793769634** or **deborah.harrison@nemhdu.org.uk**.

Section 1: About the support you have received

First of all, we would like to ask your opinion about any advice or support you have received from the Joint Transition Support Service (JTSS).

1. Please tell us how you would rate the following:

(Please circle one choice for each item listed below. If not applicable, tick the 'N/A' box)	Very poor	Poor	OK	Good	Excellent	N/A
How quickly you were contacted by the service	1	2	3	4	5	☐
Your case worker's knowledge of local services	1	2	3	4	5	☐
Your case worker's knowledge of issues faced by service leavers	1	2	3	4	5	☐
How well your case worker communicated with you	1	2	3	4	5	☐
The overall quality of the support you received	1	2	3	4	5	☐
How well your health and wellbeing needs were met	1	2	3	4	5	☐

2. On a scale of 0 to 10, how highly would you recommend the JTSS to other service leavers?
(Please circle one number below)

0 1 2 3 4 5 6 7 8 9 10

Would not recommend at all

Would highly recommend

3. Please tell us a little more about why you are happy or unhappy with the service, including any recommendations for improvement:

Section 2: Health and wellbeing

Now we would like to ask you a few questions about your health and wellbeing; both **now** and **before** you first contacted (or were contacted by) the JTSS.

4. During the time since your first contact with the service, have you experienced any changes to your overall health and wellbeing (including any particular condition you may have)?

Would you say that you... (Please circle only one)

Feel a lot better now	Feel a little better now	Feel about the same	Feel a little worse now	Feel a lot worse now
1	2	3	4	5

5. Do you think any changes to your health or wellbeing have happened *as a result of* your contact with the JTSS? (Please tick one box)

- ☐ Yes – things have improved
- ☐ No
- ☐ Yes – things have got worse
- ☐ I don't know
- ☐ It's too early to tell

6. Thinking about your day-to-day life, during the *time since* your first contact with the JTSS, taking everything into consideration would you say you are NOW more or less satisfied with your...

(Please circle one choice for each item below, or tick the N/A box if not applicable)	Much more satisfied now	A little more satisfied now	About the same	A little less satisfied now	Much less satisfied now	N/A
...family relationships?	1	2	3	4	5	☐
...social relationships? (e.g. friends, neighbours)	1	2	3	4	5	☐
...living/housing situation?	1	2	3	4	5	☐
...work situation? (including volunteering)	1	2	3	4	5	☐
...financial situation?	1	2	3	4	5	☐
...leisure time activities?	1	2	3	4	5	☐
...confidence?	1	2	3	4	5	☐
...ability to function in civilian life?	1	2	3	4	5	☐
...overall sense of wellbeing?	1	2	3	4	5	☐

Now please turn over...

7. Thinking about the *time since* your first contact with the service, how strongly do you agree or disagree with each of the following statements?

(Please circle one choice for each item below)	Strongly agree	Agree	Neither	Disagree	Strongly disagree	N/A
I feel more able to cope with the transition to civilian life	1	2	3	4	5	☐
I feel better informed about where to get help if I need it	1	2	3	4	5	☐
I feel worried about moving forward	1	2	3	4	5	☐
I feel more in control of my current situation	1	2	3	4	5	☐

8. Please tell us a little more about any changes to your health, wellbeing or lifestyle during the time since your first contact with the JTSS:

Section 3: A little bit about you

Finally, we would like to find out a little bit about you. (This section is optional)

9. Are you:

☐ Male ☐ Female

10. What is your age?

☐ Under 21 ☐ 22 - 29 ☐ 30 - 39 ☐ 40 – 49 ☐ 50 - 59 ☐ 60 +

11. Are you:

☐ A service leaver ☐ A family member ☐ Other (Please specify) ....

Thank you for your time! Please return your completed questionnaire to us using the POSTAGE PAID envelope provided, as soon as possible.

If you would be interested in talking to us further about your views, or would like to take part in our prize draw, please complete the enclosed Contact Details Form and include it with your questionnaire.

Appendix F

Presenting Primary Concerns of JTSS Clients

	n/%	Min / Max	Mean (SD)
Primary Concern (Veterans, n=39)			
Employment	25 (64%)		
Mental Health	23 (59%)		
Physical Health	23 (59%)		
Other	21 (54%)		
PTSD	16 (41%)		
Housing	15 (39%)		
Relationships	12 (31%)		
Debt	6 (15%)		
Alcohol	6 (15%)		
Offending	3 (8%)		
Anger	3 (8%)		
Drugs	2 (5%)		
Total number of primary concerns		1 / 9	4.1 (2.1)
Primary Concern (Family members, n=16)			
Mental Health	5 (31%)		
Relationships	5 (31%)		
Employment	5 (31%)		
Other	5 (31%)		
Physical Health	4 (25%)		
Housing	3 (19%)		
Debt	1 (6%)		
Total number of primary concerns		1 / 4	1.9 (1.0)

Appendix G

Detailed Summary Statistics for Rickter Scales – Veterans and Family members

Pairwise (data at both initial and interim periods) Rickter Scores for Veterans (n=20)

Domain	Minimum	Maximum	Mode	Median (IQR)	Mean (SD)
Employment, training and education					
Initial	1	10	1,5	5 (4)	4.0 (2.6)
Interim	1	9	5	5 (6)	4.9 (2.7)
Accommodation					
Initial	1	10	7,8,9	7.5 (4)	7.0 (2.5)
Interim	1	10	8	8 (6)	6.3 (3.3)
Money					
Initial	1	8	3,5	4.5 (3)	4.4 (2.0)
Interim	1	9	6	6 (6)	5.4 (2.7)
Relationships					
Initial	1	10	5,7,10	6.5 (6)	5.9 (3.1)
Interim	1	10	5,9,10	6.5 (5)	6.3 (2.9)
Influences					
Initial	1	8	3,4,8	4 (4)	4.6 (2.4)
Interim	1	9	1,2,3	2.5 (2.5)	3.0 (2.1)
Stress					
Initial	5	10	5,7	7 (4)	7.3 (1.9)
Interim	1	10	8	5.5 (4)	5.8 (2.8)
Alcohol					
Initial	1	10	1	2 (4)	3.3 (3.0)
Interim	1	6	1	1.5 (2)	2.4 (1.8)
Drugs					
Initial	1	10	1	1 (3)	3.0 (3.6)
Interim	1	2	1	1 (0)	1.2 (0.4)
Health					
Initial	1	10	4	4 (5.5)	4.4 (2.9)
Interim	1	9	4	4 (4.5)	5.0 (2.7)
Happiness					
Initial	1	9	1	5.5 (6.5)	5.0 (3.0)
Interim	1	9	7	5.5 (2.4)	5.1 (2.4)

Pairwise (data at both initial and interim periods) Rickter Scores for family members (N=7)

Domain	Minimum	Maximum	Mode	Median (IQR)	Mean (SD)
Employment, training and education					
Initial	1	8	1,3	3 (4)	3.6 (2.4)
Interim	1	9	**	5 (5)	5.1 (2.8)
Accommodation					
Initial	3	9	8	7 (3)	6.6 (2.1)
Interim	2	10	5,7	7 (4)	6.4 (2.7)
Money					
Initial	1	8	1	2 (2)	2.6 (2.5)
Interim	1	9	2,5	5 (5)	4.4 (2.9)
Relationships					
Initial	1	10	10	8 (5)	7.4 (3.4)
Interim	4	10	8	8 (5)	7.6 (2.3)
Influences					
Initial	1	10	2,8	6 (6)	5.3 (3.6)
Interim	1	9	1,2	2 (5)	3.4 (3.0)
Stress					
Initial	5	10	5,8	8 (4)	7.4 (1.9)
Interim	4	10	8	8 (3)	7.9 (2.0)
Alcohol					
Initial	1	8	1	1 (2)	2.3 (2.6)
Interim	1	5	1	1 (1)	1.7 (1.5)
Drugs					
Initial	1	10	1	8 (8)	5.6 (4.3)
Interim	1	10	1	1 (4)	2.9 (3.5)
Health					
Initial	1	8	7,8	7 (6)	5.4 (2.9)
Interim	2	9	5,9	5 (6)	5.7 (2.8)
Happiness					
Initial	1	8	5	5 (5)	4.6 (2.5)
Interim	2	10	5,8	8 (4)	6.7 (2.8)

** multiple modes (scores 1,3,4,5,6,8,9 all n=1)

Appendix H

Detailed Summary Statistics for SF-8 – Veterans and Family members

SF-8 Domain & Physical/Mental Component Summary Scores at initial and interim assessment period for Veterans (N=18)

SF-8 Domain	Min	Max	Median (IQR)	Mean (SD)
During the past 4 weeks, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)? (Physical Functioning)				
Initial	21.5	54.0	44.2 (23.7)	42.7 (11.4)
Interim	30.3	54.0	44.2 (23.7)	43.1 (9.6)
During the past 4 weeks, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health? (Role Functioning Physical)				
Initial	28.3	54.0	50.5 (25.7)	44.4 (11.4)
Interim	28.3	54.0	42.8 (25.7)	42.4 (9.8)
How much bodily pain have you had during the past 4 weeks? (Bodily Pain)				
Initial	31.5	60.8	40.1 (15.4)	45.0 (10.6)
Interim	25.4	60.8	43.9 (13.3)	45.3 (10.5)
Overall, how would you rate your health during the past 4 weeks? (General Health Perception)				
Initial	22.8	59.5	46.4 (15.4)	43.2 (10.5)
Interim	22.8	52.8	46.4 (15.4)	41.8 (9.1)
During the past 4 weeks, how much energy did you have? (Vitality)				
Initial	28.1	55.6	40.5 (19.8)	43.3 (11.1)
Interim	28.1	55.6	45.2 (19.8)	44.7 (10.2)
During the past 4 weeks, how much did your physical health or emotional problems limit your usual social activities with family/friends? (Social Functioning)				
Initial	23.4	55.3	40.4 (21.5)	39.3 (12.1)
Interim	23.4	55.3	40.4 (20.0)	39.2 (10.6)
During the past 4 weeks, how much did personal or emotional problems keep you from doing your work, school or other daily activities? (Role Functioning Emotional)				
Initial	21.7	52.4	38.1 (23.1)	38.6 (11.9)
Interim	21.7	52.4	38.1 (18.1)	38.7 (10.8)
During the past 4 weeks, how much have you been bothered by emotional problems (such as feeling anxious, depressed or irritable)? (Mental Health)				
Initial	21.4	56.8	36.6 (28.2)	36.4 (12.0)
Interim	21.4	56.8	36.6 (20.6)	38.2 (12.6)
Mental Component Summary Score (n=19)				
Initial	6.3	56.3	33.6 (30.6)	34.0 (16.0)
Interim	13.5	63.7	35.8 (27.0)	35.7 (15.4)
Physical Component Summary Score (n=19)				
Initial	22.1	61.4	44.1 (28.0)	44.2 (13.8)
Interim	22.4	61.2	44.8 (17.4)	43.5 (10.6)

SF-8 Domain & Physical/Mental Component Summary Scores at initial and interim assessment period for Family Members (N=7, pairwise)

SF-8 Domain	Min	Max	Median (IQR)	Mean (SD)
During the past 4 weeks, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)? (Physical Functioning)				
Initial	21.5	54.0	54.0 (23.7)	42.6 (14.5)
Interim	30.3	54.0	54.0 (23.7)	43.8 (12.7)
During the past 4 weeks, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health? (Role Functioning Physical)				
Initial	23.0	54.0	46.9 (25.7)	41.2 (14.1)
Interim	28.3	54.0	46.9 (25.7)	42.0 (13.0)
How much bodily pain have you had during the past 4 weeks? (Bodily Pain)				
Initial	25.4	60.8	47.7 (29.3)	46.7 (14.9)
Interim	25.4	60.8	40.1 (29.3)	43.4 (14.9)
Overall, how would you rate your health during the past 4 weeks? (General Health Perception)				
Initial	22.8	52.8	38.4 (13.8)	40.0 (10.0)
Interim	32.6	52.8	46.4 (14.4)	44.0 (7.7)
During the past 4 weeks, how much energy did you have? (Vitality)				
Initial				
Interim	28.1	55.6	45.2 (10.4)	47.2 (9.9)
	28.1	55.6	45.2 (0)	44.2 (8.1)
During the past 4 weeks, how much did your physical health or emotional problems limit your usual social activities with family/friends? (Social Functioning)				
Initial	23.4	55.3	40.4 (31.9)	37.4 (14.4)
Interim	23.4	55.3	49.5 (20.0)	42.4 (11.9)
During the past 4 weeks, how much did personal or emotional problems keep you from doing your work, school or other daily activities? (Role Functioning Emotional)				
Initial	21.7	45.7	38.1 (7.6)	38.0 (8.0)
Interim	29.3	52.4	38.1 (14.3)	42.0 (8.5)
During the past 4 weeks, how much have you been bothered by emotional problems (such as feeling anxious, depressed or irritable)? (Mental Health)				
Initial	21.4	41.5	31.6 (9.9)	33.0 (6.9)
Interim	21.4	49.6	49.6 (18.0)	40.4 (11.9)
Mental Component Summary Score				
Initial	17.9	44.0	33.4 (6.7)	33.2 (8.1)
Interim	20.0	49.9	46.5 (19.6)	40.2 (11.6)
Physical Component Summary Score				
Initial	19.5	61.2	52.6 (32.6)	44.8 (17.6)
Interim	24.0	58.6	45.8 (30.3)	43.0 (15.8)

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