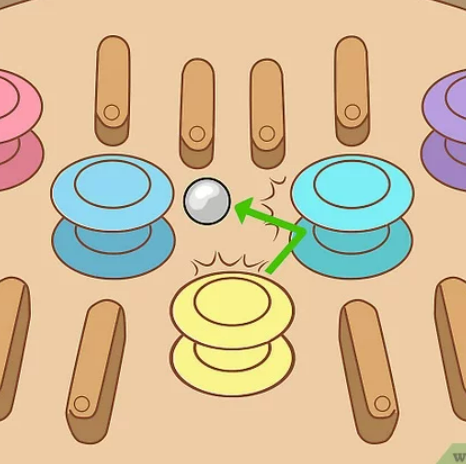
**Veterans’ Places, Pathways & People Programme**

**Consultation with Veterans and Families / Carers**

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**Executive Summary**

**May-July 2024**

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Description automatically generated**By Paul Rhodes Consulting**

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# 1 Foreword by Paul Rhodes, Independent Researcher.

As an independent social researcher coming fresh to research with Veterans, I was struck by two things most of all. The courage and unflinching honesty with which Veterans and family members shared their stories, and the consistency of the themes coming out of the focus groups and interviews, regardless of location. I was humbled by what they told me.

Veterans and families have taken this opportunity to a clear message about the challenges they face, the broad types of support they require and, critically, how it should they should be delivered.

The feedback you will read is compelling, but it is important to frame these findings in context. Compared to Veterans from previous generations, there is now far more support available, but, and it’s a big if, if it is known about and accessible.

Low awareness appears to be the key underlying challenge to address.[[1]](#endnote-1) This comment sums it up “The Veterans that I help, they don't know what's out there. They have no clue about a lot of what is out there.”

Veterans who have found and access a suitable hub will be in more advantageous position than their peers who are unaware or live too far away. Our research is admittedly hub-centric, however, in terms of potential to provide holistic support and potentially build capacity across other third sector organisations, hubs as a model have merit. Investing in hubs that are capable of the ‘generous leadership’ required to look outwards and involve others is one natural conclusion from this research.

The needs of families and carers have for too long been overlooked, but VPPP could mark the start a sea change in how families are treated. Families feel they need permission to take part. The programme should continue to listen and co-develop support with families, as this aspect is the least developed.

Veterans care little for the wiring behind the scenes that connect the various National Ops to regional and local support. They do care about being treated honestly, with respect and by someone with the knowledge and experience to help them. Welfare and Liaison Officers play a central role in helping to navigate the system. The plethora of small charities who do not connect with the wider sector and /or hold their Veterans tight are not seen to be acting in the best interests of the Veteran or family.

Accountability is seen to be lacking – organisations that claim to be ‘Veteran friendly’ often fail to live up to that. The VPPP programme could lead by example in this respect.

Holistic support requires strong partnership working, and to be most effective, the connections and active support from the MOD to provide the best chance of tackling the deeply rooted stigma about mental health, so Veterans and families who need support can reach out before they reach crisis point.

# 2 Introduction

In 2024, the Government made a further £10 million available to The Armed Forces Covenant (2011, updated 2022) to fund the Veterans Pathways, Places and People Programme (VPPP) for a further 3 years. The next period (2024-2027) builds on the progress and learning from the first phase, and has four key intended outcomes which were consulted on.[[2]](#endnote-2)

**Methodology**

To inform how the VPPP is delivered in the North and Midlands regions led by DMWS, there was a consultation phase (April-September 2024) to engage with the intended beneficiaries of the programme. This report presents the findings from Veterans and their families and carers.

* In total 88 Veterans and / or family members / carers were engaged in this phase of the research in 11 face to face focus groups and 3 depth interviews.[[3]](#endnote-3)

A companion report focusses on the consultation findings with the Voluntary, Community, Faith and Social Enterprise sector (VCFSE).[[4]](#endnote-4) DMWS also conducted a review of secondary sources, which provided the quantitative evidence to underpin the next phase of delivery

# 3 Key findings

The key findings from the consultation are presented here using the four intended outcomes and the simple framework of “the challenge” and “potential solutions”.

**Outcome 1: Significant improvements in help-seeking behaviour among the veteran community.**

***Challenges***

* There are multiple challenges to improving help seeking behaviours (around mental and / or physical help.
* The relationship with the Armed Forces was often damaged by how people were treated when they left, which is also a barrier to seeking help from any service run by or funded by the military.
* There is a reluctance to seek help that is seen to be programmed into serving personnel; combined with pride and a value of putting others first. This means people often reach crisis before taking action.
* Other than perhaps the MOD, no organisation can reach all or most Veterans directly. Families are a further step away.
* Awareness of the support available is low, and provision is geographically patchy. The cost of accessing suitable support may be a barrier for some.
* Veterans and their families may not identify with the being a Veteran, or wish to (for example with members of the LGBT+ community who served pre ban).

***Potential Solutions***

* Veterans and families alike agreed that early contact was key to encourage Veterans to seek help sooner – preferable integrated into and beginning before they leave the Armed Forces.
* In the short term, inviting serving personnel to VPPP events would help to both raise awareness and reduce the disconnection Veterans often feel with the military after they leave.
* Awareness and promotion to reach the disparate Veteran community needs to be approached like a business, utilising a range of promotional channels and not just relying on social media. Informal gatherings like breakfast clubs were seen to offer good opportunities to promote other opportunities.
* Hard to reach or engaged Veterans alike may respond more positively to the offer of support from another Veteran.
* Families have a key role to play in supporting a Veteran to seek help, but only if they are listened to.
* Peer buddy systems, already operated by different regiments, could be extended to all – thus reducing the reliance on the Veteran always being the one to seek help.
* Serving personnel and their families could be educated so they know they are a veteran, and therefore eligible for support. There is also larger, longer-term opportunity to educate the public about what the Armed Forces do in order to lift the status of Veterans.
* Success in the long term could be a local social support group for all Veterans and for all Veterans to have three contact numbers in their phones that they can call on for support.

**Outcome 2: Reducing the stigma associated with mental health and seeking help and support.**

***Challenges***

* Stigma around mental health is a long term, ‘wicked’[[5]](#endnote-5) societal problem. Reducing it will require long term investment from multiple actors in the system. There was significant scepticism that VPPP could ‘nudge the dial’ on stigma.
* Overlaid on the existing societal stigma Veterans also have to contend with the long-term impacts of being trained to ‘man up’, and not show any weakness or emotion for fear of negative consequences.
* Families too were conditioned to keep problems behind closed doors, again lest the issue was reported and had repercussions. Families described not being believed or supported when they stepped forward.
* Negative experiences for those who did disclose have reinforced the stigma.
* LGBT+ Veterans, especially older ones, have additional layers of stigma to contend with.
* PTSD is a loaded and often misunderstood condition that Veterans in particular have to contend with.

***Potential Solutions***

* Out of scope for VPPP, arguably the best way to tackle stigma among Veterans is for all serving personnel to undertake some form of stigma-busting programme. A common shared experience may then reduce the associated stigma. Societal attitudes will be still harder.
* Educating the general public that not all Veterans are either ‘mad, bad and sad’ is also beyond the means of VPPP to achieve. However, the suggestion, inspired by the Rotherham’s Military Community Veterans Centre (MCVC) “Hidden Faces’ project[[6]](#endnote-6) to present “the hundred faces of PTSD” may be an opportunity to make a valuable contribution that impacts both on the Veteran community and the wider public.
* For some Veterans, talking about their experiences and challenges is part of their recovery. A smaller subset wants to go further, “their mini crusades” against mental health or PTSD. The programme could provide the forum and the launch pad for these stories to have greater reach.
* Link or welfare officers in Hubs may help Veterans to ‘step over the threshold’ for support. LGBT+ welfare officers may be a particular gap that VPPP could consider linking with Fighting With Pride to fund.
* Finally (and the subject of chapter 4.3) ensuring that those seeking help receive a positive and supportive response.

**Outcome 3: Better holistic approach to supporting veterans focusing on mental and physical health services and activities.**

***Challenges***

* The challenges to providing better holistic support include the barriers to improve help seeking behaviours and reducing stigma – summed up as locating and building sufficient trust that a Veteran and / or their family are aware then able to reach out.
* Raising awareness among the wider Veteran community appears to be the most significant challenge.
* Families especially need to know they have permission to access VPPP
* The wording of this outcome is a barrier, participants disliked it and a number thought it related to alternative medicine (which might be part of the offer of course)
* Eligibility issues and a lack of continuity of support were significant barriers. Where Veterans needed to meet multiple criteria prevented access. Veterans also described postcode restrictions and inconsistent support depending on where they lived.
* Waiting times to access statutory service support were lengthy.
* Veterans want to receive fair treatment, not special treatment, but this has often not been the case. A bone of contention was organisations that display Veterans accreditations but not then enacting those commitments.
* Charities were not seen to effectively collaborate with one another.
* From the user’s perspective, one of the main challenges was the time limits placed on support. Veterans were rarely ‘fixed’ by short duration programmes, and would prefer either longer interventions or the facility to repeat or extend.
* Again, from a user’s perspective they described being like ‘the ball in a pinball machine’, bounced around and not knowing where they would end up. Users have very little control beyond engaging or walking out.
* Veterans who have received a poor experience in the past will be more reluctant to try again.
* The extent to which support was joined up around the needs of Veteran and family appears to be limited, and determined more by funding and availability than need.
* There will be significant variation in the support offered and available to Veterans and families depending on their location.

***Potential solutions***

* The consultation participants did not generally talk about specific services, more *how* and *from whom* they wanted support to come from.
* Veterans often spoke about how for them the support they had received from or through the Hub had been lifesaving, and on that basis, investing in services for the most at risk, and in hubs generally feels logical.
* Navigators (Link Workers, Welfare officers, the title is less important) are seen to be essential to help navigate through a complex, changing system. To be credible they do need a direct connection to the Armed Forces or a clear passion.
* Pilot programmes have funded a GP Nurse to attend hub sessions, leading to improved and quicker take up of treatment.
* Peer to peer support was valued above all other forms of support (perhaps as it is free to access, always available, non-judgemental and delivered by someone trusted, i.e. another Veteran or another Veteran family). This qualitative finding is also backed by research evidence.[[7]](#endnote-7)

**Outcome 4: Improved support for veterans' carers and veterans' families.**

***Challenges***

* The challenges described in the preceding sections are also relevant for families. The consultation revealed that support that includes families is far from the norm.=
* Families described their perceived lack of status when their partner was serving (although many partners met while in the Armed Forces) – simply “the wife or husband of…”
* Families, in general, did not feel that they have been listened to or involved.
* Divorced or separated partners described being abandoned.
* Like Veterans, families talked about keeping their problems hidden for fear of negative repercussions.
* Veteran families have a distinctive set of experiences and challenges as a result of their service – some of which may only come to the fore years later (for example a partner looking after a Veteran with early-stage dementia who is starting to be relive his time in the army and can be violent).
* This qualitative research provides a snapshot into the diversity of family units, and we have heard from wives, husbands, ex-partners, bereaved partners, bereaved divorced mothers, sisters and brothers.
* There will be other ‘significant others’ not represented.
* There are also family dynamics to consider, family members may be uncomfortable accessing support from the same organisation as their Veteran, nor may feel that they have failed to help them.

***Potential solutions***

* Families are an integral part of the Veteran community,
* Awareness raising will be central to engaging with families and carers – they talked of “being given permission” to engage.
* The range of services available to Veterans should, ideally, also be available to families. Families would likely put the Veteran first, so accustomed are they to doing so.
* The starting point may simply be listening to Veteran families and letting them know that the support available to Veterans is also open to them. This may be an opportunity to promote and celebrate organisations that are working well with families to encourage the wider sector.
* Veterans again wanted simplicity – so ‘family’ could be anyone that the Veteran says is family.
* Partners described how it would help to learn more about how to support their Veteran.
* Peer support was again considered a have a key part to play – with the additional suggestion that families could potentially support Veterans who were on their own.

# 4 Independent Recommendations

The independent researcher would like to propose the following 14 recommendations for DMWS to consider, based on the findings from this consultation with 88 Veterans and / or family members.

Suggested ‘success measures’ to assess the progress of VPPP are also put forward for consideration.

**Baseline position**

1. Undertake research of secondary sources to identify the most relevant baselines for help seeking behaviours and levels of stigma around seeking help for mental health.

**All outcomes**

1. For all of the four intended outcomes the VPPP programme is seeking, awareness raising and education will be required, therefore we recommend that collateral is developed that can be disseminated and spread through the networks. Any collateral should be simple, jargon free and in accessible formats.

The wider education piece for young people and communities is out of scope for VPPP on its own, but the programme could consider contributing to the education efforts of others, for example the in-school work carried out by the Royal British Legion.

**Outcome one: Significant improvements in help seeking behaviours...”**

1. We recommend that the programme invests in a connected network of high-quality hubs that are Veteran-led or with strong Veteran links (both have merits). Hubs should display generous leadership, i.e. the capability to take an outward looking stance and to upskill and work with the wider sector for the benefit of Veterans and their families.
2. Explore the replicability of the GP secondment approach piloted by Loughborough Wellbeing Centre.

The success measures for outcome one will be Veterans reporting that they are seeking help sooner than before, increased numbers of Veterans or family members engaging and Veterans and families reporting reduced isolation. Another success measure is every Veteran having at least three numbers in their mobile phone that they can call if they or those around them need support.

**Outcome two: “Reducing the stigma associated with mental health…”**

1. Stigma is a long term, intergenerational, ‘wicked’ issue that is beyond any part of the Veteran support ecosystem to tackle alone. We recommend that the programme engages at an early opportunity with the Ministry of Defence to explore the scope of and the viability for an enhanced follow up scheme for anyone leaving the armed forces. Our recommendation is for a wallet card or similar for all leavers augmented with one or more follow up calls.
2. We recommend VPPP explores at an early stage with the Ministry of Defence the scope to host or to carry out large scale interventions with serving personnel so that mental health stigma may be reduced as a result of that shared experience.
3. We recommend VPPP supports hubs to identify veterans who are willing to share their story more widely, and to use that in a way that can amplify the reach and impact of those stories in the hope that it encourages others. Alternatively, Veterans could contribute to a “100 (or) 1000 faces of PTSD” campaign inspired by the Hidden Faces project in Rotherham.

Success measures for outcome two are increased numbers of Veterans And families engaging and self-reporting that they were able to engage or that they felt there was less stigma to them engaging.

The longer-term impact for outcomes one and two will be a reduction in harmful behaviours, improved health and wellbeing and reduced isolation.

**Outcome three “Better holistic support…”**

1. We recommend that, through the network of hubs, consultation and co-design mechanisms are created (or supported where they are already in place) so that Veterans and families are able to continue to shape VPPP.
2. The asks from veterans are clear, the practicalities of making it happen much more challenging. We recommend that the programme actively talk with the creators of the Liberated Method approach[[8]](#endnote-8) to delivering public service then use VPPP as a way to implement this approach at scale so that support is designed around the individual.
3. Consider funding (or co-funding with other investors) liaison / support / welfare officers in the hubs to help Veterans to navigate the system.

Success measures for this outcome will be Veterans agreeing that the support available to them is more connected and joined up, fewer Veterans disengaging or dropping out, and an increase in the proportion of veterans willing to recommend support services to their peers. An accountability measure “VPPP does what it says it will do for me” could also be considered.

**Outcome four: Improved support for Veterans’ carers and families…**

1. Consider undertaking a mapping exercise to identify the extent to which services are currently accessible to families
2. Produce good practice case studies on Veteran family engagement and support
3. Ensure that all VPPP collateral includes families
4. Establish a Family advisory / user group to test and refine ideas as the programme rolls out.

Success measures for carers and families are as per outcomes 1-3. There may be additional impact measures that families report that they are more resilient than previously and agreeing that the programme values and supports them.

**In summary**

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# 5 Further Research Suggestions

There are groups who have either not been meaningfully engaged yet in the programme or who may merit further consultation and research.

We recommend that further research is considered, with following subgroups (in order of perceived importance). Research should be undertaken in collaboration with third sector organisations with expertise and beneficiaries in these groups:

1. Younger veterans
2. BAME groups – e.g. Gurkhas
3. Non-heterogenous families
4. National service veterans
5. Pre ban LGBT+ veterans.

# 6 Contact Details

We welcome your feedback, comments and suggestions on this research study:

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**Disclaimer**:

The information presented in this independent research summary is presented in good faith and deemed to be accurate at time of submission (September 30th 2024), however the author cannot accept responsibility for errors or omissions. Please see the full report for more detail and context.

1. **End Notes**

   A finding echoed in the research literature, e.g this [2023 study](https://jmvfh.utpjournals.press/doi/pdf/10.3138/jmvfh-2022-0009). “Future service delivery and policy should focus on improving the variety of sources of support that ex-serving personnel are aware of, and willing to use, to enable them to make informed choices about where to seek help if needed.” [↑](#endnote-ref-1)
2. The wording of the Programme outcomes for the next phase of VPPP were revised slightly during the consultation period – but did not introduce any new outcomes. The final version is:

   1. Enhanced Help Seeking:

   a. Significant improvements in help-seeking behaviour among the veteran community.

   b. Reducing the stigma associated with mental health and seeking help and support.

   2. Holistic Support Approaches:

   a. Better holistic approach to supporting veterans focusing on mental and

   b. Tailor activities and support services to address the diverse needs of veterans.

   3. Support for Carers and Families:

   a. Strengthen support networks for veterans’ carers and families.

   b. Provide resources and services that cater to the wellbeing of the entire family unit. [↑](#endnote-ref-2)
3. \*One female took part in both a Veterans and Carers group – hence the total of 89 not 88. [↑](#endnote-ref-3)
4. In total 74 people were engaged from the VCFSE sector, from 66 different organisations, as part of 13 focus groups. This part of the consultation was led by coproduction specialists every-one - [***www.every-one.org.uk***](http://www.every-one.org.uk/) [↑](#endnote-ref-4)
5. https://www.stonybrook.edu/commcms/wicked-problem/about/What-is-a-wicked-problem [↑](#endnote-ref-5)
6. https://mcvc.org.uk/projects/hidden-faces/ [↑](#endnote-ref-6)
7. See this 2024 study on Combat Stress. https://journal-veterans-studies.org/articles/10.21061/jvs.v10i1.480 [↑](#endnote-ref-7)
8. Mark Smith, Director of Public Service Reform, Gateshead Council.

   <https://www.changingfuturesnorthumbria.co.uk/liberated-method> [↑](#endnote-ref-8)