A Realist Evaluation of a Voluntary Sector Drop In Service for Veterans

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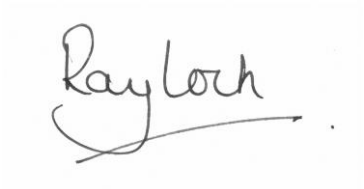
Foreword

One of the most admirable qualities of a charity is a desire to improve, and to share its learning with others. In the case of Veterans Outreach Support, their initiative to invite the University of Portsmouth to conduct an independent evaluation is admirable, and their request for funding from Forces in Mind Trust is exactly what we were established to fulfil. Of course, this is not without risk – it is fashionable at the moment to pick on those areas where charities can improve to feed headlines, and ignore the enormous amount of good the charity does. Doubtless some deserve such opprobrium – but Veterans Outreach Support is certainly not one of them. Indeed, it quickly became apparent as the project progressed, that it was by nature action research, when findings are swiftly acted upon to improve performance. This report should be read not as an evaluation of Veterans Outreach Support 2018, but rather as a description of a journey of continuous improvement, from whom everyone can learn.

And there is a good deal to learn from this project. Drop-in centres for 'veterans' have proliferated across the United Kingdom, as the popularity of the Service club has diminished, this being in part a reflection of society's move away from that style of venue, and in part a matter of a younger demographic's tastes. But the need for ex-Service personnel of all ages to gain access to information, services and comradeship endures. The size, composition and ancestry of many drop-in centres mitigates against their becoming standalone charities, with the associated framework of governance. Issues though such as safeguarding, data protection and simple effectiveness and competence will affect all, regardless of size. That is why this report is required reading for all those involved in drop-in centres, as well as for those representing them such as Cobseo, the Confederation of Service Charities, and the nascent Association of ex-Service Drop-In Centres, ASDIC.

So I applaud the boldness of Veterans Outreach Support, their ability to learn, and their willingness to share with others: a wonderful example of collaboration. We should ensure that others adopt this open attitude, and apply the lessons the University's excellent research team have clearly identified for such Centres. This is a growing sector – we all share a responsibility to ensure it grows strong, and safe.



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A Realist Evaluation of a Voluntary Sector Drop In Service for Veterans

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Abstract

Objectives: How best to support veterans is a key question for service providers and policy makers. The objectives of the current study were to evaluate a drop in service for veterans delivered by veterans, in terms of effectiveness and cost-utility.

Design: A realist evaluation was used to evaluate the drop in service. Realist evaluations seek to understand what works for whom and in what context, and are traditionally mixed method.

Methods: The realist evaluation comprised three Work Packages. Work Package 1 involved the development of the programme theory, based on stakeholder interviews, current evidence base, and organisation documentation. Work Package 2 was a retrospective study and included; a retrospective analysis of the service's dataset of CORE outcomes, one-to-one interviews with veterans and service providers, and a survey of past and current users. Work Package 3 was a prospective study following new users for a maximum of 6 months, which included a cost utility analysis including use of the CSRI.

Results: A number of interesting themes arose from the components of the service, with each element providing vital triangulation. Two types of users emerged from the findings; those who access the service for the mental health provision and those who attend to receive practical support from attending agencies. The drop in service was seen as a safe haven, and the military-like environment acted as a core mechanism for change. Comparisons with other services, particularly NHS, were favourable. Cost utility analysis found that the service is cost-effective if improvement is maintained for one year.

Conclusions: VOS represents a trusted, familiar environment that meets a range of different needs. Despite this, there are areas that require consideration. Findings suggest that one size does not fit all; what works for those who present with psychological or physical need may not work for those who present with practical or social need. What might suit the former is a quieter drop in, with formal psychological assessment, risk monitoring, and where onward referral is efficient. The power of the military-like environment comes to the fore here as a mechanism. What suits the latter is a busier drop in, with no psychological assessment, and where agencies and service users can network. Of importance to this group is the efficiency of a 'one stop shop'. What is important for both is greater privacy afforded to them while at the drop in and, arguably, a more frequent drop in.

This report has been written in accordance with RAMESES II reporting standards for realist evaluations (Wong, Westhorp, Manzano, Greenhalgh, Jagosh, & Greenhalgh, 2016).

Executive Summary

Overview of evaluation

How best to support veterans is a question that is of current importance to service providers and policy makers. The objectives of the current study were to evaluate a drop in service for veterans in terms of effectiveness and cost-utility. More specifically, to gain insight into usual treatment pathways, explore perceived effectiveness, barriers, and facilitators in attending VOS.

This report presents the findings of a realist evaluation of a non-NHS voluntary sector drop in service, Veterans Outreach Support (VOS). Using VOS as an example model, this realist evaluation sought to understand the concept of the 'drop in' from both a theoretical perspective as well how theory translates into practice. In addition, it was important to understand who might benefit from this type of service (and which particular elements of VOS), how, and at what cost.

The realist evaluation involved the development of the programme theory and subsequent testing through: the analysis of the service's existing dataset; one-to-one interviews with service users and providers; the completion of a survey study; prospective case studies to follow new users' journeys through VOS; and an economic evaluation. Overall, this method gives rise to an understanding of what works for whom and in what context, through the development and testing of context, mechanisms, and outcomes, or CMOs.

Programme Theory	• Review of literature (mapping against current recommendations) • Review of organisation documentation • Interviews with the two clinical leads
Work Package 1: Retrospective study	• Analysis of VOS dataset • Interviews with service users and providers (with repeat interviews post changes at VOS) • A survey study concerning perceptions and use of VOS
Work Package 2: Prospective study	• A series of case studies following participants over 6 months VOS use • Economic evaluation: Calculating costs of running drop ins, and utilising CSRI and EQ-5D to analyse from a societal perspective

Summary of Research Programme.

Programme Theory

VOS was established in 2008 and is based at the Royal Maritime Club (RMC) in Portsmouth. It is a charitable organisation, and offers a community based drop in service, considered to be a 'one stop shop' run by formerly serving personnel, specifically for veterans and their families. No referral is

necessary for attendance at VOS, as such, it is a self-referral process, and the drop in takes place on the first Wednesday of every month from 2 pm – 5 pm. The drop in involves a registration process for checking in and the standard completion of clinical outcome measures on arrival. These measures assess risk and this triage on registration allows for therapies to be offered to veterans considered to be in need of support. Prior to 2013, therapeutic interventions were offered to veterans, but services were limited. In 2013 VOS was awarded LIBOR funding, which provided the means to offer weekly therapies over the course of 6 weeks to veterans who are identified at the drop in sessions, and for a further 6 weeks where necessary (a 12-week model).

A working hypothesis was established:

VOS works for those who require formal psychological or physical health intervention as well as practical support, and those who seek peer support. Since it is a 'one stop shop', with initial assessments on registration, service users do not need to know what support they need when engaging with VOS for the first time. In addition, time between assessment and service engagement is fast, happening either on the day or, in the case of therapy, the week after. An additional mechanism is that the service is provided by veterans for veterans, and this military-like environment facilitates change through trust. Those who engage with VOS will experience enhanced mental health and wellbeing, increase in perceived social support, and a reduction in risk.

Key Findings

Overall, a number of interesting themes arose from the components of the service, with each element providing vital triangulation. VOS was seen as a safe haven where the military-like environment acted as a core mechanism for change. The one stop shop nature of the drop in also provided timely face to face contact with agencies. Barriers were experienced, including the general infrastructure, but these were not significant enough to prevent attendance, although those who have never engaged with the service could not be reached for inclusion. Comparisons with other services, particularly via NHS, were favourable. Cost utility analysis found that the service is cost-effective if improvement in quality of life is maintained for one year.

Context

- Users attend VOS for singular practical needs or more complex needs that might be practical, emotional, and/or psychological in nature. Few attend to meet social needs alone.
- Self-referral is common, and a number attend to meet case workers/health professionals from other organisations, who also attend VOS as it is a convenient place to meet.
- It appears that service users are split into one of two groups; those who attend once only, and those who have a more prolonged relationship with VOS, and this seems to map onto the type of need. Those with practical needs tend to go to one drop in once only, while those with more complex needs attend for longer.
- Concerns were raised time and again about the appropriateness of the checking in process and waiting area, particularly for those with mental health needs. Service users and agencies expressed frustration about waiting times.
- Comparison to other services (including NHS services) is favourable. This is in part due to a variety of VOS offerings, and access to complementary therapies.

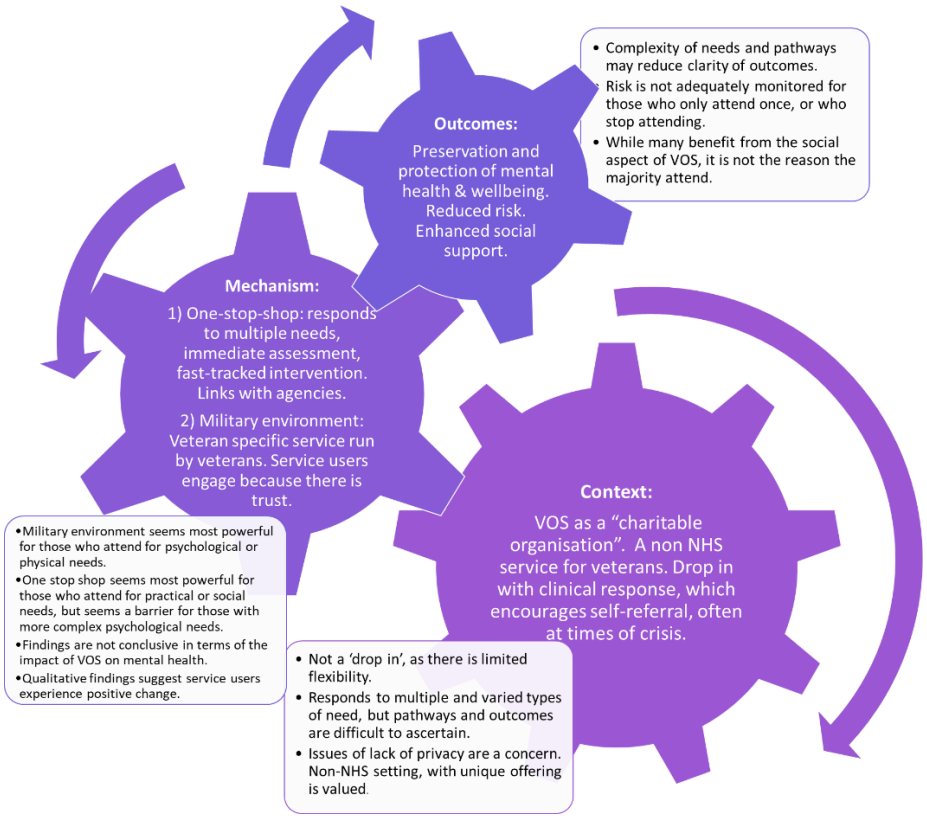
Mechanisms

- One stop shop: For those seeking more practical support, the one stop shop nature of VOS meant that their needs could be met very quickly; even on the same day for some. However, the *busyness* of the drop in created by its one stop shop nature did not suit those presenting with psychological needs.
- Military environment: the provision of a trustworthy environment was vital, particularly for those engaging with psychological therapies. The very idea that the therapist could understand and would not judge was powerful, and ensured that the context of the service (non-NHS, self-referral, shorter waiting time) worked to achieve outcomes. A cautionary note is that some users perceived a rank system to be in place, which created a sense of 'othering'.

Outcomes

- Overall, needs, whether they be psychological, physical, social, or practical, or indeed, singular or multiple, seemed to be met.
- Social needs were met via comradeship.
- Findings from the retrospective analysis of CORE-OM data suggest that VOS has a positive impact on service users; however, CORE-OM scores do not seem to show clinically significant change for the whole sample.
- While risk was reduced for a number of users at VOS, for a small number risk increased (as measured by CORE-OM risk items).
- Service users were concerned about the lack of follow-up carried out by VOS and implications for risk.
- VOS provided a service that was probably cost-effective within the usual National Institute for Health and Clinical Excellence (NICE) threshold range of £20,000–£30,000, if the change in quality-adjusted life years (QALY) was sustained for more than 1 year. However, there is considerable variability in the costs and outcomes of different participants.

The figure below provides a visual representation of the original CMOs, alongside findings from the evaluation.



Summary of findings

Conclusion

Findings suggest that one size does not fit all; what works for those who present with psychological or physical need may not work for those who present with practical or social need. What might suit the former is a quieter drop in, with formal psychological assessment, risk monitoring, and where onward referral is efficient. The power of the military-like environment comes to the fore here as a mechanism. What suits the latter is a busier drop in, with no psychological assessment, and where agencies and service users can network. Of importance to this group is the efficiency of a 'one stop shop'. What is important for both is greater privacy afforded to them while at the drop in and, arguably, a more frequent drop in.

What is true is that the type of service VOS represents seems to provide a trusted, familiar environment that meets a range of different needs. Despite this, there are areas that require consideration. Recommendations are made here, and are intended to promote aspects of VOS that were found to be well received, as well as to highlight areas that require attention by drop in services in general now and in the future.

Recommendations

1. **Risk and Crisis Management:** Adverse events (i.e. unexpected, unintended and preventable harm, resulting from action or lack of action) are difficult to monitor in the context of drop in services. However, it is vital that drop in services of this nature monitor risk and other adverse events, particularly for those who disengage with the service.
2. **Ensure the infrastructure supports the needs of the service users:** Where multiple needs are catered for, the environment drop ins are provided in must be carefully considered to ensure that the environment and processes pose no negative impact for service users.
3. **Identification of pathways of service use:** VOS represents a complex service catering for multiple needs in a relatively informal drop in format. While this user-led approach is extremely powerful, it presents challenges for monitoring and evaluating outcomes and, more vitally, adherence to treatment and risk assessment.
4. **Recognise the value of non NHS service delivery:** One of the most powerful themes arising from the evaluation is that non-NHS drop ins are not required to adhere to NHS delivery. It is recommended here that these types of services occupy a unique position and, while they can and should conform to best practice, they provision of complementary and alternative therapies is valued by service users.
5. **Data management and ongoing evaluation:** It is vital that drop in services develop and adhere to data management protocols. In addition, economic evaluation should be considered in evaluations, and accurate baselines and end points should be determined where possible.
6. **Facilitating transition:** Given the nature of drop in services, engagement is not time limited. Aside from discrete courses of therapy, service users can be involved socially or for signposting for as long as they wish to be. This must also be considered moving forward if drop ins serve to aid transition.
7. **Limitations of military environment:** Services run by veterans for veterans must be aware of limitations of a military-like environment; namely discouraging transition to civilian status and the possible presence of an inherent rank structure.
8. **Improve links with statutory organisations:** Drop in services in the voluntary sector must review these links and consider the position they occupy in terms of sharing data with other health professionals involved in their service users' care.

Chapter One: Introduction

This chapter provides an overview of support services offered to veterans in the UK. Issues such as service uptake and adherence are discussed, followed by an introduction to drop in services and the aims of the current evaluation. The realist evaluation method is described and the programme theory presented. The programme theory as to how VOS is thought to work forms the foundation for the evaluation and is tested in subsequent chapters.

1.1 Rationale for Evaluation

It is estimated that around 16,000 people leave the armed forces each year (Ashcroft, 2014; Forces in Mind Trust, 2017). While the majority leave having experienced benefits associated with their military career, there is evidence that some are negatively impacted by their experiences. In particular, early service leavers and those with mental and physical health issues are more likely to find transition difficult (Buckman et al., 2012). These are also the individuals who may continue to experience difficulties into their futures (Mental Health Foundation, 2013). As such, for some, health and wellbeing needs may still be present many years after leaving (Settersten, 2006). Though some veterans benefit from informal support from comrades as well as family and friends, for others it is not enough. Some benefit from structured signposting to support their welfare needs, while others require psychological or psychiatric interventions. Navigating these sources of support is further complicated by the varying level or complexity of need. MacManus and Wessely (2013) articulate that some mental health needs may be too complex for primary care, but are not severe enough for community mental health services. Of course, needs are not mutually exclusive, with some veterans requiring practical, social, and psychological support.

Around 80% of military personnel who perceive themselves to have a mental health need do seek support. In addition, for those who enter treatment for mental health needs, the treatment rates are lower for UK service personnel than for the general population (13% vs. 26%; MHF, 2013). The picture for veterans is less clear, but a recent study found that help-seeking veterans experience PTSD (82%), anger (74%), common mental health disorders (72%), and alcohol misuse (43%), and comorbidity (32%; Murphy, Ashwick, Palmer, & Busuttil, 2017). For those who do not seek support, this reluctance in seeking intervention may be attributed to perceptions of stigma, lack of understanding of service providers, as well as a perceived or actual absence of suitable services (for a summary, see Mellotte, Murphy, Rafferty, & Greenberg, 2017). Another important theme to consider is the perception that veterans may not engage with NHS services in particular due to feelings of not being understood, even though services are likely to offer interventions that could be of benefit (Kitchiner, Roberts, Wilcox, & Bisson, 2012). In a recent report for NHS England concerning mental health services for veterans, 77% of those surveyed felt that *no-one would understand my armed forces experience* (NEL, 2016). At the very least, there seems a need that services are sensitive to post-military life, even if those who provide the services are not formerly serving themselves (Ben-Zeev, Corrigan, Britt, & Langford, 2012). Despite concerns about stigma preventing help-seeking, a recent study has found that a greater barrier to accessing care is simply not self-identifying need. Where stigma may impact is on initial interaction with mental health services (Rafferty, Stevelink, Greenberg, & Wessely, 2017). Addressing mental health and wellbeing is essential for successful transition, much as ensuring that practical support is also offered. Due to these needs, attention has turned to the support that could and, perhaps, should be afforded to the armed forces community through the provision of suitable services. In particular, The Armed Forces

Covenant, formalised in 2000, has been the driving force in the development of initiatives to support not only successful transition, but also to provide longer term support and intervention (Ministry of Defence, 2011).

Services for veterans exist in both the NHS and in the voluntary sector, and the provision and delivery varies. For instance, within the NHS there is fast track access to talking therapies such as Talking Change via Improving Access to Psychological Therapies (IAPT). Residential services also exist, such as Combat Stress and services provided by the Recovery Teams of Help for Heroes (see MacManus & Wessely, 2012 for a comprehensive summary). Another prevalent format is the 'drop in', which is offered by both the NHS (e.g. as part of Veterans First Point NHS Scotland) and the voluntary sector. Despite this, evaluations of services are generally limited and few consider cost implications. Indeed, a recent review of veteran mental health suggested an absence of evidence regarding the effectiveness of these services, either in the NHS or in the voluntary sector (MHF, 2013). There was particular concern that voluntary based initiatives be well coordinated so that resources are used effectively and meaningfully. Arguably, this would also include ensuring that these services are well governed and conform to best practice.

One of the most comprehensive studies concerning mental health services was conducted by Dent-Brown et al. (2010), in which six pilot community mental health services for veterans were compared to three existing services. The initiatives were evaluated using existing data sets, a questionnaire study, interviews with clinical leads, staff diary data, and documentary data. While focused on mental health services, the findings are still useful here. The evaluation determined that the more successful services were those that allowed for self-referral, had staff who were also veterans, facilitated group work, were attended by other agencies for joined up working, had short waiting times for intervention, participated in joint working with the NHS or other agencies, and accessed Armed Forces' service records for new referrals. The least successful features were those that were assessment only, pathways that involved onward referral and related waiting times, staff with little to no experience of working with veterans, sole practitioners leading to discontinuity of care, and long traveling distances.

It is important to note that almost all the services evaluated by Dent-Brown et al. (2010) were provided by, or at least linked with, NHS Trusts. There are many services provided by the voluntary sector that have not as yet undergone such analysis. In addition, services in the voluntary sector might not necessarily be considered *mental health services* and so conclusions based on previous research do not necessarily capture the holistic nature of drop ins, where one might attend for psychological, social, and practical support. Nevertheless, the recommendations are used to support the current evaluation.

The current evidence base certainly indicates the vital importance of supporting the formerly serving community, in particular to address issues concerning health and wellbeing. However, help-seeking and adherence to treatment is relatively low, with issues around stigma, and a perceived absence of suitable services (Iversen et al., 2010). Intuitively, it follows that a veteran specific service may break down potential barriers and enhance help seeking, adherence and, in turn, health and wellbeing. Currently there is limited evidence for the effectiveness of services offered by the voluntary sector. Given that the voluntary sector depends on donations of money and time, it is also essential that the costs of these services in relation to the benefit they provide are also considered. These costs have implications for the feasibility of setting up services as well as their sustainability.

The purpose of the current programme of research was to evaluate a voluntary, community based drop in for effectiveness and cost-utility with a view to understanding the value of this type of service to the veteran community.

A realist evaluation (Pawson & Tilley, 1997, 2004) was carried out, which allows for an exploration of understanding as to if and how a service works, and which aspects in particular create change. This type of knowledge is particularly useful when determining whether a service or intervention is suitable for 'rolling out' to other contexts. Furthermore, taking a realist perspective on causation, realist evaluations also seek to uncover the underlying mechanisms for change, asking 'what works, for whom, in what context?' (Pawson & Tilly, 1997, 2004). This moves away from outcome based evaluation, which looks at whether a service 'works' or not, moving more towards an acknowledgement that it is the way in which a service is delivered and responded to that has an impact. The design is a theory driven evaluation, starting with the theory underpinning the provision of the service (the way in which it is expected to work), leading to an exploration of how it is working (mechanisms), along with for whom it works (context), and in what way is it working (outcomes). Realist evaluations acknowledge that services are theories 'incarnate' (Wong et al., 2016), and so seek to develop a programme theory, along with CMO configurations, which are the interactions between various Contexts and Mechanisms, leading to specific Outcomes. The programme theory is then tested, usually via mixed methods, and refined or refuted.

1.2 Programme Theory

In order to establish the programme theory, three sources of information were used. First, interviews were conducted with the two clinical leads of VOS, who had each been involved at various points with VOS in the duration of the evaluation. These interviews were audiotaped, transcribed, and analysed using thematic analysis to determine key features of the programme theory. Second, we reviewed VOS literature, including the charitable aims. Third, the team used findings from the current literature concerning currently available services for veterans in the UK (much of which features in section 1.1) to add further understanding. Themes concerned Context, Mechanisms, and Outcomes, which are discussed below. At the end of the chapter, an evaluation hypothesis is presented.

1.2.1 Description of the Drop In

VOS was established in 2008 and is based at the Royal Maritime Club (RMC) in Portsmouth. As the first clinical lead explained, it developed *'from four people coming together and saying there is a service required for veterans' (CL1).* VOS is a charitable organisation, and offers a community based drop in service, considered to be a 'one stop shop' run by formerly serving personnel, specifically for veterans and their families. No referral is necessary for attendance at VOS, as such, it is a self-referral process, and the drop in takes place on the first Wednesday of every month from 2 pm – 5 pm. The drop in involves a registration process for *checking in* and the standard completion of clinical outcome measures on arrival. These measures assess risk and this triage on registration allows for therapies to be offered to veterans considered to be in need of support. Prior to 2013, therapeutic interventions were offered to veterans, but services were limited. In 2013 VOS was awarded LIBOR funding, which provided the means to offer weekly psychotherapeutic therapies over the course of 6 weeks to veterans who are identified at the drop in sessions, and for a further 6 weeks where necessary (a 12-week model). This funding also supported the creation of a

permanent office for VOS in the RMC. As Clinical Lead 2 states *'it relies strongly on grants from bigger or more central charities'* and this has an impact in terms of sustainability.

1.2.2 Context

1.2.2.1 Aims of the drop in

The charitable aims provide an objective and consistent description as to the purpose and function of VOS. Therefore, they provide the foundation of the programme theory. The charitable aims of VOS, according to the Charity Commissions website (VOS charity no: 1154429), are as follows:

"The preservation and protection of the mental health, wellbeing and the relief of need for Armed Forces Veterans (both Regular and Reservist) or former members of the merchant marines and their family members, insofar as they have charitable need, by the provision of a drop in service providing assessment, treatment, support, advice and advocacy."

As such, the aim of the service is to support the transition that veterans face when moving from military to civilian life and to improve overall wellbeing. Support is focused on a number of areas; welfare, wellbeing, and mental health. Initially, *it was very much an informal helping, agency group' (CL1)* with no formal therapeutic pathway, though a psychiatrist was present at drop ins. But has since developed into the service it is today.

1.2.2.2 Routes to VOS

The perception of the clinical leads is that pathways to VOS tend to be mainly self-referral or via a health professional, for instance *'We get referrals from other organisations like Combat Stress for a specific in-house therapeutic intervention' (CL1)*.

1.2.2.3 Types of need

The types of need that veterans present with range from needing practical support to more complex needs. Where multiple needs were recognised, these tended to be both psychological and physical. As CL2 indicated:

I still retain a strong interest in what's sometimes technically called dual diagnosis which is when people have both mental health and drug and alcohol problems. And actually that is often very relevant to the people who present to Veterans Outreach. Quite a lot of the people who come here have also got physical injuries which may be service-related and that of course will have a knock-on in terms of ability to cope, self-esteem, depression and anxiety and so on' (CL2).

1.2.2.4 Pathways to support

To meet these needs, two pathways are offered to service users. First, veterans can speak with agencies such as the Citizens Advice Bureau, a solicitor, local housing and employment agencies, as well as informal opportunities for peer support and support from the Padre. Second, they may be referred to the in house clinical team if they are, for instance, experiencing mental health needs such as depression, anxiety, or PTSD. In this respect, VOS endeavours to deliver the ideal, which is *'drop in with a clinical response' (CL1).*

1.2.2.5 Comparison with other services

According to the literature presented in Chapter One, VOS occupies a relatively unique position in terms of its offering to formerly serving personnel. While it is situated in the voluntary sector, not itself unique, it also offers therapeutic intervention. It is arguably this combination that makes an evaluation most worthwhile, as there are policy implications here.

The NHS also offers a number of veteran-specific services, inspired by the findings of Dent-Brown et al's 2010 evaluation previously mentioned. In collaboration with the veteran mental health organisation Combat Stress, the NHS expanded the mental health provision including a posttraumatic stress disorder (PTSD) treatment programme to veterans nationwide (Murphy, Palmer, Westwood, Busuttil & Greenberg, 2016). By and large, these services require either referral by a healthcare professional or self-referral via telephone or online form. An assessment is then conducted by an NHS outreach mental health therapist or on-site by a mental health community nurse. NHS services provide veteran-specific interventions conducted after assessment, and either in partnership with the mental health charity Combat Stress, or, on-site at the NHS trust location itself with military-experienced or civilian professionals. These services do not tend to provide walk-in or drop in access to veteran-specific support, although they might signpost to such a service. An exception to this is NHS Scotland's six Veterans First Point services, all which feature a drop in centre and provide peer-support workers, peer-led activities, mental health assessment and treatment interventions from clinical staff.

There are a number of other drop in services that operate in the UK, separate from the NHS, on a similar basis to VOS. These include: Hull Veterans Support Centre, Surrey Heath Veterans and Family Listening Project (SHV&F-LP), Shoulder-to-Shoulder (England & Scotland), Stoll.org, and The Royal British Legion Pop In Centres for example. Again, these might involve agency attendance and peer support. A number are also walk in services, and are not limited to monthly or weekly drop in sessions. What arguably makes VOS different is the availability of courses of weekly therapy.

In terms of the locality, there are no offerings that are similar to VOS. There are veteran services, which may provide signposting and informal support, but not the other aspects of support offered by VOS. Otherwise, there is a strong IAPT service in Portsmouth, to which veterans can self-refer and they are given priority access. In this case the course of therapy is 6 weeks, but waiting times can vary and typically tend to be 2 weeks for assessment and 4 weeks for treatment (6 weeks if not prioritised).

Both clinical leads felt there were unique elements to VOS compared with other services available to veterans:

Well first of all, an immediate response. You could be offered six sessions on the telephone. But we can meet it almost immediately. Certainly on drop in days, I could do an initial assessment or at least in a meeting take down the issues and write up an assessment for ongoing to a therapist. So that's very quick. (CL1)

Finally, CL2 provided an example of one of the VOS service users who travels a distance to attend VOS. It was thought the unique offering of agencies and therapies was the reason:

'so he makes an hour trip every time he wants to be seen here, about an hour each way, and so if there was a drop in in sort of east Surrey it would suit him quite well. But on the other hand, we've got quite a broad range of contacts and therapies and skills available here, and as it is, he's already getting on really well with' (CL2).

1.2.6 Comparison with Current Recommendations

There is also an opportunity to compare the programme theory against recent recommendations highlighted by Dent et al. (2010). Table 1 lists these recommendations along with our understanding as to how the programme theory meets these. It must be noted that these recommendations relate specifically to mental health services rather than *a drop in with a clinical response*, but do provide a useful framework.

Table 1. Dent et al.'s (2010) 8 priority recommendations compared with the VOS Programme Theory.

Priority	VOS Offering	Evidence
Mental health services for veterans should provide both assessment and treatment. Where highly specialised treatment (e.g. alcohol detox) cannot be provided, priority should be invoked to ensure no further wait.	VOS provides assessment and treatment, along with a specialised alcohol service. Referrals take place when necessary.	*Certainly on drop in days, I could do an initial assessment or at least in a meeting take down the issues and write up an assessment for ongoing to a therapist. (CL1)*
Services should be staffed by people with experience of working with veterans and knowledge of armed forces' culture. Desirable to have the choice of being seen by a veteran.	VOS is well known for being staffed by formerly serving personnel, or those with a connection, from management team through to clinicians. N.B. Current clinical lead is not formerly serving.	*The people we've got are either allied to the Forces, i.e. a family member of the Forces or who have worked with the Forces or are veterans themselves. I'm a veteran, so can understand the language of veterans. That helps. (CL1)*
Services must have strong links at strategic level with other statutory and voluntary agencies, and Forces' charities.	There is evidence that there are strong links to other voluntary agencies and Forces' Charites. Links with statutory services is unknown, although there is some tentative evidence to suggest joint working with GPs.	*One of the things that the drop in model does is it provides rapid access to a lot of different agencies. (CL2)*

Groups for veterans are highly regarded by veterans for comradeship and solidarity. All service should consider group work.	Group work is offered currently.	Provided by Combat Stress.
Mental Health Services should routinely access service records of veterans so as to gain the full picture of the client's history.	VOS do not access service records.	No evidence.
A common minimum dataset should be established so that clear comparisons can be made across services. Financial support for services should be dependent on effective systems being in place.	Use of CORE-OM and VETRA data systems, but extent of use may vary.	*And making sure that the information is recorded in VETRA which is the online clinical records system that VOS uses, which is actually quite an effective system, but we all need to learn more fully as there are quite a number of us who are relatively new and still finding our way. CL2*
Routine pre-and post-treatment outcome data should be collected for all clients seen. Should be standard practice across services and a basic expectation of funders and commissioners.	Originally, CORE-OM completed at each drop in. From summer 2015 WEMWBS collected at each drop in and CORE-OM for those engaged in therapy.	Use of CORE-OM embedded in the system.
Mental health services should accept self-referrals.	Nature of drop in with clinical response achieves this.	*You could keep doing that [attending drop in] until you feel safe enough to say, could I have some intervention? (CL1)*

From the table, it can be seen that VOS, from the theoretical perspective, delivers a number of key recommendations. VOS is provided by a team with knowledge of the culture of Armed Forces. Mental health services are complemented by wider support delivered by a variety of agencies and that veterans

are provided with greater opportunities for group interaction. However, there is no routine access to service records, and there may be limitations to the extent to which there are links with statutory agencies.

1.2.2.6 Summary of context

VOS is a non-NHS, charitable organisation. A service for veterans run by veterans. It is a drop service with a clinical response. It may appeal to with singular or multiple needs that may be physical, psychological, practical, or social. Importantly, users do not need to have identified their specific need prior to attending and they may self-refer. To achieve users register at check in and complete a wellbeing assessment, which allows for continual monitoring of the service, but also timely assessment of risk and a timely opportunity to engage with psychological interventions through triage. It is relatively unique in the geographical location and there is no minimum or maximum length of engagement.

1.2.3 Mechanisms

Context provides an understanding as to the conditions necessary for change to occur, while mechanisms refer to the active ingredients that might make a drop in service like VOS effective. More specifically, mechanisms are seen to trigger users to change their reasoning or behaviours, which lead to outcomes.

1.2.3.1 One stop shop

Support is a central tenant of this drop in service, with a number of different types of support addressing a number of different types of need. From a theoretical perspective, aspects of the support offered by VOS would reflect theories around social support (e.g. Antonucci, 1985) such as; informational support (agency advice and peers), instrumental support (advocacy), and emotional (supported by Padre who attends, and peers). In addition, there is more formal support offered by psychological intervention. This might involve assessment and treatment being offered in a timely manner when compared with NHS/other settings. As such, it is the all-inclusive 'one stop shop' nature of VOS that may be an important mechanism because a number of different types of support can be offered at any one time. The following quote exemplifies the varied offering of VOS:

'biological symptoms deserve biological treatments, psychological distress deserves psychological therapy and social problems deserve social interventions. Now in other words, you match the help to the problem. And VOS does that'. (CL2)

A joined-up system of working means that, once again, there is a greater possibility of timely referral:

'Usually you get seen more quickly, and, I think, more reliable kind of signposting to other forms of help and therapy'. (CL2)

In addition, it is thought that clinicians make themselves available and approachable within the informal setting of the drop in, making them more approachable in terms of seeking more formal support. Since there is a presence of clinicians during the drop ins, the possibility that one may engage with therapies if needed was perceived to increase. It is the essence of a drop in with clinical response, the one stop shop, which was felt to provide an opportunity to veterans to come to the drop in and, when able to, seek clinical intervention:

'And you're coming through the door and you could just have a cup of tea. You could keep doing that until you feel safe enough to say, could I have some intervention? I can't see that the NHS will provide that service'. (CL1)

1.2.3.2 Military environment

The majority of comparative services also offer these types of support, but there might be a further element that makes a service like VOS particularly effective. The vast majority of clinicians and volunteers are formerly serving personnel or family members to someone who has served. While this may be true of other, similar, services in the voluntary sector, it might not be as true for services provided by the NHS. As such, a strength appears to lie in a shared culture and mutual understanding as CL1 said:

'The people we've got are either allied to the Forces, i.e. a family member of the Forces or who have worked with the Forces or are veterans themselves. I'm a veteran, so can understand the language of veterans. That helps.' CL1

From a theoretical perspective, this links to the concept of Homophily theory (McPherson, Smith-Lovin, & Cook, 2001), which suggests that a person is more likely to seek and accept support from another person when that person appears to be experientially similar to themselves. This similarity, perceived understanding, and trust, lie at the foundation of peer support (Dennis, 2003). Not only would this make the presence of veteran specific agencies important, having clinicians that are also formerly serving may be a powerful mechanism, particularly in terms of overcoming stigma associated with accessing mental health services (Stevelink et al. 2017).

1.2.3.3 Summary of mechanisms

Two prime mechanisms are predicted; the one stop shop and military environment. The military environment mechanism increases the power of support provided in the context of VOS. Homophily theory predicts that individuals are most likely to accept support from those similar to themselves, and this is the case for formal support as well as informal social support. As such, the military environment may increase the efficacy of psychological, practical, and social support. The one stop shop mechanism helps to meet the complex needs of service users. Whether individuals require practical support, or more complex psychological intervention, their needs can be identified and met quickly in the VOS context.

1.2.4 Outcomes

Outcomes are defined in the Charitable Aims as the *protection of mental health and wellbeing* but how this translates to practice is less clear. For instance, it could be related to reduction in PTSD, other anxiety related disorders, or depression. Wellbeing is more difficult to define. The World Health Organisation defines 'mental health' as:

'a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'. (WHO, 2004)

1.2.4.1 Perceived changes in outcome

Overall, it was thought that the service *meets needs admirably well (CL1).* The clinical leads considered that outcomes might be separated into categories; physical, psychological, social, and practical. As such, we might expect service users and providers to perceive change in these domains, and this would be taken as evidence of positive outcomes associated with service use.

1.2.4.2 Objective changes in outcome

VOS also record outcomes via the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM; Mellor-Clark & Barkham, 2000), which are entered into a specialised CORE software *VETRA.* The CORE-OM is a 34-item measure of psychological distress and is not focused on a single presenting diagnosis. There are four domains; Well-being (4 items), Symptoms (12 items), Functioning (12 items) and Risk (6 items). Scores are recorded in three different ways; clinical, average, and total score. Clinical score is used for this evaluation, as it is considered to be the most commonly used by practitioners. Severity Groupings can also be calculated from total score, and are as follows:

- Healthy (1-20)
- Low level (21-33)
- Mild (34-50)
- Moderate (51-67)
- Moderate to severe (68-84)
- Severe (85+)

Finally, reliable change is considered to be a change of 5 or more in the clinical score. While, clinically significant change is considered to be a move from a score in the clinical population norms to the non-clinical population norms. For the current evaluation, a decrease in severity of symptoms, as well as a decrease in risk scores would be considered predictable outcomes for the service.

1.2.3.2 Summary of outcomes

These are considered to be a perceived increase in overall wellbeing and an improvement in mental health, a reduction in severity scores and risk scores on CORE-OM, and enhanced social support.

1.2.4 Summary of CMOs

The table below provides an overview of the predicted context, mechanism, and outcome that forms the programme theory. Throughout the evaluation, these aspects will be returned to and their reality tested against the findings of the studies that follow.

Table 2. Summary of Context, Mechanism, Outcome.

Context	Mechanism	Outcome
VOS as a "charitable organisation". A service for veterans run by veterans. It is a non-NHS drop in service with clinical response. It is a relatively unique offering, particularly in geographical location. Referral is via health professionals, but also via self-referral. Responds to multiple and varied types of need through registration process. This process monitors risk, facilitates triage, and helps service users to identify types of needs. Types of needs are practical, physical, psychological, and social. There is no minimum or maximum length of engagement. Favourable comparison with other services, with shorter waiting times for psychological intervention.	One stop shop: responds to multiple needs, with immediate assessment and fast-tracked intervention. Links with agencies ensures wide range of needs are met. Military environment: Veteran specific service Volunteers/ex-veterans. Like minded individuals attending out of choice. Service users use the resources available at the drop in to engage in support to facilitate change. They engage because there is trust. Trust facilitates change.	Preservation and protection of mental health & wellbeing; operationalised by improvements in physical symptoms, psychological health, and meeting practical and social needs. Also indicated by a reduction in severity of symptoms according to CORE-OM. A reduction in risk, as measured by CORE-OM risk scores.

1.3 Evaluation Questions

The objective of the research was to evaluate the service provided by VOS as an example of an established community based drop in service, delivered in the voluntary sector, to determine effectiveness and cost-utility.

Research questions were as follows:

1) What are the pathways experienced by users of VOS: i.e. who uses VOS, for how long, and for what type of need?
2) How do users engage with the one stop shop nature of VOS and military environment to enact change?
3) What outcomes (objective and subjective) are experienced by users of VOS?
4) What does the service cost to deliver, in terms of both actual costs and cost utility?

A working hypothesis arrived at through the development of the programme theory is stated as follows:

VOS works for those who require formal psychological or physical health intervention as well as practical support, and those who seek peer support. Since it is a 'one stop shop', with initial assessments on registration, service users do not need to know what support they need when engaging with VOS for the first time. In addition, time between assessment and service engagement is fast, happening either on the day or, in the case of therapy, the week after. An additional mechanism is that the service is provided by veterans for veterans, and this military-like environment facilitates change through trust. Those who engage with VOS will experience enhanced mental health and wellbeing, increase in perceived social support, and a reduction in risk.

1.4 Ethical Approval

All stages of the research, along with adaptations to original protocols, were reviewed by the University of Portsmouth Science Faculty Ethics Committee (SFEC).

Chapter Two: Methodology

This chapter provides the rationale for utilising a realist evaluation methodology. In addition, the evaluation design is described, along with recruitment and sampling, data collection methods, and method of data analysis.

2.1 Rationale for Realist Evaluation

Realist evaluations have become increasingly used in service evaluation. The method is pragmatic and can adapt to the demands of evaluating services that must maintain the ability to respond to the needs of their users throughout the evaluation. The question is not one of whether a service works or not, but 'what works for whom in what context, and at what cost?'. A trial based study was not feasible and also raised some concerns as to appropriateness of preventing service users from accessing a service that, anecdotally, appeared to be something of a life line to those who use it. There were a number of specific challenges in adopting such an approach in the context of this evaluation. First, there was no known route to VOS from external services, which would impact on recruitment to trial. Second, the service providers indicated that veterans normally attend at a point of crisis and attendance is not planned (also see Murphy, Hunt, Luzon, & Greenberg, 2014). Third, if users of VOS have immediate needs, it would not be ethical to have delayed their attendance to VOS if randomised to a control group. Fourth, given the *busyness* of a drop in, it would have been difficult for the research team to determine whether veterans randomised to a control group were accessing the drop in (thus presenting a research protocol violation). Fifth, there were concerns that external recruitment may have placed pressure on the existing service due to increased numbers (above and beyond the natural growth of the service). Last, it was felt that it might not be possible to recruit the numbers needed to test such a complex intervention through trial methodology.

2.2 Context of Evaluation

This evaluation was initiated in by Dr Morgan O'Connell, one of the founding members of VOS, who expressed an interest to Portsmouth City Council (PCC) for VOS to be evaluated. Dr Karen Burnell was contacted by PCC and initial meetings were held with Dr Morgan O'Connell and, subsequently, Dr Kathryn Fielden (then Clinical Manager of VOS). The application was developed and discussed in collaboration with the senior management of VOS.

The evaluation took place over the course of 2 years. When the research commenced, the clinical team comprised a psychiatrist, two psychologists, two therapists, and four counsellors/therapists, including an alcohol service. VOS went through a period of change at approximately the mid-point of the evaluation, which included the appointment of a new CEO, and changes to the clinical team, including clinical manager. VOS also went through a period of time without a dedicated alcohol service and changes to the services available at VOS, such as the availability of Cranial-Sacral Therapy (CST). New management brought in other changes too. There was a streamlining to the front desk at drop in, as well as the removal of mandatory completion of CORE-OM for each service user (new or returning) at check in. Instead the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al., 2007) was adopted, with those triaged and offered therapy completing the CORE-OM.

This change in management and delivery provided an opportunity to evaluate change from the perspective of those who had been engaged with the service for some time, as well as to gain greater insight into longer term perceived changes in outcomes.

2.3 Evaluation Design

The research programme comprised three stages, each with its own component elements, taking a mixed methods approach; Programme Theory (as outlined in Chapter 1); Work Package 1 (WP 1); and Work Package 2 (WP 2). WP 1 was a retrospective study involving current and past service users, while WP 2 was a prospective study, which followed new users on their journey through VOS.

2.3.1 WP 1: Retrospective Study

The purpose of WP 1 was to gain initial understanding of the pathways to and through VOS, perceived barriers and facilitators to engagement, and outcomes (both perceived and objective). To achieve this, WP 1 comprised three elements:

1. Analysis of the existing VOS dataset
2. One to one interviews with current service users and providers
3. Survey study with past and current users.

2.3.1.1 Analysis of existing VOS dataset

The purpose of the retrospective analysis of the existing dataset was to provide indicators of: improvement of psychological health and wellbeing associated with attending VOS; factors associated with greater degrees of improvement, such as frequency of attendance; length of engagement with VOS; and services used. It was hoped that the findings would be used to understand more information regarding; usual pathways of use, underlying mechanisms, and evidence concerning outcomes.

2.3.1.2 One to one interviews

The purpose of the interviews was to explore service users' and providers' perceptions of VOS through one-to-one interviews and focus groups, using a semi-structured interview schedule. Interviews focused on service users' experiences of using VOS and the ways in which they felt it had impacted on them to date. Service providers were asked about the ways in which they felt VOS impacted on service users. In addition, focus groups were planned to explore barriers and facilitators of using VOS among current users.

Due to changes to the infrastructure of VOS in the summer 2015, there was an opportunity to revisit these individuals to interview them about these changes as well as to understand their current health and wellbeing in relation to VOS use. These interviews focused around participants' views on the changes at VOS and how these might have impacted upon or impacted their course of treatment/attendance. All participants were invited to take part regardless of whether they were still attending VOS. Where participants were no longer attending, the interviews focused on the reasons why they had stopped attending.

2.3.1.3 Survey of current and past users of VOS

The purpose of the survey was to explore the initial themes that emerged from the preliminary analysis of interviews on a larger scale, and to reach both current and past users of VOS. The survey was of mixed methods design including Likert-type scale questions with some open-ended questions to assess facilitators and barriers in using VOS services as well as perceived outcomes.

2.3.2 WP 2: Prospective Study

The purpose of WP 2 was to gain insight into the perceptions of users as they embarked with their VOS journey in real time rather than in retrospect. The secondary purpose was to explore the cost utility of the service. The initial design for WP 2 involved providing an opportunity for all new users of VOS to complete a battery of outcome measures (including measures of depression, and anxiety) at registration, as well as a quality of life measure from which Quality Adjusted Life Years (QALYS) could be derived. This could have provided a relatively large sample for analysis. Unfortunately, the decision was made by the VOS management team that the administrative burden, as well as the burden placed on service users, would have been too great. As such, WP 2 comprised the following elements a series of case studies with new users as well as a complementary economic evaluation.

2.3.2.1 Case Studies

The purpose of the case studies was to gain an in-depth understanding of individuals' journeys through VOS from first visit to last visit (or a maximum of 6 months). New users of VOS were invited to take part in 6 month long study, with face to face interviews at baseline, 3 months, and 6 months, and monthly telephone interviews. All interviews focused again on the experience of engaging with VOS, perceived outcomes, as well as facilitators and barriers of engagement. At the baseline, 3 month, and 6 months interviews, economic data were collected as detailed below.

2.3.2.2 Economic evaluation:

A societal perspective was adopted and so explored all available NHS and personal social services resources used by service users, including VOS itself and the consequences for use of primary, community and secondary healthcare, and Social Services. Use of non-VOS health and social care services and charities were collected via the Client Service Receipt Inventory (CSRI; Beecham & Knapp, 1992) and valued using published national unit cost data (Curtis & Burns, 2015) and NHS reference costs (DoH, 2016). The quality of life of VOS users was measured using the EQ-5D (The EuroQol Group, 1994) measurement tool and converted to QALYs. This allowed for cost utility analysis to be conducted.

Figure 1 provides a summary of the evaluation design.

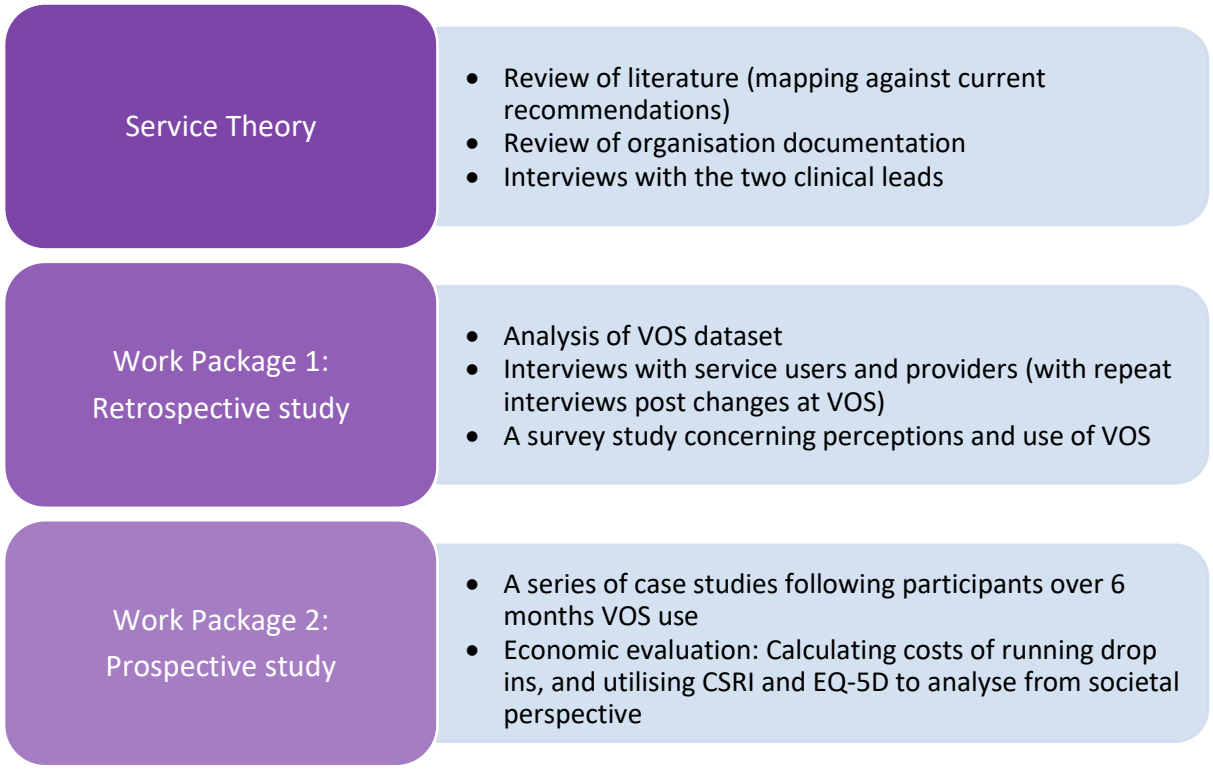


Figure 1. Summary of Research Programme.

2.4 Recruitment and sampling strategy

2.4.1 WP 1: Analysis of VOS Dataset

As this stage of the study involved the analysis of a existing database rather than primary research, the research team did not actively recruit participants. VOS sought permission from service users to use past data in this analysis through an 'opt-out' process. A letter was written and distributed by VOS to request retrospective consent. An 'opt-out' rather than 'opt-in' process was used in line with the standardised method of collecting consent by service providers, such as the NHS. The research team did not receive the data of those who opted out of the research. Data were provided on an encrypted USB stick as a series of Microsoft Excel Spreadsheets containing anonymous data, excluding name and postcodes. A unique number had been provided by the VOS team for each user, which was not the same as their ID as used by VOS.

2.4.2 WP 1: One to One Interviews

Participants were identified at monthly drop in meetings via gatekeepers, namely VOS staff members and volunteers. Service users who expressed an interest in taking part received an information sheet, and the researcher then made further contact with them at an agreed time to encourage them to ask any questions they have about the research and to book a time for the interview if they still wished to take part. In all cases there was a minimum of 24 hours between the initial contact and the interview to allow for a cooling off period. Participants were informed of their right to withdraw from the study at any point and without the need to provide an explanation. They were reassured that this would not affect their attendance at VOS or any other services they

currently received or might receive in the future. Valid informed consent was recorded using the consent form. Participants were given a debriefing sheet at the end of the interview should they wish to seek further sources of support.

For service providers, methods of recruitment, informed consent, and data collection, and analysis were the same as for the service users.

2.4.3 WP 1: Survey

A decision was made to conduct the survey online; while postal addresses may no longer be correct it was likely that email addresses had remained current. In addition, the time taken to send emails was seen to be more cost-effective than preparing a mail out for this number of people. It was not possible for the research team to carry out these administrative tasks due to confidentiality and data protection. Consequently, a VOS administrator carried out this task.

The email sent via the VOS database clearly indicated that the request to participate was from the University, but that VOS was sending the request and no personal details had been passed on to the research team. The email contained two links; one for current users and one for past users. The link was to the online survey, and participants were required to read an information sheet and tick consent to participate before starting the survey. An email address for the research team was provided. The last page of the online survey was debriefing sheet, reiterating the purpose of the survey along with the details of support organisations.

The survey was sent to all members of the VOS database, which included past and current members and totalled approximately 700 service users, 500 with email addresses. Uptake was extremely low with only 13 participants completing the online survey of the 500 emailed. This represents a 2.6% response rate, which is lower than the 8% response rate seen by Dent-Brown et al. (2010), and the 5% response normally seen for an unscheduled questionnaire (Albertson et al., 2017). It was not possible for VOS to keep an official record of the number of 'bounced emails', so we do not know how many email addresses were valid; however it was indicated to the research team that the number of invalid email addresses was relatively low.

To ameliorate the low response rate, we revisited the idea of recruiting for the survey at VOS drop ins with VOS management. Copies of the survey were taken to the VOS drop in sessions, which yielded a much higher response rate, with at least 20 surveys collected in this way. Paper copies were completed at VOS and the research team then transferred these to the online survey. An article was released in the local media in an attempt to increase uptake of the survey of past users, but this proved ineffective.

2.4.4 WP 2: Case Studies and Economic Analysis

As with previous elements of the study, participants were identified at monthly drop ins via gatekeepers, namely VOS staff members, volunteers, as well as snowballing via participants who took part in WP 1, and the other agencies present at the drop ins. Leaflets describing the nature of WP 2 were distributed to new service users who showed an interest in taking part. Interested participants then made contact with a member of the research team present at the drop in.

These individuals were informed of the study verbally, asked to read an information sheet, and encouraged to ask any questions relating to the study. As in previous stages of the research they were given at least 24 hours to consider their participation. Interested parties were followed up and sent a consent form to complete in their own time and as close as possible to their first drop in session.

2.5 Data Collection Methods

2.5.1 WP 1: Analysis of VOS Dataset

Data collected routinely by the service between the summer 2008 to winter 2015 were analysed. The database contained data relating to: basic demographics; referral routes to VOS; dates of attendance; the outcomes as measured by the CORE-OM (Mellor-Clark & Barkham, 2000); and details of agencies seen.

The dataset was cleaned, missing data identified and computed by regular conventions, and variables created as necessary for data analysis. Where variables were created, this is made explicit. It must be noted here that much data were missing from the dataset, including some basic demographics, and CORE-OM data. Not all therapists used the CORE-OM or recorded data consistently. Where inferences have been made in data analysis, these are described in Chapter Four.

2.5.2 WP 1: One to One Interviews

One-to-one interviews were carried out with current VOS users in order to look at perceived effectiveness of VOS from the perspective of service users. There were no restrictions on age, gender, length of service or any other related factors, but participants must have attended more than one drop in (i.e. they were not recruited at their first attendance).

Representatives of agencies as well as therapists (service providers) were also invited to take part in interviews. The agencies were a mixture of civilian services funded by Portsmouth City Council, but most were veteran-specific charities. Their offerings varied from practical, legal, financial and health and social care.

Interviews took place either at the headquarters of VOS (The Royal Maritime Club; RMC), at the University, or over the phone; the participant chose their preferred location. The interviews were audio recorded (including those conducted over the phone), and transcribed verbatim by an externally contracted company. The research team anonymised the transcripts prior to inductive thematic analysis to identify CMOs.

While focus groups had been planned, the first focus group gave rise to some difficulties for those who took part. These included some participants steering the focus to personal experiences and dominating the conversation (despite good facilitation of two researchers), others had less opportunity to speak, and there were conflicts between participants in the group due to differing opinions on some of the issues discussed. The second planned focus group was not conducted because of these difficulties.

All participants in the first focus group were subsequently offered one-to-one interviews, and all but one of the participants took up this offer. Those already recruited to the second focus group (to focus more on perceived barriers to VOS) were also offered individual interviews but did not take these up. Since the one-to-one interviews concerning perceived effectiveness of VOS were being carried out concurrently with the focus groups, questions around barriers and facilitators were incorporated into these interviews as well.

2.5.3 WP 1: Survey

The survey was developed in Bristol Online Surveys software and comprised questions concerning demographics, details of service history, and use of VOS including perceived barriers and facilitators to use. A version was constructed for veterans and a version for family members, all users of VOS.

As explained previously, an online version of the survey was sent to all members of the VOS database. Uptake was extremely low with only 13 participants completing the online survey of the 500 emailed. As a result, copies of the survey were taken to the VOS drop in sessions, which yielded a much higher response rate, with at least 20 surveys collected in this way. Paper copies were completed at VOS and the research team then transferred these to the online survey.

2.5.4 WP 2: Case Studies

Participants were interviewed within one month of their first use of VOS (baseline). They were then contacted for telephone interviews at 2 months, a face to face interview at 3 months, a further two telephone interviews at 4 and 5 months, and a final face to face interview at 6 months. At the first, third, and last interview, the Client Services Receipt Inventory (CSRI; Beecham & Knapp, 2001), modified for this study was completed (see below for further information).

2.5.5 WP 2: Economic Evaluation

New users of VOS were followed over a 6 month time period and quantitative data was collected at baseline, 3 months and 6 months. Services used by participants over a 6-month follow-up period were measured using the CSRI. Use of non-VOS health and social care services was valued using published national unit cost data and NHS reference costs. The quality of life of VOS users was measured using the EQ-5D (The EuroQol Group, 1994) measurement tool and converted to QALYs. This allowed for cost utility analysis to be conducted.

The CSRI was administered to collect changes in the use of services to attach costs. The CSRI is an established tool that has been successfully used in a large variety of health and social care economic studies, including community nursing services and mental health outreach services (Beecham & Knapp, 1992). This measure has the advantage of being adaptable to different client types and the necessary data requirements of the study. This information was collected at baseline and the follow-up interviews at 3 and 6 months and is used to collect information retrospectively about the use of health, social care and other relevant services, accommodation and living situation, benefits, and employment. The CSRI records service use over the past 3 months (including the service use data collected at baseline).

QALYs allow a standardised approach to compare economic evaluations of diverse health programs. Using EQ-5D to arrive at QALYs is the method preferred by the National Institute for Health and Care

Excellence (NICE). The EQ-5D is a standardised measure of health status providing a generic measure of health for clinical and economic purposes and can be applied to a wide range of health conditions and treatments and provides a single index value for an individual's overall health status. The questions comprise five main domains: mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. There is also a Visual Analogue Scale (VAS) and participants are asked to rate between 0 (worst imaginable health state) to 100 (best imaginable health status) in relation to their health status at the time of completion. The measure has previously been used with the veteran population with chronic medical conditions (e.g., Rabadi & Vincent, 2013). The EQ-5D utility values were derived using a set of weights derived from the general population of England (Devlin, Shah, Feng, Mulhern, & van Hout, 2016). Therefore, this implies that the index value can be regarded as a societal valuation of the respondent's health state.

VOS service-users were approached at the VOS drop in sessions in March, April, and May 2016. A total of 10 participants were recruited with one to three participants recruited at each drop in. Of these 10 participants, there were 3 withdrawals. Of the remaining 7, 5 completed the 6 month interview, and 2 completed baseline only. In addition, one participant was subsequently excluded as a case study as he had attended to support a friend, but had to become a registered VOS user to do so. This participant had no need to attend and had not engaged with any service.

2.6 Data Analysis

2.6.1 WP 1: Analysis of VOS Dataset

SPSS was used to carry out descriptive statistics for the majority of variables in the VOS dataset. Means and standards deviations were used to describe continuous data concerning demographics as well as variables concerning engagement with VOS. Where data were categorical, frequencies were calculated. Inferential statistics, specifically t-tests, were used to test for significant differences in CORE-OM scores.

2.6.2 WP 1: One to One Interviews

Interviews were transcribed and an inductive thematic analysis was conducted to identify context, mechanism, and outcomes. The analysis was guided by Joffee & Yardley (2004), who advocate analysis at the manifest and latent levels, the former being particularly important for analysis of mechanisms (Manzano, 2016). The preliminary analysis was carried out by the Principal Investigator and Research Associates, who each took a selection of interviews to analyse. After this initial analysis, any discrepancies were discussed and a framework for analysis was developed, and then applied to the interviews. The framework was organised into Context, Mechanisms, and Outcomes.

- Context: Types of Need, Hopes and Expectations, Referral pathways, and the 'VOS' experience: description of the service including facilitators and barriers to use.
- Mechanisms: One stop shop and Military environment
- Outcomes: Practical, Physical Psychological, and Social

2.6.3 WP 1: Survey

As with VOS dataset, SPSS was used to carry out descriptive statistics continuous data, while frequencies were calculated for categorical data. Inferential statistics were not used here due to the small sample size.

2.6.4 WP 2: Case Studies

Qualitative analysis of the case studies was carried out as per the one to one interviews. It was not assumed that the themes emerging would be the same as those in WP 1; therefore, analysis was inductive.

2.6.5 WP 2: Economic Analysis

Data were only available for five participants from the initial drop in to the final interview. Therefore, it was not possible to carry out inferential statistical analysis. However, the descriptive analysis in the results section focuses on changes in scores on the outcome measures.

To aid interpretation of the findings, the change in QALYs experienced by the cohort is shown over the observed period and extrapolated to one year, ten years, and taking a lifetime approach of the VOS user.[1] Furthermore, QALYs occurring in the future were discounted to current values with a discount rate of 3.5%. However, there is still some controversy as to whether QALYs should be discounted at a flat rate across all individuals.

2.7 Summary

The programme theory was tested in two Work Packages. WP 1 was a retrospective study and the purpose of WP 1 was to gain initial understanding of the pathways to and through VOS, perceived barriers and facilitators to engagement, and outcomes (both perceived and objective). To achieve this, WP 1 comprised three elements: Analysis of the existing VOS dataset; one to one interviews with current service users and providers; and a survey completed by past and current users.

The purpose of WP 2 was to gain insight into the perceptions of users as they embarked with their VOS journey in real time rather than in retrospect. The secondary purpose was to explore the cost utility of the service. These aims were achieved via case studies with new users of VOS along with an economic evaluation.

The findings from WP 1 are presented in presented in Chapters 3 to 5. Findings from the analysis of the VOS dataset, the one to one interviews, as well as the survey, will be collated into context, mechanism, outcomes. WP 2 findings are presented as case studies, and a summary of the economic evaluation.

[1] Assumptions regarding the gender (male) and age (55) of the average user have been made to ascertain the life expectancy from ONS National Life Tables, 2013-2015.

Chapter Three: WP 1 Context Findings

This chapter provides the findings from each of the studies in WP 1 related to context, and are arranged by theme. The research questions answered here relate to the pathways of care experience by VOS users, how long do users engage with VOS, and for what types of need; as such, the first research question is addressed here. A description of the participants is provided. Where the VOS dataset is concerned, this allows for a description of all service users. In addition, service use, type of need, the VOS 'experience', as well as barriers and facilitators to engagement, and experience of therapies is presented.

3.1. Details of Participants

3.1.1 Analysis of VOS Dataset

The VOS dataset provides information relating to all users of VOS. Both current and past.

A total of 663 unique users were present on the VOS database. Age of VOS users at time of first recorded registration ranged from 9 – 95 years, with a mean age of 49.6 years. Age was calculated from *Date of Birth* and *Date of First Registration*. It is assumed that the 9 year old is incorrect data input. The majority were male (79.8%), and veterans (81.5%). Table 3 provides a breakdown of service user type by gender.

Table 3. Service user type by gender.

Service user type	Male	Female	Total
Veteran	496	40	536
Partner	5	74	79
Offspring	3	4	7
Other	22	14	36
Total	526	132	658

The majority served, or were related to someone who had served, in the Royal Navy (including Royal Marines; 49%), and seven had served in more than one service (1.1%). Table 4 provides a breakdown of Service; note that 116 cases were missing.

Table 4. Numbers and Percentages of Branch of Armed Forces served in.

Service	N	%
Royal Navy	238	43.5
British Army	235	43.0
Royal Air Force	34	6.2
Royal Marines	30	5.5
Merchant Navy	3	0.5
Combined	7	1.1
Total	547	100

No data had been collected concerning deployment history or length of service in the dataset analysed here, so this cannot be discussed. It is understood that this is now being collected and should be analysed moving forward.

3.1.2 One to One Interviews

In total, 21 users of VOS took part in the interview. Of these, 19 participants were male, while 2 were female (and partners rather than veterans). Ages ranged from early 40s to late 70s, and so the basic demographics of those who took part in the interviews reflected the general picture of service users from the VOS dataset. Of the original 21 participants, 13 were willing to be re-interviewed. As for service providers, 8 agency representatives and 3 clinicians took part in one-to-one interviews. Further details are not provided to protect the identity of the participants.

3.1.3 Survey

The final sample was 59 people, comprising 52 veterans and seven family members. The majority of respondents were currently attending VOS (66%), while 35% were past users. The majority of service users were formerly serving in the Royal Navy (62%), of which 5% were Royal Marines. Former members of the British Army comprised 33% of the sample, along with 5% being former members of the Royal Air Force. Where family members are concerned, 2 were partners, 2 were ex-partners, 1 was a parent, and 2 were widows.

The majority of veteran respondents were aged 55-64 (50%), the next highest category was 45-54 years old (31%). The youngest user of VOS was in the 25 to 34 category, and the oldest in the 75+ category. In addition, the majority of veterans were male (85%). A similar pattern was true of family members, with the majority falling into the 45-54 category, followed by the 55-64 category. The majority of family members were female. As such, the sample seemed to be representative of the population involved with VOS based on findings from the VOS dataset.

Deployment history varied across the sample and included Northern Ireland (1969-mid 1990s), Falklands, Gulf War, Bosnian War, Afghanistan, and Iraq. The most common deployment was the Falkland (44%), followed by Northern Ireland (37%). Veterans had also served in the Gulf War, Kosovo, Bosnia, Afghanistan, and Iraq.

The majority of those surveyed joined the Armed Forces in 1970s, and the largest group then left the Armed Forces in the 1990s (these might not include the same individuals). This provides a sense of the length of time since leaving the service in which support is still required.

In terms of years of service, this is best expressed in Table 5. The largest category is formed of those who served between 5-9 years (38.5%) and those who served between 20-24 years (25%). This is interesting given that previous studies have found that early service leavers (1-4 years) may experience most need upon leaving (Buckman et al., 2012). This perhaps suggests that VOS is perhaps not as well known or attractive to this particular group, with 5.8% of the sample comprising early service leavers. Equally, the results demonstrate the need that can persist in those who have served for longer terms.

Table 5. Percentages relating to length of service.

Length of service (years)	Percentage (%)
1-4	5.8
5-9	38.5
10-14	13.5
15-19	9.6
20-24	25
25-29	1.9
30-34	3.8
35+	1.9

Not all respondents provided their rank at discharge. For those who did, rank at discharge ranged from those who were junior rates or other ranks (14 respondents) non-commissioned officers (18 respondents), and Commissioned Officers (5 respondents).

Reasons for leaving the service have also been recorded, with 38.5% having completed their service time, and 34.6% who had been medically discharged. Other reasons for leaving include, for example, redundancy, medical concerns, bullying and sexual assault, and being “disillusioned with service”.

3.2 Description of Service Use

3.2.1 Analysis of VOS Dataset

The table below provides the numbers who registered for the first time in each of the years of the analysis period. Note that these figures do not indicate the total number of users per year, but new users per year. Table 6 indicates a steady increase in new users aside from in 2015, however it must be noted that 2015 data were incomplete.

Table 6. Numbers of new users registered each year.

Year	N	%
2008	18	2.7
2009	46	7.0
2010	52	7.9
2011	67	10.2
2012	81	12.3
2013	103	15.6
2014	183	27.7
2015	110	16.7

*3 cases of missing data

Finally, in terms of referral routes, the most common source of referral is via 'other' sources (23.4%), and so is not clear. It may be suggested that this route may be self-referral or via family and friends, but this is tentative. Second and third most common referral pathways are 'word of mouth' (22.6%) and 'Combat Stress' (21.4%) respectively (see Table 7).

Table 7. Numbers and percentages of users referred by each referral source.

Referral Source	N	%
Other	154	23.4
Word of mouth	149	22.6
Combat Stress	141	21.4
SSAFA	66	10.0
RBL	51	7.7
SAMA82	37	5.6
SPVA	27	4.1
GP	16	2.4
Advert	10	1.5
Internet	5	0.8
FVF	2	0.3
RNBT	1	0.2

*4 missing cases

Data relating to service use was used to determine the most common ways in which users have engaged with VOS. In order to analyse the data, a number of assumptions were made. For instance, dates of last known use were used to determine how likely users were to still be involved in using VOS. If the user was still engaged in the autumn of 2015, they were considered likely to be current users as opposed to past users. It is hoped that this provides a conservative estimate when categorising service users, and also determining end point for data analysis. With this in mind, of the total sample (663 users), 527 (82.1%) were considered unlikely to still be engaged with the service, while 115 (17.3%) were considered likely. There were 21 cases for which date of last known attendance was unknown.

In terms of length of engagement, the current database suggests that total months of engagement vary considerably between users, with some attending only one drop in while the maximum seen was 69 months. On average, users engage for up to 7 months (*M = 6*.75 months). When those who are unlikely to still be engaged are excluded, the mean is 14 months. However, there is a trend

towards short term use. As a whole, 51.8% (*N* = 293) of the sample attended one drop in only, the second highest percentage was for 1 month involvement (i.e. 2 drop ins; 6.0%), followed by 2 months (5.5%), and 3 months (3.9%). Other 'peak' times are around 9 months (1.8%) and around 14 and 15 months (1.4% and 1.8%). In total, 85.9% of the sample are accounted for between 0 – 18 months engagement. It is not known whether these individuals are successfully referred onto other services after their engagement with VOS or not require further support. This would be useful additional information. Note that for 97 cases, any data from which to draw inferences was missing.

Frequency of attendance was another variable that was created to further understand context. This was calculated in terms of total number of drop ins attended *where agency use is recorded* divided by number of months of engagement. Clearly, this does not account for more frequent, initial attendance, which later reduces in frequency, and this is something that a) should be considered here b) captured moving forward. In addition, the database does not capture those who attend to socialise or to see the Padre. For those who attended more than once, it can be tentatively suggested that most common frequencies of attendance are monthly (29.5%), followed by every two months (19.5%) and every 3 – 4 months (18.7%). There is some indication that there may be a trend to revisit at 6 months (2.5%), every year (1%), and every two years (2%). No associations have been tested between first CORE-OM score and duration or frequency of involvement because these variables have been computed, as there is risk of over interpretation due to inferred variables. It would be useful to measure this more accurately moving forward in order for these relationships to be tested.

3.2.2 Interviews

Pathways to VOS also varied and included; self-referral, motivation from family and friends, and word of mouth from the wider veteran community or, more specifically, from the VOS community itself. Table 8 provides a summary with examples.

Table 8. Examples of quotes for referral pathways.

Pathway	Example Quote
Self-referral	*I was living there (RMC) at the time, the Royal Marines had put me in there while I was waiting to get a flat - they had a first Wednesday and I went to sign on and that was it. (ID4).*
Family/friends	*I think it was pretty much to the point of my other half saying you need to go and see someone. No excuses. Get down there and see them. (ID2).*
Veteran Community	*It was word of mouth. Nobody told me about it, I was advised, I was talking to one of the guys when I was up at Leatherhead, and he mentioned a drop in centre. (ID13).*
VOS Community	*We got the intel from Combat Stress itself, from our welfare officers. (ID10).*

The most common pathways seemed to be motivated by family or by the veterans themselves, and this might shed light on the 'other' route recorded on the VOS database. From the table, it is clear

that pathways that are either self-motivated or motivated by family members seem to involve a turning point in the veteran's life. In addition, crisis seems at the heart of some pathways to VOS:

I was living opposite to where the Veterans Outreach Support service met at the Maritime Club and they'd been there for nearly five years or whatever it was and I never knew about them. But on my darkest day I saw their sign, which means I'm still here today (ID 26).

There is a sense also within this quote that knowledge of VOS even in the local area is limited and may affect numbers who attend. Agencies involved with veterans were also a pathway, particularly those who have an agency presence at VOS, such as TRBL and Combat Stress. Members of the wider veteran community also seemed to recommend VOS.

Agency representatives and clinicians were not, understandably, as clear on referral pathways. A number of referrals into the clinical offerings of VOS seem to come from Combat Stress and often the service users concerned have problems with alcohol use. There is an emphasis on quick turnaround and assessment for these people which is something the referring agency *"probably can't do" (C2).*

There were two mentions of pathways via agencies outside of the veteran community. One was Mind, and the other was the Job Centre. In the latter example, the advisor was formerly serving. There were seemingly no referrals from health professionals outside the veteran community; again, highlighting a potential lack of awareness of VOS.

3.2.3 Survey

The survey recorded the length of past or current engagement with VOS. Interestingly, the majority of the current veteran sample clusters around relatively medium term use with 34.7% having engaged for up to a year (of this, 13.5% had been involved for under 6 months), and a further 19.2% having engaged for between one and two years. However, 11.5% had engaged for between 6-7 years indicating a need for, and dependence on, longer-term service use. This is a group seen in the VOS dataset, but is relatively small (approx. 4%) that further discussion could not be prompted. As such, it might be suggested that the findings from the study speak of those who engage long term.

The picture for family members is slightly different, with 5 of 7 involved for less than 3 years. When looking at the patterns for past and current users, it seems that the longest engagement is seen for current users, with 15 of 19 past users engaging with VOS for 2 or fewer years. Again, this is a slightly different pattern compared with the VOS dataset, but stands to reason that the majority of users, who only attend one drop in, did not engage with the survey.

In terms of frequency of attendance, the majority attend only the monthly drop ins (59.6%), with 13.5% attending every few months (rather than monthly). There is also a tentative pattern of more frequent engagement at the start, with decreasing frequency over time (5.8%). This was a pattern seen in the VOS dataset, but difficult to reduce down to a single variable. Other (13.5%) engagement currently includes one respondent who said he '*attended, received advice, obtained help and attended again'* to another respondent who said he attended on *'a couple of occasions, but (sadly) not able to help me much so did not return'.* The majority of family members (5 of 7) attend monthly.

3.3 Types of Need

3.3.1 Analysis of VOS Dataset

Given the complexity of VOS as a service, it was important to gain a sense of how service users engage with the offerings; that is whether they seek support from agencies, therapists, or both. Table 9 presents the frequencies of type of engagement. Once again, there are issues with missing data. Since *type of engagement* is a variable created from information in the dataset by the research team, only data available could be used. The categories are mutually exclusive. There were 97 cases of missing data for this variable, where no information had been recorded at all, and 120 cases where an individual had attended a drop in, but there was no record of agency use or therapy. Again, this might indicate attendance for social support, but this cannot be determined. For cases with data, the dataset was further split by attending one drop in or more than one drop in. The majority of those who attend only once do so to see agencies. Whereas those who attend more than once do so to engage with therapy as well as to see agencies. It might be inferred that for those who have attended once only and engaged with therapy did not complete the course of treatment, or were referred on. It would be important to understand exit from the service. Despite this, these patterns shed light as to the likely types of need that service users present with. The majority might be considered practical, with some need for psychological intervention. Of interest here are the numbers of those who attend more than once and engage with both agencies and therapies suggesting multiple need.

Table 9. Type of engagement.

Type of engagement	One drop in (N)	More than one (N)	Total
Agency	161	55	216
Therapy	16	47	63
Both	6	161	166
No evidence	110	10	120
Total	293	273	566

3.3.2 One to One Interviews

There were a number of different reasons why veterans accessed VOS for the first time. In some cases there were multiple needs for instance, one participant said '*I got asked who did I need to see and I said I don't know what to do, I've got a list of things' (P39).* While others did not know what their need(s) was. Specific needs were also mentioned and can be grouped into psychological, physical, social, and practical needs. Table 10 summarised these needs.

Table 10. Examples of quotes for types of need.

Type of Need	Example Quote
Psychological	*I needed assistance with therapy and a therapist who would try and help me sort out my mental issues and anxiety (P13).*
Physical	*I've got chronic back problems now and I'm registered disabled so that's why I decided to use Veterans Outreach (P3).*

Social	*To get me out of the house and to actually open myself up to being in a sort of group environment (P1).*
Practical	*I used the legal side of things for divorce stuff (P17).*

Of interest here is that of those interviewed, practical needs came to the fore, which included issues such as financial concerns, housing, and legal support. However, there were also those who indicated that they were in crisis the first time they attended:

I fell through the doors at VOS at the Maritime Club crying my eyes out, somebody picked me up, they took me away to a more private area and talked to me and then they reassured me and let me know that help that I was seeking was there for me too (P26).

In terms of continued attendance, participants mentioned the maintenance effect of VOS:

I suppose I use VOS like a power pack. I go there on a Wednesday, charge my power pack up, and then I kind of hope it will last me until the next VOS. So that's why I use it. (P19).

It is also important to note that some veterans attend for the first time even though they *'didn't know what I was going for' (ID27).* The idea that veterans can attend without a clear sense of what it is they need, but can be supported to determine what their needs are, is powerful and supports the programme theory.

Agency representatives and clinicians also provided their insight as to how and why VOS may impact on service users. The types of problems seen by these agencies varied from serious mental health problems (such as PTSD), to serious health problems (alcohol misuse) and more practical problems, such as financial support. Clinicians' indicated that Service users present to VOS clinicians with varying mental health difficulties, such as PTSD, substance misuse (including alcohol), anxiety, depression, trauma, grief, and issues with guilt.

Associated with need, participants highlighted areas of their lives they hoped would be addressed or improved following involvement with VOS. Much as with types of need, these hopes mapped on to psychological, physical, social, and practical aspects of veterans' lives. Table 11 provides a summary of these expectations and it is important to emphasise here that the majority of hopes and expectations aligned with practical needs, perhaps because practical needs are more tangible.

Table 11. Examples of quotes for hopes and expectations.

Hopes and expectations	Example Quote
Psychological	*I'm pretty fit, pretty healthy except for the mind and that's what need fixing because if the mind is not fixed your body can't cope. (ID11).*

Physical	*It's (CST) all to do with energy, positive energy and stuff, you know? Because I was diagnosed with borderline sleep apnoea, I'm right on the border (ID3 – CST for relaxation and improved sleep).*
Social	*I mean maybe in another six months or a year's time I shall have gained a lot more by being a member of the group (ID33).*
Practical	*All I wanted to see was somebody about the housing. I wanted to see a SSAFA rep. (ID 31).*

The clinicians interviewed did not hold opinions as to the hopes and expectations the service users might have. However, the hopes the clinicians had for their service users concerned enhancing quality of life through providing an initial period of stabilisation:

"we work through a process of initially it's stabilisation for people…first thing is to improve quality of life for people who come to see us and ask for help" (C3).

3.3.3 Survey

Respondents of the survey were also asked about the type of support they felt they needed when they first engaged with VOS. These categories are not mutually exclusive and it is important to note that veterans had multiple needs on their first visit to VOS. In total, 75% of respondents felt they needed psychological support, which includes therapy, counselling, psychiatric treatment, and support from the Padre. In addition, 59.6% felt they needed practical support, which includes legal, financial, and housing advice as well as employment. Finally, 25% felt they needed social support when they first engaged with VOS. Other responses (14%) included a respondent who was *'unsure as to what [he] needed'.* Others cited physical injuries, support with finances, and one explicit mention of needing CST.

For family members, the most common need was psychological support (5 counts) followed by practical support (3 counts). Again, these categories were not mutually exclusive. There was also another explicit mention of needing CST.

3.4 The VOS Experience

This theme captures what it is like to engage with and use VOS. Essential information concerning the checking in and registration process, experience of engaging with VOS including descriptions of the infrastructure, engagement with agencies and therapies, as well as some of the facilitators and barriers to use. The themes captured in the interviews, were further explored in the survey.

3.4.1 One to One Interviews

Descriptions of VOS concerned the way in which VOS is set up physically at the RMC, as well as processes such as checking in (including form filling). Themes concerning waiting times and access to agencies are also discussed in the section concerning mechanisms where they relate to the one stop shop nature of VOS.

The comments concerning the VOS infrastructure were comprehensive and both positive and negative. The overriding sense from the participants was a disconnect between the purpose of VOS, which by very nature welcomes veterans with all types of needs, and the lack of privacy and the sense of busyness experienced at drop in. A number of the participants found it an overwhelming atmosphere, particularly unsuited to those with anxiety disorders, such as PTSD.

Other comments concerned the frustrations around form filling, such as the inappropriateness of the CORE-OM with its risk items, for those who simply wanted help to access practical support. Waiting times were also an issue, with some participants indicating they had waited for hours to be seen, and a sense of worry or frustration that they had been forgotten. Table 12 provides a summary.

Table 12. Description of VOS.

Description of VOS	Example Quote
Physical environment	*Positive: Tea and coffee is nice, yeah, I like that. It's nice because if you're thirsty, you can just go and get it, all the facilities are there (ID1).* *It's still a welcoming, safe, comfortable place to be and it's…I really look forward to that afternoon going down there (ID17).*
	Negative: It's intimidating. It's everything that I…it makes me panic, it makes me anxious, it's something…I always think people are staring. And they do. You walk in that room and everybody goes [looks round]. So yeah, I personally just want to run because that's something that's in me to run (ID12). *But it's a little bit open for me, for people to, you know open up and tell you a lot of personal things. Because they are not going to when there's someone sat right next to them talking to the solicitor man (ID27).*
Checking in process	*Positive: I sat down and the lady that I dealt with on reception was very calm, very nursey like, I don't know, very sort of calm, caring, interested, very quiet in the way that she spoke (ID39).*
	Negative: It's chaotic at the front desk (ID24). *It reminds me a bit of a jumble sale when you go in. It's a bit like doing the egg and spoon race; you've got to go over there and fill in your form and get your number, and then you've got to go over there to get your egg and spoon, and then you've got to go and wait there for your race to begin. And it's very chaotic and it's very intimidating and you honestly get people come and walk out. (ID26).*

	Why do they have to keep bringing this form, how you've been all week, they don't need to do that so everybody fills it and, oh, fill this stupid form in again and that's the way I'm getting, you know, I'm going…I don't even look at the questions. (ID1).
Waiting times	*Positive: I'm often sitting there for like three hours before I get called down for it but it's nice to be forced to sit and to do nothing without having…thinking, oh I should be getting up and doing this, or what have you (ID17).*
	Negative: and you, sort of, put your name at the front, but I've tried that and I waited two and a half hours and I just lost interest. I find it too long to wait, I didn't know there were some more people in front of me (ID1). *It's the time basis I don't like, as I say, I get there early at 12 o'clock, and I'm one of the last to leave at 7 o'clock, and sometimes I don't even see the people I want to see (ID19).*
Access to agencies	*Positive: Another advantage of VOS as well that's it's free, and all the access to the access to the agencies are free. So for a lot of veterans, that's just about what they can afford (ID10).*
	Negative: I just felt a bit daft because I could see the person I wanted to go and see but I had to wait for someone to pick me up and take me to see that person. And it seemed the other person was reluctant to talk to me unless I went through the official channel for fear of getting into trouble from the organisation for not waiting to see me. (ID39).

Finally, one participant was able to provide his insight into his first experience of using VOS, which was one of confusion and limited information. This also raises the possibility that people attend VOS with little knowledge of the support available to them and, if they do not know what to ask for, they might not receive support. This challenges one of the important assumptions of VOS; that one can arrive not knowing specifically what their need is, but can still receive support:

I was then told to sit in quite a pleasant room with a lot of other people who I didn't know anybody there initially, and there was coffee and some biscuits, but there was still not really any information. I hadn't been given any information about what Veterans Outreach Support was. But initially you didn't know what it was about basically. You were stuck on a table, you went and got your coffee and a biscuit, and you didn't know what was going on. And then people kept on disappearing with numbers, and I thought nobody's given me a number, should I have a number? (ID31).

As mentioned previously, changes occurred in the summer of 2015, which sought to address some of these perceived issues. This was not as a result of this evaluation, but as a result of changes to the management team and the appointment of a new CEO. These changes included replacing of CORE-OM with the WEMWBS at registration, (which could be taken away to complete rather than completing at the desk) and the issuing of ticket numbers to those waiting to be seen.

On the whole, it would seem that users experienced a faster, more streamlined process after these changes were made, but only once users had reached the front desk. However, there were concerns from service users that no longer using the CORE-OM meant that risk was no longer identified as quickly and efficiently as before. Users reported that they complete the new measure in a room with many other users. The issue concerning the change of outcome measure is important to focus on here. One participant spoke of an occasion in which he went to VOS in need of support, but it was not recognised. This highlights issues of risk management with the new system:

(I went) where the library is because I was suicidal but no one was picking it up. I mean she just said, hello, how are you, but at that time I wasn't going into the main room because I was suicidal and I was anxious. But if I wasn't seeing a therapist that day, like CST, or seeing anyone that day I wasn't asked to fill one of those in (ID9).

This also highlights a problem in the process of checking in. While the protocol is that all attendees complete the CORE-OM/WEMWBS, this might not happen in practice, and could help to explain the extent of missing data.

Privacy also remained an issue, with concerns for those who needed to talk about more personal issues. Finally, communication was seen to be better as there was transparency as to which agencies were present at the drop in.

Table 13 provides a summary of VOS after changes were implemented. It would seem that for some users, the physical environment had worsened their experience, and they found it busier than before.

Table 13. Description of VOS after changes.

Description of VOS post summer 2015	Example Quote
Physical environment	*Positive: The changes I saw…I was well looked after and I was put through the system quite quick. You now, on the days I was going, I thought the organisation was a bit more calmer (sic). It didn't seem hectic (ID1).*
	Negative: I think it's quite manic (ID9). *I find that when you go to be assessed – I don't know if they're still in the big hall bit – you're still listening to other people (ID1).* *Well, it gets a lot noisier (ID15).* *If you're sent into that room with about 50 other people and you're all sat there going like that – oh. If you're just starting out to get help, that's a recipe for a panic attack and I'm out of there (ID16).* *Since [founding members have] retired, it's gone downhill and it's not comfortable for people with psychological problems, because you go there, you get herded into a crowded waiting room, where if you've got problems, it's not the right place to be.. It's not a happy place to be, and it's totally changed (ID16).*
Checking in process	*Positive: Yes, they were a bit more organised at the front table (ID1).*
	Negative: You don't like answering all of that especially when you're sat in a room full of people and you sit in that room because you've got your coffee and you're on big tables and everybody's sat around and you're ticking really personal stuff. So, yes, I didn't like the idea of that one (ID2). *The fact that you are pressurised to sit in the waiting room (ID16).* *I thought the old forms were a lot better, because it made you think more. It went into a lot more depth about your mental health or your mental state, which I don't think the new forms do (ID15).* *You book in, you get given a number and your form. But then you go and fill the form in and they come in and call the number. You're going backwards and forwards a little bit (ID17).*
Waiting times	*Positive: It might seem to take longer before they call you forward, but from that point onwards, once you're in the system and you're running, things seem to happen faster. Because the way the management system is running on that desk now, the flow of information getting you from A to B, from person to person, there are now*

	three people running around getting the guys to the different departments that they're seeing, and making sure the department now is ready for the next person (ID13).
	Negative: Getting to the desk is still taking time, because it's not the staff on the desk that's taking the time, it's the guys going to the front desk and then sit there for 15 minutes, wanting to talk about it (ID13).
Access to agencies	*Positive: N/A*
	Negative: And suddenly you have (new clinician) coming with the NICE guidelines and stopped that (CST). (New clinician) is a box ticker. Box-ticking don't work. When you're dealing with people with psychological problems and you sit there with a form and say tick this, thick that – no, that doesn't work (ID16) NB. Clinician mentioned is neither clinical lead represented in service theory.
Communication	*Positive: They've got a list of who's there which is good which they didn't have before, on a….I think it's a board, they've got a list of who's attending when before they never used to do that (ID24).* *So we've got to have the guarantee from the agencies they're going to turn up, and if they're not, they need to let us know, so we can let other people know (ID2).*
	Negative: There were no updates on, you should be seeing….that, that and the other, If no one's telling you, then oh well, they've forgotten about me, I'll walk out (ID16).
Role of volunteers	*Positive: If we have someone that's a returning attendee, that is in a bad way, and they need to be seen quicker, and we spot it, I've been able to come and say, look, this person needs to be seen now. Or, needs to be the next person in with this person. We can, even if they've literally come in and there's ten people before them, if it's really necessary, we can just jump them straight up. There's a much more professional….with delivering the service. Yes, we are volunteers, but we're delivering the service (ID2).*

Clinicians and agency reps also provided their insight into the VOS experience for users. As with service users, this theme captured the experience of engaging with VOS including descriptions of the infrastructure, engagement with agencies and therapies, as well as some of the perceived facilitators and barriers to use.

Descriptions of VOS varied considerably with some feeling very positively towards the way VOS is run, while others echoed the sense of confusion and busyness they imagined the users to feel. This included the need to complete clinical outcome measures when the user's need may be social. Conversely, clinicians raised questions as to the appropriateness of asking those in crisis to complete outcome measures on registration. Some also questioned the description of VOS as a drop in service,

which is a powerful observation in the context of the programme theory. Concerns about the infrastructure, including the physical environment and checking in process, were raised by clinicians. Regarding the physical environment of VOS, concerns about the noise levels and general busyness, particularly for service users who present with anxiety, echoed the concerns of the service users themselves.

Table 14. Description of VOS (service providers).

Description of VOS	Example Quote
General description	*Positive: "it does run very well…it is a great resource…I think it is one of the best outreach in the area" (A3).*
	Negative: it's not clear what to do when you arrive here" (A4/A5). *nowadays they tend not to come in from nelson lounge- the noisy lounge is a barrier for trauma based personalities people who are claustrophobic or suffer with social anxiety will struggle with the new VOS layout" (C1).*
Checking in	*Positive: "Clients come to the drop in with an enquiry. Clients select which agency they would like to talk to. They are given a contact card and they tick which agency they want to talk to on this card. Then we are told by reception that a client wants to see us" (A3).*
	Negative: The downside of the way VOS is set up in relation to that is they become a gatekeeper of the reception. Whereas it's not really a drop in. They kind of have to know we're here to ask for us, and I don't mean just us, it's probably any organisation. So a potential service user can't walk around and look at the menu, as it were, of services that are on offer" (A4/A5). *"I have received a few comments from veterans about their signing in process. I understand that VOS have to do it for their data collection. But I have been sat for 2 hours with no-one coming to see me and I know there are people waiting just to see me. Sometimes I have to give the reception a nudge to remind them I am available and waiting. There always seems to be a mad rush at the end of the day. I don't know if this is because it takes so long to process the paperwork" (A8).*
Completion of outcome measure	*Positive: N/A*
	Negative: "You know, on occasions I've had people who've come in and say, actually I haven't got anybody I really want to see today, I just want to come and have a chat, but they still have to do the CORE 34 form, they still have to book in. Where actually what they really want to do is treat it like a proper drop in" (A4/A5).

"Can trauma based people really be expected to fill out forms until they are seen as getting better- they can't manage a form, it starts to panic them. X used to say you never have to fill them in, but CST therapists will sit with them to fill them out." (C1).

3.4.2 Survey

Themes emerging from the WP 1 interviews about the reception area and checking in process were further explored in the survey. Although respondents in both the interviews in WP 1 and the survey had indicated there were issues with the reception area, 62% are either satisfied or very satisfied with the reception area. When it came to the availability of the appointments at VOS, there is a mixed picture with 32.7% being very unsatisfied or unsatisfied, while 43.1% are either satisfied or very satisfied. However, 77.6% were either satisfied or very satisfied with the waiting area in the coffee room. From the interviews it is known that the coffee room is where the majority of the socialising happens. It is also where the veterans have an opportunity to speak with the Padre who attends. Unfortunately, there is no item on the survey asking about satisfaction with waiting time, however this is a theme that has emerged from the interviews in WP 1 and was explored further in the follow up interviews in WP 1 and WP 2. Finally, although some service users who were interviewed mentioned issues with completing the CORE-OM on arrival, only 15.5 % indicate they are either very unsatisfied or unsatisfied with this, while 56.9% indicate they were either satisfied or very satisfied.

There were also issues around the privacy afforded at VOS e.g. one veteran saying that *'I felt there was a lack of privacy'* and the importance of having no queues for those who lack mobility. These concerns link with comments about the use of the RMC generally. For instance, there were comments about the numbers of people attending the drop in now; *'It is getting so many attendees that it now needs to expand to its own premises and have more staff. RNH Haslar has sat dormant. Why not use that?'.* Another called for a dedicated space along the lines of other well-known services in Portsmouth such as Age UK:

'It is only once a month, I think there should be a place, a specific building which could house all the agencies or people residing in a building who could refer on a regular basis. Something like Age UK, or Social Service specifically for Armed Forces etc that should be able to access on a daily basis. The place could also have a café for socialising and an internet café also act as a job centre. Should be run by ex-services as well as civilians'.

This would also address the issues around frequency of attendance as well as the busy-ness of the drop ins, which can impact negatively with one veteran saying that people were *'loaded into a waiting room that was noisy and no good for people with psychological issues.'*

3.5 Barriers and Facilitators of use

3.5.1 One to One Interviews

Facilitators and barriers related to the types of issues that made attending VOS for the first time easier or, conversely, harder. There are limitations to this theme given that all participants have used

VOS. Powerfully, though, a number still spoke of barriers. The findings concerning facilitators and barriers are summarised in Table 15 below.

The most powerful facilitator seemed to be having support to attend. Some participants spoke of needing to take someone with them for the first time, while others spoke of standing outside the drop in, not able to go in. In these cases, it seems that current members of VOS took the time to provide support to these newcomers. Although peer support is recognised in the programme theory, this particular function of peer support was perhaps unknown, and also highlights the need to offer training and support to those willing to help their fellow service users.

Conversely, barriers concerned location, lack of awareness of VOS generally or the VOS offering, and, most powerfully, self-stigma, with the latter being the most powerful of all barriers. Perceived or anticipated stigma almost prevented attendance for some. This links with the important role peers can play in supporting attendance for the first time, but also highlights that these fears can be present when contemplating a non-NHS drop in.

Table 15. Examples of quotes for facilitators and barriers.

Facilitators	Example Quote
Location	*The location is fine for Portsmouth and Hampshire because it's easy to get to. It's located in a good place (ID11).*
Conduit to other services	*You won't get to Leatherhead (Combat Stress) unless you come here first. Because there is a long waiting list to go to Leatherhead' (ID 27).*
Support to attend	*He brought me in. He came out, he's seen me there, he's like, what's he doing still out there, and he brought me in. And basically he's the one that kept me there, otherwise I would have turned round and walked out. But that's the easy part. Anyone can pull someone in to the front, but he didn't leave my side, he stayed with me. He went through the forms with me that we've got to fill out. He went through everything. And he stayed with me the whole time I was there. (ID2).*
Barriers	
Location	*(if) you've had a bad session, you've got to come back (ID10).*
Lack of awareness	*So it's practical (barrier) because it's just not knowing that the service is there' (ID 17).*
Misconceptions	*A lot of people think it's just for PTSD, and things like that, they don't realise it's a vets' drop in for every situation (ID19).*
Fear of judgement	*I think there's a reluctance anyway for ex-forces to ask for help, big boys don't cry, and I had to break through that. (ID28).*

Perceived facilitators and barriers were mentioned by agency representatives and clinicians. As for service providers, facilitators related to the importance of having support to attend, particularly for the first time. Barriers related to waiting times during drop ins as well as the need to complete forms

to attend. Clinicians also felt that difficulties in asking for help prevented some veterans from attending for the first time. Table 16 provides a summary of these themes.

Table 16. Facilitators and barriers (service providers).

Facilitators	Example Quote
Support to attend	*"I think that's the thing that the friend, oh, we've been to the drop in, why don't you come along, it's alright, you get free coffee, tea, you know" (A7).*
Barriers	
Completion of outcome measures	*"You also have to fill in their mental health form what also puts a lot of people off. [] it's very scary coming through those doors, especially when you are about to go cap in hand to a charity - especially if you need financial help or emotional help and then you have four forms to fill out…Then the charity that you go see gives you another form"(A6).*
Waiting times	*Because sometimes a person's been waiting there an hour and they go, they can't stand it and they go. And I think that's got to be just managed very, very carefully"(A7).* *Sometimes if you take an hour with one representative - an hour with a user, a veteran user then we've had people storm out because they've waited two hours because the representative didn't know that there was four people waiting (A6).*
Difficulty asking for help	*"People would say, I've been three times. The first time I couldn't come in that door. And that's a very high level of anxiety. And of course the main thing that I hear is, it's about their pride. Asking for help is very difficult for some of these people" (C3).*

3.5.2 Survey

The survey also explored the factors that impact on making attendance either more or less likely from a quantitative perspective. VOS being a drop in centre where one can go as and when needed seems to be an important factor with 72.4% of respondents agreeing or strongly agreeing that this impacts on attendance. In addition, 69% agree or strongly agree that VOS is a comfortable environment for them. Of particular salience to the VOS design, 77.6% of respondents agree or strongly agree that the VOS staff being ex-service is important in terms of feeling understood, linking with an aspect of context that VOS is a drop in for veterans run by veterans.

Further aspects of VOS explored included location of VOS, financial costs of attendance, appointment availability, and other factors. Once again, these issues emerged from the WP 1 interviews**.** Users of VOS are satisfied or very satisfied with the location of VOS (75.8%), and 74.1% are either satisfied or very satisfied with the distance they had to travel to get to VOS. The decision was made not to ask respondents to provide their address or postcode. This was because there may have been a risk of identification with such a small sample. As such, it is not possible to know whether those who attend are satisfied with location because they are local. In addition, 56.9% of respondents are either satisfied or very satisfied with the personal financial cost of attendance.

In terms of exploring what would make it less likely for veterans to attend VOS, a series of items are included, inspired by the interviews in WP 1. These included whether treatment would make symptoms worse and whether they would consider seeking treatment to be 'weak', for example. Participants were asked to rate the extent to which they agreed with the statement on a scale of 1-5 where 1 is strongly disagree and 5 is strongly agree. It must be noted that there is a limitation to this section of the survey with the sample. Although we asked the respondents about whether these made it less likely for them to attend in the past, the sample includes those who have engaged with VOS and, consequently, are less likely to have experienced some of the barriers as keenly as those who have yet to attend. Yet, the sample still reported potential barriers, most of which were felt by a quarter of the sample. These items are briefly summarised in Table 17:

Table 17. Summary of perceived barriers to attending VOS.

Statement	% Agree or strongly agree	Mean score
It is not advertised widely enough	56.9	3.57
I do not like to talk in groups	37.9	2.98
It's scary to attend on my own	29.3	2.93
I would be seen as weak	29.3	2.71
I am worried about confidentiality when I talking about my problems	25.9	2.66
It would be too embarrassing	25.9	2.66
I don't know what to expect if I were to attend	24.1	2.84
I should be able to handle my problems on my own	24.1	2.76
I have been to therapy before and it did not help	22.4	2.66
My life is too busy for treatment	17.2	2.43
The treatment will make my symptoms worse	6.9	2.22

Open-ended questions provided an opportunity for survey respondents to elaborate on these perceived barriers and facilitators. As well as comments about location and travel, comments were made concerning the importance of peers to support initial visits and that those attending know there is a military connection i.e. *'in other groups they don't seem to know what you have been through'.*

In terms of what makes it more difficult to attend, issues around lack of privacy in the venue, anxiety preventing attendance, and clashes with work commitments came to the fore. Indeed, one of the family members said *'when in crisis not enough privacy'.* There was also mention of having no control over when agencies can be seen and to be informed of waiting times when they apply. While these also relate to general descriptions of VOS, they are presented here because the impact of these issues can become preventative to attendance. For instance, some did not feel they *'got the support needed'*, while another cited waiting times explicitly:

'they have not helped in the last few years. The vicar has been helpful and I haven't had to book an appointment with him. I have had to wait hours to speak to an agency and have just left as it was taking too long and no one told me how long it would be'.

Other reasons for stopping attendance at VOS were also explored. For four of the respondents who no longer attend, ill health was cited as the reason. Others had moved, or could not attend because *'the timing and remembering to pop along doesn't always fit in [with schedules]'.*

Despite these experiences, one service user felt that despite the bad experience of the previous month '*I am considering not coming back, but then who else would help me at all!'.* It would seem that continued attendance might not necessarily be associated with satisfaction.

The survey also asks respondents whether they will continue to use the VOS service, or whether they would attend again the future if they are past users. Of the current users, 74.5% reported that they would continue to use VOS, leaving a total of 22.4% who would not. Of the past users, 100% reported they would *not* use VOS again.

3.6 Engagement with therapies and agencies

3.6.1 One to One Interviews

Engagement with therapies and agencies was also explored. For therapies, the overwhelming majority of those who had experienced therapies provided by VOS had nothing but positive words for the therapists they had worked with. Many felt that they had been treated with compassion, understanding, and respect. Within this was the sense of being treated with no judgement, which was an essential element. The alcohol service was well received, again focusing on the whole person. In addition, and as one would expect, therapies focused on not only military life but also pre-service experiences and were person-centred.

Where there were negative comments, these were associated with particular therapeutic approaches or therapists, the environment for therapy, and communication with other therapists or health professionals external to VOS. The lack of continuity with changes in staffing was also problematic for some, and has broader implications for the importance of sustaining a team in a charitable setting. In addition, the offering of complementary therapies, unique to a non-NHS

settings, was also prized by users and the impact when they were removed in favour of evidence based practice was keenly felt. Themes concerning a lack of communication between VOS and other voluntary and statutory services also emerged. In addition, the loss of group therapy offered by Combat Stress was highlighted: Table 18 provides a summary of the themes.

Table 18. Engagement with therapies.

Experience of therapies	Example Quote
Description of experience	*Positive: She is my lighthouse. Thoughts of conversation with her enabled me to stay away from the rocks of depression (ID26).* *She comes from a stance of compassion, that's why she does what she does and is very intuitive so she goes with the flow, if I decide that we're going to talk about war she'll talk about war and she's never, ever criticised anything I've ever said (ID39).*
	Negative: I don't like his method of psychiatry (ID19). *My therapist has left. She handed me over to a therapist called (name). She lasted about three sessions, then she left she just upped and disappeared, very little notice, left very few notes. I don't think she left any forwarding information. I'm now with a guy called (name) who's my latest therapist having lost (original therapist), at some point I lost focus. Because I was seeing (name) on a weekly basis, I was kept focused on what I was trying to do to improve my situation (ID13).*
Communication with statutory and voluntary services	*Positive: N/A*
	Negative: I saw Dr (X) for the first time I gave him my doctor's details, my email, and everything (on seeing another therapist) I mean I said, when I saw you the second time you should have had in front of you my file that I gave to Dr (X) with my doctor's details and (the second therapist) said I hadn't got your details so I can't send (information to your GP) I think my details should have been on there…on the computer. I mean even when I saw (third therapist), I mean, she should have….I think she should have had my details (ID9).
Changes to offering	*Positive: N/A*
	Negative: You can't offer someone something and give it them for a period of 12 months or more, and suddenly say, well, these aren't within NICE guidelines; we're stopping them (ID16). *I think the major issues we really do have is, losing the Combat Stress meeting, (ID2).*

There were mixed perceptions and experiences as far as the use of agencies was concerned. For some, they had always had very positive experiences of the agencies, and felt that the variety of agencies on offer was a considerable benefit of the service. However, others felt that they had not been helped and, in a sense, felt rejected by these agencies. A particular theme arose for the use of CST, which was originally part of the VOS offer, but changed to being an associated agency midway through the research programme; this led to a perceived withdrawal and reinstatement by service

users. Many of the participants had positive experiences of CST. For a few, it provided a balance between the therapy sessions that '*confuse, frighten, worry me'* whereas the *'CST balances me, really' (ID13).* Others spoke of relaxation, as well as having been able to reduce medication as a result of engaging with CST. There were those, for whom CST was not as positive, while another had received poor care. The use of CST was revisited, with some participants indicating that CST was growing in usage and even its presence once a month is not enough to meet demand. The impact of its absence was also explained, with one describing that as a *safety net* that had been taken away (ID17), and others talking about anger at its perceived withdrawal.

Table 19. Experience of agencies.

Experience of agencies	Example Quote
Description of experience	*Positive: All the agencies that go there are helpful. You've got the Royal Navy Benevolent Trust, Soldiers and Sailors Air Force, Air Association. They're all there, lawyers, you've got the lot, you know, and it's really, really good (ID11).* *I'm quite shocked at The British Legion in that way, you know, fighting for you in your corner, you know, of DSS and form filling and I've found they're very helpful in that way she's 20 years' experience with this and she goes the tribunals, so there's a wealth of knowledge and they do it all free (ID1).*
	Negative: The Royal British Legion only want to help causes, they don't want to help people. That's the way it's come across to me. And SSAFA who is the other one, they didn't give a reason, they just said, sorry we can't help you (ID13) *Well if someone's going to send an email and say, we're going to phone you next week or I'm going to phone you up next week and it's not done. And it's the little things all build up, and you think, well she's a professional (ID9).*
CST	*Positive: it really does make a massive difference (ID17).* *The withdrawal of the therapy, CST in particular, for me – that made a big difference, because I really benefited from CST one of my major coping strategies is just taken away, just like that I'm quite angry about the fact that that was withdrawn and nothing else offered (ID16).*
	Negative: I've been having CST therapy for two and a half years and my CST therapist started shouting at me and telling me I had a good life on benefits, get off benefits and get back to work. She said my anxiety was boring (ID9).

Service providers also provided some limited commentary on engagement with agencies and therapies. The mention of evidence-based approaches is of interest here, as it raises awareness that, since the changes seen at VOS, evidence-based therapies are being offered. While this was spoken with mixed perceptions by the service users, clinicians seem positive:

"Over time we've become registered with lots of different bodies and we now have people who practice EMDR and we didn't have that facility before" (C3).

3.6.2 Survey

When asked about the clinical response at VOS, 65.5% agree or strongly agree that their therapist really cares about them, 77.6% agree or strongly agree that VOS staff are really trying to help them, but only 60.3% agree or strongly agree that treatment will make them feel better. In terms of types of therapies, only 38% agreed or strongly agreed that group therapy had helped them.

Issues were identified by the respondents, which are arguably associated with the way the one stop shop currently functions. A few respondents implicitly highlighted important current caveats of the VOS offering, namely the extent to which VOS is (or is not) working in collaboration with GPs and lack of contact when people do not attend. For instance, one respondent highlighted that they had been *'attending VOS for 8 years [but no] written communication had been sent to my GP'.* This highlights an issue concerning communication between other organisations. Others highlighted issues around lack of contact with VOS i.e. to *'answer clients' phone calls'*. Of more concern is that some felt VOS should follow up those who do not attend, for instance:

'They should call service users if they notice they aren't attending. For all they know something could have happened to me. Just a follow up letter or call to ask if I am OK and whether I would still like to attend the service'. And another *'remain in contact and more often. No contact for 6 years'.*

This highlights potential risk that is embedded in the VOS model, while it is a drop in service, there is opportunity, and one might suggest a responsibility, to follow up service users. This would enhance the outreach nature of the service and would allow for adverse events to be monitored, which currently are not.

3.7 Comparison to other services

3.7.1 One to One Interviews

Many of the participants had experienced other services, the most common being therapies through the NHS. The overriding theme from the interviews concerned a perceived lack of understanding from civilian services and civilian health professionals, as well as the perception that these therapies were unsuitable. A number spoke of the uniqueness of VOS, even in the context of other services specifically for veterans. These issues were predominant for the participants who had accessed VOS for mental health issues. Table 20 summarises the main themes.

Table 20. Comparison to other services.

Comparison to other services	Example Quote
Lack of understanding	*The civilian NHS don't realise about the ex-serviceman and what they've been through, it's a completely different way of life (ID24).*
Long waiting times	*I knew that the waiting list, because I'd got a letter through, was nearly 18 weeks for the NHS to do anything. That was even to have a first appointment (ID12).*
Unsuitable intervention	*There's one through the NHS, Talking Change. I got….through the VOS they've got people form the NHS there as well, and one of them recommended Talking Change to cover the anxieties, bits of depression and PTSD. I got put on a course for mild anxiety and depression. And after the second week, a person in there said, this is totally the wrong course for you (ID2).*
Lack of alternative	*If it wasn't for VOS though I wouldn't know where to return to because there's no one out there to help, so I'm lucky VOS is there really (ID24).*
Favourable comparison with other veteran services	*The VOS is…Combat Stress is like the sticking plaster over a wound, yeah? But the VOS is like a triage where they change and keep that wound clean as best they can. (ID 10).*

Agencies interviewed commented on VOS in comparison to other services for veterans. Some compared VOS favourably to other outreaches, with particular reference to the number of agencies that attend. Clinicians commentated positively on VOS' willingness to accept veterans with complex needs, when other organisations have stricter exclusion criteria. However, comments were also made that the facilities to cater for specific groups of service users could be enhanced at VOS. In addition, clinicians felt that the limitations in length of therapy, particularly where NHS services are concerned, made VOS an attractive option. This was similarly the case with waiting times. One clinician also ventured that veterans may approach VOS even when their needs might otherwise be met effectively by the NHS. Table 21 provides a summary of themes.

Table 21. Comparison to other services (service providers).

Comparison to other services	Example Quote
Number and variety of agencies	*I believe VOS differs from the other outreaches we visit because it is a lot larger and it has many different agencies… Best way to differentiate what is different at VOS from the other outreaches we visit, is the number of agencies that are at the drop in. Nothing else can match that. (A3).*
Comparison with services for specific needs	*Yes, you've got the combat stresses, but they don't, you know, they won't take...they've got all sorts of exclusion criteria, which we don't have to; we can work with things like drug abuse and things, or alcohol abuse, things like that (C2).* *VOS is certainly one of the biggest…There are Drug/alcohol misuse difficulties with clients there and this is similar at other outreaches like Weymouth. We have our own rooms in pop-in centres, but they have panic alarms fitted in them. If people are on substances things can get easily out of hand. (A3).*
Uniqueness of VOS	*our service doesn't attend anything veteran specific apart from VOS, which is why it is so unique, as all the veteran services are under one roof. I used to refer to Talking Change/NHS, but now I just refer to the Psychologists and Psychiatrists at VOS" (A8).*
Offers an alternative	*Hopefully in years to come there will be something for my children as well. There's a massive hub at Help for Heroes at all of their houses and they run outreach hubs as well. Yes, it's run by Help for Heroes, but they signpost everyone else. The problem with the other hubs, what I will say is a problem is if you don't like the Legion, or you don't like Help for Heroes, you have a lot of service users put off. It would have been nice to have somebody independent (A6).*
Comparison with NHS services	*but I think you wouldn't be getting complex stuff, hopefully, within an assessment, in the NHS, people would realise that if someone was pretty complex you wouldn't be putting them through four to six session, which are going to make people fail or get that sense of failure because it hasn't worked. So you would be putting them into secondary services, sort of...I know that probably doesn't work because often people have to go through the system to then reach the other end…Here we don't have that. We don't grade people. And you know, sort of, that, you know, step two, step three, kind of client that we just don't have that here (C2).* *You know the combat stress statistic of thirteen years before they, before somebody actually approaches help for issues. So people...you know these things are very, very entrenched and so to really make much difference you've got to have really quite long or intensive therapy (C1).* *I think that we probably and indeed do see people a lot quicker when they enter our service and ask for help (C3).* *Now, it might be that we are not very good at actually referring people back into the NHS, which we may need to get better at because I think probably we're taking people when people could go into the NHS. But I think because we have a fairly short waiting-list...less than a month pretty much...I think, you know, people prefer to come here (C2).*

3.7.2 Survey

Respondents are also asked about other services they had used**.** A total of 64.4% have used services other than VOS. These included PCAW, or SPACES to find accommodation, Help for Heroes respite care, TRBL and Combat Stress, as well as NHS services. When asked about their satisfaction with these others services, the responses were extremely mixed with 23.1% being very unsatisfied, 23.1% responding neutrally, and 30.8% being very satisfied.

When comments were analysed, a series of themes emerged that concern what an asset VOS is to the veteran population and a wish that it could be *'replicated across the country'* and that the members of staff provide a *'level of care that I have not found accessing treatment via NHS'.* When the open-ended responses are analysed, a number of respondents highlight issues with support received from the NHS. The quote that best exemplifies these issues is as follows: *'It was a waste of time. The therapist tried treating me like a mother with PND and didn't understand what the scenarios I suffer from were'.* This highlights once again the role that shared understanding might play as a mechanism for change, which is revisited in the following section concerning mechanisms.

Finally, there was disquiet at therapies such as CST and EFT being stopped at VOS, and an implicit awareness that it might have been to do with a drive towards evidence based practice i.e. *'it's irrelevant that it's not approved by the NHS – IT WORKS'.* This is a key finding in that one of the main benefits of the voluntary sector offering is the opportunity to provide support that is different to mainstream intervention.

3.8 Summary

This chapter presented the collated findings concerning context from the studies in Work Package 1. A summary of findings are presented in the table below.

Table 22. Summary of Context findings across studies.

Analysis of VOS Dataset	Interviews	Survey
In total, 663 service users were involved in this analysis and demographics of users were similar to users of other veteran specific services. Numbers of new service users each year has steadily increased from 2008 to 2015 indicating good uptake. Most common pathways are not clear and could be 'self-referral'. Responds to multiple and varied types of need through registration process. This process monitors risk, facilitates triage, and helps service users to identify types of needs. Types of need appear to be practical with agency use the most common type of use, particularly for those who only attend one drop in, followed by users who seek support from both agencies and therapists. Only 63 users seek the support of therapists alone.	VOS as a "charitable organisation". A service for veterans run by veterans. It is a non-NHS drop in service with clinical response, though the description of VOS as a 'drop in service' was somewhat contested. It is a relatively unique offering, particularly in geographical location, however the time of the drop in was a barrier for some due to work commitments. Referral is via health professionals, but also via self-referral. Many of the service users and providers interviewed commented on health professional referral. The service was seen to respond to multiple and varied types of need through registration process. This process was seen to monitor risk, facilitates triage, and helps some service users to identify types	VOS as a "charitable organisation". A service for veterans run by veterans. The demographics mirrored the VOS dataset and, thus, samples in comparative research. Family member users of VOS were included in the sample. Length of engagement: For this sample, the most common length of engagement was up to a year, but the survey sample did comprise those who had longer engagement than the average for VOS users. Frequency of engagement: The majority of the sample attend monthly drop ins. There is a tentative pattern for more frequent engagement at the beginning of use, which decreases over time. Reasons for use: Psychological supports was most common, perhaps related to the fact that the

Length of engagement varies with half the sample attending one drop in only, while the other half engaged from between 1 month and 69 months. The average seems to be 7 months. Frequency of attendance on average seems to be monthly. CORE-OM scores are lower for those who attend one drop in only compared with those who attend more than one drop in. No direct evidence of comparison with other services.	of needs. However, some service users find the set up difficult to navigate and overwhelming. Types of needs are practical, physical, psychological, and social, but most present with practical needs on first attendance. There is no minimum or maximum length of engagement, and service users in particular value this, but there is a risk of hindering transition. Favourable comparison with other services, with shorter waiting times for psychological intervention was borne out through the interviews.	sample consisted of those who have attended VOS for longer. Practical support seems to be linked to a shorter length of engagement. The variety of agencies and therapies offered was perceived positively, with the mix between conventional and complementary therapies valued. There was some disquiet that VOS did not communicate adequately with services in the statutory and voluntary sectors. The majority of users felt that the VOS staff care and try to support the service users, and 60.3% felt that treatment they receive will make them feel better. However, only 38% felt that group therapy had been a positive experience. Overall the sample was satisfied with the infrastructure of VOS in terms of the check in process and completion of outcomes measures. However, it must be noted that the sample for the survey study seemed to be longer term users. The lack of privacy within RMC was an issue, along with anxiety generally affecting attendance. The time of the drop in was also difficult as it clashed

		with work commitments and led some to question whether the set up really could be labelled a 'drop in'. In general, the service was seen to compare favourably with NHS services.

Chapter Four: WP 1 Mechanism Findings

This chapter presents the findings from WP 1 concerning mechanisms. As such, the focus concerns the second evaluation question: How do users engage with the one stop shop nature of VOS and military environment to enact change?

Two mechanisms were hypothesised as part of the programme theory; the one stop shop service, and military environment. Of interest to this evaluation is that current debate about veteran services concerns where veteran services should be provided, and by whom; that is, in particular whether mental health services should be provided by the NHS or the voluntary sector. In addition, one of the features of a drop in service is that a number of services are provided at once. Arguably, it is the combination of agencies with a 'clinical' response, that is less common and a potentially important mechanism.

4.1 One stop shop

4.1.1 Analysis of VOS Dataset

The data suggesting that users attend for multiple needs does link with the mechanism of the one stop shop; that offering services to meet different types of need during one drop in is valued by users. Table 23 below shows the usage of each agency over the course of 2008-2015. The VOS clinical team, although exclusive to the drop in is not recorded as being used extensively, with only 1% of the sample having made use of the service. The most commonly used agency is TRBL, with 355 uses by 191 people (48% of the sample), and it is used on average twice by each user. Of interest is that CST is the next most used (277 uses), though has fewer people using it (60 and 15% of sample). Despite this, each person who uses CST does so five times. CST is commonly associated with improving sleep and easing physical pain. Other commonly used agencies are those that primarily focus on meeting practical needs.

The number of times users accessed agencies was also analysed. Again, this required significant manipulation across numerous databases. Results indicate that users engage with two agencies in total during their journey with VOS. It must be remembered that approximately half the sample only attend one drop in, and the data relating to service use would support this, with 57.5% of agency use occurring over just one drop in. When average numbers of agencies seen per drop in is analysed, results indicate that 66% of users see one agency per drop in, followed by 29.4% seeing two, 4.1% seeing three, and 0.5% seeing four. As such, it might be that, although VOS is a one stop shop, users attend more than once to see multiple agencies.

Table 23. Use of agencies.

Agency	Total uses	Total Number of people using service	Percentage of usage per whole sample	Average number of uses per person
VOS Clinical Team	4	3	1	1
TRBL	355	191	48	2
CST	277	60	15	5
SPVA	175	113	29	2
SSAFA	163	104	26	2
CS	136	76	19	4
Coffin Mew	100	78	20	1
Other	90	56	14	2
CAB	83	65	16	1
Poppy Factory	28	19	5	1
CDG	27	22	6	1
RNBT	19	13	3	1
Warrior Programme	11	10	3	1
The White Ensign	9	9	2	1
NHS	8	5	1	2
AA	4	3	1	1
SAMA82	2	2	1	1
RFEA	2	2	1	1
FVF	1	1	0	1
BLESMA	1	1	0	1

4.1.2 One to One Interviews

VOS as a 'one stop shop' was spoken about spontaneously by the service users. Many of the participants spoke of the importance of having this *one stop shop for everything (ID13).* Powerfully, this did not only concern the plethora of agencies, but also the clinical presence too, relating to the importance of VOS as a drop in with clinical response. In addition, themes concerned the ability of a one stop shop to meet multiple needs, even when the service user was unaware of these needs. VOS as a gateway to other services, as well as speeding up access to services by referral was also mentioned. The theme concerning 'flexibility of offering' featured as part of the description of VOS; here it is used to highlight the impact of flexibility provided by a one stop shop service. Finally, the social aspect of VOS came to the fore in this theme. While not many people attend initially to find a support network, it was experienced by virtue of the environment; a theme returned to in the section concerning perceived outcomes. Table 24 presents some example quotes.

Table 24. Example quotes for 'one stop shop' mechanism.

One stop shop	Example Quote
Drop in with clinical response	*And again, the advantage of the Maritime Club, is it's not just the agencies that are there, it's the clinical team that are there as well, so you can see a psychiatrist, you can see a psychologist, you know? (ID10).*
To meet complex needs	*How would I ever have found [name], the lady that's Criminal Justice, I didn't even know they had Criminal Justice people. How did I know she was going to be a mental health nurse and also Criminal Justice and a veteran, how would I have ever found that person? How would I have known that the Citizens Advice person would be the right person to speak to because she used to be working for the Royal British Legion and she knew inside and out veterans and their policies and procedures? How did I know that she had a relationship with the lady from SSAFA and how did I know they lady from SSAFA had a relationship with [x]? That wouldn't have happened unless it was VOS (ID39).*
Gateway to other services	*VOS was my first point of contact but since VOS I've had psychological help off Combat Stress, I've got a support network a project and I get respite at Help for Heroes (ID16).* *I go because I want to keep my name on the top of the list for Combat Stress and that lot, because it foes help if they know that you are attending, they know that you're still looking for treatment, that you still need treatment (ID19).*
Flexibility of offering	*I didn't get on with the tapping. We didn't do the tapping because all I needed to do was go and blurt out what had happened to me. And so sometimes she just said, let's have a chat. That helped me more, which was when I realised then, I said to (therapist), that's what I needed, which was CBT. And that's what I got (ID11).*
Speed of referral	*And things started to happen over that first month and then I went the second month but there was no real reason for me to go again because I was more or less touching base with people (ID39).*
Social support	*So it's also now a social gathering as well as a clinical and an opportunity to speak to the various agencies (ID10).*

The themes above provide information as to how the one stop shop nature of VOS may facilitate change. However, themes also emerged that shed a more negative light on the one stop shop as an important mechanism. Issues have already been raised as to the physical environment of VOS in the section concerning context, yet when impact of the physical environment on engagement is explored, for some service users the environment is not conducive to facilitating change. The inherent lack of privacy afforded by a busy drop in means that some service users do not feel able to engage with therapies they are directed to after registration. As one service user explained:

I began a period of counselling which was less than private because it was conducted in the corridors (ID26).

This was also felt by those who had engaged with group therapy offered at VOS by Combat Stress:

More confidential. I know the confidentiality rules state, but there's other people walking in anyway, so, you know, I know it's cost and all that and I know that, but surely there's a room around that we could use (ID1).

The attempt to meet multiple needs in one location and by one process may mean that the one stop shop nature of VOS as a mechanism hinders engagement.

Agency representatives and clinicians both spoke of mechanisms they perceived to make the context that VOS operates in effective. Perhaps unsurprisingly, agency representatives spoke primarily of the one stop shop nature of VOS, while clinicians spoke of the impact of the military environment; however, there was overlap.

There was a sense that the location of VOS allows veterans to feel more comfortable with engaging with civilian services. In particular bringing the service to the veteran when they are particularly vulnerable. This echoed the voices of service users who spoke of the importance of VOS for complex needs. The importance of social support was also highlighted as the drop in provides the opportunity for veterans to socialise with each other and *"it's a shortcut to meeting other people" (A7).* As a result, there is a third interaction where agencies are helping other service users to meet each other too. Finally, agencies value the opportunity for regular, informal, face to face contact.

One theme which was voiced a number of times was that of inter-agency referrals. Agencies said that they were more likely to refer on to other agencies because of all the agencies being there at the drop in. This means that service-users can be given more accurate information about other services that might be helpful. As such, there is a *"vital…and really helpful" (A7)* opportunity to network with other agencies. One agency attributing VOS to being a major part of the agencies success because it is "so easy and is all under one roof" (A8). The increased awareness of other agencies, allows agencies to offer accurate information about who else might be able to help them, and also means that service users can be signposted to agencies outside of VOS too, indicating that onward referral may be supported by the one stop shop set up.

Further to this, one agency emphasised that there were quicker access times to clinicians at VOS in comparison to the NHS pathway; emphasising how important it is that the drop in has a clinical response too. Again, this links with the aim of the organisation to meet complex needs. Example quotes are provided in Table 25.

Table 25. Examples of positive quotes for 'one stop shop' mechanism (service providers).

One stop shop: Positive Impact	Example Quote
Drop in with clinical response	*If the veterans have mental health needs then she will make a referral to the clinical team at VOS as it is all under one roof and is quicker to access then referring on to NHS (A8).* *It is a good place to get referrals and signpost own patients here to gain access to psychologists and Psychiatrists at VOS (A8).*

To meet complex needs	*Vulnerable people that need help and advice can't always access other routes because of their situation… we come and meet them on their own terms (A1).*
Interagency referral	*The bringing together of other charities and the space that they have here at the Maritime Club is also, is amazing… I think for some of the people who have experienced the charities before, for somebody who is new I think this is brilliant signposting, having them all here in one room is brilliant (A3).* *I've built up a lot of contacts where I think, you know, I can sort of signpost them or contact them. And I think is what is so really important, is so very important, when you meet these various people, you know, who a lot of them do need help (A7).*
Onward referral	*I offer more of a catch up appointment with existing veterans that have been referred through the hospital. My aim is to get the veterans integrated with other services (A8).*
Face to face contact	*Being able to see someone from X face-to-face can be really helpful… Some clients drop in regularly for help. I think that regular contact with us is really helpful (A3).*
Social support	*One of the guys did say to me today, he said, oh, I haven't come to see anybody, I just want to catch up with a few of the guys, and that's exactly what he's done (A4/5).* *Sometimes what's happening is, they're coming here really to talk, not always to see people…because if they come regularly, you know, they would talk (A7).* *I was arranging for one patient who is struggling to meet another of my patients who is coping really well at VOS (A8).*

However, a number of issues were raised by agency representatives and clinicians as to the registration process and waiting times; just as were raised by service users themselves. One such issue is that service providers did not feel that service users know which agencies are in attendance at VOS. Three agencies raised the same point that if the service user does not know about the agency before they arrive, then they will not know to ask for them. Interestingly, another agency has felt quite restricted by VOS to interact with service users, again questioning the nature of VOS as a drop in.

Some agencies were able to describe the process of the drop in/registration, but others struggled to do so, saying *even if somebody asked me now, having been coming for two years, how does it work, I couldn't tell you" (A4/A5).* One agency mentioned that on several occasions a service user has come over when the agency were free to talk and the agency did not get their card for 2 hours and this was the only agency they wanted to see. Another issue identified by the agencies concerns risk. One agency shared that a service user's risk was identified and *"picked up by the process slightly late".* The agency were not aware that the service user had been identified as at risk and they left the service before they were assessed by a clinician. Indeed, clinicians further indicated that they had not been given important information about the service users referred to them, highlighting the potential absence of communication during drop ins. Finally, one of the service providers hinted at the presence of preferential treatment during registration. Table 26 summarises these points.

Table 26. Examples of negative quotes for 'one stop shop' mechanism (service providers).

One stop shop: Negative	Example Quote
Unclear as to which agencies attend	*There are charities here that have been coming for years and I can tell you now if you went to the people in that waiting room they wouldn't have a clue who they are or what they do, because that front desk is not advertising them - the whole reason that person is here is to advertise themselves (A6).* *I'm their representative and they've got to get past the front desk to even find out what I do (A6).*
Waiting times	*[Service user] walked out on three occasions because he has come to see me and has been waiting hour". The agency perceived that the long wait means "they never get the help that they need (A8).*
Regulations are restrictive	*I'm not even allowed to say hello and have a chat to somebody that I know because I am a representative and they have to book in (A6).*
Non-communication between VOS team and agencies/clinicians	*Never given any information about the service users that we saw, no medical history etc. was given to us (C1).*
Preferential treatment	*It's a conflict of interest and a lot of the charities here have a conflict of interest because they overlap. Who you know and who is your friend on the front desk really can be a bit incestuous that's why as I said if the front desk don't know who I am or don't like me or they don't like my charity, then I'm not going to get anyone. (ID protected).*

4.1.3 Survey

A total of 70.7% agree or strongly agree that getting everything in one place makes it more likely they would continue to attend VOS and the majority valued VOS as a drop in service. However, a number felt that *'a list of who is here [at VOS]'* and the type of help those services provide would be helpful to have. In addition, respondents also indicated that the time they spend with the agencies they were seeking support from could be longer or more frequent.

Another respondent suggested that it would be positive *'if VOS was run more than once a month and the time with all the visitors was a bit longer'.* There was also concern that those working for agencies should have up to date information, as misinformation had been communicated to some of the users; this has a direct impact on the efficacy of VOS as a one stop shop.

The survey asks about the types of services, including agencies, that the respondents have engaged with to date. The results indicate that a vast range had been accessed, with the top five agencies as follows: VOS Clinical team (64.4%), TRBL (57.6%), Combat Stress (50.8%), SSAFA (39.0%), and SPVA (35.6%). Aside from the VOS clinical team, the same pattern is seen in the larger VOS dataset. It is interesting to note that of these five most highly used, only one is exclusive to attending the VOS drop ins (VOS Clinical team) and, as such, may indicate that users of VOS find accessing these

services to be more efficient via VOS. Respondents reported using specific therapeutic services like CST (20.3%) more than the alcohol service (only 1.7%).

When asked about the three agencies that had helped the most, three clearly emerge. These were the VOS clinical team (59.3%) and The Royal British Legion (45.8%), and Combat Stress (35.6%). Indeed, two further items of the survey ask about the skills of the therapists of VOS and also the experience of engaging with therapy. A total of 79.3% of respondents are either satisfied or very satisfied with the skills and expertise of the therapy team. In addition, 78% are either satisfied or very satisfied with their experience of engaging in therapy.

Survey respondents were also asked whether there were any agencies that would be useful but are not there at the moment (or during the last visit), 42.4% answering 'yes'. When asked further about this, responses ranged from four respondents wanting more CST (which had been cut from the service over the summer of 2015, and recently reinstated but offering fewer sessions). In addition, others wanted a local authority housing and benefits presence, and another wanted help from government agencies such as child services. This raises an important issue concerning the types of agencies present at VOS. At present, there is no involvement or attendance by social work professionals at VOS and this might be a point to take forward. In addition, many of the agencies are *veteran* specific, but users of VOS have varying needs and non-veteran agencies may need to have a presence to further support transition.

4.2 Military Environment

4.2.1 One to One Interviews

Participants spontaneously spoke of the familiarity of VOS, akin to a military environment, and the positive impact this had. This feeling of familiarity gave rise to feelings of belonging and, in turn, safety too; in part helped by the location of the VOS drop in being the RMC or 'the Home Club'. This familiar environment arguably draws people in to attend VOS. However, there is a maintenance of these feelings of trust, and also an opportunity to experience comradeship once again, and to be part of a culture with its own language, which in itself has a positive impact. Finally, there is a sense that a service delivered specifically for veterans by veterans provides a sense of shared experience. Table 27 presents example quotes.

Table 27. Examples of Positive Quotes for 'Military Environment' Mechanism.

Military environment: Positive impact	Example Quote
Sense of belonging and safety	*I knew all the routines, I knew the language, I knew what they were saying, I knew what they were all about, in other words, rank, serial number, I felt comfortable, the staff are friendly I felt at ease, because I felt comfortable, I felt at home (ID1).* *I find it's my time when I get there, I find the whole thing has toughened me over the month, I can disclose, feel safe, comfortable, people understand where I am coming from, because they've been in that situation before or will be and also I feel that I'm more relaxed, it's my time to be there. I find it beneficial (ID1).*

Location of VOS	*I suppose, because it's a maritime club, your sailor will be happy there, you know, because he remembers the times he used to go there (ID11).*
Positive interactions	*I go and meet him every month and we have a little go at each other because he was in the military police, I was in the Marines. It is fun and you've got to have a laugh. If you have a laugh a day you can get through anything (ID4).*
Shared experiences	*I think, as well, is that it helps a lot of the new guys coming in, because they're coming down there and they think they're the only one with this. And they get in there, and they see, I don't know, ten, twenty of us, who are suffering with it. And they know straight away, there's a burden taken that they're not the only one (ID10).*

These quotes complement the broad literature concerning the importance of shared experiences, language, and culture, which contribute to feelings of comradeship; known to have an impact on psychological adjustment post-service. Of particular relevance here is the added impact of therapists who have served. All these factors together seem to provide a mechanism by which change can happen because service users feel safe, understood, and accepted without judgement.

This particular element of the military environment as a mechanism resonates particularly for those who attend VOS for psychological intervention. A number of the participants spoke about feeling safe because others are experiencing the same symptoms and through this understanding, a burden is lifted and there is a sense of being able to disclose.

The interviews also revealed a negative impact that the military environment created at the drop in. These related to the sense of rank and hierarchy that is part of the culture at VOS and the perceived 'otherness this creates'. In addition, while for many, sharing experiences was seen as an important aspect of attending VOS, for others the impact of this was not so positive. One participant spoke of feeling burdened and negatively affected by those sharing their experiences, which seemed to impact his recovery. This has important implications not only for the set-up of drop ins and the physical environment afforded to service users, but also has lessons for any peer support initiative: peers can provide valuable and effective support, but they must also be supported and be in a suitable place in their recovery to be able to support. Once again, this is in line with some existing literature and should be considered by similar types of service. Another potentially negative impact was less explicit. There was a sense from a number of the interviews that the military environment may serve to maintain military identity. While this may be adaptive in the short term, given that there is no maximum length of engagement with VOS, it may mean that transition is hindered. See Table 28 for example quotes.

Table 28. Examples of Negative Quotes for 'Military Environment' Mechanism.

Military environment: Negative impact	Example Quote
Sense of 'otherness': Rank structures maintained	*I still feel when I'm spoken to by certain people that I'm spoken to in the way that, they're an upper deck and I'm a lower deck (ID26).*
Burden	*I was their listening ear, you know, they could talk to me. So it was a, kind of, support, which I thought was helping me but actually it was making me worse because I heard some horror stories, but there you go because you're all suffering from the same thing, you know, you tend to go in the main room for your coffee and your biscuits while you're waiting for your appointment and you all sit there chatting about it anyway, you know, and telling each other what's happened to you (ID11).*
Maintaining identity	*I'm privileged really, because I go to Combat Stress, I go to Help for Heroes, I go to VOS. And I, in some respects, I'm still in the services, you know, because I'm still associated with service people (ID19).*

Clinicians spoke of the importance of the military-like environment predominately in terms of how this impacts therapies; particularly the therapeutic alliance. For instance, one clinician felt that service users may see people who work in the NHS as outsiders. Since the majority of VOS clinicians have a military background, this may contribute to the therapeutic relationship through VOS. In fact, clinicians explicitly felt that the military-like environment offered by VOS provided stability in transition; much more than it hindered transition. From the agencies' perspective, VOS was considered a *safe place (A4/A5)* and there was a tangible sense that to be effective at VOS, an agency needs to be seen as credible, and as part of the *military family.*

An interesting finding within this theme was, just as many positives had been spoken about, there was also a sense that there was a further subculture within VOS. Ultimately, one that could well produce some inequity, and provide some explanation as to why waiting times may increase on occasion: Ultimately, this may impact on the efficiency of the one stop shop nature of VOS as it is currently designed. Further to this links with concerns mentioned previously that who one knows (that is one's connections at VOS) is a powerful resource, and that some agencies, as well as servicer users, are favoured over others. This is particularly important when we consider the overlap that some agencies have in terms of the services they provide. While this was not a common theme, it is an important theme to consider moving forward. Finally, agencies in particular spoke of the sense of community and comradeship experienced at VOS and its invaluable nature. See Table 29 for examples.

Table 29. Example Quotes of 'Military Environment' Mechanism (Service Providers).

Military environment	Example Quote
Positive impact on therapeutic alliance	*I think because, I think...you know this goes back to your earlier question about the relationship...is that the culture of the military is such that you're an outside, civilians are outsiders. People who work in the NHS are outsiders. And, you know, why would somebody open up to somebody, you know, whereas they know that most of us, well all of us, have experience working with veterans, and some of us have experience working with the MoD as well, and then other people have also served themselves, so they are themselves veterans. So it's like a, you know, it really helps with the relationship, just setting that scene (C2)*
Stability in transition	*Particularly with the forces, it's the adjustment. The adjustment from being in a lovely, well not lovely particularly...a stable-ish environment and then coming out and really not having a clue how to try and maintain that stability for themselves (C2).*
Enhances credibility	*I think it's also about credibility. You've got to be seen to be here from the point of view of service users from organisations to be part of the military family that is supporting the military community… If you're not at VOS you're not part of that community. I don't mean that in a negative way. That's important… because we would be forgotten about very quickly (A4/5).*
Sense of community	*That's a typical military comment, is actually also I think there's something quite sincere in that. It's as much as that it's more of a community than it is just a drop in (A4/5).*
VOS Subculture	*There is a sub culture in the VOS but you won't hear this from anyone else…Lots of people do not book in – they accidentally bump into other representatives in the bar or the restaurant because you have to book in to see people, so there is a contingency of people here who go under the wire (A6).*

4.2.2 Survey

The military environment as a mechanism offered was also explored and 69.0% felt VOS provided comradeship and familiarity. In addition, 70.7% agree or strongly agree that talking to other veterans is very supportive. In addition, 67.3% agree or strongly agree that the social communication is good for them. As such, the processes or mechanisms that may be important to how VOS works become clearer with these findings.

When the statements relating to the mechanisms thought to be present at VOS, the most valued is that VOS staff are formerly serving and there is a perception that this leads to greater understanding. Respondents may not have felt that the one stop shop nature of VOS was as important. Despite this, one pertinent theme to the military environment resonates; *'I cannot condone the separation between officers and men',* which may refer to the implicit rank structure created due to those who run VOS being high ranking retired officers, which was also raised during the interviews with service users. Table 30 below provides a summary of the statements relating to mechanisms.

Table 30. Summary of statements relating to potential mechanisms.

Statements concerning mechanisms	Mean score
Some VOS staff are ex-service too and I feel they understand	4.16
I like that it is a drop in and I can go as and when I need	3.95
Talking to other veterans is very supportive	3.93
I get everything I need in one place	3.86
VOS offers comradeship and familiarity	3.81

Note. Scored on a scale of 1-5 where 1 is strongly disagree and 5 is strongly agree. Statements in white relate to military environment. Statements in black relate to one stop shop.

4.3 Summary

The findings from the studies in WP 1 map clearly onto the two hypothesised mechanisms of VOS being a one stop shop as well as the military-like environment seemingly allowing for engagement and change. The table below summarises the key findings from each of the studies.

Table 31. Summary of Mechanism findings across studies.

Analysis of VOS Dataset	Interviews	Survey
One stop shop: There is evidence of the service responding to multiple needs, however the concept of the one stop shop is somewhat challenged by the dataset with the majority of those who engage with agencies only seeing one agency per drop in. The most commonly accessed agency is TRBL. CST is used relatively highly and is the most commonly revisited agency. A large number of agencies attend and are used during monthly drop ins. Military environment: No evidence from dataset	One stop shop: responds to multiple needs, with immediate assessment and fast-tracked intervention. Links with agencies ensures wide range of needs are met. However, it is not always clear as to which agencies are present or how to make an appointment to see them. Limited flexibility in the registration and checking in process means that waiting times can be lengthy, despite both agency and service user being free at the same time. There was also some concern that preferential treatment is given to some service users, while others did not register at all and are then able to see the agencies they require when they require. Military environment: Veteran specific service Volunteers/ex-veterans. Like minded individuals attending out of choice. Service users use the resources available at the drop in to engage in support to facilitate change. They engage because there is trust. Trust facilitates change. This is particularly true of the therapeutic alliance. However, there were indications that the military environment may also	One stop shop: 70.7% of the sample agreed that getting everything in one place made it more likely that they would continue to attend VOS. In addition, being free to come and go when necessary with no commitment was also seen positively. There is a caveat with this: Drop in nature of VOS means that follow up is not expected, but users felt this increases risk. The maintenance of contact, or lack thereof, was considered to be an issue by some. Military environment: The survey asked questions particular to the fact that VOS operates within a pseudo military environment. The majority agreed that they felt understood by VOS staff because the majority are formerly serving, that VOS provides comradeship and familiarity, that talking

	hinder transition and that there is the sense of *othering* based on rank while in service.	to other veterans is very supportive, and that social communication is good for them. Despite this, there were voices, although in the minority, that felt an implicit split between ranks at the drop ins.

Chapter Five: WP 1 Outcome Findings

This chapter presents the findings in terms of outcomes associated with using VOS. These outcomes are taken from the VOS dataset and involve an analysis of the CORE-OM, as well as perceived change as gleaned from the one to one interviews. Finally, perceived outcome and extent of change associated with VOS use was gathered from the survey. As such, this addresses the third evaluation question: What outcomes (objective and perceived) are experienced by users of VOS?

5.1 Analysis of VOS Dataset

CORE-OM data have been collected as standard from the start of VOS to autumn 2015, when it was replaced by the WEMWBS. As previously stated, the CORE-OM was completed at the registration desk upon arrival at VOS for the monthly drop in. The CORE-OM might have also been completed as part of continuing therapy sessions, but dataset provided to the research team was incomplete and therapy data are not analysed here.

Wherever possible, the CORE-OM score taken at first registration has been taken as a baseline. Where not available, the next best baseline (for instance a day later at the start of therapy) has been used as a proxy. For this reason, 'first known score' is used here, rather than 'baseline'. It is also important to note that there is no standard follow-up data collection and, so, for service users who attended just one drop in, there is no follow up measure. In addition, because VOS does not operate a standard length of intervention, as side from discrete courses of therapy, the time between baseline and last follow-up differs between each user. To note, mean length of time between first known and last known scores was 9 months.

Where follow up data could have been collected, there was a large amount of missing data. In total, 186 (28.1%) of cases had complete outcome data, which rises to 54.6% if those attending only one drop in are included. Only 9 cases of missing data were attributed to service users not attending therapy appointments. As such, all other cases of missing data are a result of lack of adherence to data management protocols, such as no use of forms, no data input from forms, no follow up recorded though individual did attend, no data recorded or input of any type for registered user, and incomplete CORE-OM. These reasons account for 40% of missing data at baseline, and 25.2% at follow-up. The percentage of missing data at both baseline and follow-up was 21.1%. These findings highlight an essential need to improve adherence to data collection protocols moving forward, but also provide caution when interpreting outcome data presented next.

In terms of first known CORE-OM scores, there is a significant difference between the first known scores for those who attended one drop in only compared to those who engaged with two or more. Table 32 indicates that those with longer engagement had higher first known CORE-OM scores indicating greater distress at first known use, though it must be noted that all first time users present within the norms for a clinical population.

Table 32. First known CORE-OM Scores for one drop in vs. more than 1 drop in.

CORE-OM	First Known: One drop in M (SD)	First Known: more than 1 drop in M (SD)
CORE-OM Clinical	16.22 (8.94)	19.31 (7.45)
CORE-OM Average	1.62 (0.89)	1.93 (0.75)
CORE-OM Total	54.93 (30.25)	64.93 (25.15)

The difference between scores for each row is significant ($p < .05$)

For those who engaged in more than one drop in. Table 33 shows the mean scores for each of the three ways the CORE-OM can be calculated. 67.0% of the population for whom there was more than one CORE-OM score showed an improvement. The difference between the first known score and last known score was significant ($p < .001$).

Table 33. Change in CORE-OM Score.

CORE-OM	First Known M (SD)	Last Known M (SD)	Difference Score M (SD)
CORE-OM Clinical	19.11 *(7.66)*	15.19 *(8.35)*	-3.92 *(8.63)**
CORE-OM Average	1.91 *(0.77)*	1.52 *(0.84)*	-0.39 *(0.86)**
CORE-OM Total	64.27 *(25.74)*	51.46 *(28.36)*	-12.81*(29.07)**

*Difference is significant ($p < .001$)

Statistical analysis was carried out to determine if difference in clinical score was significantly associated with other variables. Variables tested were length of engagement, frequency of attendance, and extent of engagement (i.e. whether involved with agencies, therapy or both). No variables were found to be significantly associated with change.

Despite the majority showing a statistically significant improvement, the last known average score is still not below the cut-off point for clinical score (10), or average score (1.19) derived from normative data (available from the CORE System User Manual). This indicates that even after involvement with VOS users remain part of a clinical population. While those who do not attend therapy sessions are contacted, those who no longer attend drop ins are not followed and adverse effects are not known. This needs to be considered moving forward. For this reason, the data were further interrogated, with reliable change and clinical change also explored. For those with a first and last known clinical CORE-OM score, 15% showed a reliable improvement, with a further 14.7% showing a clinical improvement.

Risk scores were also calculated and change between first and last known scores were explored. For 50.5% of the sample there was a reduction in risk, 26.9% of whom experienced a reduction to 0. In addition, 25.3% scored 0 at both time points, perhaps giving an indication as to the variance in types

of need of those who access VOS. For 18.7% of the sample, there was an increase in risk score, but the reasons for this are not known.

Given that there is no standard intervention received by all users of VOS, changes in severity provides a more descriptive understanding of changes associated with VOS. Of the total 191 service users, 51.8% of the sample showed some improvement in severity scores, while 19.9% showed a worsening in severity scores. It could be that this worsening is experienced by people during therapy, who have not yet come to the end of their treatment course. Severity of symptoms was also explored and Table 34 shows the change between severity for first and last known Total CORE-OM scores.

Table 34. First and Second Score Severity Groupings.

		Severity grouping for second score						
Severity Grouping for first score		Healthy	Low Level	Mild	Moderate	Moderate to Severe	Severe	Total Worsening
	Healthy	3	0	4	1	0	1	6
	Low Level	7	4	4	1	2	0	7
	Mild	4	4	12	7	1	2	10
	Moderate	7	5	17	9	5	1	6
	Moderate to severe	5	4	8	12	8	9	9
	Severe	6	1	7	3	9	18	0
	Total improving	29	14	32	15	9	0	

To summarise, although change is seen, it is not clinically significant and, furthermore, it is not clear from the current dataset what is associated with the change; that is the particular types of context and the interaction with possible mechanisms. However it would appear that the one stop shop nature of VOS is used and valued and that, in general, there is a positive trend towards improvement in mental health and wellbeing and a reduction in risk.

5.2 One to One Interviews

While the majority of hopes concerned practical issues, perceived outcomes also concerned psychological, physical, and social outcomes. Many of the veterans interviewed spoke about perceived improvements to their mental health and wellbeing broadly. As one participant said, VOS had *'given me a better quality of life' (ID 10).* Another spoke of having their life back once again, giving this individual a greater sense of wellbeing and with less anger. Others spoke of more specific improvements such as greater relaxation or fewer feelings of paranoia.

In terms of physical outcomes, improvements in exercise and sleep were reported, as well as the improvement of specific physical symptoms. Interestingly, the majority of these physical changes were associated with CST. Social outcomes, such as supportive friendships, and less isolation were reported. Importantly, improvements in intimate relationship, and in relationships with children were also mentioned. Such outcomes were not considered by service users as hopes and expectations or types of need at the beginning of their journeys with VOS. Practical outcomes concerned precisely those mentioned as hopes and expectations. There was also a sense that VOS plays an important role in the journey towards improvement, with the outcomes not yet achieved,

but tangible. Finally, an interesting finding concerned a reclaiming of veteran identity for one participant, and can be seen to represent the importance of continuity of identity post-service. Table 35 summarises the main themes.

Table 35. Perceived Outcomes.

Perceived Outcomes: Service users	Example Quote
Overall Wellbeing	*It's given me my life back. I've got a life. I've got a reason to live. I've got things to do. I'm fairly happy most of the time. Before I went to VOS I was a prisoner in my own home. I didn't like me. I didn't think anyone else liked me. I was totally paranoid, not at all happy, very angry, prone to outbursts. I wasn't looking after myself (ID16).*
Psychological	*My mental wellbeing has improved (ID1).* *I'm now a nicer person to know. I'm not Mr Angry (ID13).*
Physical	*[CST] does work. It helps. I don't know what it does, but it just takes you to a level, and it just relaxes you enough. But it does make me, when I do have it – it's like last night. I did fall asleep quite quick (ID2).*
Social	*My relationships, we were separated, we're now back together and my relationships with other people in my family which were strained maybe because of…the whole thing about people taking sides, whereas that's disappeared now (ID26).*
Practical	*I had a solicitor, I had Legal Aid, I had benefits, my application for PIP, which is the disability type stuff, had gone in (ID39).*
A journey of improvement	*When I leave there after having treatment, I do feel different. And then coming up to the next one, it is a cycle, but I don't feel anything like I did back in June. I know that there's a light, my tunnel's just long (ID22).*
Reclaiming identity	*They've enabled me to reclaim my service because I truly did not believe I could even call myself a veteran when I first entered the building [] I wear my medals with pride (ID26).*

When hopes and expectations are considered alongside perceived outcomes it is clear that participants had few hopes and expectations in comparison to the outcomes they feel VOS helped them to achieve. In addition, the types of outcomes are different; while many participants indicated practical issues they hoped would be resolved, on engagement with VOS they had also experienced improvements to their mental health and wellbeing and support networks that appeared to be unanticipated.

Unfortunately, there were also incidences of hopes and expectations not being met and this is something to consider further:

I got to VOS and I think I'll get something out of this today, I do get things out of it, but I don't get the things I want out of it'.

Service providers perceived outcomes to include psychological and physical change, as well as social change. Perhaps to be expected, agency representatives spoke more about social change, while clinicians spoke more of physical and psychological change. Agency representatives felt there were social benefits to the service, while others felt that VOS impacts on confidence, which has further implications for employment, for example. One clinician offering complementary therapies highlighted that often helping service users with sleep was important for them to be able to function. In terms of specific outcomes, such as reductions in depression, anxiety, traumatic symptoms etc., no details were given. This may be attributable to the clinicians who accepted to be interviewed as part of this piece of research. See Table 36 for a summary.

Table 36. Perceived outcomes (service providers).

Perceived Outcomes: Service providers	Example Quote
Overall Wellbeing	*Aim to reach the outcome that they wish for at the beginning, 'cause that…as I said, that's the important part… I haven't known any of the people that I see to reach the end of therapy and not to have reached at least a large way in to the way they wanted to be" (C3).* *If VOS wasn't here it would leave a lot of people who need monthly care or assistance in a much more vulnerable state (A3).*
Psychological	*Being able to sort of leave the past really in the past, so they can actually lead a more happy (sic) and more comfortable and more healthy life (C2).*
Physical	*You can't cure through complementary therapies but you can improve quality of life (C3).*
Social	*It (VOS) encourages people to come along and make contact. I think that's the important thing (A7).* *They realise that they're not the only person in the situation (A4/A5).*

5.3 Survey

Given that the majority of veterans had a clear reason for attending VOS, it is interesting to note that 73.1% felt that their expectations of VOS had been met, while 26.9% felt their expectations had not been. For these family members, 5 of 7 felt their needs had been met. When we consider whether the expectations of service users were met in relation to current or past user status, we find that for current users, 84% have had expectations met compared to 55% of past users. Furthermore, of those who sought practical and psychological support, 71.7% felt their expectations had been met, followed closely by 73.9% of those who sought social support.

When asked to explain exactly whether their need was met and in what way, the responses varied. Analysis of the open-ended responses indicated that positive experiences and met expectations appeared to be associated with psychological support. Respondents spoke of seeing therapists and this being *'brilliant'* or *'really helpful'*. In particular, support from referrals to Combat Stress was

highlighted, along with CST. Powerfully, there were mentions of the support being *'life-changing'* and that it *'showed me that I was not suffering on my own'.*

Mixed perceptions mainly concerned practical support. For instance, one individual said that *'I got help moving to my bungalow. But last month had very incorrect advice that cost me a lot of money'.* In addition, when agencies were not available at a particular drop in, this had a negative impact, for instance *'Sometimes agencies are not available. Usually just passed on to maybe an internet site',* which again emphasises the importance of informing attendees.

Some themes were more negative, mainly focusing on the quality of practical support with agencies not being able to help *'not even to guide filling in a form'*. One respondent highlighted an important gap in service provision when intimating needing support in dealing with social services.

Despite the majority of respondents' expectations being met, in terms of satisfaction with support, the findings were mixed with some respondents being very satisfied, while others were not satisfied (see Table 37).

Table 37. Satisfaction with support for veterans and family members.

	Type of support		
Rating (%)	Practical	Psychological	Social
Very satisfied	32.2	47.5	27.1
Satisfied	23.8	15.3	23.7
Neutral	18.6	11.5	16.9
Unsatisfied	3.4	5.1	1.7
Very unsatisfied	11.9	11.9	9.6
Not applicable	*10.2*	*10.2*	*22.0*

When the survey results are analysed by current user vs. past user, interesting patterns emerge, as demonstrated in Table 38. The most marked difference in pattern is for satisfaction with psychological support with 27.8% of past users being very unsatisfied with support vs. 5.7% of current users. What is interesting here is that practical support seems to involve a shorter relationship, and so the experiences of current and past users may be more comparable than for

psychological or social support, for instance. That is, one reason as to why people may stop attending VOS for practical reasons may be due to satisfaction with outcome, whereas those seeking psychological or social support may stop attending due to dissatisfaction.

Table 38. Satisfaction with support for veterans and family members by current or past user.

Type of support						
Rating %	Practical		Psychological		Social	
Type of User	Current	Past	Current	Past	Current	Past
Very satisfied	44.1	21.1	57.1	44.4	38.8	26.7
Satisfied	23.5	31.2	22.9	5.6	38.8	13.3
Neutral	17.6	26.3	8.6	16.7	12.9	40
Unsatisfied	2.9	5.3	5.7	5.6	3.2	0
Very unsatisfied	11.8	15.8	5.7	27.8	6.5	20

The research team also explored perceived effectiveness of VOS through the survey. Three items asked respondents about the way they felt prior to going to VOS for the first time, how they feel now, and the extent to which they feel VOS has contributed to their feelings now. The following graph shows affect (feelings) before first attendance at VOS and after first attendance.

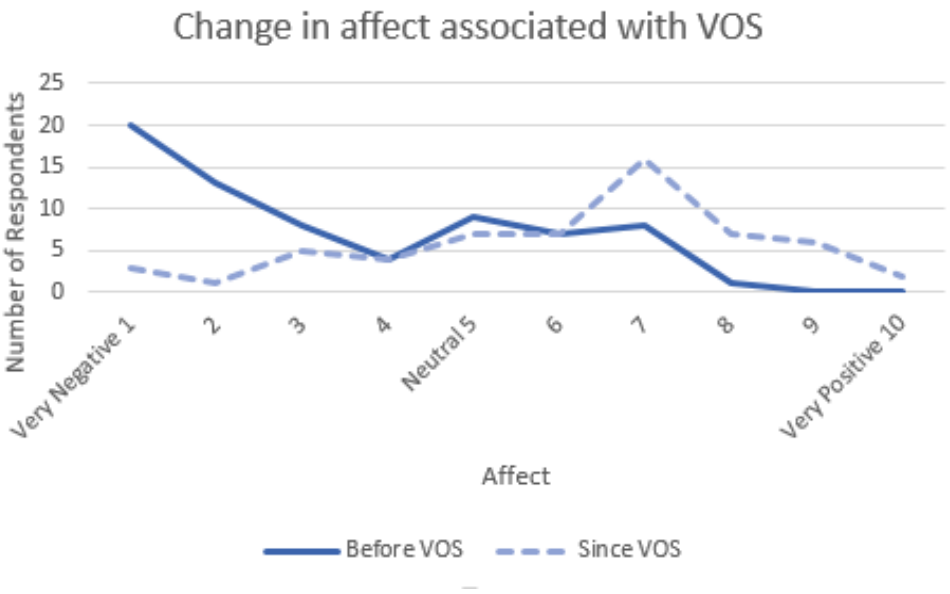


Figure 2. Reported Changes Associated with VOS.

When asked the extent to which the respondents believed VOS to have contributed to this change, once again, results are mixed. The item was marked along a 10 point scale in which 1 was *not at all*, 5 was *somewhat*, 10 was *entirely*. When scores are combined, those scoring 1 – 3 totalled 22.2% indicating they did not feel that VOS has contributed to this change. Whereas those answering 8-10 totalled 31.5 indicating that these respondents felt that VOS has contributed to how they are now. Though 53.7% fell into the middle range of this question, when subjected to a paired samples t-test, there appears to be a significant difference between the median scores before and after involvement with VOS.

When probed further to find the ways in which VOS may have contributed to change, we found the following (Table 39). The questions asked in the survey are based on quotes from veterans who took part in WP 1.

Table 39. Extent of agreement with statements concerning change.

	Response on scale (%)						
Statements of change	0	1	2	3	4	5	*Mean*
My mental health has improved	6.9	13.8	19.0	19.0	31.0	10.3	3.84
I am able to relax more and feel calmer	5.2	17.2	22.4	29.3	19.0	6.9	3.60

I can cope with problems better when they arise	8.6	8.6	24.1	37.9	15.5	5.2	3.59
My relationships with friends and family have improved	12.1	17.2	17.2	19.0	25.9	8.6	3.55
I am more confident	8.6	13.8	22.4	29.3	22.4	3.4	3.53
Family and friends have noticed a positive change in me	13.8	15.5	20.7	15.5	24.1	10.3	3.52
My social support network has grown	8.6	24.1	20.7	20.7	19.0	6.9	3.38
My physical health has improved	7.7	30.8	10.3	25.6	23.1	2.6	3.36

It would seem that some respondents felt that VOS has had an impact on their mental health, with 41.3% indicating they feel that VOS has definitely or most definitely impacted. The findings are less strong for physical health (25.7%), which also has one of the highest percentages for 'not at all' (30.8%). This could be because it was not relevant for some respondents. In terms of coping, 20.7% felt VOS has definitely or most definitely impacted. Some felt more confident, with 25.8% each for those who feel definitely and most definitely more confident. The extent to which family and friends have seen a change is also quite high in the top two categories (34.5%), second highest after changes to mental health. Results are mixed for the respondents' ability to relax and feel calmer and the impact on social support networks. These findings seem to tie in with the satisfaction scores in terms of psychological support and social support, with greater change being reported for psychological support.

There was also opportunity for respondents to indicate what else they feel has changed as a result of attending VOS. Many of these open ended comments mapped onto the construct of improvement in mental health, but also physical health, and practical outcomes. Others felt that VOS performed a preventative or grounding role describing the service as an '*anchor'* and that *'VOS provides a preventative experience as well as dealing with the problems once they have occurred'.* Table 40 provides a summary.

Table 40. Summary of qualitative responses concerning perceived outcomes.

Overall wellbeing	
'reinvent myself. Feeling a lot more confident, able to return to work and also help with mental and physical wellbeing'.	
Mental Health	
'I felt I had support and could talk to someone face to face when things got bad'.	VOS helps to '*maintain a level of mental health and given access to help when I need it'.*
Physical Health	
'I was medically reassessed and my disability upgraded'.	
Practical Outcomes	
'I was able to start a degree course'.	

Unfortunately, there were also instances of negative change where incorrect advice had impacted to one respondent's detriment. In addition, others strongly indicated that any positive changes were not to do with VOS. For instance:

'They have not contributed to my positive state of mind because they have not been in touch or followed up my phone calls and I have had to sort a lot of problems out for myself, which has helped me but not VOS directly that have helped me'.

This links with concerns around maintained contact, which were once again raised:

'I would like contact with VOS to see how I am and whether I still need their services'. In addition, the issue of risk was raised with VOS only being available once a month and *'follow up contact tends to slip and/or be very slow even when situations are extremely urgent'.* This is an extremely important finding where risk is concerned.

5.4 Summary

Findings concerning outcomes were presented in this chapter, and included both objective as well as perceived outcomes and change from the studies in WP 1. The table below provides a summary of these findings.

Table 42. Summary of Outcome findings across studies.

Analysis of VOS Dataset	Interviews	Survey
67% of the sample showed a statistically significant improvement for the CORE-OM. However, 15.4% of the sample showed a reliable improvement, while 15.9% of the sample showed a clinically significant improvement. For 68.7% of the sample, there was no reliable or clinical change. In terms of severity ratings: 51.8% improved of the sample showed an improvement in severity scores; that is a lessening of symptoms. However, for 19.9% of the sample worsened. In terms of risk, for 50.5% of the sample, there was a reduction in risk scores, with 26.9% of the sample reducing their risk score to 0. However, for 18.7%, risk scores increased.	Preservation and protection of mental health & wellbeing; operationalised by improvements in physical symptoms, psychological health, and meeting practical and social needs. While most attend with hopes relating to practical problems, many report improvements in wellbeing, but also psychological functioning, improved sleep, and increased social connectedness. There may be a reduction in risk for many; however there are a few for whom symptoms have not been identified or managed.	31.5% of the sample felt that VOS had contributed to perceived change. 73.1% felt expectations had been met, particularly where psychological support was concerned. In terms of perceived outcomes, the most commonly felt outcome was improvement in mental health, with improvements in physical health the lowest. Practical support was mixed, with some negative experiences and also the impact was felt when agencies did not attend drop ins as expected. Satisfaction with the service is mixed and when expectations are not met, this is associated with a decrease in satisfaction In terms of risk, there were concerns that risk was inherent in the VOS model as service users are not followed up.

Chapter Six: WP 2 Findings

The purpose of WP 2 was to follow users of VOS from first visit to 6 months post visit. This would provide a prospective view of context, mechanism, and outcome tested retrospectively in WP 1. Of particular relevance here is that by following users' journeys, greater insight might be gained as to mechanisms. WP 2 addresses the first three evaluation questions. The prospective design also allowed the opportunity for use of social and health care data to be collected over 6 months. This formed the basis of the health economic evaluation and addresses the final evaluation questions: What does the service cost to deliver, in terms of both actual costs and cost utility?

6.1 Case Studies

Six people took part as Case Studies. Participants ranged in age from 40 – 62 years of age. Five were male and one was female. Five had served in the Royal Navy (with one of these WRNS), and one had served in the Army. Years in service ranged from 4 years to 26 years. Reasons for leaving also varied with some having come to the end of their service time with others being medically discharged. Overall, these individuals seemed to represent similar participant demographics to those who took part in the WP 1 interviews and survey and, more broadly, with VOS users as a whole as per the VOS dataset.

Since the purpose of this element of the research is to track pathways through VOS, the findings are presented as a series of case studies, with context, mechanisms, and outcomes presented together for each individual. Demographics are not presented individually for each individual in order to protect anonymity.

6.1.1 Case Study A

A completed only the baseline interview.

A first visited VOS as his Combat Stress practitioner had scheduled a meeting to take place at the same time as a VOS drop in. The reason for engagement with Combat Stress was due to a diagnosis and subsequent treatment of PTSD. Prior to meeting with his Combat Stress practitioner, the participant visited the VOS website and found out more about the service. He planned to engage with TRBL as he required support to complete some paperwork. Prior to visiting VOS, he did not know what to expect nor did he have any hopes or expectations. His initial thoughts about the service were that it seemed intimidating to visit for the first time and, if he had not visited the website, he would have thought that it was just a place to socialise and have a hot drink. He felt that there was no explanation of the process or waiting times, which he found confusing and very slow. This was despite having arrived as soon as the drop in meeting started. He felt that the one stop shop nature of VOS was very valuable; however, he only had a need to see Combat Stress who he could meet with outside of VOS. As such, he stopped attending VOS and dropped out of the study after this first interview.

Table 43 Summary of CMOs for Case Study A.

Context	Mechanism	Outcome
There was no clear need expressed by the service user. Instead, reason for attendance was to attend a meeting with health professional from Combat Stress. Health professional was pathway, but this was not as the result of a referral. Length of engagement was one drop in only. No further involvement was needed due to needs being met by another veteran service. VOS was described as intimidating and processes were confusing and slow.	One stop shop: Service user could see the merits and value of a one stop shop, but did not have a need to access multiple agencies or therapies. Military environment: No evidence from case study.	There was no perceived changed associated with VOS for this service user.

6.1.2 Case Study B

Baseline: B visited VOS for the first time on the recommendation of his Combat Stress counsellor. He required support with employment, discharge, and disability. In particular, he needed support with a forthcoming tribunal. B reported that ease of access (by a bus stop) and also the provision of teas and coffees were certainly facilitators to this first attendance. Despite having specific hopes and expectations, B found the checking in process complex, as he did not know who he needed to see, and waiting times were an issue. He felt that having a list of agencies presented would have helped him at this point. He also needed to see the agencies more frequently than once a month.

3 and 6 months: B took part in interviews at 3 months and 6 months; however, he had not attended VOS since his first visit. He reported no desire to go to VOS to socialise and, since it was not always clear which agencies would attend each month, this was a considerable barrier. Although B had positive experiences of attending VOS and positive interactions and support from agencies, there was a perception that agencies attend to 'drum up' (participant's phrase) paid business. In addition, it was felt that the solicitor fees are too high after the initial free consultation at VOS. B felt that there is a need for a key worker assigned to all new users of VOS to support and facilitate their journey.

Table 44. Summary of CMOs for Case Study B.

Context	Mechanism	Outcome
Needs were practical and physical. Health professional was pathway. Length of engagement was one drop in only. No further involvement was needed as needs were met by actions taken as a result of attending one drop in. VOS was described as complex, despite having a clear sense of need.	One stop shop: It was not always clear which agencies would attend at each monthly drop in and this become a barrier for attendance. Given the complexity of the drop in, B felt the allocation of a key worker would make the drop in more efficient and effective. Also, a perception that agencies attend in order to elicit further, paid, business. Military environment: No evidence from case study.	Needs were met as a result of attendance.

6.1.3 Case Study C

Baseline: C visited VOS for the first time to meet with his Help for Heroes care worker. He had support and encouragement to attend from his wife, however he did indicate that it was hard to find time to attend as he is employed. In attending VOS he hoped to be able to socialise and to understand other people's experiences of service life to put his 'into perspective' [participant's phrase]. Despite this, he found the experience quite intense and it was not possible to socialise in the way he had expected. In fact, he found the registration process so intense that he almost left without registering. He persevered as he had hoped to see Combat Stress to address feelings of depression. He did not know who or what to ask for at reception, which made the experience worse. He engaged with CST and found this a very positive experience. Even after his first visit he was unsure of the unique offering of VOS as he could have gone to Combat Stress directly, as well as seeking CST. This is contradictory to the concept that VOS being a one stop shop is a powerful mechanism. In terms of recommendations, he felt that new users should have a guide or at least someone to welcome new users. He also suggested that the day/time of the drop in could change as those who are employed can find it difficult to attend.

3 and 6 months: C had tried to attend VOS again, but had struggled to do so due to his work commitments. It remained that he valued his treatment from the CST team.

Table 45. Summary of CMOs for Case Study C.

Context	Mechanism	Outcome
There was no clear need expressed by the service user. Instead, reason for attendance was to attend a meeting with health professional from Combat Stress. Health professional was pathway, but this was not as the result of a referral. Length of engagement was one drop in only. No further involvement was needed due to needs being met by another veteran service. VOS was described as intimidating and processes were confusing and slow.	One stop shop: Service user could see the merits and value of a one stop shop, but did not have a need to access multiple agencies or therapies. Military environment: No evidence from case study.	There was no perceived changed associated with VOS for this service user.

6.1.4 Case Study D

Baseline: D had heard about VOS from two sources; the VOS community itself as well as from SAMA82. He attended for an appointment with his Combat Stress nurse, who had scheduled the appointment to take place at VOS. He had agreed to attend because VOS is local to him; however, D did lose a day's pay to attend VOS. He also expressed feelings of being a fraud and feeling too proud to attend. Other needs were financial and legal. In terms of the VOS experience, D found registration to be long winded but a 'necessary evil' (participant's phrase) and he planned to take full advantage of the agencies and support available. VOS as a one stop shop, as such, was evident. D also expressed the benefits of being 'amongst veterans'; the military environment an important aspect of VOS. Experiences of engaging with the therapist at VOS was not entirely positive. Initial recommendations concerned the importance of a case worker for all new users.

3 months: D had not used VOS again as he had no need to engage in other services. All benefits had been as a result of his first attendance in terms of support for gaining further employment, which further increased his sense of self-worth. These were unexpected psychological outcomes. These were attributed to the one stop shop nature of VOS but also the military environment and importance of having someone to talk with. Ultimately, D saw VOS as a safety net for veterans and one that addresses many needs. He was also making enquiries into volunteering for VOS as a peer.

6 months: Between the 3 months and 6 months interviews, D had engaged with VOS again on two more occasions for two different needs. The only experience with an agency that was not entirely positive concerned legal advice. The interaction with the service itself was efficient, but the cost of legal action was prohibitive. In conclusion, D felt that VOS was valuable as a network, which made him feel that he was 'no longer alone'. He was volunteering as a peer at the time of the last interview.

Table 46. Summary of CMOs for Case Study D.

Context	Mechanism	Outcome
There was no clear need expressed by the service user. Instead, reason for attendance was to attend a meeting with health professional from Combat Stress. The service user engaged with VOS via the VOS community and also via another service charity. While VOS was local, barriers to engagement were the loss of a day's pay to attend. Other barriers concerned feelings of pride that made attendance difficult. Length of engagement: Engaged with 3 drop ins over the course of 6 months. The registration process was described as long winded and as a necessary evil.	One stop shop: Service user could see the merits and value of a one stop shop, and intended to make best use, primarily to support employment goals. However, the allocation of a guide or key worker to help navigate was seen to be important. Needs were met due to signposting that occurred from one drop in only. Military environment: The service user indicated that it was important to be among veterans.	Gains in employment were attributed to engagement with VOS. This in turn increased feelings of esteem. D also established a support network via attendance at VOS.

6.1.5 Case Study E

Baseline: E presented with a practical need. He wished to see SSAFA for support in moving into his new accommodation and also to receive white goods. When asked why he did not contact SSAFA directly, he indicated that he knew he would see someone face to face at a VOS drop in and that his needs would be met more quickly. Help for Heroes had recommended VOS and he had the support of his family and friends in attending. He found VOS intimidating and felt there was a distinct lack of privacy. E felt that registration was relatively smooth, but he attributed this to be because he was clear as to who he wanted to see. At this stage, E felt that being able to see agencies face to face was a key benefit of VOS along with the opportunities this brings to be signposted between agencies; the essence of the one stop shop.

3 months: E was interviewed at 3 months and 6 months, but had not attended VOS again since all his needs had been met during his first attendance. He felt strongly about becoming a volunteer to give back to VOS. He mentioned once again the lack of privacy afforded to users during the registration process. Despite this, the one stop shop nature of VOS was mentioned as an important mechanism along with the importance that this is provided within a military environment, which provides continuity and empathy.

6 months: E reported being 'desperate' (participant's phrase) to get back to VOS in order to support others as a volunteer, but had not been able to due to work commitments.

Table 47. Summary of CMOs for Case Study E.

Context	Mechanism	Outcome
E presented to VOS with a practical need. The service user engaged with VOS via the wider veteran community. E had the support of family members to attend. Length of engagement: Engaged with 1 drop in and needs were met. Wished to attend more frequently, but could not due to work commitments. VOS was described as intimidating, and a lack of privacy was expressed a number of times. Registration was smooth; F felt this was because he knew who he wanted to see.	One stop shop: E spoke of the benefit of attending VOS in order to speed up process with agency needed. Timely face to face contact was facilitated by VOS. E also spoke of being signposted to other agencies while at VOS and valued this. However, the allocation of a guide or key worker to help navigate was seen to be important. Needs were met due to signposting that occurred from one drop in only. Military environment: Provides continuity and empathy.	Practical needs were met.

6.1.6 Case Study F

Baseline: F reported having multiple needs that were both psychological and physical. She had been referred by the alcohol dependency unit to attend VOS, she wished to have support to change her medication. Other hopes were to also receive support to stop alcohol use and to improve health more generally. A significant facilitator for F was that the services at VOS were free to access. After her first visit, F felt immediately positive because she felt listened to. She had experienced positive interactions with other agencies, such as SSAFA, and she had spoken with a member of the clinical team. She felt that counselling would be a possibility for her due to these positive experiences. The important mechanism here was that the one stop shop nature of VOS provided access to multiple types of support.

3 months: Unavailable.

6 months: A six months, F was still involved with VOS continuing with therapy. Even if there was no other need to attend, F felt strongly that she would continue to attend just 'to be part of it', thus meeting a social need. What is important to note is that VOS had given F a sense of hope and had facilitated a change process to take place that was ongoing at the 6 month interview.

Table 48. Summary of CMOs for Case Study F.

Context	Mechanism	Outcome
F presented to VOS with complex needs. The service user engaged with VOS via referral from a health professional. Length of engagement: Engaged up to 6 and continued beyond duration of study. No comment was made regarding a description of VOS.	One stop shop: F spoke of multiple needs and these being addressed by the one stop shop nature of VOS. F felt listened to. Military environment: no comment.	Initial needs relating to medication had been met. F had engaged in counselling and was gaining in terms of social connectedness. VOS had also provided hope.

6.1.7 Summary of findings from case studies

Following participants for up to six months of their VOS journey provided useful insight into the 'real time' experiences of those who use VOS. Not only are reasons for attending captured at the time of first use, but perceived changes are also captured in a timely fashion. The case studies also provided an opportunity to further explore the differences between those who attend for practical reasons and those who attend for psychological reasons, and associated patterns in terms of length of engagement in particular. Importantly, even those who attended for practical reasons seemed to find the drop in quite busy, which was not a theme captured for one time users in WP 1 due to difficulty in recruiting those who had only attended once.

Table 49. Summary of CMOs from case studies.

Context	Mechanism	Outcome
VOS as a "charitable organisation". A service for veterans run by veterans. It is a non-NHS drop in service with clinical response, though only one case study participant made use of the clinical aspect of VOS. It is a relatively unique offering, particularly in geographical location, however the time of the drop in was a barrier for some due to work commitments. Referral is via health professionals, but also via self-referral. Many of the service users and providers interviewed commented on health professional referral. A number of participants attended to meet with health care professionals from other organisations.	One stop shop: Overall, the one stop shop nature of VOS was seen positively, with agencies and therapists present as and when needed. While some agencies could be approached directly, being able to make contact face-to face was seen as a significant aspect of this mechanism. Military environment: This mechanism did not seem to be as significant to the participants who took part in the case studies.	For all case study participants, needs were met and these ranged from changes in medication, successful job applications, and general improvements in wellbeing. There were unexpected outcomes too, with a number wishing to become peer supporters for VOS.

Types of needs are predominantly practical and engagement is short term on the whole. Where needs are more complex, engagement is longer. It should be noted that some of the case study participants were already having psychological needs met by other organisations. A number of case studies described the service as intimidating and, as with interviews, some found the set up difficult to navigate and overwhelming.		

6.2 Economic Evaluation

The purpose of the economic evaluation was to determine costs associated with delivery of the service as well as costs associated with change from a societal perspective. Taking a societal perspective allows for changes in service use as a result of engaging with VOS to be considered ensuring that a more holistic view of cost is considered. To achieve this, the CSRI was administered to gather information on service use, while the EQ-5D was used to produce QALYS. (See Chapter 2 for further details concerning data collection and analysis).

6.2.1 Quality Adjusted Life Years

Four of the five monitored participants expressed higher or equivalent QALY values at the end of the 6 months than they expressed at either the drop in or the baseline recording; that is, they felt their quality of life had improved as captured by EQ 5D scores. On average, clients saw a 6.4% increase from scores given at the drop in, and 5.5% from baseline (as increases had already been experienced at the drop in). Most of the positive changes occurred in the dimensions of anxiety/depression and pain/discomfort, and would map to psychological and physical outcomes.

These findings, however, mask the variety of experiences and the fluctuations of responses across the monitored 6 month period. No clear trajectory or trend was present across all participants. Two of the five participants had high initial and final QALY values and only experienced minor fluctuations in the latter half of the observations. Others had low initial values and experienced some positive change in the first few months that were then overshadowed in the final month when some dimensions increased to the severest recordable levels. Some experienced their highest QALY values mid-way through the monitoring, with final values returning close to the initial value.

A similar trend is evident with the EQ VAS scores. Overall, the average increased from 0.702 to 0.747, with four of the five participants reporting an increase by the end of the 6 months. The greatest increases came between the drop in and the baseline recording, which highlights the importance of recording outcomes at the end of drop in attendance, but also the impact the drop in has almost immediately. Month-by-month, the EQ VAS scores broadly follow the direction of the QALY values, with the exception of the participant with the lowest EQ VAS score.

Table 50. EQ VAS score, average of all participants by month.

	Drop in	Baseline	Month 2	Month 3	Month 4	Month 5	Month 6
Mean average EQ VAS score	0.702	0.708	0.760	0.727	0.709	0.752	0.747
Standard Deviation	0.336	0.404	0.258	0.308	0.437	0.423	0.322

The change in QALYs is calculated from the baseline interview (as opposed to the initial drop in) to the final 6 month interview to allow comparison with the CSRI costs, which were first collected at baseline. However, it is worth noting that if the average change was taken from the initial drop in

value, then the change in QALYs would be close to 15% higher on average. In other words, there was already some positive change in the QALY between the initial drop in and baseline interview that is missed. This is further supported by self-reported improvements in the EQ VAS. Again, this was not the case for all participants; two experienced no change, two experienced positive change, and one experienced a negative change.

The sustainability of an additional gain in the index value drastically determines the size of the change in the QALY. For example, if it was assumed that the change in the QALY only lasted as long as the observation period then the change would be as low as 0.015 of a QALY. Whereas, if the final health state was expected to be sustained for the lifetime of the participant (using a discount rate of 3.5%) then the change is as high as 0.695 of a QALY. The choice of the duration of a health state resulting in an additional gain in QALY will therefore impact the cost-utility analysis; the longer the sustained duration of the health state, the higher the QALY, and therefore the lower the cost to achieve one QALY.

Table 51. Average change in QALY.

Based on:	Observation period	1 year	10 years	Lifetime
Drop in to 6 month interview	0.022	0.045	0.386	0.798
Baseline to 6 month interview	0.015	0.039	0.336	0.695

6.2.2 Cost-Utility Analysis

The cost-utility analysis takes a societal perspective including savings to NHS and related services. Therefore, this includes the direct costs of providing VOS and the indirect costs in terms of increase/decrease in use of other services as a result of attending VOS.

The opportunity cost of providing VOS drop in sessions is calculated for 2014-15 at £106,701 in total, or £8,891.75 each. This includes[2]:

- Variable costs incurred by VOS to provide drop ins and other therapies: £104,292
- Agency representatives' time: £20,567
- Volunteer time: £15,631
- Attendees' travel and treatment time: £23,358
- Equivalent venue hire: £9,709

It is assumed that the price paid, or the market cost, represents the opportunity cost. In other words, the resources used that are no longer available for use in their next best alternative. Direct

[2] However, £66,856 has been removed from the total as this may not be specifically related to the provision of the drop in, i.e. individual therapy, VOS alcohol advice and craniosacral therapy.

costs are included but productivity costs and intangibles are not counted. Values are presented in 2015/16 prices, using the UK GDP deflator. Costs over a one-year period (financial year 2014-2015) have been used. Only the variable costs of providing the drop in sessions have been included. This does not include a share of the fixed costs, overheads or management for the operation of VOS, only those that directly contribute to the provision of the drop in sessions. The provision of the telephone support line or marketing activities have not been included.

It is assumed that there were 12 drop in sessions a year with 505 attendees. It is conservatively assumed that each agency representative, volunteer and attendee remained for the full four hours of the drop in session. This may result in an over-estimate of costs but somewhat reflects additional travel time incurred.

It is assumed that one representative from each of the agencies attended every drop in. The opportunity cost of these 23 representatives is calculated by using the average equivalent hourly salary and on-costs of an employee in an equivalent role. The majority of these have been sourced from the *Unit Costs of Health and Social Care 2014* (Personal Social Services Research Unit), with the exception of those providing welfare, employment or legal support, which has been based on the cost of provision of advice from the Citizens Advice Bureau.

The opportunity cost of volunteer time has been calculated using the national minimum wage (2014, assuming aged over 21). However, there is the possibility that this severely under-estimates the opportunity cost of voluntary time provided by professionals and clinicians. This requires further investigation.

The monetary value of attendees' time has been calculated using the methodology published by the Centre for Health Economics (Van den Berg, Gafni, & Portrait, 2013). It is assumed that there is no waiting time and the full four hours is used by a combination of travel and treatment time, which perhaps results in a more conservative estimate. Given that the value placed on treatment and travel time are very close, the larger of the two has been used. Equivalent venue hire is based on the cost of hiring the same spaces for half-a-day.[3]

The cost per client attending one drop-in is £211.29. If it is assumed that each client being monitored for 6 months attended each of the drop in sessions, then the cost of direct provision of the service is £1,267.73 per client.

Costs are measured from a societal perspective, calculated at 2015/16 prices and relevant unit costs should represent the long-run marginal opportunity cost. A discount rate has not been used on the costs given the short duration of the study. The number of service contacts and duration of appointments are multiplied by the corresponding unit cost. This calculates the full cost of the care package for each individual at the baseline, and across the defined observation period set by the follow-up interviews.

[3]Reception Area, Compass Area, Nelson Lounge, Ballroom, Brocks Bar, Board Room, Compass Balcony and Basement Bar.

Table 52 Costs of non-VOS services used by the client within the last 3 months, collected by CSRI.

Case Study	Baseline	3 month follow-up	6 month follow-up
B	£525	£192	£260
C	£356	£439	£826
D	£11,356	£156	£1,116
E	£233	£78	£0
F	£4,126	£1,426	£5,892
Mean average	**£3,319**	**£458**	**£1,619**
Standard deviation	**£4,779**	**£558**	**£2,429**

Almost all participants exhibit an immediate reduction in service use (cost) within the first 3 months, which then increases in the final 3 months. However, this often remains below the baseline cost. The 3 months prior to the baseline tended to include more inpatient hospital services, with those months after the baseline including a greater proportion of community-based services and community care.

As there were no alternative or comparison sites to measure changes in service use against, an assumption is made that the services used in the 3 months prior to the baseline interview would have continued. Therefore, the change in service use is compared against this assumption. Four of the five participants presented a cost saving, ranging from £388 to £21,444. However, one participant presented an increase in cost of £553. The high outlier baseline costs presented by Case Study D was excluded from the cost-utility calculations and replaced with the average savings of the remaining four participants (£342).

There were no significant changes in participants' accommodation, employment, medication or contacts with the criminal justice system.

Combining these elements, the costs of service and the utility measure, allows for a cost-utility measure of effectiveness to be calculated: the cost per QALY. This allows the efficacy of the VOS to be measured and compared to other outreach services with the potential for use of the incremental cost-effectiveness ratio. In addition to the comparison to similar services and interventions, VOS can also be compared to certain cost per QALY thresholds, such as those used by the National Institute

for Health and Care Excellence (NICE) to judge which treatments are likely to be recommended for use in the NHS.

Amongst the five participants were some extremes: high savings to society from reduced service use, and some increase in service use. Similarly, changes in QALY values were positive, negative and neutral.

Table 53. Cost per QALY, by participant.

	Duration of health state			
Case Study	Observation period	1 year	10 years	Lifetime
B	£122,558	£50,366	£5,851	£2,833
C	£25,369	£9,800	£1,139	£551
D	(£ 76,769)	(£36,386)	(£4,227)	(£2,046)
E	N/A	N/A	N/A	N/A
F	£53,422	£21,515	£2,500	£1,210

Table 54. Cost per QALY (Average).

	Duration of health state			
	Observation period	1 year	10 years	Lifetime
Based on VOS costs only	£85,560	£32,434	£3,768	£1,824
Based on societal costs (VOS and other service use)	£62,487	£23,687	£2,7572	£1,332

If the change in QALYs was sustained for one year, then the cost per QALY would broadly meet the NICE thresholds. However, this is based on the average change in QALY of only five participants and on the other service costs of only four participants. The relatively small cohort, and the disparate outcomes reported even within this small cohort, reduces the confidence in the generalisability of these findings to the VOS. Given the known variance in length and frequency of engagement, it is vital that attempts are made to capture associated costs in future evaluations so that more accurate conclusions can be drawn.

The CSRI unearths a net reduction in the resource use of other services. This reduces the societal cost of the VOS drop in sessions below the direct costs of provision. The VOS drop in service appears to elicit a minor positive net increase in QALYs. However, the duration of this improved health state is unknown. If the improved health state only lasts for the observation period then the cost per QALY remains prohibitively high. However, if the duration of the health state was more than one year then, even after discounting, it would broadly meet the NICE thresholds. However, the relatively small cohort and the disparate outcomes reported, reduces the confidence in the generalisability of the findings.

6.2.3 Summary of Findings from Economic Evaluation

- The economic evaluation was carried out in two parts. The first was an analysis of the costs of delivering a VOS drop in. The cost of attending one drop in is £211.29 per user. The cost of providing one drop in is in total £8,891.75
- In terms of the evaluation of the case studies, VOS provides a service that is probably cost-effective within the NICE threshold range of £20,000 - £30,000 if the change in QALY is sustained for more than one year.

Chapter Seven: Discussion

7.1 Summary of Findings

This realist evaluation sought to understand VOS from both a theoretical perspective as well as from how this theory translates into practice. In addition, it was important to understand who might benefit from VOS (and which particular elements of VOS), how, and at what cost.

The original evaluation hypothesis was as follows:

VOS works for those who require formal psychological or physical health intervention as well as practical support, and those who seek peer support. Since it is a 'one stop shop', with initial assessments on registration, service users do not need to know what support they need when engaging with VOS for the first time. In addition, time between assessment and service engagement is fast, happening either on the day or, in the case of therapy, the week after. An additional mechanism is that the service is provided by veterans for veterans, and this military-like environment facilitates change through trust. Those who engage with VOS will experience enhanced mental health and wellbeing, increase in perceived social support, and a reduction in risk.

While the findings of this evaluation support aspects of this hypothesis, two distinct users of VOS engage for different needs, demonstrate different lengths of service use, and experience change as a result of engaging with one mechanism. In essence, different elements or pathways through VOS benefit different types of users.

7.1.1 Context

Findings related to context revealed that users attend VOS for singular practical needs or more complex needs that might be practical, emotional, and/or psychological in nature. Few attend to meet social needs alone. Self-referral is common, and a number attend to meet case workers/health professionals from other organisations, who also attend VOS as it is a convenient place to meet. The analysis of the VOS data set shed light on pathways through VOS. It appears that service users are split into one of two groups; those who attend once only and those who have a more prolonged relationship with VOS. These two different pathways seemed to map onto the type of need. Those with practical needs tend to go to one drop in once only, while those with more complex needs attend for longer.

The VOS infrastructure seemed to be the area of most negative perceptions, and these themes arose from interviews with service users, agencies, clinicians, survey participants, as well as from service users followed through the first 6 months of their VOS experience. Concerns were raised time and again about the appropriateness of the checking in process and waiting area, particularly for those with mental health needs. These themes came to the fore even with the changes that had been brought in to simplify the checking in process and waiting times, though not to the same extent. Linked with this, service users and agencies expressed frustration about waiting times, which directly contradicts assumptions made in the programme theory. Of value to this evaluation was also the disquiet at limiting or removing interventions that were not NICE approved or evidence based, as well as ceasing to use the CORE-OM, which left some feeling that risk was no longer monitored.

In addition, findings from the interviews, surveys, and case studies challenged the notion that an individual did not need to identify need prior to attending the drop in. However, comparison to other services (including NHS services) is favourable. This is in part due to a variety of VOS offerings, and access to complementary therapies.

7.1.2 Mechanisms

Interviews with service users, agencies, and clinicians helped to explore themes relating to the programme theory in greater detail. Of particular salience here were the findings surrounding mechanisms; military environment and one stop shop. For those seeking more practical support, the one stop shop nature of VOS meant that their needs could be met very quickly; even on the same day for some. Of course, there were also social needs and the comradeship felt at VOS provided this support. Of importance here, however, is that it seems service users do know who they need to see; contrary to the evaluation hypothesis. Comments were raised as to the perceived control over procedures at VOS, as well as its limited similarity to other drop ins, which offer flexible networking. Arguably, the one stop shop nature of VOS works as a mechanism because it is believed by service users that support can be found when needed and that need can be met efficiently.

However, the busyness of the drop in created by its one stop shop nature did not suit those presenting with psychological needs. Despite this, having a familiar, trustworthy environment was vital, particularly for those engaging in psychological therapies. The very idea that the therapist could understand and would not judge was powerful, and ensured that the context of the service (non-NHS, self-referral, shorter waiting time) worked to achieve outcomes. In essence, the sense of trust created at VOS ensures a feeling that it is safe to talk about experiences in a therapeutic context. A cautionary note is that some users perceived a rank system to be in place, which created a sense of 'othering'.

7.1.3 Outcomes

Overall, needs, whether they be psychological, physical, social, practical, or indeed singular or multiple, seemed to be met. Findings from the retrospective analysis of CORE-OM data suggested that VOS has a positive impact on service users; however, CORE-OM scores do not seem to show clinically significant change. Caution was needed with interpreting these data as a number of variables were created in order to facilitate data analysis, but there were issues surrounding the quality of data collection.

Findings from the survey would also support these themes. By and large, users are satisfied and feel their needs have been met. In addition, many surveyed felt that the improvements to their lives were attributable to the care received from VOS. The survey powerfully highlighted issues around risk and the need to follow up service users in some way. According to the interviews, there were instances were needs had not been met, and these seemed to be associated with agencies and other organisations not within VOS' responsibility or remit. This, once again, highlights an area that requires further evaluation.

Findings from the economic evaluation indicate that VOS provides a service that was probably cost-effective within the usual National Institute for Health and Clinical Excellence (NICE) threshold range of £20,000–£30,000, if the change in quality-adjusted life years (QALY) was sustained for more than 1 year. However, there is considerable variability in the costs and outcomes of different participants.

7.1.4 Comparison to Programme Theory

When findings are compared to the original hypothesis as well as the CMOs derived from the programme theory, interactions between context and mechanism are noticeable. What works for those who present with psychological or physical need may not work for those who present with practical or social need. What suits the former is a quieter drop in, with formal psychological assessment, risk monitoring, and where onward referral is efficient. The power of the military environment comes to the fore here. What suits the latter is a busier drop in, with no psychological assessment, and where agencies and service users can network. Of importance to this group is the efficiency of a 'one stop shop'. What is important for both is greater privacy afforded to them while at the drop in and, arguably, a more frequent drop in. What is true is that VOS seems to provide a trusted, familiar environment and, given this could be seen as an important mechanism, it is worth enhancing the service. Where costs were analysed, it would appear that VOS provides value for money if outcomes are sustained for one year.

The table below provides a summary of the original CMOs from the programme theory alongside the findings from the evaluation, which are presented in italics.

Table 55. Summary of comparison of CMOs from Service Theory with CMOs derived from research programme.

FINDINGS		
Context	**Mechanism**	**Outcome**
Organisational context: VOS as a "charitable organisation". A service for veterans run by voluntary veterans. Drop in service with clinical response, which encourages self-referral, *often at times of crisis. Some evidence to suggest that it is not a 'drop in' in the truest sense of the word as there is limited flexibility in who sees which agencies/therapists, and when.* Responds to multiple and varied types of need, *but this seems to make understanding pathways through VOS as well as outcomes difficult to ascertain. It also seems to have an impact on how appropriate the environment is for those with complex needs. Issues of lack of privacy are a concern for all.* Length and frequency of engagement *varies across service users with those engaged with VOS for practical needs engaged for less time. Those engaged with VOS for complex needs, including psychological need, engage for longer. This is also borne out by the findings from the*	One stop shop: responds to multiple needs, with immediate assessment and fast-tracked intervention. Links with agencies ensures wide range of needs are met. *This mechanism seems most powerful for those who attend for practical or social needs, but seems a barrier for those with more complex psychological needs.* Military environment: Veteran specific service Volunteers/ex-veterans Like minded individuals attending out of choice Service users use the resources available at the drop in to engage in support to facilitate change. They engage because there is trust. Trust facilitates change. *This mechanism seems most powerful for those who attend for psychological or physical needs.*	Preservation and protection of mental health & wellbeing. *Findings are not conclusive in terms of the impact of VOS on mental health.* *Findings from the VOS dataset indicate some change in severity and a reduction in clinical and total scores, but the VOS population remain a clinical population.* *Qualitative findings suggest service users experience positive change. While many benefit from the social aspect of VOS, it is not the reason the majority attend.* *Complexity of needs and pathways may reduce clarity of outcomes.* Reduced risk. *Risk is not adequately monitored for those who only attend once, or who stop attending. While risk*

CORE-OM data suggesting that those with more severe scores attend for longer periods of time. Non-NHS setting, *which does not adhere to a set of intervention protocols. As such, it is difficult to ascertain end points of treatment, for instance. It also means that for those engaging in therapies, there are a number of different choices. This enhances user experience but makes evaluation difficult.*		*scores decrease according to CORE-OM findings, there are some incidences of no change or increased risk.*

7.2 Strengths, Limitations, and Future Directions

The strength of the realist approach is that evaluations move beyond determining whether a service works or not, in favour of understanding what aspects of the service are engaged with to create change. From the evaluation we have a better understanding as to the two quite distinct types of service users who may engage with a drop in, and the way drop ins can be optimised to provide the opportunity for change. The findings from the evaluation have implications for service provision in the voluntary sector. Clearly, services must conform to best practice standards, however this requires constant monitoring to a level that may be unfeasible; yet remains essential if services aim to cater for complex needs, including mental health needs. Alongside this are issues created by an informal drop in; by its very nature it is difficult to provide discrete interventions. This is not necessarily an issue for those who attend for practical support, though whether or not needs have been met would be useful data to collect, but it is an issue for those who present with mental health needs. In these more complex cases, issues around not only adherence to treatment, but also of governance come to the fore.

An issue that runs alongside the variability in the individual pathways of service use associated with VOS is that of evaluation. The call for services such as VOS to be evaluated in terms of effectiveness is problematic. Such flexibility of service provision valued so much by service users does mean that treatment protocols are hard to establish and define. While this evaluation has gone some way to identify different types of service use, the magnitude of data collection and monitoring for the purposes of evaluation may be difficult to achieve within the voluntary sector.

Limitations arise predominantly in the area of outcomes. Data analysed from the existing data set indicated that there was no clinical change as measured by the CORE-OM associated with VOS. However, it was not clear from the dataset those who had completed a course of therapy, or the extent to which they had adhered to their treatment plan. In addition, for those seeking practical support, needs might have been met after the single drop in attended. Since these individuals were not followed up, change could not be established. In short, this evaluation could not determine outcomes with accuracy, and this impacts on the conclusions drawn. With greater understanding of pathways through VOS and with improved data collection practices, questions concerning engagement with VOS and the factors associated with greater change will be easier to ascertain moving forward. What will remain is a difficulty in determining end points in a service of this type where there is no set intervention period and service users can attend for as long as they wish. Defining use, whether practical, psychological, or social is also important so that appropriate outcome measures are utilised.

Finally, there is a point of caution in terms of the advantages of a service by veterans for veterans. It has been argued that services for veterans that sit outside the NHS may be accessed more frequently as issues of stigma are reduced. While those who attend VOS spoke of the importance of feeling understood, even longer term users spoke of initial feelings of pride and stigma becoming a potential barrier for engagement. From the current evaluation, the numbers of those who have not engaged with VOS due to these barriers is not known. Once engaged with the service, the importance of the military environment is clear and services such as VOS compare favourably with other services as a result. However, some service users also spoke of issues around perceived rank structures and, implicitly, of services such as VOS substituting for life in service.

7.3 Comparison with Existing Literature

The current evaluation is one of few to explore drop in services for veterans and associated impact. Consequently, there are no direct comparisons to be made with existing literature. However, the findings presented here contribute to the existing knowledge base. Of most salience is the notion that barriers to seeking support must be considered in the context of the drop in. This links to the recent work of Stevelink et al. (2017) and the notion that while perceived stigma can present a barrier to support seeking, a greater barrier is not recognising need. VOS service users reported feelings of stigma associated with attending a drop in for the first time. Where the drop in format could be advantageous is in ensuring that those who seek help do not need to specify the type of support needed on attendance. Another important aspect here is that veterans sometimes attend VOS at the point of crisis, which overcomes any felt stigma. This echoes the work of Murphy et al. (2014) and also raises an important issue concerning the availability of VOS, which is limited to once monthly drop ins.

Linked with this is the power of the military-like environment in overcoming barriers and increasing the likelihood that additional support for mental health needs may be sought due to feelings of trust and understanding. Unfortunately, we do not have estimates from the VOS dataset as to the types of needs presented and addressed, and so comparisons with the current literature in terms of prevalence of support needs is unknown. Importantly, findings from the survey suggest that early service leavers make up a small percentage in VOS users, which aligns with the current literature (e.g. Buckman et al., 2012). In addition, those who left the service some years ago seem to be main users of VOS, which aligns with the work Murphy (2016), who determined that time between leaving the armed forces and help seeking is around 12 years.

When compared with recommendations from previous research, VOS, as an example of voluntary sector drop in service, fares well and provides a strong framework for replication. Where recommendations are not fully met, it may be argued that these objectives may be difficult to achieve by services operating in the voluntary sector. Primarily this relates to continuity of service provision, for instance in the case of the alcohol service and group work (see Table 56). In addition, links with statutory services appeared less strong. An important balance will need to be found between meeting aspects of best practice while maintaining the essential nature of a drop in delivered in the voluntary sector.

Table 56. Dent et al.'s (2010) 8 priority recommendations compared with the VOS Service Theory, and VOS Service Testing.

Priority	VOS Offering: Programme Theory	VOS Offering: Programme Testing
Mental health services for veterans should provide both assessment and treatment. Where highly specialised treatment (e.g. alcohol detox) cannot be provided, priority given to veterans should be invoked to ensure no further wait.	VOS provides assessment and treatment, along with a specialised alcohol service. Referrals take place when necessary.	It would appear that this is indeed offered by VOS, although there is a current absence in terms of perceived availability of the alcohol service. Referrals take place both to and from VOS.
Services should be staffed by people with experience of working with veterans and knowledge of armed forces' culture. Desirable to have the choice of being seen by a veteran.	VOS is well known for being staffed by formerly serving personnel, or those with a connection, from management team through to clinicians. N.B. Current clinical lead is not formerly serving.	'Military environment' seems powerful, particularly for those who attend with psychological need. However, there were some issues around separation by rank, which needs to be reflected upon.
Services must have strong links at strategic level with other statutory and voluntary agencies, and Forces' charities.	There is evidence that there are strong links to other voluntary agencies and Forces' Charites. Links with statutory services is unknown, although there is some tentative evidence to suggest joint working with GPs.	Links appear strong with other veterans' charities. However, the links with statutory organisations seems less strong. There seems limited awareness of VOS for health professionals in civilian settings.
Groups for veterans are highly regarded by veterans for comradeship and solidarity. All service should consider group work.	Group work is offered currently.	Service users perceived that group work was no longer offered at VOS. There was evidence that these had been well received and valued.

Mental Health Services should routinely access service records of veterans so as to gain the full picture of the client's history.	VOS do not access service records.	VOS do not access service records.
A common minimum dataset should be established so that clear comparisons can be made across services. Financial support for services should be dependent on effective systems being in place.	Use of CORE-OM and VETRA data systems, but extent of use may vary.	CORE-OM data collection indicated much missing data. WEMWBS now used, with CORE-OM still used for those in therapy. Data collection protocols need to be reviewed. Data for cost analysis should be considered.
Routine pre-and post-treatment outcome data should be collected for all clients seen. Should be standard practice across services and a basic expectation of funders and commissioners.	Originally, CORE-OM completed at each drop in. From summer 2015 WEMWBS collected at each drop in and CORE-OM for those engaged in therapy.	As above.
Mental health services should accept self-referrals.	Nature of drop in with clinical response achieves this.	Many of those who attend VOS do so as self-referral. Powerful findings indicate that some present at times of crisis.

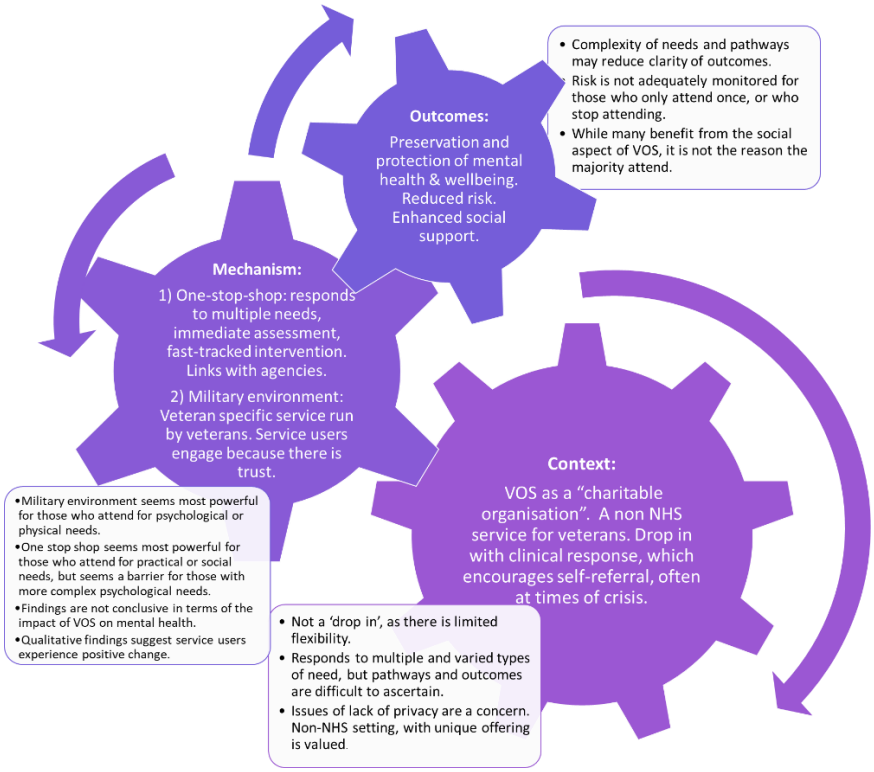
Chapter Eight: Conclusions and Recommendations

8.1 Conclusions

While generally supportive of the programme theory hypothesis, findings suggest that one size does not fit all; what works for those who present with psychological or physical need may not work for those who present with practical or social need. What might suit the former is a quieter drop in, with formal psychological assessment, risk monitoring, and where onward referral is efficient. The power of the military-like environment comes to the fore here as a mechanism. What suits the latter is a busier drop in, with no psychological assessment, and where agencies and service users can network. Of importance to this group is the efficiency of a 'one stop shop'. What is important for both is greater privacy afforded to them while at the drop in and, arguably, a more frequent drop in.

What is true is that the type of service VOS represents seems to provide a trusted, familiar environment that meets a range of different needs. Despite this, there are areas that require consideration. Recommendations are made here, and are intended to promote aspects of VOS that were found to be well received, as well as to highlight areas that require attention by drop in services in general now and in the future.

The figure below presents a pictorial representation of the findings.



Summary of findings

8.2 Recommendations

1. Risk and Crisis Management
Adverse events (i.e. unexpected, unintended and preventable harm, resulting from action or lack of action) are difficult to monitor in the context of drop in services. However, it is vital that drop in services of this nature monitor risk through the use of outcomes measures, as well as attempt to monitor other adverse events, particularly in those who disengage with the service. If disengagement from a drop in service is not monitored, it is not known if service users attend only once because their needs have been met or not. By allowing for follow up, all service users can be followed up, even by light touch means. In addition, there are also implications for out of hours provision, and the opening hours of services like VOS. This needs to be considered moving forward.

2. Ensure the infrastructure supports the needs of the service users
The environment must be suitable for the needs of the service users. The current evaluation highlights potential issues for a drop in providing practical, psychological, and social support. While the venue of this particular drop in proves extremely accessible for those who attend, the space inside is perhaps more of a barrier. Comments concerning the need for privacy and the 'busyness' of the drop ins must be considered by drop in services generally to ensure that the environment and processes pose no negative impact for service users.

3. Identification of pathways of service use:
VOS represents a complex service catering for multiple needs in a relatively informal drop in format. There is little to identify discrete episodes of use and it is often difficult to determine pathways of service use, and when a natural end point has been reached. For instance, service users may attend drop ins and, after a while, engage in therapy. While this user-led approach is extremely powerful, it presents challenges for monitoring and evaluating outcomes and, more vitally, adherence to treatment and risk assessment.

4. Recognise the value of non NHS service delivery
One of the most powerful themes arising from the evaluation is that non-NHS drop ins are VOS represents a drop in that is informal and is not required to adhere to NHS delivery. However, changes have occurred during the course of this evaluation which have arguably identified a tension within the drop in to either conform to interventions that would be provided within an NHS setting, or to maintain the unique mix of therapies on offer; some of which would be considered complementary. It is recommended here that these types of services occupy a unique position and, while they can and should conform to best practice, do have the freedom to provide complementary and alternative therapies.

5. Data management and ongoing evaluation
It is vital that drop in services develop and adhere to data management protocols, and there must be an explicit commitment to collect and record data. It could also be argued that there should be timely analysis and regular audit. There should training for the measures used. Other forms of data must also be considered, such as satisfaction forms, and these are to be implemented. It is also suggested here that economic evaluation be built into evaluations of these types of services moving forward. Critical here is determining accurate baselines and end points, which is a challenge for all drop in services.

6. Facilitating transition

Given the nature of drop in services, engagement is not time limited. Aside from discrete courses of therapy, service users can be involved socially or for signposting for as long as they wish to be. Evidence from this evaluation suggests that some may even be involved up to 6 years. It is important for drop in services to monitor length of engagement, reason for engagement, and ongoing outcomes. It might be that drop ins continue to provide a much needed social space long after welfare or mental health needs have been met. This type of use has implications for ongoing evaluation as well as cost-effectiveness, arguably deflating the findings concerning improvement or cost. However, there are also some that may engage for a long time and not improve, or may not maintain functioning if they no longer attend. This must also be considered moving forward if drop ins serve to aid transition.

7. Limitations of military environment

Linked with the point on transition above is that there may be some limitations with the military-like environment of a veteran service. Certainly it presents an important mechanism for services such as VOS; however, if these types of services are to aid transition to civilian status and discourage dependency, limitations must be considered. In addition, recognition of inherent rank structure must be recognised by veteran run services. For instance, a number of service users spoke of the importance of civilian agencies attending drop ins, not only those with a military connection.

8. Improve links with statutory organisations

An inherent potential issue in voluntary settings is the extent to which links are developed and maintained with statutory organisations. In order to improve service outcomes, drop in services must review these links and consider the position they occupy in terms of sharing data with other health professionals involved in their service users' care.

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Appendices

Summary of findings from analysis of VOS dataset

Table 57 Summary of CMOs from VOS database.

Context	Mechanism	Outcome
In total, 663 service users were involved in this analysis and demographics of users were similar to users of other veteran specific services. Numbers of new service users each year has steadily increased from 2008 to 2015 indicating good uptake. Most common pathways are not clear and could be 'self-referral'. Responds to multiple and varied types of need through registration process. This process monitors risk, facilitates triage, and helps service users to identify types of needs. Types of need appear to be practical with agency use the most common type of use, particularly for those who only attend one drop in, followed by users who seek support from both agencies and therapists. Only 63 users seek the support of therapists alone. Length of engagement varies with half the sample attending one drop in only, while the other half engaged	One stop shop: There is evidence of the service responding to multiple needs, however the concept of the one stop shop is somewhat challenged by the dataset with the majority of those who engage with agencies only seeing one agency per drop in. The most commonly accessed agency is TRBL. CST is used relatively highly and is the most commonly revisited agency. A large number of agencies attend and are used during monthly drop ins. Military environment: No evidence from dataset.	67% of the sample showed a statistically significant improvement for the CORE-OM. However, 15.4% of the sample showed a reliable improvement, while 15.9% of the sample showed a clinically significant improvement. For 68.7% of the sample, there was no reliable or clinical change. In terms of severity ratings: 51.8% improved of the sample showed an improvement in severity scores; that is a lessening of symptoms. However, for 19.9% of the sample worsened. In terms of risk, for 50.5% of the sample, there was a reduction in risk scores, with 26.9% of the sample reducing their risk score to 0. However, for 18.7%, risk scores increased.

from between 1 month and 69 months. The average seems to be 7 months. Frequency of attendance on average seems to be monthly. CORE-OM scores are lower for those who attend one drop in only compared with those who attend more than one drop in. No direct evidence of comparison with other services.		

Summary of findings from interviews with service users and providers

Table 58. Summary of CMOs from interviews with service users and providers.

Context	Mechanism	Outcome
VOS as a "charitable organisation". A service for veterans run by veterans. It is a non-NHS drop in service with clinical response, though the description of VOS as a 'drop in service' was somewhat contested. It is a relatively unique offering, particularly in geographical location, however the time of the drop in was a barrier for some due to work commitments. Referral is via health professionals, but also via self-referral. Many of the service users and providers interviewed commented on health professional referral. The service was seen to respond to multiple and varied types of need through registration process. This process was seen to monitor risk, facilitates triage, and helps some service users to identify types of needs. However, some service users find the set up difficult to navigate and overwhelming. Types of needs are practical, physical, psychological, and social, but most present with practical needs on first attendance.	One stop shop: responds to multiple needs, with immediate assessment and fast-tracked intervention. Links with agencies ensures wide range of needs are met. However, it is not always clear as to which agencies are present or how to make an appointment to see them. Limited flexibility in the registration and checking in process means that waiting times can be lengthy, despite both agency and service user being free at the same time. There was also some concern that preferential treatment is given to some service users, while others did not register at all and are then able to see the agencies they require when they require. Military environment: Veteran specific service Volunteers/ex-veterans. Like minded individuals attending out of choice. Service users use the resources available at the drop in to engage in support to facilitate change. They engage because there is trust. Trust facilitates change. This is particularly true of the therapeutic alliance. However, there were indications that the military environment may also hinder transition and that there is the sense of *othering* based on rank while in service.	Preservation and protection of mental health & wellbeing; operationalised by improvements in physical symptoms, psychological health, and meeting practical and social needs. While most attend with hopes relating to practical problems, many report improvements in wellbeing, but also psychological functioning, improved sleep, and increased social connectedness. There may be a reduction in risk for many; however there are a few for whom symptoms have not been identified or managed.

There is no minimum or maximum length of engagement, and service users in particular value this, but there is a risk of hindering transition. Favourable comparison with other services, with shorter waiting times for psychological intervention was borne out through the interviews.		

Summary of findings from survey study

Table 59. Summary of CMOs from Survey Study.

Context	Mechanism	Outcome
VOS as a "charitable organisation". A service for veterans run by veterans. The demographics mirrored the VOS dataset and, thus, samples in comparative research. Family member users of VOS were included in the sample. Length of engagement: For this sample, the most common length of engagement was up to a year, but the survey sample did comprise those who had longer engagement than the average for VOS users. Frequency of engagement: The majority of the sample attend monthly drop ins. There is a tentative pattern for more frequent engagement at the beginning of use, which decreases over time. Reasons for use: Psychological supports was most common, perhaps related to the fact that the sample consisted of those who have attended VOS for longer. Practical support seems to be linked to a shorter length of engagement. The variety of agencies and therapies offered was perceived positively, with the mix between conventional and complementary therapies valued. There was some disquiet that VOS did not communicate adequately with services in the statutory and voluntary sectors.	One stop shop: 70.7% of the sample agreed that getting everything in one place made it more likely that they would continue to attend VOS. In addition, being free to come and go when necessary with no commitment was also seen positively. There is a caveat with this: Drop in nature of VOS means that follow up is not expected, but users felt this increases risk. The maintenance of contact, or lack thereof, was considered to be an issue by some. Military environment: The survey asked questions particular to the fact that VOS operates within a pseudo military environment. The majority agreed that they felt understood by VOS staff because the majority are formerly serving, that VOS provides comradeship and familiarity, that talking to other veterans is very supportive, and that social communication is good for them. Despite this, there were voices, although in the minority, that felt an implicit split between ranks at the drop ins.	31.5% of the sample felt that VOS had contributed to perceived change. 73.1% felt expectations had been met, particularly where psychological support was concerned. In terms of perceived outcomes, the most commonly felt outcome was improvement in mental health, with improvements in physical health the lowest. Practical support was mixed, with some negative experiences and also the impact was felt when agencies did not attend drop ins as expected. Satisfaction with the service is mixed and when expectations are not met, this is associated with a decrease in satisfaction In terms of risk, there were concerns that risk was inherent in the VOS model as service users are not followed up.

The majority of users felt that the VOS staff care and try to support the service users, and 60.3% felt that treatment they receive will make them feel better. However, only 38% felt that group therapy had been a positive experience. Overall the sample was satisfied with the infrastructure of VOS in terms of the check in process and completion of outcomes measures. However, it must be noted that the sample for the survey study seemed to be longer term users. The lack of privacy within RMC was an issue, along with anxiety generally affecting attendance. The time of the drop in was also difficult as it clashed with work commitments and led some to question whether the set up really could be labelled a 'drop-in'. In general, the service was seen to compare favourably with NHS services.		