WALKING WITH THE WOUNDED
Supporting Those Who Served

An Evaluation of Walking With The Wounded programmes

Final Report

Rebecca Dunn | Dr Laura Goodwin | Dr Samantha Brooks | Professor Neil Greenberg

January 2019

KING'S College LONDON
KCMHR
ADMMH

CONTENTS

EXECUTIVE SUMMARY 3

- Background 3
- Key findings 3
- Recommendations 4

INTRODUCTION 5

- Background and context 5
- Third Sector Support 5
- Need for research evaluation 8
- Evaluation objectives 8

METHODS 9

- Design 9
- Participants 9
- Procedure - Impact Evaluation 10
- Procedure - Process Evaluation 11

FINDINGS 12

- Head Start impact evaluation 12
- Qualitative process evaluation 13

DISCUSSION 18

- Strengths & Limitations 20
- Summary & Recommendations 21

CONCLUSION 22

REFERENCES 23

EXECUTIVE SUMMARY

Background

Transition out of the military presents service leavers with numerous opportunities and challenges. Whilst most personnel manage to navigate transition successfully, a minority cope less well. Military personnel are unquestionably more resilient than the public believe, but equally they are human and taking time to adjust to civilian life should be considered a normal response. Those who struggle to adjust in the longer-term are often unable to come to terms with their new identity and find themselves in a new world in which they do not fit. These individuals may require additional support to truly resettle in civilian life, through third sector services for example.

The third sector has grown exponentially over the last 20 years and attempts to support and collaborate with government organisations to fulfil society's duty as set out in the Armed Forces Covenant. Walking With The Wounded is one such charity established in 2010 to raise funds for the re-education and re-training of wounded, injured, sick and socially vulnerable ex-service men and women. There is currently little UK based evidence on the appropriateness and effectiveness of the services offer charities to support ex-service personnel into civilian reintegration and engagement. Walking With The Wounded have commissioned King's College London to undertake an evaluation of the programmes that support their clients, in order to examine the effectiveness of their programmes which help veterans successfully engage with civilian society. A quantitative service evaluation was conducted for Head Start and qualitative process evaluation was conducted for Head Start, First Steps and Home Straight.

Key findings

This study assessed the effectiveness of Head Start in respect of improving functionality and mental health, through the use of quantitative data and used qualitative interview data to provide an insight into the impact of all three programmes on the beneficiaries that used them.

The overall evaluation findings for the three programmes were positive. Head Start was found to lead to a sustained improvement in work and social functionality which is likely to be particularly valuable in terms of beneficiary's ability to gain or remain in sustainable employment.

Clinically, Head Start beneficiaries experienced improvement in both anxiety and depression scores by the end of therapy; however the improvement in depressive symptoms were not sustained at follow up even though beneficiaries still reported significant and meaningful improvements in work and social function. Those engaged in First Steps found the educational programme/course funding useful, but commonly that they did not make good use of the gains in their post-course employment, despite the respect veterans had for the rigorous assessment process to establish genuine need. Home Straight beneficiaries considered the Employment Advisors as invaluable, reportedly increasing their confidence, self-esteem and overall individualised work readiness, rather than just focusing on job applications. Across all three programmes there was limited awareness that WWTW had funded the beneficiaries' care or support which may impact on successful beneficiaries encouraging other veterans to approach WWTW for help.

https://walkingwiththewounded.org.uk/Home/Programmes/17
https://firststeps.wwtw.org.uk/

Recommendations

The research findings suggest that the following should be considered by Walking With The Wounded:

1. **Head Start:**

- Increasing the depth of initial assessment to better identify the presenting problem (e.g. depression or complex PTSD), with the view to review appropriateness of treatment and/or therapeutic alliance after a few funded sessions, as well as the potential for offering top-up treatment.

- There may be benefit in providing better follow-up contact for beneficiaries after the formal end of therapy to crystallise the impact of therapy and assess for any further needs as well as garnering feedback on perceived satisfaction with therapists. Follow up contact may well increase their sense of appreciation of the charity and their own sense of self-worth. It may also help mitigate any the impact of any negative life experiences experienced after positive treatment experiences.

2. **First Steps:** Increase the involvement/engagement between the charity and the veterans to promote the use of the skills/knowledge gained in order to generate related positive employment outcomes.

3. **Home Straight:** Although outside the control of the charity, it appears that it would be beneficial if local authorities and homeless residences could work together to promote sustainable progression of independence.

4. Increased use of a holistic approaches to care, utilising other WWTW and non-WWTW programmes to increase the likelihood of positive outcomes. The complexity of veterans means that problems rarely occur in isolation.

5. For ongoing monitoring of effectiveness (and potentially to do so on a larger scale), increased scope and consistency of routinely collected data would be required and would be beneficial, particularly with employment as the focus (the primary focus of WWTW).

INTRODUCTION

Background and context

It is widely reported, but often misunderstood, that most personnel leave the AF and smoothly re-enter civilian life (1). The Forces in Mind Trust (2) estimate the cost of poor transition to the UK economy to be approximately £105 million, in 2017 rising to £110 million a year by 2020.

Given the magnitude of the impact poor transition and the continued outflow of personnel into civilian life having a detailed understanding the challenges associated with leaving service is all the more important now. Some of the transitional challenges personnel face include employment, finding housing, establishing a new social network, social and cultural differences between military and civilian environments, and possibly common mental health issues as a cause or consequence of other challenges. A minority of service leavers also come into contact with the criminal justice system. Although the scope of difficulties experienced by service leaves is wide, much of the media, political and indeed research interest in service leavers revolves around post-traumatic stress disorder (PTSD) (3-5) with many charities, interventions, and publicity focusing on this phenomenon, while everyday transition issues remain under-researched and under-supported.

The recent conflicts in Iraq (2003-2011) and Afghanistan (2001 to 2014) have led to military service becoming more visible across society, leading to a surge in the media profile of the UK's Armed Forces. Additionally, advances in healthcare science have led to an increase in the number of wounded, injured and sick personnel becoming part of society once they leave the forces.

Evidence has shown that, just as is found in civilian society, a minority of veterans who might benefit from formal support actually receive it. This is in part due to delayed help-seeking and stigma (6), and in part due to mental health problems not becoming problematic until personnel have left service (7). As such it is likely that it will be many years yet before we see the real impact of the more recent conflicts. The need for additional support will be ongoing for as long as the AF and its veterans exist and is likely to increase with the restructuring of the UKAF, and with more personnel surviving traumatic physical and mental injuries.

Third Sector Support

Medical support provided by the AF ends when service personnel leave with primary responsibility for healthcare assumed by the National Health Service (NHS). During the military-civilian transition process in particular, third sector organisations can sometimes assist in providing support for personnel where the NHS may struggle (e.g. specialist treatment or service provision, shorter waiting times) (8-10). The charitable sector has become increasingly important in providing health and welfare support to AF community, with many veterans reportedly preferring to work with therapists and other welfare professionals who have experience of, or expertise in, helping military personnel (6, 11, 12). However, with more than 2000 service related charities, many of which have overlapping objectives (13) and it can be a difficult area to navigate for a veteran in need.

Walking With The Wounded

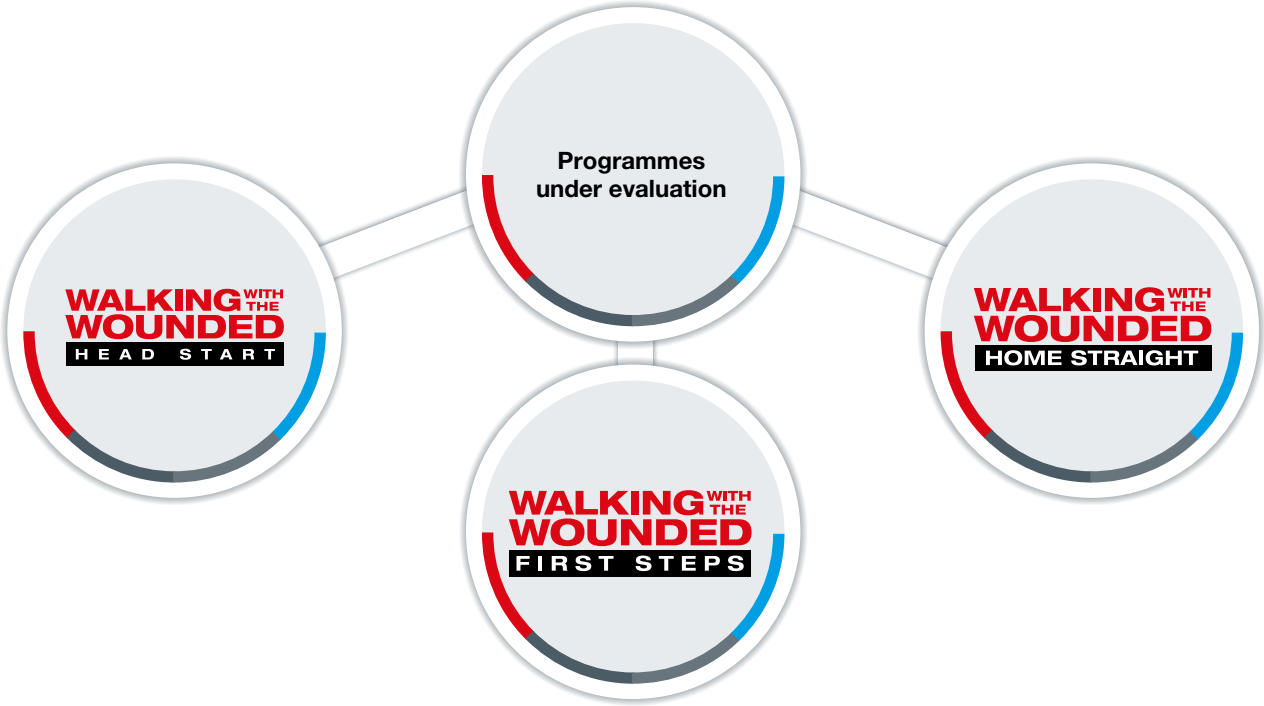
WWTW was established in 2010 to raise funds for the re-education and re-training of wounded, injured, sick and socially vulnerable ex-service men and women. They now support pathways for the most vulnerable of ex-service personnel, the 'at-risk' and 'hard to reach' individuals, to re-integrate back into the civilian community and maintain independence, with employment at the centre of their focus. WWTW offer a number of programmes aiming to improve opportunities to gain or maintain employment. They offer individualised programmes to help ex-service personnel avoid or exit the criminal justice system, avoid or recover from mental health problems and avoid or overcome homelessness, and ultimately obtain and maintain employment, through education or retraining and employment advisory and support.

In response to recognised need for increased provision and collaboration for veterans who may be struggling with the transition, WWTW recognised their obligation to evaluate the services they provide and commissioned King's College London to undertake an evaluation of three of programmes that support their clients. The evaluation aimed to help WWTW understand if the services they provide are achieving a good standard, are likely to be effective, and are well received or deemed acceptable. Additionally, the research aimed to highlight potential areas for improvement.

Their charitable objectives are:

1. To provide resettlement assistance and relief of financial and other charitable need for personnel who are leaving or have left the Armed Forces, in particular but not exclusively those who have been wounded whilst serving, including but without limitation, by providing funding for education and training to assist them in finding work and jobs and to attain the skills required to obtain and retain work outside the Armed Forces.
2. To provide relief of financial and other charitable need for the dependants of such persons
3. The promotion of social inclusion of current and former service personnel, in particular but without limitation of the UK, who are excluded from society or parts of society as a result of being wounded whilst serving, in particular by:
    a. promoting knowledge and raising awareness of:
        - their capabilities notwithstanding their injuries and,
        - the special health, financial, educational, social and employment problems faced by them; and
    b. providing them with opportunities to build capacity by participating in expeditions and other activities to relieve their needs and to assist them to integrate into society.

The three WWTW programmes evaluated are:



Head Start[1] provides 1-2-1 private therapy for ex-service personnel with mild to moderate mental health difficulties such as depression, anxiety, PTSD and adjustment disorder. Therapy is provided via face-to-face and digital sessions. Evidence-based talking therapies including cognitive behavioural therapy (CBT) and Eye Movement Desensitisation Reprocessing (EMDR) are delivered by accredited private therapists within the ex-service personnel's local community.

Upon leaving the Armed Forces, the NHS becomes central to ex-service personnel receiving support and help should be sought through the NHS first. However, in circumstances where the NHS has less geographical reach, treatment is unavailable or there are long waiting lists, Head Start is able to provide private therapy alternatives, locally to the ex-service person.

WWTW's Head Start programme falls under step three of the mental health stepped care model, as seen in Figure 1.

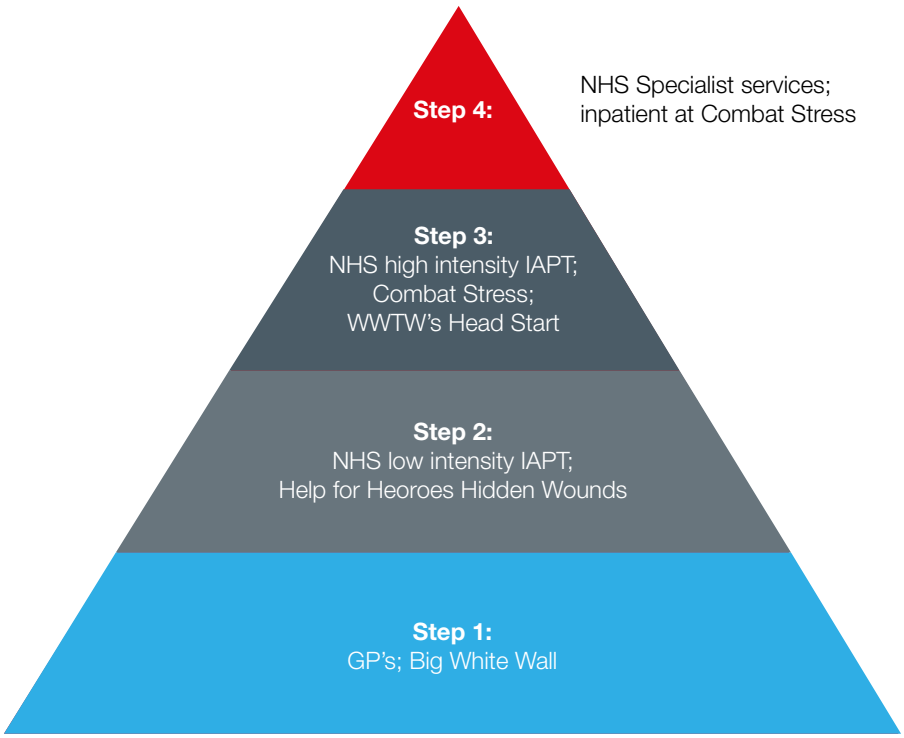


Figure 1: Stepped Care model

First Steps[2] is designed to help ex-service personnel take their first steps onto the path of gaining sustainable employment. Whilst recognising the skills acquired during service, enhanced training and vocational skills are provided to complement existing qualities for new careers outside of the military.

First Steps is designed to provide access to entry level, formal education or vocational training and to support other necessary costs relating to education or establishing a new career. These may include travel, books and equipment. The aim is to support veterans to identify their new career path and then gain the qualifications and tools necessary for them to make a successful move into civilian life. This programme is only open to those with service attributable injuries (wounded, injured or sick/socially disadvantaged; WIS) that may impact upon their ability to gain and maintain civilian employment.

Home Straight[3] Employment Advisors (EAs) are embedded in veteran supported accommodation residences or with NHS regional Veteran and mental health teams (for the comparable purposes of this evaluation, only EAs in residences were included), helping unemployed veterans on the 'Home Straight' to finding employment and rebuilding their lives. EAs work with ex-service personnel to build confidence, organise work placements, source funding for any required training and ultimately assist in gaining sustainable employment.

Support offered closely resembles the Individual Placement and Support (IPS) model, but without the integration with mental health care and support which is at the heart of the traditional IPS model. However, in certain geographical locations, EAs work alongside NHS mental health teams to offer IPS for ex-service personnel with mental health problems.

[1] *https://walkingwiththewounded.org.uk/Home/Programmes/17*

[2] *https://firststeps.wwtw.org.uk/*

[3] *https://walkingwiththewounded.org.uk/Home/Programmes/15*

[4] *www.cobseo.org.uk*

[5] *The mid-way data collection points differed upon which programme the beneficiaries were enrolled on; participants enrolled on Home Straight were invited to complete mid-way surveys every six months, and those in First Steps were invited to complete a mid-way survey at the mid-way point of their course (if longer than one month). Mid-way data collection for Head Start was collected by the therapists and provided to WWTW at the end of treatment, as therapists collected such data routinely as well.*

[6] *As is done by many NHS primary care mental health services the nature of the primary presenting problem was determined by the results of questionnaires. As such the problems presented in this report are not formal diagnoses.*

Effect size is the magnitude of the difference between groups, as a result of the intervention.

Equivalent data from NHS IAPT services providing talking therapy to equivalently unwell patients (step 3) is not available/easily accessible. NHS IAPT data is often presented as mixed care of step 2 and 3 together, and when step 3 is presented alone, dissecting improvement, recovery and reliable recovery, for different populations is not straightforward.

NHS IAPT data includes both step 2 and 3 (common mental health problems) while Head Start is step 3 only (more complex/severe common mental health problems and complex mental health problems).

'Contact' are a group of charities working alongside the NHS and MoD for clarity in support provision; www.contactarmedforces.co.uk

Need for research evaluation

Despite the well-meaning nature of most charities, some may not know how to, or simply choose not to, follow evidence-based guidance, or appropriately monitor and evaluate their initiatives to demonstrate the value of their provisions (13). The Confederation of Service Charities (COBSEO), to which many but not all service charities belong, outlines a set of agreed upon values by which service charities should abide, including being accountable for providing best practice services. However, there is scant evidence on the appropriateness and effectiveness of UK service charities (14, 15). Services focused on veteran populations are rarely evaluated, with only a few UK veteran organisations having done so including Military Veteran Improving Access to Psychological Therapies in the Pennine NHS Care Trust (14); Combat Stress (16) and Right-Turn Recovery (17). Thus, little is known about veterans in need, what is important to ensure positive outcomes, and if/where improvements are required. Although recognition of this need is increasing.

Evaluating service provision and learning more about the population for which an organisation is providing, as WWTW has set out to do, is important. Such knowledge will assist in minimising psychological harm and the frequency of ex-service personnel drifting in and out of service engagement, as well as assisting in the advancement and improvement of programme outcomes. Such information can also foster collaboration, sharing knowledge between organisations to ensure the safety and consistency of support and treatment, and to encourage better transitional trajectories for the ex-service personnel themselves.

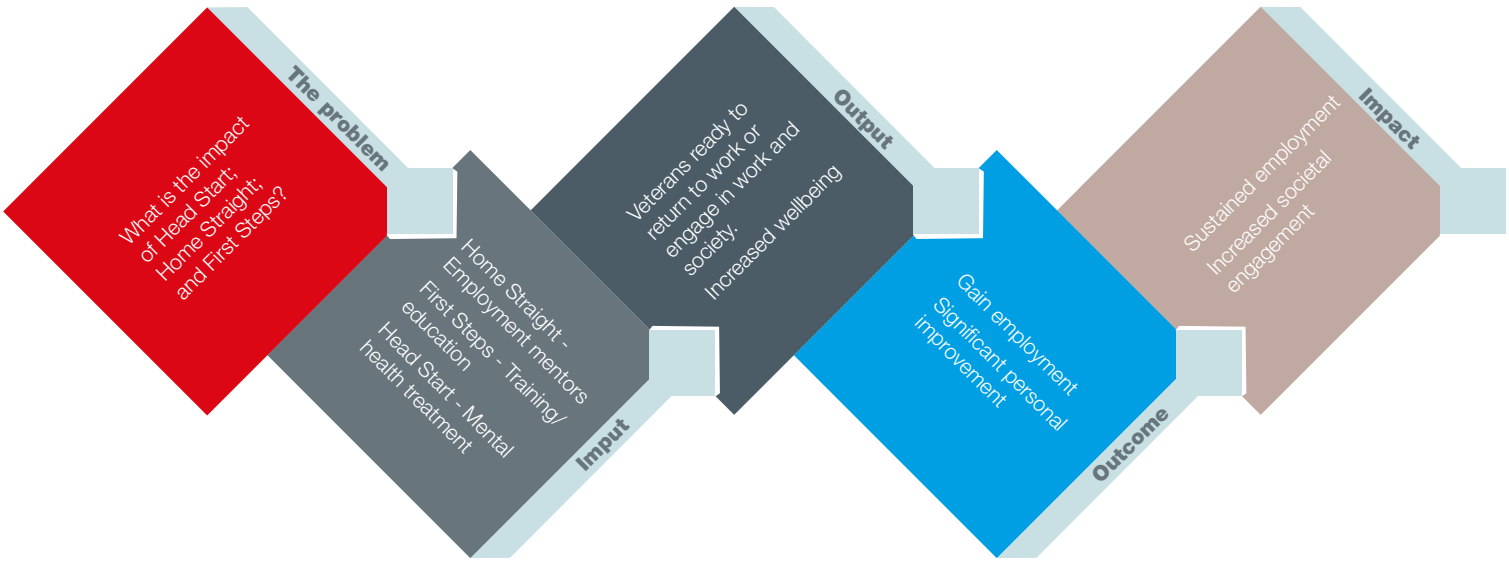
Evaluation objectives

This evaluation aimed to provide information to improve upon the support WWTW provide ex-service personnel as well as to identify factors that may influence transitional outcomes, which can be looked out for or considered during an individual's programme. Transitional outcomes may include, gaining and maintaining employment, having stable accommodation, and developing a civilian social network. A logic chain has been developed to illustrate the project objectives and intended outcomes, see Figure 2.

Objectives:

- To establish effectiveness of the Head Start by achievement of sustained improvement in employment readiness and mental wellbeing measures 3-6 months after treatment.
- To understand the processes of Head Start, First Steps and Home Straight (e.g. what happened, what went well/not so well; how are the programmes experienced) and all three programmes from a beneficiary perspective.

Figure 2: Logic chain of evaluation



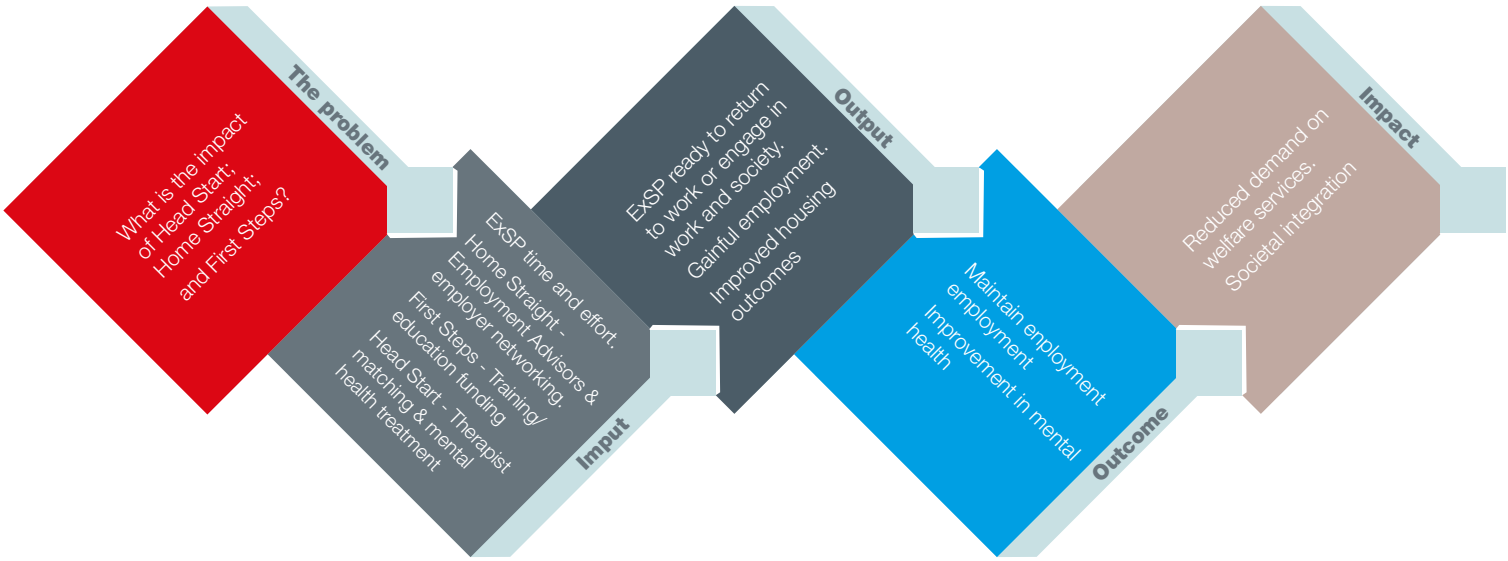
METHODS

This report is based on findings of study funded by WWTW but independently carried out and analysed by the King's Centre for Military Health Research, King's College London. This report discusses the findings of the processes and outcomes of the three support programmes offered by WWTW.

Design

An impact and process evaluation was chosen (18) for this investigation. The evaluation was formed by a non-experimental, pre/post design (with the intention to follow up those who dropped out of services for contrast), supplemented by qualitative interviews nested within the quantitative data evaluation to explore the processes of programme engagement (e.g. what happened, what went well/not so well). Below in Figure 3, is an illustration of a logic chain for this project.

Figure 3: A logic chain to illustrate the project objectives and intended outcomes.



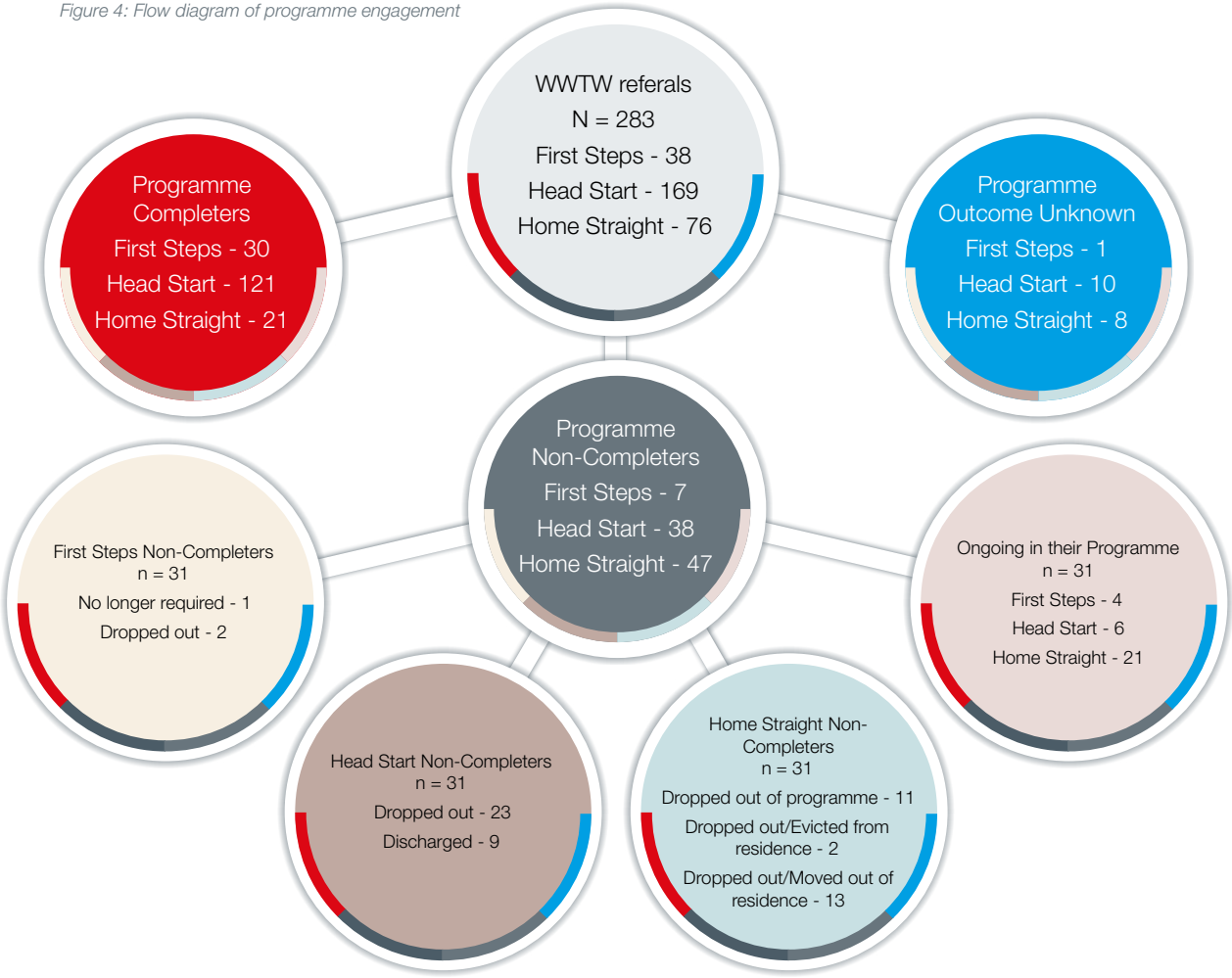
Participants

A total sample of 283 beneficiaries engaged in the three WWTW programmes, with 172 completing, 61 dropping out or disengaging and 31 still ongoing at the time that data collection ended in February 2018, see Figure 4. There were no eligibility criteria for the evaluations apart from programme referrals and acceptance. Due to the typical length of the Home Straight programme (~18months), and the frequency of First Steps referrals, lower numbers engaged in the full evaluation. First Steps and Home Straight were therefore only formed part of the qualitative process evaluation. Table 1 below details the response rates for the Head Start impact evaluation.

Table 1: Head Start evaluation engagement

	Responses	
Engaged in Head Start	169	
Invited to the evaluation	156	13 contact details were incorrect
Entered into the evaluation, completed baseline survey	76	20 specifically opted out
		60 did not respond
Continued to Endpoint survey	57	8 opted out 8 did not respond 3 reached the end of the evaluation before their next survey
Continued to Follow-up survey	52	1 opted out 1 did not respond 3 reached the end of the evaluation before their next survey

Figure 4: Flow diagram of programme engagement



Procedure - Impact Evaluation

Service evaluations are designed to determine the accuracy and effectiveness of existing interventions/policies/services, to form conclusions, make future recommendations or changes. Data was therefore routinely collected with no alterations or amendments made to any aspect of the WWTW programmes. Beneficiaries who were referred to and engaged in any of the three programmes were notified of and entered into the evaluation although they could choose to opt out. They were informed that the evaluation was being carried out by King's College London. As the veteran population can be hard to engage, beneficiaries were informed of a financial incentive to participate; a £25 shopping voucher from WWTW after completion of the baseline survey and a further £25 voucher after completion of the final/follow-up survey.

Each beneficiary was invited to take part via email with a link to an online survey, with follow-up surveys sent at regular intervals throughout.

Table 2 and Table 3 show the data collected in the evaluation.

WWTW Referral form		Evaluation survey & Head Start therapist data
Gender	Service branch	PHQ-9
Date of birth	Role / Trade	GAD-7
Marital status	Discharge reason	ICECAP-A
Employment status	Regular / reserve	WSAS
Date of enlistment	Deployments	RRTW
Date of discharge	Injury type	
Rank on discharge	Service attributable injury	

Table 2: Sources of data within the evaluation

Topic	Measures	Score range	Caseness threshold	Clinical change
Depression	Patient Health Questionnaire-9 item (PHQ-9)	0-27	≥10	≥6
Anxiety	Generalised Anxiety Disorder-7 item (GAD-7)	0-21	≥8	≥4
Functioning	Work and Social Adjustment Scale (WSAS)	0-40	≥10	≥8
Social Wellbeing	Investigating Choice Experiments CAPability measure for Adults (ICECAP-A)	0-1	Summary scores	unclassified
Work Readiness	Readiness to Return to Work (RRTW)	0-20	Summary scores	unclassified

Table 3: Measures included in evaluation survey

Educational status/history, employment status/history, military rank and deployment location is not routinely or consistently collected by WWTW (and their third-party staff) across all three programmes and was thus not available.

The evaluation began on 18th July 2016 and final follow-up data was collected on 28th February 2018. See Figure 5 for data collection procedure . Ethical approval was granted by King's College London Research Ethics Committee for secondary data analysis of the WWTW data (LRS-16/17-38900).

Procedure - Process Evaluation

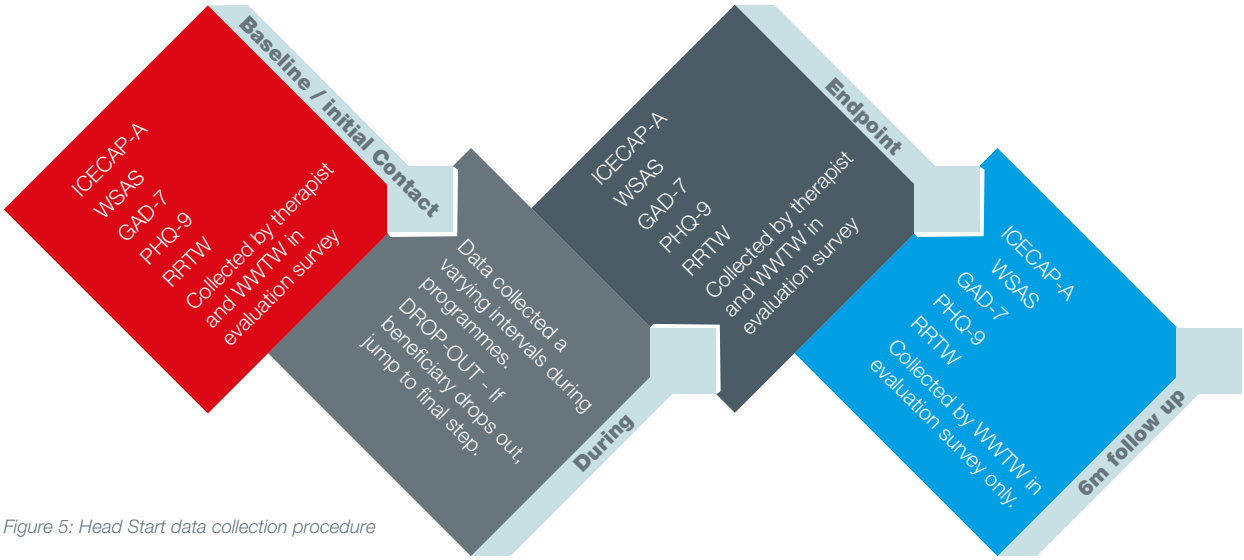


Figure 5: Head Start data collection procedure

Beneficiaries were invited by WWTW to take part in an independently evaluation conducted by King's College London. To be eligible beneficiaries must have completed, dropped-out or disengaged from any of the three programmes. Table 4 provides response rates. Interviews were one-to-one semi-structured carried out over the telephone. Questions covered opinions and experiences of the programmes/charity, including reasons for dropping out (if applicable). All interviews were audio recorded and transcribed with pseudonyms. Framework analysis was used to analyse the transcripts (19). Ethical approval was granted by King's College London Research Ethics Committee for the qualitative interviews (HR15/162558).

Table 4: Recruitment and response rates for the qualitative interviews from the service evaluation

	First Steps n (%)	Head Start n (%)	Home Straight n (%)	Total n (%)
Responded to invitation				
Completer	16	26	0	152
Non-completer	0	4	7	11
Still engaged	1	0	3	4
Total	17	30	20	67
Participated				
Completer	8	13	3	24
Non-completer	1	2	3	6
Still engaged	0	0	2	2
Total participated	**9 (52.9)**	**15 (50)**	**8 (40)**	**32 (47.7)**

[5] *The mid-way data collection points differed upon which programme the beneficiaries were enrolled on; participants enrolled on Home Straight were invited to complete mid-way surveys every six months, and those in First Steps were invited to complete a mid-way survey at the mid-way point of their course (if longer than one month). Mid-way data collection for Head Start was collected by the therapists and provided to WWTW at the end of treatment, as therapists collected such data routinely as well.*

FINDINGS

Head Start impact evaluation

Head Start is a mental health focused programme by WWTW, that provides a local therapist for ExSP who are suffering from mild to moderate mental health problems, but this does not have to be as a result of service.

A response rate of 48.7% (76/156) was achieved for the baseline surveys. A follow-up response rate for the Head Start evaluation was 68% (52/76). The mean age of the 52 veterans who engaged in the full evaluation was 46.8 (sd 10.19), with more than half (59.6%) in a relationship and nearly two-thirds employed (65.4%). Most veterans had served in the Army (71.2%) and for between 5-21 years (53.8%). Most had voluntarily left service (51.9%) more than two years earlier (92.3%; mean of 13.36, sd10.75). The primary presenting problem , as assessed by the Head Start therapist was depression (57.7%) with nearly two-thirds (61.5%) engaging in 7-12 therapy sessions and nearly all (98.1%) veterans attended all their funded treatment.

Table 5: Demographic characteristics of all clients engaging in WWTW programmes upon referral (n=52)

Demographic	n (%)
Age Groups	
<40	14 (26.9)
40-49	16 (30.8)
50+	22 (42.3)
Relationship status	
In a relationship	31 (59.6)
Not in a relationship	15 (28.8)
Employment status upon referral	
Employed	34 (65.4)
Not employed	12 (23.1)
Service branch	
Army	37 (71.2)
Naval Services	4 (7.7)
RAF	11 (21.2)
Service length	
Early Service Leaver (0-4yrs)	3 (5.8)
Mid-Long Service (5-21yrs)	28 (53.8)
Full Service (≥22yrs)	15 (28.8)
Discharge Reason	
Voluntary	27 (51.9)
Involuntary (medical)	14 (26.9)
Involuntary (other)	2 (3.8)
Unknown	1 (1.9)
Years since discharge	
<2yrs	4 (7.7)
2-10yrs	23 (44.2)
>10yrs	19 (36.5)

**Totals may not add up to 52 due to missing data.*

Table 6: Overview of Head Start programme (n=52)

	n (%)
Primary mental health problem	
Depression	30 (57.7)
Anxiety	18 (34.6)
Missing	4 (7.7)
Number of sessions attended	
1 – 6	7 (13.5)
7-12	32 (61.5)
13-18	11 (21.2)
Missing	2 (3.8)
Head Start Status	
Completed	51 (98.1)
Dropped Out	1 (13.6)

Table 7 shows that there was a 19% reduction in the proportion of beneficiaries meeting the symptoms threshold for depression (≥10), with mean scores reducing but remaining above the depression threshold at baseline and follow-up. It is notable that the mean scores at the end of treatment did however fall below the depression threshold. There was a 33% reduction in the proportion of beneficiaries meeting the symptoms threshold for anxiety, with mean scores steadily declining across time; however, it is notable that the mean scores remained about the anxiety threshold at all timepoints. Significant clinical improvement for anxiety was sustained at follow-up (≥4 points). While the change for depression was statistically significant at follow up, it did not meet the accepted definition of clinically significant change (≥6 points) at the end of treatment or follow-up. The size of the effect of Head Start on symptoms was found to be significantly moderate for depression symptoms (0.52 at end of treatment and 0.42 at follow-up) and significantly moderate to high for anxiety symptoms (0.71 at end of treatment and 0.99 at follow-up); see Table 7.

[6] *As is done by many NHS primary care mental health services the nature of the primary presenting problem was determined by the results of questionnaires. As such the problems presented in this report are not formal diagnoses.*

[7] *Effect size is the magnitude of the difference between groups, as a result of the intervention.*

Veterans significantly improved in their functioning after having engaged in Head Start which was sustained (with a 19% reduction in scores at follow-up, despite a slight increase from end of treatment to follow-up). Effect sizes were found to be significantly moderate both at end of treatment (0.67) and follow-up (0.52). Functional improvement appeared independent of clinically significant symptomatic improvement, although change appeared greater for those who clinically improved as well.

Table 7: Mean mental health scores and caseness across timepoints (n=52)

	PHQ-9		GAD-7		WSAS	
	x score (sd)	Caseness n (%)	x̄ score (sd)	Caseness n (%)	x̄ score (sd)	Caseness n (%)
Baseline	13.35 (6.31)	39 (75)	13.02 (4.96)	43 (83)	21 (9.25)	42 (81)
End of treatment	9.74 (7.33)	24 (48)	12.92 (5.03)	41 (82)	14.10 (11.19)	28 (54)
Follow-up	10.96 (7.26)	29 (56)	8.88 (6.13)	26 (50)	15.35 (11.61)	31 (60)
	x̄ change (sd)		**x̄ change (sd)**		**x̄ change (sd)**	
Baseline to endpoint	3.46 (5.54)**		5.16 (4.57)**		6.30 (7.31)**	
Baseline to follow-up	2.38 (4.61)**		4.13 (4.77)**		5.44 (6.93)**	

**significant at p<0.0001*

The NHS definition of reliable recovery is clinically reliable change (improvement) and a change in caseness between baseline and end of treatment for both depression and anxiety (recovery). In line with this definition, the recovery rate for Head Start was 23.1% at the end of treatment, and carrying this definition forward to follow-up, the recovery rate was 15.4% .

Qualitative process evaluation

Thirty-two veterans were independently interviewed by King's College London about their experiences of the processes involved with the three WWTW programmes and about the charity itself. Nearly half (46.9%, n=15) of all veterans invited to take part were from Head Start, with almost equal numbers from First Steps and Home Straight (28.1%/n=9 and 25%/n=8 respectively). Nineteen of those interviewed engaged in the evaluation survey, from which it was found that approximately one-third (31.2%, n=10) improved in the symptoms of depression after their programme, while nearly half improved in their symptoms of anxiety and functional impairment (46.9%/n=15 and 40.6%/n=13 respectively). Most (71.8%, n=23) had served in the Army in an enlisted rank (59.4%, n=19) and had served 5-21 years (65.6%, n=21).

[8] *Equivalent data from NHS IAPT services providing talking therapy to equivalently unwell patients (step 3) is not available/easily accessible. NHS IAPT data is often presented as mixed care of step 2 and 3 together, and when step 3 is presented alone, dissecting improvement, recovery and reliable recovery, for different populations is not straightforward.*

[9] *NHS IAPT data includes both step 2 and 3 (common mental health problems) while Head Start is step 3 only (more complex/severe common mental health problems and complex mental health problems).*

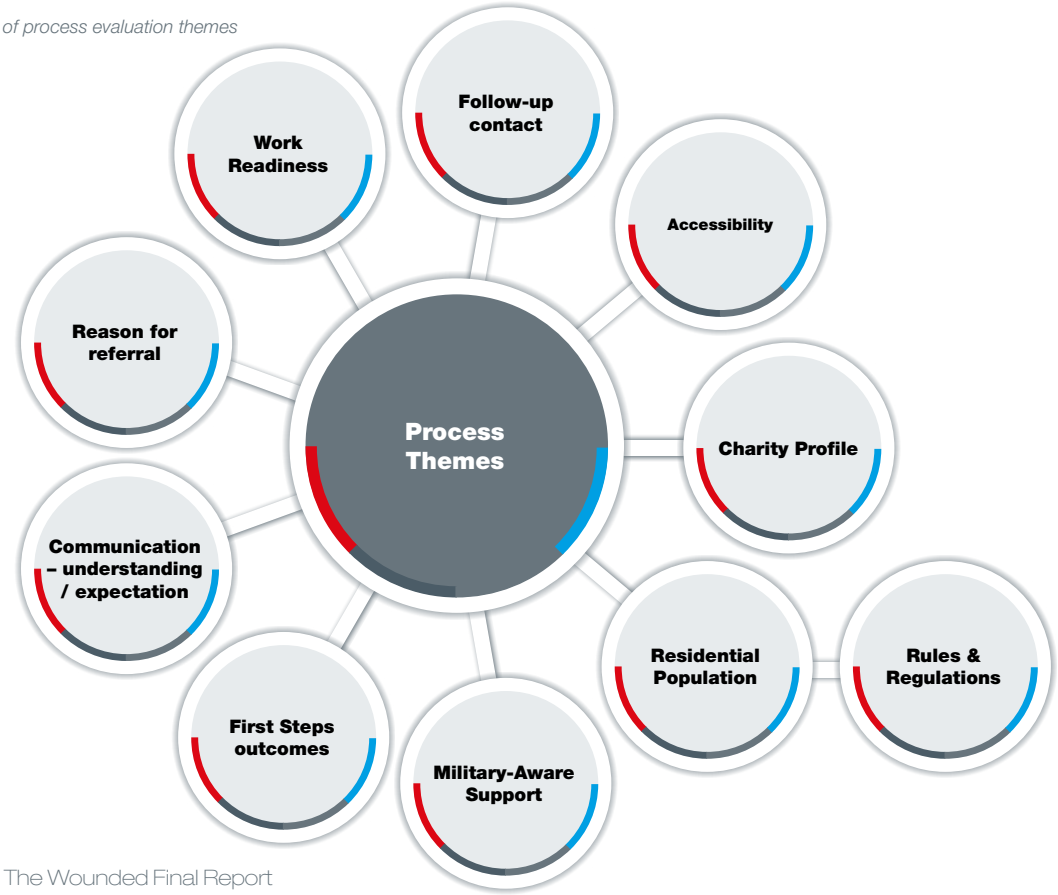
'Contact' are a group of charities working alongside the NHS and MoD for clarity in support provision; www.contactarmedforces.co.uk

Table 8: Demographics for veterans interviewed (n=32)

Personnel Demographics	WWTW Veterans n(%)	Programme Demographics	WWTW Veterans n(%)
Age		**WWTW Programme**	
25-29	1 (3.1)	Head Start	15 (46.9)
30-39	8 (25)	First Steps	9 (28.1)
40-49	13 (40.6)	Home Straight	8 (25)
≥50	10 (31.2)		
Service branch		**WWTW Injury type***	
Army	23 (71.8)	Mental	-26 (81.2)
Naval Services	4 (12.5)	Physical	4 (12.5)
RAF	5 (15.6)	Social	7 (21.9)
Rank		**Change in PHQ-9**	
Enlisted	19 (59.4)	Improved	10 (31.2)
NCO	10 (31.2)	Deteriorated	8 (25)
Officer	3 (9.4)	No change	2 (6.25)
		Missing data	12 (37.5)
Years served		**Change in GAD-7**	
<4	1 (12,5)	Improved	15 (46.9)
5-10	10 (31.2)	Deteriorated	4 (12.5)
11-21	11 (34.4)	No change	1 (3.1)
≥22	7 (21.9)	Missing data	12 (37.5)
Discharge reason		**Change in WSAS**	
Voluntary	10 (31.2)	Improved	13 (40.6)
Involuntary (medical)	12 (37.5)	Deteriorated	4 (12.5)
Involuntary (other)	10 (31.2)	No change	1 (3.1)
		Missing data	14 (26.9)
Years since discharge			
<2	4 (12.5)		
2-5	8 (25)		
6-10	5 (15.6)		
11-20	8 (25)		
≥20	7 (21.9)		

Although a framework of themes was generated based on team discussions prior to the interviews, further themes became apparent from the data during analysis. See Figure 6 for an overview of the final themes.

Figure 6: Overview of process evaluation themes



Head Start

Reason for referral / Prior support: Most veterans had sought prior support but expressed a strong sense of disillusionment with service provision from either the NHS or the through the AF. Beneficiaries appeared to believe that a military charity may provide better support, finding the 'military front door' helpful in encouraging them to initially ask for help. Some, with strong held beliefs, had bypassed mainstream services altogether. Although a service attributable mental health problem is not a condition of treatment in Head Start, all participants stated that their problems were related to their service to some extent. Additional to everyday difficulties of their mental health related concerns (e.g. sleep problems, anger), participants frequently cited other life issues as the driving force behind seeking help (e.g. losing driving licence, getting divorced).

Accessibility: Most participants reported that they had found it easy to engage with the charity and positively commented on the speed and efficiency of their referrals. Cited as a significant advantage was having a therapist in close proximity to client's home town.

Military-Aware Support: Despite a pre-treatment desire for military specific therapists, more than half of participants felt that a thorough understanding of mental illness and an individualised approach with an appreciation of where they may be coming from was just as beneficial. Thus whilst the military 'front door' was helpful for their initial help-seeking, after experiencing a positive therapeutic relationship with a therapist through the Head Start programme, they acknowledged that military awareness may not be essential.

An extension of this theme was that veterans felt they were primarily offered coping strategies and symptom management as opposed to root-cause counselling, which some had expressed they were expecting. This was not always mentioned as a criticism, more an observation.

Communication (expectation & understanding): There was substantial ambiguity surrounding the understanding of the number of sessions that would be funded and the need for further treatment. A few felt they were still in need when their sessions ended but did not know the process to seek a continuation of therapy or if that was possible.

Follow-up contact: Most veterans expressed confusion, concern and disappointment at the lack of follow-up contact and described feeling lost afterward. One veteran reported difficulties organising sessions with his therapist and dropped out after 6 sessions, but with no follow-up contact from the therapist or WWTW, he did not restart treatment either. Quite often, not receiving an expected follow-up was reported to have tainted otherwise positive experiences.

WWTW Profile: Most participants admitted to not having known much about WWTW prior to their referral. Some participants had heard of them, but their understanding of them was limited. Of those who were aware, it seemed that the famous expedition campaigns led some participants to believe they were only a fundraising charity, funding other charities to provide care. Most believed that only physically wounded veterans were eligible for support.

First Steps

Quantitative descriptive data is presented below to gain a better understanding of the programme before going on to present the qualitative process evaluation data.

Table 9: Summary of First Steps beneficiaries (n=38)

	n(%)
Type of funding	
Equipment only	6 (15.8)
Vocational course	32 (84.2)
Length of vocational courses	
1 day	4 (12.5)
Less than 1 week	7 (21.9)
1 week to 1 month	8 (25)
1-6 months	8 (25)
>6 months	5 (15.6)
Programme status	
Completed	30 (79)
Dropped out	2 (5.3)
Application withdrawn	1 (2.6)
Ongoing	4 (10.5)
Missing	1 (2.6)

Table 10: Summary of outcome data (n=38)

	n (%)
Baseline employment status	
Employed	5 (13.2)
Unemployed	7 (18.4)
Missing	26 (68.4)
Follow-up employment status	
Employed	9 (50)
Unemployed	8 (21.1)
In education/training	10 (26.3)
Missing	1 (2.6)
1Change in employment status for those in evaluation (n=12)	
Gained employment	4 (33.3)
Maintained baseline employment	2 (16.7)
Lost baseline employment	2 (16.7)
Maintained baseline unemployment	3 (25)
Missing	1 (8.3)

Accessibility: This was widely discussed in a positive light. Respondents felt it was easy and straightforward to gain funding, with the only major requirement to pass the vocational assessment. Participants were assessed to ensure they had carefully considered their future and that the course/equipment they had chosen was right for them. This tended to impress participants who generally respected the hard line that WWTW draws to in order to provide ensure they provide appropriate resource for veterans in genuine need.

Outcomes: Despite the thorough assessment of need/occupational interest in the veterans, utilisation of skills/qualifications/equipment funded was mixed, with less than half of veterans going in to related occupations. Those who did, viewed the programme as essential to them being able to progress in their career. Those who did not use their qualifications, or equipment, had stated that other opportunities had come up, or that their personal circumstances were preventing occupational progression irrespective of the assistance of First Steps. Gaining knowledge/skills/qualifications did not always appear sufficient, as veterans described other factors that prevented them gaining or maintaining employment, suggesting 'readiness' may have a role to play in occupational outcomes.

Follow-up contact: Follow-up contact appeared inconsistent across First Steps. Some reported phone calls to enquire as to how they were getting on and whether they needed any further support/guidance, while others reported nothing. Veterans who did not receive any follow-up, described feeling disappointed and subsequently anonymous. This was particularly the case for those who felt they needed further support and were unsure how to get it.

WWTW profile: As found with Head Start, few veterans had a clear understanding of WWTW as a charity and their provisions. Several were unsure as to why they were taking part in the interviews, unaware that WWTW were behind their support they had received.

Home Straight

Quantitative descriptive data is presented below to gain a better understanding of the programme before going on to present the qualitative process evaluation data.

Table 11: Summary of Home Straight beneficiaries (n=76)

	Overall programme engagement
Home Straight Status	**n(%)**
Completed	21 (27.63)
Dropped out	11 (14.47)
Evicted	15 (19.74)
Ongoing	21 (27.63)
Unknown	8 (10.53)
Length of programme	**($\bar{x}$ months, sd)**
Overall	5.59 (6.34)
Completed	3.94 (5.56)
Dropped out	7.57 (8.22)
Evicted	6.57 (6.32)
Follow-up employment status	**n(%)**
Employed	23 (30.26)
Unemployed	23 (27.63)
Still engaged	21 (27.63)
Dropped out	2 (2.63)
Missing	30 (39.47)

Reason for referral: Veterans reported a domino effect of mental health on their relationship and financial situations and this was seen as the primary reason or contributor to homelessness, directly and indirectly attributable to military service.

Work readiness: Work readiness appeared to play an important role in occupational outcomes of veterans, demonstrated by the varying programme lengths for those who gained or did not gain employment and the reflections of the veterans. The length of time of reportedly receiving support for veterans who gained employment was nearly half that of those who dropped out or were evicted. However, the length of time for those still ongoing in the residential home at the time of the evaluation ended, was in fact longer than the advertised maximum length of stay at the residences.

Residential population: Most veterans valued the 'veteran specific' nature of the housing, believing that the needs of civilians differ from that of veterans. Differences were expressed in a way that suggested that these two different populations could not realistically live alongside one another. Feelings of injustice were described, whereby ingenuine veterans (e.g. not served in combat or served too few years) and civilians were seen as wasting resources and support which was intended for genuine veterans. However, some felt this could also be negative, encouraging social segregation and emphasising veteran sub-groups.

Rules & regulations: Discretion and ambiguity was reported in the rules and regulations, possibly accounting for the misunderstandings of entitlement and inconsistency between residents. Veterans described the perceived negative impact of the UK council housing system as not facilitating success for homeless personnel (e.g. rent increases, having to move out upon employment, etc.) limiting their progression and occupational stability. Veterans also reported there being limited incentive, except for personal motivation and life goals, to gain employment.

Military-Aware Support: Veterans reported positively on the care and attentiveness of their Employment Advisors, and felt understood and supported, regardless of any military knowledge, believing individualisation of support was key. Irrespective of occupational outcomes, veterans described having gained confidence and self-esteem from the support of their Employment Advisor through the skills they had learned. Support received ranged from practical support to psychological/emotional support, of which the latter was rated most valuable and contributed to their perception of being ready to return to work.

WWTW Profile: Again, few veterans appeared fully aware of the charity, or its connection between their Employment Advisor. Several justified their lack of knowledge of WWTW as being due to not being a wounded veteran; akin to their name, but contrary to their mission statement.

DISCUSSION

The objective of this evaluation was to understand the processes and effectiveness of the services WWTW provide. This evaluation quantitively examined the effects of Head Start, and qualitatively explored the processes of Head Start, First Steps and Home Straight.

Head Start: The output for the Head Start programme was the therapy sessions, which aimed for outcome of stabilised or improved mental health intending to generate an impact of significant sustained improvement in anxiety and depression, leading to increased functioning (e.g. societal engagement like joining of social groups) and looking positively toward the future. Sustained, significant reliable clinical improvement in anxiety symptoms was found in just over half of participants. This was not the case for symptoms of depression. Although there were measurable improvements in depressive symptoms at the end of treatment and at follow up, these were not clinically significant. Overall, Head Start was found to be a clinically effective programme for anxiety symptoms with long-term positive outcomes. Importantly, this evaluation found clear and significant sustained improvements in functioning for both disorders which was independent of improvements in mental health status. Improvements in functional impairment, and associated personal recovery, is likely to enable greater likelihood for re-engaging in one's life with purpose (e.g. employment), as health is more than simply the absence of illness (20, 21).

It is difficult to directly compare Head Start to another service, even though it is closest to the NHS high intensity IAPT services (step 3). Unfortunately, NHS-IAPT services data are primarily based on mixed care (step 2 and 3 together) and it can be challenging to dissect or disentangle the relevant data. Although an unequal comparison, it is the closest comparison that can be made; When compared to other veteran services (MVIAPT) (14, 22), who have broken down their recovery results using the NHS definition but for each disorder in isolation, Head Start had similar rates of recovery for anxiety (Head Start was at 33% vs 30% for MVIAPT), but lower rates for depression (Head Start at 23% vs 33% for MVIAPT) and was below the rates for the general population (42-44%) (23, 24). Interestingly, results were a similar pattern to another veteran mental health service evaluation (25), whereby depression mean change scores were below that of reliable clinical improvement for treatment of less than six-months, but was greater than clinical improvement threshold for treatment lasting more six-months, suggesting that depression may only be sensitive to prolonged treatment, or that top-up treatment may be required. It thus seems that Head Start compares reasonably well to other veteran services. It is important to remember however, regardless of the comparator, that the rates of clinical recovery observed in the current evaluation were above the 5-20% estimated for natural recovery or for minimal intervention (26, 27).

The observed differences between the outcomes for depression and anxiety are interesting as they are not observed to such a degree within the general population data or in other veteran datasets. This may be due to the complexity and comorbidity of veterans who are referred to the Head Start programme with primarily depressive symptoms. It is possible that the reported depressive symptoms may result from some of the veteran's primary disorder actually being complex PTSD. Due to the need not to overload the participants of the study with a multitude of questionnaires we were not able to include a specific measure of PTSD symptoms with which we could have assessed this issue. Also, the presence of other psychosocial stressors such as employment concerns or relationship problems may have manifested as depressive symptoms. Indeed, qualitative data from Head Start participants revealed employment instability, financial concerns, and relationship troubles as contributing to their mental ill health. Such challenges are not likely to be directly influenced by depression treatment (28) and the persistent impact of these stressors upon beneficiary's mental health may go some way towards explaining the reduced effectiveness of Head Start for these individuals from a symptomatic viewpoint. It may also be that until someone is able to function better, levels of depression may well remain high. Indeed, gaining employment, especially satisfying employment, may, in itself, also improve mental health. Improvements in functioning in this evaluation were greatest in veterans who achieved clinical improvement in depression and/or anxiety. One limitation of this study though is that we did not assess treatment fidelity and the remote nature of the private therapists in Head Start through WWTW, which means that it is not possible to truly understand how consistent and structured the interventions provided to veterans were. Also, our qualitative data showed that veterans primarily reported developing coping mechanisms and strategies to deal with their problems as the outputs of their treatment. These techniques may be better suited to managing symptoms of anxiety than dealing with more intractable stressors which cause depressive symptoms. Those who were seeking more in-depth treatment may indeed have not been suited to the type of therapy on offer, most often cognitive behavioural therapy.

[9] *NHS IAPT data includes both step 2 and 3 (common mental health problems) while Head Start is step 3 only (more complex/severe common mental health problems and complex mental health problems).*

[10] *'Contact' are a group of charities working alongside the NHS and MoD for clarity in support provision; www.contactarmedforces.co.uk*

Qualitative data revealed that overall, Head Start was highly regarded and perceived to be beneficial. The speed and locality of treatment was reported as invaluable and directly compared to the NHS as superior. Interestingly, military awareness of therapists was initially thought to be vital, but by the end of therapy the ability of the therapist to individualise their treatment approach and demonstrate empathy was seen as more important. Lack of follow-up contact was most notably mentioned by almost all veterans in Head Start, which for some, did not appear to be a significant issue, but for those who felt they were still in need, was regarded as having been disappointing after a generally very positive therapeutic experience.

First Steps: The output for the First Steps programme was attendance at courses and/or purchasing of equipment, which aimed to generate an outcome of increased skills, knowledge, qualifications and/or tools for employment, impacting upon gaining and maintaining employment, reducing demand on welfare services and support and looking positively toward the future. However, qualitative data revealed that utilisation of the skills/qualifications/equipment funded was mixed, with less than half of veterans interviewed going in to related occupations. Those who did not make use of the First Steps outputs reported finding other issues limiting their progression (e.g. mental health, finances). Many veterans reported being impressed by, and respected, the strict guidelines for course/equipment funding, which may reflect opinions felt from Home Straight veterans who believed that resources were sometimes wasted on those who were not in true need. Most interestingly, almost all the veterans in First Steps had little knowledge of WWTW and were relatively unaware of where their support came from. This may partially explain the limited use of the skills/equipment/qualifications since veterans may not have valued or felt connected to their funder, feeling little accountability to make use of the resources given to them.

Home Straight: The output for the Home Straight programme was increased work readiness through individualised employment mentoring (career focused counselling, practical skills development and employer targeting), resulting in an outcome of gainful employment, with an impact of employment maintenance and subsequent reduced demand on welfare services and support, and looking positively toward the future. Qualitative data revealed that residential Employment Advisors were highly regarded, increasing veteran's confidence and self-esteem. Individualised approaches to their employment paths were perceived to increase their readiness, or highlighted areas in need of management prior to employment. Veterans in the sample also believed that the UK council housing system does not facilitate success for homeless veterans, whereby veterans are almost set up to fail, thus leaving them little incentive to make attempts to gain employment. Veteran's views of the residences were mixed, with some beneficiaries thinking that civilians and veterans cannot feasibly live in harmony, whilst others felt the segregation was reinforcing the gap in civilian society.

General: A significant theme across all three programmes was the limited knowledge of WWTW as a charity. While this is of little importance from a support attribution perspective, it is significant from a veterans help-seeking point of view. Veterans often believed that WWTW was only for physically wounded soldiers (of which there were only four in the interview sample, 12.5%) or was a funding-based charity providing other charities with money to support veterans. Veterans in the sample were generally unaware that WWTW was a charity which would fund support for people like themselves.

Strengths & Limitations

Strengths for this evaluation include:

- Head Start produced a good response rate for the evaluation especially given that veterans are a hard to reach population (29). A 48.7% response rate for the baseline survey was obtained, and a 68.4% response rate at follow-up for those who engaged at baseline.

- Most evaluations are primarily based on quantitative findings, and while vital for making more concrete conclusions, qualitative data can contribute to the understanding of the processes and the 'why' behind findings and experiences.

- The response for the qualitative interviews was also very good, with an overall rate of 47.7% across the three programmes. While qualitative data is not about generalisability, a substantial sample size provides greater opportunity to garner perspectives that are representative of the whole target population including varied and contrasting views which this study identified.

Limitations for the evaluation include:

- Due to the length of the Home Straight programme and the infrequent nature of First Steps referrals, the number of veterans entered into the evaluation and then those who responded, was low. This meant that for these two programmes, only a qualitative perspective could be taken. Speculating on some of the reasons for the low evaluation response rates of those who did engage in the programmes:

a. Although the sample in the evaluation were a help-seeking sample, they were still trying to manage their conditions and circumstantial problems. The multitude of problems experienced by Home Straight participants in particular (e.g. homelessness, mental ill health, relationship difficulties, financial problems and unemployment) may be reflected in the low baseline rates (n=23, 30%).

b. The remote nature of WWTW support, primarily for First Steps and Home Straight, may explain the reduced engagement in both the evaluation surveys and the qualitative interviews. Interviewing participants from both programmes revealed that many were not aware of WWTW's involvement in their care, with one participant even declining to take part in the interview as they felt they had nothing to contribute to the feedback of the charity.

- Despite one of the primary objectives of WWTW to increase independence through engagement in employment, the collection of employment related data was limited to not available, reducing the potential for outcome analysis.

- As we did not assess treatment fidelity in Head Start, it is not possible to truly understand how consistent and structured the interventions provided to veterans were.

Summary & Recommendations

The provisions of WWTW are not replicated by other charities and offer a number of benefits over mainstream services (e.g. speed and locality of treatment) as well as providing veterans the fast-tracked opportunities to improve their mental health and ability to function well in day to day life, gain skills/qualifications and tools to increase sustainable employability and guidance on the occupational transition process. Overall, Head Start was found to be an effective programme for anxiety and functional impairment. Whilst the programme positively impacted depressive symptoms these effects of treatment did not appear to lead to sustained clinical improvements. This result suggests that the complex needs of many veterans may necessitate a greater need for holistic care, with the addition of other support services in tandem with their primary support programme, as almost all reported other issues hindering their mental health or employment progression. It may also be that some Head Start beneficiaries, especially those with depressive difficulties, would benefit from more sustained treatment and/or follow-up monitoring and care to consolidate treatment gains. This may come in the form of a treatment review after four funded sessions to establish appropriateness of treatment type and therapeutic alliance, and/or later top-up sessions.

Support provision is a vital part of the transition from the Armed Forces, for those who do well and those who do less well, whether it be in the early stages of civilian life through military resettlement or later mental health support. Since the formalisation of the Armed Forces Covenant in 2011, state provision for the AF community has grown and improved. However, considering the realistic capabilities of the Armed Forces Covenant, it is likely the third sector will continue to hold a significant role within the Armed Forces community, providing valuable and varied support where the state may be less able to. The Head Start programme is an example of this, providing evidence-based mental health care which is similar to NHS care, but provided in a more timely and local manner.

Across all three programmes it was apparent that there was limited awareness of WWTW, with beneficiaries primarily referring to the larger, more established charities believing that they provided most/all care or were entirely unsure. As previously noted, the size of the charitable sector has grown exponentially in the last decade, but the speed with which charities have established themselves may well have left some veterans feeling lost and overwhelmed. With this in mind, the results of this study suggest that strategies to improve the awareness of support services provided by WWTW should be explored which may lead to increased help-seeking opportunities and highlight the charity as a realistic option for veterans in need. Despite Head Start providing free civilian therapists, several veterans attributed delayed help-seeking to thinking that there was no support out there for veterans in civilian society, certainly not provided by the state. These views appear to be persistent across the veteran community in spite of the growth in both NHS and charitable provision of mental health services. Furthermore, although there was lack of understanding as to the provider of support for WWTW participants in all three programmes, it demonstrated the seamless collaboration of service charities for the benefit of the veterans, without desire for recognition or credit. This provides some promise that all service charities (and the state) can indeed work together (e.g. Contact) and provide enhanced care, whilst limiting the opportunity for duplicate provision and flooding of the sector.

The results also suggest that it may have to maintain the positive impact that services are having on veterans, if WWTW and other charitable services could increase the follow-up contact they have with their beneficiaries. Not only will this reduce the feelings of being forgotten, reminiscent for some of leaving the Armed Forces, but also maintain engagement and participation in the support being provided, increasing chances of successful outcomes. This was most notable in First Steps, with veterans feeling disconnected from the charity and found to not utilise the gains from their funding for later occupational opportunities, which also becomes a ‘wasted’ resource. It was also a persistent theme across the qualitative research element of this study.

CONCLUSION

Walking With The Wounded commissioned King's College London to undertake an evaluation of the programmes that support their clients, in order to examine the effectiveness of their programmes which help veterans successfully engage with civilian society. The overall evaluation findings for the three programmes was positive. Head Start was found to lead to improved mental health and functionality, (although with slightly less long-term success with symptoms of depression), which is likely to be particularly valuable for employment achievement and maintenance, a primary aim for WWTW. Qualitative feedback on First Steps and Home Straight was positive, although it appeared that a more holistic approach may increase positive outcomes. Awareness of WWTW as a charity and as a funder was limited, which may have significant implications for future help-seeking.

[10] *'Contact' are a group of charities working alongside the NHS and MoD for clarity in support provision; www.contactarmedforces.co.uk*

REFERENCES

1. *Ashcroft. The Veterans' Transition Review: Second Follow-Up Report, October 2017. 2017.*
2. *FiMT. Continue to work: The transition mapping study 2017. Forces in Mind Trust; 2017.*
3. *Iversen A, van Staden L, Hughes JH, Browne T, Hull L, Hall J, et al. The prevalence of common mental disorders and PTSD in the UK military: using data from a clinical interview-based study. BMC Psychiatry. 2009;9:68.*
4. *Murphy D, Busuttil W. Exploring outcome predictors in UK veterans treated for PTSD. . Psychology Research. 2015;8:441-51.*
5. *Tsai J, Harpaz-Rotem I, Pietrzak RH, Southwick SM. The role of coping, resilience, and social support in mediating the relation between PTSD and social functioning in veterans returning from Iraq and Afghanistan. . Psychiatry: Interpersonal & Biological Processes. 2012;75(2), 135-149.*
6. *Ben-Zeev D, Corrigan PW, Britt TW, Langford L. Stigma of mental illness and service use in the military. Journal of Mental Health. 2012;21(3):264-73.*
7. *Hunt EJ, Wessely S, Jones N, Rona RJ, Greenberg N. The mental health of the UK Armed Forces: where facts meet fiction. Eur J Psychotraumatol. 2014;5.*
8. *Dandeker C, Wessely S, Iversen A, Ross J. Improving the Delivery of Cross Departmental Support and Services for Veterans. . Ministry of Defence 2003.*
9. *Macmanus D, Wessely S. Veteran mental health services in the UK: are we headed in the right direction? J Ment Health. 2013;22(4):301-5.*
10. *Iversen A, Dyson C, Smith N, Greenberg N, Walwyn R, Unwin C, et al. 'Goodbye and good luck': the mental health and treatment experiences of British ex-service personnel. British Journal of Psychiatry 2005;186:480-6.*
11. *Iversen A, Greenberg N. Mental health of regular and reserve military veterans. Advances in Psychiatric Treatment. 2009;15(2):100-6.*
12. *Mellotte H, Murphy D, Rafferty L, Greenberg N. Pathways into mental health care for UK veterans: a qualitative study. Eur J Psychotraumatol. 2017;8(1):1389207.*
13. *Ashcroft. The veterans transition review. Lord Ashcroft Polls; 2014.*
14. *Clarkson P, Giebel CM, Challis D. Military Veterans Improving Access to Psychological Therapies (MV IAPT) Services: Final Report of an Independent Evaluation to Pennine Care NHS Foundation Trust. Manchester: Personal Social Services Research Unit; 2013.*
15. *FiMT. Call to Mind: A Framework for Action. Community Innovations Enterprise; 2015.*
16. *Murphy D, Hodgman G, Carson C, Spencer-Harper L, Hinton M, Wessely S, et al. Mental health and functional impairment outcomes following a 6-week intensive treatment programme for UK military veterans with post-traumatic stress disorder (PTSD): a naturalistic study to explore dropout and health outcomes at follow-up. BMJ Open. 2015;5(3):e007051.*
17. *Albertson K, Best D, Pinkney A, Murphy T, Irving J., Stevenson J. "It's not just about recovery": The Right Turn Veteran-Specific Recovery Service Evaluation. Sheffield Hallam University; 2017.*
18. *HM Treasury. The Magenta Book: Guidance for evaluation. London: HM Treasury; 2011.*
19. *Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Brymna A, Burgess RG, editors. Analysing Qualitative Data: Taylor & Francis Books; 1994. p. 173-94.*
20. *WHO. WHO definition of health Geneva World Health Organisation (WHO); 2003 [Available from: http://www.who.int/about/definition/en/print.html.*
21. *Slade M. Mental illness and well-being: the central importance of positive psychology and recovery approaches. BMC Health Serv Res. 2010;10:26.*
22. *Clarkson P, Giebel CM, Challis D, Duthie P, Barrett A, Lambert H. Outcomes from a pilot psychological therapies service for UK military veterans. Nursing Open. 2016.*
23. *Gyani A, Shafran R, Layard R, Clark DM. Enhancing recovery rates: lessons from year one of IAPT. Behav Res Ther. 2013;51(9):597-606.*
24. *Richards DA, Borglin G. Implementation of psychological therapies for anxiety and depression in routine practice: two year prospective cohort study. J Affect Disord. 2011;133(1-2):51-60.*
25. *Irvine Fitzpatrick L, Prior S, Forsyth K. An evaluation of V1P Centres across Scotland. Veterans First Point Scotland; 2018.*
26. *Clark DM, Layard R, Smithies R. Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. Behaviour research and therapy 2009;47(11):910-20.*
27. *Posternak MA, Miller I. Untreated short-term course of major depression: A meta-analysis of outcomes from studies using wait-list control groups. Journal of Affective Disorders. 2001;66(2-3):139-46.*
28. *Rossom RC, Solberg LI, Vazquez-Benitez G, Whitebird RR, Crain AL, Beck A, et al. Predictors of Poor Response to Depression Treatment in Primary Care. Psychiatr Serv. 2016;67(12):1362-7.*
29. *Fear NT, Van Staden L, Iversen A, Hall J, Wessely S. 50 ways to trace your veteran: increasing response rates can be cheap and effective. Eur J Psychotraumatol. 2010;1.*

WALKING WITH THE WOUNDED
Supporting Those Who Served

WALKING WITH THE WOUNDED

HEAD OFFICE

Stody Hall Barns, Stody, Melton Constable, Norfolk NR24 2ED

t 01263 863900 **e** info@wwtw.org.uk **w** wwtw.org.uk

MANCHESTER OFFICE

42 Canada Street
Manchester
M40 8AE

t 0161 205 9287

LONDON OFFICE

33 Ranelagh Gardens
Royal Hospital Chelsea
Royal Hospital Road
London SW3 4SR

Registered Charity Number 1153497