A Protocol for Evaluating Serious Stress in Military Veterans, their Carers and Families

ABSTRACT

In 2018, the Armed Forces Covenant Fund Trust (ACFT) allocated approximately £4M to seven UK projects to address Serious Stress in Military Veterans, their Carers and Families. These programmes commenced between May and October 2019 and will conclude in August 2021.

This paper outlines the protocol for the evaluation of the Serious Stress programme and the novel support provided to grant holders. Entry into the programmes were through multiple routes including self-referrals with an anticipated sample of approximately 2000 participants. A common outcomes framework was designed to measure outcomes. Grant holders accepted ownership for data collection and quality, and were supported through accompanying guidance material. Ethical approval was obtained at the University of Cxxxxxx.

Veterans were often reluctant to seek support, and the anonymous and confidential nature of the evaluation plus the study team's military background helped address this. Participant's voices were a key part in developing the protocol, leading to results to inform policy and highlight success, efficiency, cost effectiveness, and provide markers for future development.

The study provided a reservoir of information. Interim reports indicated compliance with performance indicators and provided timely evidence. Shared learning provided grant holders with an indication of what was helping the beneficiaries, and what needs to be improved. The combination of all data sets provided the ACFT with a resource to demonstrate success and insight into projects where improvement was required, and indicators of how to redress these problems. The study protocol provided a platform for building lasting partnerships.

Key messages:

Shared learning provided grant holders with an indication of what helped beneficiaries, and what needed to be improved.

The combination of data sets provided a resource to demonstrate success and facilitating insight into projects where improvement were required.

The evaluation indicates what was successful in getting veterans and their families back into employment, improving their lifestyle, physical and mental health.

The results indicate factors negatively impacting on help seeking behaviour in the Armed Forces Community.

The study provided a platform for building lasting collaborations with leading authorities and organisations, governmental agencies, professional bodies, charities, business, and appropriate networks.

A Protocol for Evaluating Serious Stress in Military Veterans, their Carers and Families

Introduction

In the United Kingdom (UK), there is a considerable focus on assisting veterans to handle adverse physical and MH difficulties related to their military career.[1] The Armed Forces Covenant sets out the UK's commitment to those who have served in its Armed Forces and this includes access to healthcare, as well as support in a number of the wider determinants of health, including education, family wellbeing, and housing.[2] The Armed Forces Covenant Fund Trust (ACFT) delivers the Covenant Fund; and source projects that support military veterans and their families. In 2018, the ACFT allocated in the region of £4M to seven projects to address Serious Stress in Veterans, their Carers and Families (See Figure 1). This *Serious Stress* initiative was required to improve the wellbeing of veterans, their carers' and families whilst addressing possible barriers to accessing health care faced by former members of the Armed Forces. The rationale being that if veterans and their families are provided with these appropriate interventions, within an environment that values leadership and that tackles stigma, then stress can be effectively managed. These projects commenced between May and October 2019 and will conclude in August 2021.

The University of Cxxxx's (UoC) xxxxx Centre for Research in Veterans (The Centre) was awarded an ACFT grant to undertake an independent evaluation of the *Serious Stress* projects. This was the first time such an approach had been adopted by the ACFT, and this paper outlines the development of the protocol, how to conduct a survey, the support provided to the grant holders, and reflects on feedback obtained.

Figure One Here

Background

The inclusion criteria for classification as a UK military veteran is one day of service in either the Regular Armed Forces or Reserves. The UK veteran population is 2.4M in number, and they are embedded in an Armed Forces Community (AFC) that includes their families and personnel still serving. While veterans seem not to differ from the general population in terms of many wider determinants of health, the risk of mental illness does appear to be highest in

early service leavers[3] combat experience,[4] those evacuated from operational tours due to an injury[5] and reservists.[6]

Serious Stress

A major cause of stress is aligned to physical ill health.[7] In addition, stress will be caused by multi-factorial psychosocial stressors that influence the onset of Mental Health (MH) and depressive disorders. Life events such as relationship problems, family problems and occupational issues (not military specific) are the most common stressors leading to MH problems within the Armed Forces irrespective of rank, age and gender.[8] A UK veterans transition review [9] indicated evidence of anxiety and depression being more common among veterans who were either divorced, not in paid work, caring for someone else in their household, or living on their own. Veterans are perceived as being more susceptible to MH issues due to previous operationally linked traumatic events, particularly when colleagues were injured. Some find the transition from military to civilian life difficult due to homelessness, unemployment and financial problems.[10] Research also indicates that female soldiers were significantly more likely to attend for a MH assessment; be admitted to hospital for a MH disorder, and were also more prone to being diagnosed with depression and stress reactions.[11] Individuals' responses will depend on their coping mechanisms which may include alcohol misuse.

Help seeking is poor, and veterans often "bottle up" their feelings; fearing the impact of sharing personal burdens with their family or appearing weak [8] and within Primary Healthcare only approximately 8% of veterans are correctly coded.[12] It is recognised that a MH problem for one member of a family has a ripple effect onto other relatives.[13] In addition into approved psychological treatments, serious stress may be managed by social prescribing interventions that can positively and successfully promote help seeking and reduce stigma. These include yoga,[14] and organised recreational activities such as archaeology. [15]

A Common Assessments Framework

Common assessment frameworks that provide the structure for simultaneous evaluations are uncommon. The *Serious Stress* model introduced in this paper was informed by W.K. Kellogg's Foundation's Logic Model Development Guide and Evaluation Handbook, [16]

the World Health Organization's services program evaluation model [17] and MoD assessment of Military MH (MMH) hospital admissions. (8, 11]

The *Serious Stress* common outcomes framework was designed in different levels, placed along a continuum that can be shaped and extended depending on the requirement and complexity of the projects. This is presented diagrammatically in Table 1.

LAYER	REQUIRMENT	EXAMPLE	DATA	RESULTS	COMMENT
1a	Demographic & Population Specific Detail	Age, gender, length of occupation.	Quantitative – Entry & Exit Questionnaire.	Mean, spread and distribution of results in areas such as ethnicity, gender and age. Include Likert Scales.	Provide baseline data and measure quality of intervention – may indicate statistical significance. Can include written text for content analysis. Individual beneficiary's specific intervention and the benefits gained.
1b	Specific population stressors	Housing, accommodation, education, finance and employment			
1c	Current situational stressors (empirical basis)	Relationship, family problems, occupational stressors			
1d	Exit Data	To include evaluation and satisfaction			
2a	Psychometric Questionnaires	Mental and Physical Health. Quality of Life & Wellbeing.	Validated such as: GHQ, AUDIT, WEMWES (see text for detail)	Annotate measures of improvement / deterioration	Can be applied at times along the different times (pre and post) for longitudinal analysis.
2b	Health Programme	Weight, blood pressure , alcohol consumption	Primary and Secondary measurements		
3a	Commissioner's Performance Indicators	Defined per grants programme	Quantitative	Measure of success against stated criteria.	Can be captured at other periods such as monthly.
3b	Advanced Audit	Consideration of existing data sets, research	Quantitative	Retrospective measurement of data.	Can provide legacy detail and pointers for development. Lessons learnt.
4a	Self-Declarations & Ripple Effects	Benefits for the whole family or close friends / relations. Highlight areas for development.	Qualitative	Personal qualitative interview such as case study. Indicators of wider beneficiary improvements.	Determine the influence of the local medical services, lifetime stresses, stigma and help seeking behavior.
4b	Focus Groups			Group discussion.	
4c	Journey Mapping – Veterans Voice	Customer journey mapping technique		View of the beneficiary's journey.	Process of tracking and describing all of the experiences that customers have as they encounter a service or set of services.
5	Social Return on Investment	Use of medication, resolution of health issues, beneficiary specific detail such as return to employment	Quantitative	Determine extra-financial value measured by health, environmental and social outcomes, relative to the resources invested.	Calculating the social, environmental and economic impacts.
6	Research Specific – Randomised Control Trials	Allocation a number of personnel to a control group which could be standard practice or no intervention	Quantitative	Inferential statistical calculation and indicated of transferability of results	Power calculation for defined sample size.

Table 1. Outcomes Measurement Framework data collection model

This framework provides the structure for the collection of standardised, valid, and reliable information from multiple activities and a clear pathway from the collection of data to dissemination of results which, in the short, medium and long-term assist in offering value for money. The findings will place an emphasis on generality and sustainability to reliably inform policy and highlight success, efficiency, safety, cost effectiveness, markers for future development, and detail to inform occupational recommendations regarding the emerging themes.

Sample Size and Eligibility Criteria

Entry into the Serious Stress programmes were through multiple routes including self-referrals, statutory bodies or Charities. Once a beneficiary had been assessed at one of the seven *Serious Stress* grant holders, then the client would be referred to approximately 50 delivery partners who would provide a significant variety of the interventions. The grant holders anticipated participant enlistment ranging from 100 to 550 participants resulting in an sample of approximately 2000.

Questionnaire Design

The questionnaire was to capture data to ensure compliance with the ACFT's performance indicators. Next was to establish the best data collection methods, whilst utilising military knowledge and experience to demonstrate a clear insight into the literacy levels and abilities of the population under investigation. The study team assessed the volume of work, geographic challenges, sample group characteristics and allocated research resources appropriately. The development phase is outlined in Figures 2 and 3.

The Principal Investigator (PI) (Author 1) designed the questionnaires. The data collection configuration was chosen to facilitate the sustainable collection of information from multiple activities, with a structure based on best practice guidelines for questionnaire design, interviewing and attitude measurements.[18] The questionnaires collected core demographic data with age, gender, socioeconomic status, relationships, sexual orientation, ethnicity, dependent children, and occupation. This supplied profiling information to meet the aim of the study and determine if certain groups responded better to the ACFT funded projects and to highlight vulnerable groups. There was military specific detail regarding branch and length

of service, rank, cap badge and operational tours. There were a series of questions that identified existing stressors such as finance, education, housing, employment, and accommodation. Information was also gathered to identify the motivators that stimulated participants to enter the *Serious Stress* programme and the role of the local medical services, lifetime stresses, stigma and help seeking behaviour.

The questionnaires included tick boxes answers to annotate the participant's exposure to biopsychosocial situational stressful factors. These were supplemented with Likert scale questions to measure outcomes and reflect changes at different stages of any grant project. There was space for written content on significant events so that participants had the option to express their concerns and highlight actions taken to resolve problematic issues. It was important to involve participants in measuring user satisfaction, and this offered a useful way of evaluating outcome and monitoring service quality information. This was included in the exit questionnaires.

Additional validated and reliable psychometric questionnaires were added with the intent to establish feasibility and sustainability by assessing physical health, MH and well-being. These were the General Health Questionnaire (GHQ),[19] Patient Health Questionnaire 9 (PHQ-9),[20] Generalised Anxiety Disorder (GAD-7),[21] Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)[22] and the Alcohol Use Disorders Identification Test (AUDIT).[23] A cost benefits analysis was included to model the economic returns that could be expected in different payback timescales. This determined extra-financial value measured by health, environmental and social outcomes, relative to the resources invested. This data was informed by EQ5D 5L,[24] and Work Productivity and Activity Impairment Questionnaire (WPAI).[25] The Centre obtained copyright permission for the questionnaires.

Internal verification followed consultation with clinical and administrative staff, military, legal, lay-personnel, veteran groups, and AFC family members. Wider external consultation was provided by a committee of senior personnel from charities, academia, NHS, and the MOD. Following which, recommendations for extra questions were added to the questionnaires. Then the questionnaires were sent to grant holders for their feedback including their assessment of the best way to evaluate the project. This consultation laid the foundations for consistency in the interpretation of any questions sets and to inform any amendments. The result was the production of six questionnaires; three for entry into a

programme (veteran, carer or family member) and three for exit which included participant satisfaction data. They questionnaires take approximately 15 to 20 minutes to complete, and were written in plain English, but available in Welsh and other formats; such as larger font for the elderly and those with eyesight difficulties. These processes were intended to ensure consistency in the interpretation of any questions sets. Each questionnaire contains a unique participant identifier to ensure pre and post questionnaires could be matched whilst ensuring confidentiality. The questionnaires are available online (26)

Grant holders

Grant holders facilitated community projects, social prescribing, respite care, employment support, crisis intervention, and peer mentor case management with delivery from clinical personnel, psychosocial teams and peers. Projects followed the principle that stress and associated mental and physical health problems affects the whole family, and recovery requires resilience in the entire family system.

The PI conducted site visits at the chosen location of the grant holders as it was essential that they accepted ownership for data collection and quality. The Centre provided direction on how to: complete a survey, anonymise personal identification, storage, back-up and secure transfer of information; and disclosure of personal or sensitive information. The visits included a testing of practice scenarios and vignettes; and reaffirmed the importance of this being an independent evaluation. These visits highlighted that the completion of the entry questionnaire must make sense to the grant holders, delivery partners, and most importantly the participants. That clearly on occasions will not be the first meeting, as the person's health and immediate support must be the clinical priority. Completing the questionnaires could be accomplished once the participant was feeling better. Also, grant holders may provide extended maintenance / safeguarding interventions after the *Serious Stress* programme, and therefore would not wait for participants to be heading out of the door to ask them to complete the exit questionnaire, but rather receive the information on the completion of the specific *Serious Stress* element.

The Centre produced accompanying reference / guidance material in the form of a step by step (question by question) guide on completing the study questionnaires and uploaded this onto the UoC website portal. There was a telephone/email helpline with the intent to answer queries as soon as possible and within 48h (on working days). Emerging themes were added

onto a Question and Answer section of the Centre website. These measures were intended to bypass problems before they occurred and thereby safeguard the quality of the results.

There was recognition that veterans were often reluctant to seek support, were negatively influenced by stigma, and often mistrusted official services and subsequently hide their symptoms. There was sensitivity regarding factors such as potential legal implications or substance abuse. As such they be may be fearful that disclosure would result in disciplinary action and this would compromise the overall quality of feedback. The anonymous and confidential nature of the evaluation partially addressed this, and an E-bulletin was one way of sharing with delivery partners the study team's military background. (26)

Patient and Participant Involvement

Representing participant's voices was a key part of associate working along the customer journey and the role of delivery partners reflected the priority to embrace public and user involvement, welcoming participants as equal partners alongside any other collaborator (Table 2).

1	Personnel currently enrolled on a study. The study team gauged participants' understanding of the data collection tool, language and that it was clearly absorbed. Identified potential problems such as why participants may not disclose information for reasons such as distrust, or the release of sensitive/incrementing evidence. This would determine if questions need to be added to reflect participants' aspirations.
2	Participants who have completed a programme. Gauged their assessment of the validity of the question set and identified shortfalls.
3	Delivery Partners. Assessed fieldworkers: commitment to engage; understanding of the data collection method; views of the challenges, benefits and what they would do differently.
4	Key figures. For example, in an older peoples' study then it would include community nurses, care home assistants and charities. Their opinions would help determine any particular characteristics in this group.
5	Spouses and family members. Determined their views, and identify the "ripple effect" where benefits to the participant impact on the wider family.

Table 2. Public and participant involvement

At the earliest opportunity, the researchers held IT platform (e.g. Skype) / telecommunication calls with the focus on the evaluation questionnaires, data collection and transmission. The grant holders were aware of the importance of communicating to participants the essential requirement and rationale for follow up data. The Centre's strategy for engagement with

respondents was built on clear and consistent communication within a close working relationship with proactive assistance offered as required. The study team's background and their understanding of military language and abbreviations offered another layer of credibility.

The Center embraced participants feedback on how to improve the evaluation. Grant holders indicated that after the completion of the questionnaire data collection that they would welcome a qualitative evaluation for both staff and participants. A series of focus groups or interviews would provide an overview of the participant's physical and MH wellbeing, emotional, and social functioning. In addition, grant holders identified the benefits in continuing data collection after the participants exited the *Serious Stress* programme with the repeated observations identifying improvement / deterioration over time.

Data Collection, Management, Storage and Sharing

Data collection was the responsibility of the grant holder which expedited data collection over multiple sites and a large UK geographic area. Governance arrangements were installed to ensure data accuracy, protection and confidentiality from the point of creation through all stages in its existence. The grant holders nominated a person to be responsible for data collection, and participants had the option of a paper or online questionnaire. The questionnaires were submitted to the Centre on a weekly basis and quality checked, and where appropriate referred back to the delivery partner co-ordinator for clarification. The Centre also initiated weekly phone calls with grant holders and ensured that the number of questionnaires received mirrored the number of participants registering for programmes. Finally, monthly online Webinars were introduced to highlight successes and on-going challenges.

The *Serious Stress* projects were not a linear process, with grant holders utilising multiple delivery partners for a single participant; which from a coding aspect was challenging. The grant holders were therefore advised to either: a) code the first delivery partner offering support or b) the delivery partner offering the most support. The participant's written feedback in the exit questionnaire would go some way to providing a narrative to capture the complexity of the intervention.

The study quantitative data was inserted into the IBM SPSS Statistics software database (Version 23), and qualitative data and free-text was coded and entered into the NVIVO software package (Version 12). The standard data collection and interconnectivity of databases facilitated the option to share and export data to other modalities, and were compatible with government, academic and health service configurations enabling data to be compared, contrasted and benchmarked as required.

Data Analysis

Analysis combined demographic detail with inferential statistical examination included an Analysis of Variance, non-parametric tests and regression analysis. Multi-variant examination would identify significant correlations to present the multi-factorial causes of stress. Data management was extended to accommodate validated psychometric questionnaires. The intent being to produce result to inform policy and highlight success, efficiency, safety, cost effectiveness, and provide markers for future development.

Small amounts of free text written responses were evaluated via a content analysis.[27] Quantitative and qualitative information would be triangulated to examine emerging classifications from different cohorts or interventions in order to demonstrate relevance in different settings. This could help validate the findings as trustworthy and authentic.

In the initial stages, the participants were diligent in comprehensively completing the questions. Analysis has produced accurate, authentic, and reliable data to provide resources that should actively help beneficiaries and inform clinical practice, education, and policy.

Ethics

The *Serious Stress* evaluation was approved by the UoC's Research Ethics Committee. The Centre apply systematic and structured access to the data at the earliest stage to ensure security of patient identifiable information and the Centre receives anonymous and confidential data, and the researchers do not know the identity of the participants. There was the potential that the studies psychometric questionnaires would duplicate those being used for a clinical assessment. These factors were detailed in a comprehensive invitation letter, participant information sheet, informed consent form and participants are given full transparency of the data storage requirements.

Conclusion

The study database has provided a reservoir of information. Interim reports indicated compliance with performance indicators and provided the ACFT with timely evidence that could be used to address parliamentary questions and / or freedom of information requests. Shared learning provides grant holders with an indication of what was helping the beneficiaries, and what needs to be improved. This was included in E-Bulletins containing contributions from the ACFT, UoC and grant holders, and highlights good practice, evaluation findings and other relevant information.

At an operational level, the combination of all data sets provided the ACFT with a resource to demonstrate success and insight into projects where improvement was required, and indicators of how to redress these issues. This provides both the grant holders, the ACFT and the NHS with clear information of how the expenditure was successful in areas such as reducing stress by getting veterans and their families back into employment, improving their lifestyle, physical and MH and wellbeing, helping with the interface / communication with health and social care. This many also inform other veterans with similar issues but were not seeking help. The study protocol provided a platform for building lasting collaborations, and identifying means for developing partnerships with leading authorities and organisations, governmental agencies, professional bodies, charities, business, and appropriate networks, and access other national and international committees under the same jurisdiction.

FIGURE LEGEND:

1. Covenant Stress Grant Holders
2. Developing the Evaluation Outcomes Measurement Framework
3. Outcomes Measurement Framework

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