



An Evaluation of Veteran-Led Peer Support Services for UK Veterans with Complex Mental Health Needs

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PROGRAM PROFILE

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ABSTRACT

The aim of this study was to determine the acceptability and effectiveness of veteran-led peer support services for veteran participants, members of the clinical team, and the peer support staff engaged in service delivery within Combat Stress, a United Kingdom (UK) based veterans' mental health charity. Three hundred veterans actively engaging at the time of evaluation were invited to participate in an anonymous survey. A cross section of staff were also invited to participate to provide an insight into their perspective of the effectiveness of the service. The results highlighted that peer support delivered by UK-based veterans' mental health charity, Combat Stress, is a well-received service and is valued by staff and veterans alike. The survey data indicated that peer support helps veterans engage with clinical services, whilst also reducing isolation and stigma. This program profile suggests that peer support may be an effective bridge to help veterans engage in treatment, potentially increasing treatment completion rates and improving treatment outcomes. Additionally, the results complement other work in this field that has identified a reduction in perceived stigma from those who use peer support.

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PROJECT BACKGROUND

Combat Stress is a United Kingdom (UK) based, national charity that supports veterans with complex mental health needs that have arisen as a result of their service experiences. In particular, treatment is offered to those with Posttraumatic Stress Disorder (PTSD), Complex Posttraumatic Stress Disorder (C-PTSD), and associated comorbidities such as anxiety, depression, and substance misuse. Veterans are not required to have a medically made diagnosis and suitable treatment is agreed upon between the veteran and assessing clinician through a combination of recognised psychometric measures and in-depth interdisciplinary clinical assessments. Combat Stress provides evidence-based clinical interventions and offers a range of outpatient, residential, and digital services. In addition to the clinical treatment, Combat Stress provides family support to those identified by the veteran as important relationships and peer support. It is the peer support element of the service that is evaluated in this program profile.

Peer support has been defined as:

A system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through the shared experience of emotional and psychological pain. (Mead et al., 2001, p. 135)

The notion underpinning peer support is that connection with others who share a similar lived experience may promote recovery, improve well-being, and promote social integration.

According to Davidson et al. (2006), peer support falls into three broad models. The first of which is informal peer support (naturally occurring mutual support), this being the least structured. The next level is peer run services that capitalise on shared lived experience in a more formal, but often volunteer setting; and lastly, there is the model that utilises paid members of staff.

Combat Stress has offered a peer support provision to veterans experiencing service attributable complex mental health challenges since 2016. Initially, the Canadian "Operational Stress Injury Social Support" (OSISS) model (Heber et al., 2006; Richardson et al., 2008) was replicated. The OSISS model has endured for two decades within Canada and utilises both paid members of staff and volunteers to facilitate the groups. Peer support within OSISS is not a formal treatment, rather it is a network of peer support

that allows veterans, serving military personnel, and their families to access peer-support groups. These groups meet regularly and are part of a nationwide network throughout Canada and is supported by the Canadian Armed Forces and Veterans Affairs Canada. Groups are facilitated by veterans with lived experience of mental health concerns and have an element of professional oversight provided by a clinical psychologist. Once a veteran is involved with the service, they are able to access the group for life. In addition, veteran attendees have the freedom to attend when desired and if they choose not to attend, there is no structured follow up to nonattendance. Work by Duranceau et al. (2022) found that the OSISS service was most used by veterans also engaging in clinical treatment for PTSD, which further supported its suitability for use within Combat Stress, as 68% of veterans accessing Combat Stress displayed symptomology associated with PTSD/C-PTSD (Murphy et al., 2021). The original peer support offer within Combat Stress was a veteran-led service that was run by veterans with lived experience of both service life and mental illness. This demonstrated the value placed upon experiential expertise and, at the time, was the first of its kind in the UK. The service was essentially one for life—those who attended would not face discharge and could attend as and when the attendee felt it would be most helpful. Originally, this was a project funded by the Royal British Legion, a significant UK-based veteran charity. A subsequent internal review identified that the project was well received by veterans and as peer support groups were so well attended, peer support was included as a core service of the charity in 2018. In 2020, the convergence of the recent recognition of C-PTSD in the ICD-11, a patient needs study that highlighted the multiple traumas experienced by those accessing Combat Stress, and of course, COVID-19, led to a significant service redesign of the way treatment was provided by Combat Stress. As a result, this included a review of the peer support service to ensure it was still a good model for use within this changing landscape.

As Combat Stress moved towards the delivery of a more recovery focused model of treatment, it was clear that the OSISS model for delivering peer support was no longer a good fit for the charity. The main reasons for the need to deliver an alternative form of peer support included the need for a discharge process and for the inclusion of a more robust nonattendance process to ensure the well-being of those who were unexpectedly absent from the group. It was felt that it was no longer adequate for what was now a very targeted clinical service delivering evidence-based treatment to be offering an unending peer support service with a possible side effect of prolonging the phase of the patient role. Additionally, the peer support case load

was reaching unmanageable levels and also, it felt that a “forever” service did not convey the recovery philosophy which was central to the new Combat Stress ethos. The initial step was to consult with the veteran participants for their view of the required changes; this was then followed by a steady but conscientious effort to refine the delivery and governance of the service to ensure it was safe and recovery focused. An additional challenge was to ensure that the changes occurred without compromising the experience of attendees or demoralising the existing peer workers who greatly enjoyed their role.

NEW PEER SUPPORT SERVICE MODEL

Peer support is now embedded into the clinical pathway that Combat Stress offers. It can be accessed by any veteran who has received a Full Clinical Assessment (FCA) from a member of the clinical team. Peer support is available for the entirety of the time that a veteran is involved with clinical services, and a further 12 months post-discharge from treatment. Whilst no longer “for life” as under the previous model, this timeline allows for a multiyear involvement with peer support for many veterans. It is felt that the 12-month timeframe allowing access to peer support post-discharge from clinical treatment is crucial for several reasons. Firstly, and perhaps most significantly, this timeline prevents a “cliff edge” drop off in support for those leaving what is likely to have been an intense period of therapy and associated support. This allows for a period of monitoring, and where necessary, ease of re-referral into treatment, all whilst continuing to help veterans achieve their stated goals, such as increasing their social circles. Secondly, it allows sufficient time, in an environment conducive to recovery, to embed new behaviours and for local support in the community to be identified.

INCLUSION CRITERIA AND EMBEDDING STAFF INTO THE CLINICAL TEAM

There are only 5 Regional Peer Support Coordinators (RPSC) to cover the entirety of the UK. All RPSC are veterans with lived experience of military attributable trauma, and it is their role to arrange and facilitate group and individual sessions with veterans engaged with Combat Stress. The current low number of RPSCs means that demand currently outstrips capacity. Previously, volunteers had been used; however, this was placed on hiatus as a result of the pandemic and has yet to recommence. As a result of capacity issues, a decision was taken to ensure referrals were made only when clinically indicated. This would allow access for all, but at a point in their treatment pathway that would maximise the benefits to the individual’s recovery

whilst protecting the service from becoming overloaded. It was recognised that for some, the most helpful time for peer support would be at the point of entry to clinical treatment. To avoid excluding anyone that would benefit from the intervention, the following inclusion criteria for those entering peer support immediately following their entry to the service was established:

1. Extreme social isolation
2. Extreme levels of self-perceived stigma and/or shame in relation to their mental health needs that peer support could usefully address directly or indirectly through normalisation and modelling of vulnerability
3. Extremely low self-esteem and/or low self-determination, particularly low confidence in their capacity to engender positive changes for self
4. A strong ambivalence or patterns of fluctuating engagement with past treatment
5. A cynical view of treatment
6. Previous history of treatment not achieving desired outcomes with Combat Stress or other mental health services
7. Difficulty in consistently engaging with mental health services

To access peer support, the veteran and their clinician agree that it is both desired and appropriate, then the referral will be discussed at the Inter-Disciplinary Team (IDT) Meeting. This is held weekly in each region and involves all professional groups. RPSCs are an intrinsic part of the IDT. They provide expert opinions having experienced both military service and recovery from mental ill health.

UPSKILLING OF PEER SUPPORT STAFF

Additionally, the RPSCs have all received training in intentional peer support (Mead, 2024), motivational interviewing (Rollnick & Miller, 1995), safeguarding, domestic abuse, and Mental Health First Aid (MHFA; see *Mental Health First Aid England, 2023*). They are viewed as professionals in their own right and have both regular supervision and reflective sessions and also their own continuing professional development plan. Having the RPSC at the centre of clinical discussions is one way that Combat Stress demonstrates value for the voice of lived experience.

ENGAGEMENT PROCESS, SESSION CONTENT, AND INNOVATIONS

Once a referral to peer support is agreed upon, a formal referral form is completed by the referring clinician. Once received, the RPSC has 5-working days to attempt contact with the veteran and to offer an initial appointment. During this initial appointment, the RPSC and the veteran will agree

on whether or not peer support remains a suitable service for the veteran. At the start of the veteran's engagement with peer support, through the completion of an initial engagement form, they are asked to identify up to three goals that have a relational focus. These goals are distinct from clinical goals and are reviewed every 6-months through the use of a simple Goal Attainment Scale. This ensures that the work remains both person centred and recovery focused. To assist in moving towards these goals the veteran will be offered either one-to-one mentoring sessions with the RPSC or access to peer support groups. The one-to-one mentor sessions allow for the RPSC to normalise the help seeking experience and to role model the possibility of recovery. Additionally, these sessions can be used to help a veteran engage in prosocial activities, such as supporting them to attend a local group or club of interest to them. If group work is decided upon, there is an opportunity for the veteran to select from a number of groups that can be either in-person or virtual.

In an effort to deliver a service that is both innovative and one that explores the value of the concept of being a "peer," there is a selection of groups available. The decision to offer a selection of groups, rather than one homogenous peer support group, is informed by the principles of intersectionality (Crenshaw, 1991). These principles suggest that many people will share certain characteristics, but that their experience of the world will be mediated differently based on other nonshared characteristics. The most obvious example with veterans would be the different experiences a woman may have had compared to a man, and these different experiences may be delineated based on gender. Other examples may include age and conflicts served in. For example, although a 65-year-old Falkland veteran will share common threads of experience with a 25-year-old Afghanistan veteran, there are also substantial differences in all other aspects of their military experiences and social lives. Therefore, a number of groups have been established to provide choice and to create a camaraderie that is relatable and shared by all in attendance. Additionally, there are a number of non-military themed groups to include prosocial activities such as walking and yoga. Further groups are added in response to issues of international significance such as the Ukraine conflict and will run on a time-limited basis allowing for a level of agility to meet the needs of the veterans at the time. There is at least one virtual peer group held at various times every working day, which allows for all veterans to be in a position to attend at least one meeting each week.

All groups are run in 3-month blocks, upon completion of which the veterans are invited to either attend for a further 3-months, or to step away for a period of time not longer than 3-months. During this time, there are still regular

interactions with the RPSC to promote their well-being; they just no longer participate in group activities during this time. In addition to the extensive virtual offer, in-person working remains a central feature of the service, allowing for those in the same region to meet at an established location—encouraging both the enhancement of local support networks, and also mobilising the motivation to leave the house, or to travel into a city. For some veterans, these in-person groups may form the majority of their interaction with the external world.

Both group and one-to-one peer support sessions follow a similar formula. Around a quarter or more of the session explores a recovery topic, such as benefits of a healthy lifestyle or importance of maintaining social relationships, and the remainder of the session might focus on practical issues, as well as space for "military humour." The military is a culture in its own right, with a collection of social norms and beliefs that often sit outside of the rest of society (Coll et al., 2011; Reger et al., 2008). Holding this in mind whilst also remaining professional is a fine line to navigate. Military humour can be used by serving military personnel to get them through and to recover from incredibly challenging experiences—experiences not shared by any other group in society. Military humour can therefore be an incredibly powerful tool in establishing rapport and trust, and in creating a feeling of acceptance. However, military humour could also be used as a euphemism to excuse unacceptable behaviour both in the military and outside the military environment. Therefore, whilst some aspects of military humour will deepen connections, for some, it will be a reminder of many negative experiences from their service life. It is therefore important that the value of this cultural component is acknowledged whilst also retaining clear boundaries about what is acceptable within Combat Stress facilitated peer support sessions.

It was also felt that we needed to delineate clear rules of conduct and expectations from those engaging with the service, such as communicating when they are unable to attend a session. As such, now, if a veteran does not attend a session they were expected at, the RPSC will complete a follow up well-being check and consider whether or not a police welfare check may be required. This is designed to communicate to the attendees that they are valuable, and their lack of attendance will be noted. Also, it was aimed to move subtly towards being a service that has participants who actively "opt in" rather than passively attend or do not attend. Ensuring this stayed within the boundaries of conveying value and concern, whilst empowering veterans to participate in recovery activities more intentionally without it being perceived as an overly clinical or bureaucratic process, was a challenge that took some navigating—particularly due to the high numbers of

veterans on each RPSC case load. As such, one of the first steps in redesigning the peer support service was to manage the case load size to make the new processes achievable. Efforts to achieve this were further complicated by COVID restrictions meaning that peer support was the only social interaction many veterans had; therefore, a considered decision was made to delay the implementation of the 12-month time limit until after the lifting of all restrictions placed upon society during the pandemic to ensure that all veterans had at least 12 months to re-engage with the world post lockdown.

WHEN PEER SUPPORT IS NOT A SUITABLE INTERVENTION AND DEALING WITH COMPLEXITY

In some rare instances, it may become apparent the peer support is not a suitable intervention. The exclusion criteria are not a deterministic set of rules, rather the criteria guide decisions regarding whether peer support is suitable:

1. Unaddressed and/or active substance abuse problems that make sober attendance unlikely
2. Ongoing civil or criminal legal proceedings of a serious nature
3. Radicalised political or social views that could impact the healthy recovery of others in peer support
4. A lack of desire to engage in peer support
5. Emotional dysregulation that would not be conducive to group work or non-clinical engagement
6. Style of interpersonal functioning that would not be conducive to group work or nonclinical engagement

To further engrain the intertwined nature of peer support and the clinical pathway, the RPSCs are expected to return cases of complexity to IDT for discussion. Examples could include poor engagement, interpersonal difficulties that are displayed in either mentor or group sessions, or any other challenging situation that would be best supported through interdisciplinary case formulation. To compliment the IDT case discussions, RPSCs are provided peer-led line management supervision, which is valuable in supporting RPSCs at Combat Stress. This allows a veteran to join Combat Stress as a paid employee and progress into a managerial position. Staff are also provided with group reflective practice sessions held every 2-months by a senior member of the clinical team. Additionally, the staff group is encouraged to meet weekly as a well-being group. It is intended that a combination of line management supervision, reflective practice sessions, and regular well-being groups create a mix of what is required to promote professional and safe delivery of services, professional development, as well as staff cohesiveness and resilience.

MOVING TOWARDS EVIDENCE OF EFFECTIVENESS

The final addition to the new delivery model was the collection of Routine Clinical Outcome Measures (RCOMs); the measures selected were DIALOG (Priebe et al., 2007) and the UCLA Loneliness and Isolation Questionnaire (Hughes et al., 2004). These measures were selected to allow for the evaluation of service effectiveness. They could also both be used conversationally to help generate action plans that were coproduced and led by the veteran. The DIALOG (Priebe et al., 2007) is an 11-question measure asking for a self-reported evaluation of happiness in multiple life domains, including relationships, employment, medication, and view of mental health services. This provides for meaningful discussions and workplans around the areas most important for the veteran; furthermore, it offers an opportunity to measure change. The UCLA Loneliness and Isolation Questionnaire (Hughes et al., 2004) asks only three questions related to how connected the veteran feels to their wider social work. This can be used as a means to validate the impact of attending groups within peer support. The data from these measures that has yet to be collated will feature in a future evaluation.

DATA COLLECTION

The 300 veterans who participated in peer support were anonymously surveyed to ascertain their views about the service during the previous 12 months. This survey provided a mix of demographic questions, satisfaction measures set on a Likert scale, and free text response. Of the 300 surveyed, 56 veterans responded. Veterans were frequently surveyed for the last 24 months to help evaluate service developments and to inform future changes to peer support. This survey was part of routine data collection, although additional demographic data were requested. Veterans were invited to complete the survey as part of the regular email contact from their RPSC, and the survey was completely optional. The peer support staff from each region (all of whom replied) were also invited to share their views. Anonymous surveys were sent to the five operational managers and it was requested that they asked a further four staff members from their region to complete it. Nine responses were received.

ETHICAL CONSIDERATIONS

As this was a service evaluation and used routinely collected information, no formal ethical approval was required; however, those who replied were made aware that the surveys would be used to complete an analysis of the peer support provision in Combat Stress. Additionally,

at the point of assessment, Combat Stress obtains consent for participation in research and evaluations. All surveys were anonymous by design in the hope that this would both protect confidentiality, whilst making it easy for veterans or staff to provide critical feedback if they felt it was warranted. The survey was distributed to a central mailing list with a link to an online survey, which upon completion did not provide any form of digital identification. The questions asked for generic age ranges and some other demographic information to allow for an accurate evaluation of the service; however, there were no questions requesting personal information such as names or location. In the free text section, some chose to provide personal details; however, all data included in this report was anonymised to ensure that there is no identifiable information contained in the document.

RESULTS

VETERAN DEMOGRAPHICS

The survey data highlighted that peer support is currently provided to a population group who is predominantly white, British, heterosexual males who served in the Army for at least 6-years with a weighting towards those who served significantly longer. The tables below provide a clear indication of who is accessing the service and also who is not. There are many possibilities as to why many groups are underrepresented, and this is an area that should be explored further. **Table 1** (below) provides a breakdown of the demographic data.

HOW VETERANS PERCEIVE THE SERVICE

The replies from veterans were overwhelmingly positive, reporting that the service was an important part of their recovery, reducing isolation, enhancing their social networks, and experiencing a reduction in negative stigma.

A 5-point Likert scale was used to explore 11 questions relating to how veterans experienced the service, and how the intervention intersected with their recovery. When asked about the overall perception of the service, all but 1 of the 56 participants who replied advised that they believed the service to be either very good or good.

Veterans were asked to provide additional feedback via free text: 31 comments were received in total. The theme from the comments was one of gratitude that the service exists and appreciation for the staff that run the service. A selection of comments can be found below:

1. Thank God we have Combat Stress.
2. The importance and value of peer support should not be underestimated.

AGE	NUMBER (n)	%
35-44	3	5
45-54	16	29
55-64	24	43
65-74	13	23
SEX	NUMBER (n)	%
Male	47	84
Female	6	11
Prefer not to say	3	5
SEXUAL ORIENTATION	NUMBER (n)	%
Heterosexual	51	91
Gay or Lesbian	1	2
Prefer not to say	4	7
SERVICE BRANCH	NUMBER (n)	%
Royal Navy	1	2
Army	41	73
Royal Air Force	10	18
Reservist	2	3
Multiple	2	3
LENGTH OF SERVICE	NUMBER (n)	%
3-6 Years	5	9
6-9 Years	12	21
9-12 Years	9	16
12-15 Years	9	16
15-19 Years	4	7
18-22 Years	5	9
22 Years +	12	21
LENGTH OF TIME SINCE LEAVING SERVICE	NUMBER (n)	%
3-6 Years	3	5
6-9 Years	2	3
9-12 Years	6	11
12-15 Years	6	11
15-19 Years	4	7
18-22 Years	10	18
22 Years +	25	45

Table 1 Demographic Data.

3. Peer support is irreplaceable.
4. I believe that the Combat Stress peer support service is a superb element of the organisation, which complements the clinical support veterans receive.

5. Combat Stress has saved my life and after [Staff name removed] asked me to be a peer support volunteer has helped me and encouraged me so much to go forward with my progress and recovery with my PTSD.
6. Combat Stress saved me and my marriage. Can't thank the organization enough. It provides me with an outlet and a social when I need it. I feel supported and so does my wife and family.

REPORTED IMPACT OF PEER SUPPORT

Table 2 (below) provides an overview of 56 replies received regarding the veteran reported impacts of peer support; notably 89% (n = 50) felt it increased their motivation to engage in clinical services, and 94% (n = 53) felt that peer support contributed to a reduction in negative stigma, which support the previous work of Heber et al. (2006). There was a reported reduction in isolation, concurrent to an increase in social networks, and an overwhelming view that those facilitating peer sessions must themselves be veterans.

PEER SUPPORT STAFF

What was indicated from the replies is that delivering peer support to veterans is a vocation that provides both purpose and meaning for staff, and that they feel like valued members of the organisation. As all peer support staff are veterans with their own experiences of mental ill health, the importance of purpose and meaning within recovery can not be understated. Therefore, to have those in recovery find this through their employment is an incredibly positive outcome. Furthermore, the integration of nonregistered health and social care professionals into the clinical pathway proved challenging and these replies indicate how far the charity has come in the value the organisation places on this service and staff that deliver it.

CLINICAL, ADMINISTRATIVE, AND OPERATIONAL STAFF OPINION

A common theme from the replies from clinical, administrative, and operational staff was that they feel the role of peer support is valued by all stakeholders. It was also noted that 77% of those who replied have at least weekly contact with the peer support professionals in their region, indicating how comprehensively the peer support staff are networked into the operational delivery of clinical services. Furthermore, 92% of respondents felt that the peer support reduced feelings of negative stigma, and 100% felt that the service enhanced veteran motivation to engage with clinical services and reduced isolation. This supports the value of the service as observed by those not directly involved with its facilitation.

Several areas to improve were suggested by members of the clinical team. These included more communication between the RPSC and the clinicians, including them with more substantial and regular updates on a veteran engagement with peer support, and also better communicating what additional services peer support can provide. This could include details on individual mentor sessions, or the running of short term, but highly topical groups such as the group for Falkland veterans during the 40th anniversary of the conflict.

The following comments relate to the views of peer support, shared by members of the clinical team.

1. Peer support is an invaluable part of our service.
2. If anything, I'd increase it.
3. Just a massive thanks to our peer support colleagues without whom our service would be greatly diminished.
4. I think we would benefit from having more peer support workers as their knowledge and input is invaluable.
5. Peer support is an invaluable part of our service.

	TOTALLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	TOTALLY DISAGREE
Accessing peer support gave me confidence and/or motivation to engage with other clinical services.	50%	39.3%	10.7%	0%	0%
As a result of peer support, I feel less isolated.	53.6%	32.1%	14.3%	0%	0%
As a result of peer support, I have made new friendships with other veterans that I now class as friends.	42.9%	37.5%	17.9%	0%	1.8%
I feel peer support contributes to a reduction in negative stigma felt by veterans with mental ill health.	69.6%	25%	3.6%	0%	1.8%
It is very important that the peer support service is ran by veterans.	83.9%	10.7%	5.4%	0%	0%

Table 2 Impact of Peer Support.

IMPLICATIONS FOR CLINICAL PRACTICE AND FUTURE RESEARCH

Peer support remains a well-received service despite some initial reservations regarding the need for change from the attendees and the staff group that facilitated the service. However, there are further areas for improvement to enhance each veteran's experience with the service. The feedback received from veterans and staff has led to the creation of the following action plan:

1. RPSC to inform referring clinicians on initial outcome of the referral and provide regular ongoing updates
2. RPSC to ensure their documentation is detailed and up to date
3. RPSC encouraged to be more active participants in the IDT
4. Further training on professional boundaries
5. Head of Service to be included at an early stage to address any concerns
6. Any feedback, positive or negative, to be recorded on the incident recording system as standard practice
7. Groups will be advertised and loaded in 3-month blocks and shared with all staff and veterans to create options and increased awareness of what is available

The information gleaned from the survey provides a detailed breakdown of who currently accesses peer support in Combat Stress. By default, it also identifies groups that are underrepresented. This is an area that should be addressed, and the solution to this is most likely multifaceted. A potential way to address the disparity amongst the veteran population accessing Combat Stress is to enhance our external reach into organisations that aim to support minority groups. An example of this could include Fighting with Pride, the Army Women's Network, or more locally run groups such as those held by the Nepali community (who have a sizeable presence amongst the British Army).

This program profile has indicated that self-reported survey data support the efficacy of peer support. This should be the springboard to a further three projects to ascertain the value and effectiveness of peer support. Firstly, an evaluation of the outcome data at intervals including after 12 months of collection should occur. Additionally, the areas of significance identified in the survey, such as positive reduction in stigma or enhanced motivation to engage in clinical services, should now be explored further using recognised psychometric measures. Finally, an effort to further qualitatively capture the experiences of the users of this service should be sought via another project utilising focus groups.

LEARNING

The inclusion of a nonclinical support service into a clinical pathway is a challenging process. It requires

long held assumptions of professionals to be challenged and processes to be changed in order to ensure the safe delivery of the service—yet these processes cannot seek to overly “clinicalise” the service or to turn the staff members into quasi-clinicians. The value of this service is that it is delivered by nonclinically trained members of staff, all of whom have been employed to capitalise on their expertise through their experiences. Therefore, despite the distinction that this is not a clinical service, veterans report this service enhances their motivation to engage with clinical treatment, and clinical staff report the value of the voice of lived experience within clinical meetings is invaluable. The challenge is therefore less about making this service fit within a clinical model, and more about embracing the differences in which it does not.

A limitation of this service evaluation was that the data was collected only from those engaged with the peer support services. It is possible that had other veterans been included, they may have provided insight not currently captured. Furthermore, the data was taken at a fixed point in time, and therefore does not provide an indication of acceptability of peer support over time.

OVERALL SUMMARY

The survey data also indicates that peer support is a valued service provision amongst the wider Combat Stress treatment offer. It indicates that veterans who attend peer support are motivated to engage in treatment, and that the service boosts both social networks and self-esteem whilst eroding negative stigma, stigma that may have been particularly engrained whilst serving in the military. The presence of veteran members of staff is particularly well received amongst the hubs, and the staff that deliver the service take a huge amount of professional satisfaction from the work they do. The importance of staff satisfaction should not be understated as all RPSC are veterans themselves and would not tolerate the delivery of a suboptimal service to their fellow veterans. Whilst some areas for development were identified, the veterans who participated report that peer support has positively contributed to their recovery.

COMPETING INTERESTS

The author is employed by Combat Stress.

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