

THRIVE TOGETHER VETERAN AND FAMILIES CONSULTATION

2025-2026



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THRIVE TOGETHER

Empowering Veterans and Families:
Creating Connections. Building Futures

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1 Executive Summary

Introduction

These are the summary findings from a set of 10 focus groups with Veterans and Veterans' families carried out between July 2025 and March 2026. Consultation is an integral part of the Thrive Together programme in the Midlands and North regions. This is to ensure the views of Veterans and families are regularly being listened to and heard. This report contains the results from the second phase of the consultation – and will be valuable to practitioners working with Veterans and also to policy makers who are reconfiguring the Veteran support landscape at regional level utilising Valour.

At a glance:

- 10 focus groups with Veterans and family members: 6 in the North, 4 in the Midlands.
- 66 Veterans and family members took part, to discuss early help-seeking, holistic support and support for families
- The focus was on depth of information rather than duplicating quantitative monitoring or programme impact measurement
- Focus group discussions and interviews took place between July 2025 and March 2026.

Accompanying this report is a detailed set of quotations from the groups (and the previous consultation in 2024) and a PowerPoint summary.

Before we get into the findings, here is a flavour of who took part. Across 10 groups, participants ranged from Veterans in acute crisis (homelessness, justice involvement, addiction and

bereavement) to families who had experienced long-term strain, and serving families at a rural RAF base.

“They trained us, they broke us down and made us into what they wanted. I did not realise, until I came here, that it was these two that made me start realising my absolute worth somehow.” (Veteran, Midlands)

“I was sleeping out one night. It was pissing down with rain, lightning... I thought to myself, I can’t do this anymore. I need help. I went to the library, started looking up any support that I could get, because I had to get off the streets.” (Veteran, North)

Families described joining the military system, only without the uniform, then being left to manage with very limited support.

“Families are still here, the military is not.” (Family, Midlands)

This is a ‘hub-centric’ consultation, reflective of the Thrive partners. Hubs are repeatedly described as ‘family’: relationship-based, familiar, and low-barrier.

“This is just a walk in and out. You do not need an appointment. It is okay for anybody to just walk in and out.” (Veteran, North)

“Support for family and carers is difficult. Hubs like this are an alternative family for Veterans, they make this different kind of happy.” (Family, Midlands)

The focus group discussions were focused on the intended outcomes from the programme.

Key messages

- **Hubs are like a second family.** Participants repeatedly described Thrive partner hubs as relationship-based, familiar and low-barrier spaces that create safety, belonging and a route back, particularly for people who are isolated, mistrustful of formal services, or in crisis.
- **Help-seeking continues to happen late, so warm navigation is important.** Many Veterans and family members delay seeking support until they feel they are in crisis. When they do engage, they prefer active advocacy rather than being ‘signposted’ without ongoing support.
- **Holistic, activity-based support is a core part of the Thrive model.** Practical and social activities (not just formal interventions) help to rebuild routine, a sense of purpose and connection. Wellbeing and quality of life outcomes and human connection were treated as valid, important outcomes, especially for Veterans unlikely to return to work.
- **Peer support remains central, and could be extended.** Peer support is working because it is rooted in trust and credibility. Blurred lines between staff/peer/Veteran identities can create boundary and sustainability pressures. For some, there may be scope to formalise peer support (inspired by the Welsh peer support model).
- **Families are a less mature segment of the Veteran community, but there are promising green shoots of engagement.** Most family participants are engaging because the Veteran is already connected to a hub, or because a small, trusted local project invested significant time building trust. Family members often default to talking

about the Veteran's needs rather than their own, reinforcing the need for explicit permission and a very clearly family-inclusive offer.

- **Sustainability remains an active threat due to, although potentially improved by, Valour.** Partners reported displacement effects already, as organisations position for future contracts and funding pressures disrupt collaboration. There is cautious scepticism about larger regional models replacing local trust-based provision. The 'Thrive Loop model' was seen as something that should be integrated into this new landscape, not displaced.

Recommendations for future programmes

1. **Thrive programme leads (DMWS) and future commissioners:** Establish a programme-level Family Reference/Advisory Group to test assumptions (e.g., about 'what younger families want'), co-design offers across different family types (partners, children, bereaved and including serving families) and act as a sounding board for the sustainability phase.
2. **Future commissioners.** Move from short-term grants to more stable commissioning/contracting where possible, with clear outcomes and accountability—protecting local collaboration and reducing destabilising competition as evidenced by Valour procurement.
3. **DMWS and agreed partner organisations.** Pilot a peer support infrastructure informed by the Welsh model (role clarity, training, reflective supervision, and boundary support), recognising dual identities are a strength but need structure to avoid burnout and blurred expectations.
4. **Thrive programme team:** Pilot a mechanism to connect and activate Veteran / family social value opportunities at programme level by connecting local authority SV agendas and willing businesses to co-create or scale community offers/events framed explicitly around prevention and community benefit.

Key findings: Early help-seeking

- Late help-seeking persists. Across the focus groups, Veterans and families confirmed that many only reach services when they were already in crisis, homelessness, in the justice system, acute mental health breakdown or bereavement. Many group members talked about attending funerals of Veterans who had taken their own lives.
- This does not negate the value of Thrive Together; since without this collaborative network of hubs and partners there would be, in the words of one Veteran **"more illness, isolation, abuse and deaths"**.
- Veterans stressed that simply saying **"seek help sooner"** is meaningless if people do not know where to go, or if what they find is only signposting. As with our previous study, an effective transition from service would go a long way to reduce the challenges these Veterans describe.

"You say 'seek help sooner'? How do you achieve that? Because until you find one of these places, you won't find anyone. You can never, from my perspective, find help sooner, because it's not there. It is advertised, but until you're looking, you'll never see

it, and you're only going to be looking probably quite a long way down the line." (Veteran, Midlands)

- Awareness-raising and information sharing need a multi-channelled, consistent approach and ideally joined up in a locality. Negative first impressions from the past persist, so building trust renewal should be explicit rather than assumed. Help for Heroes are particularly good at advertising and promotion and there is existing funding allocated for video content. For example, MCVV (where there are many fine storytellers) are producing videos gradually so Veterans can get used to the process.
- Transition however is still seen to be a critical weak link. Although the accounts in the focus groups are historic (typically at least 10 years ago, sometimes 30), the evidence suggests that this is especially the case for younger early service leavers and those medically discharged who may not absorb offers when they are least ready. Our focus groups contain more positive reports on Veterans encounters with the national ops (including Op COURAGE and Op FORTITUDE), but partners report that their effectiveness still depends heavily on local capacity and funding stability.

"Transition is horrible. They lose the routine. They lose the structure..." (Family, North)

- Family members called for transition support to be extended for them as well as the Veteran. This would be an acknowledgement that spouses have often set aside their own careers while their partner serves, and would benefit from accessing similar support to that on offer for the Veteran.

"You sign up with them. You might not wear the uniform, but your whole life is shaped by it." (Family, North)

Key findings: Holistic support

- The strongest evidence across all 10 groups is that holistic, person-centred support is working. Veterans and family members can see that practical help with accommodation and housing, benefits; social connection; meaningful activities; mental health support; and advocacy is making a difference. This could be the feeling of a weight lifting to spend time with others who get you, respite for family members or the multi-disciplinary expertise required to take a homeless Veteran and help them to start again.

"It's your little escape as well. It's like a bit of respite. I didn't imagine my life like this... I just didn't think I'd be 30 and looking after my wife pretty much full time." (Family, Midlands)

- Veterans are aware of the difference between signposting and genuinely empowering people to take ownership of their recovery journey. Veterans would prefer advocates rather than a 'signposter'. This makes them feel valued, with the onus on 'the right people' being able to help them to achieve a fast-track referral that they haven't managed for themselves. At the same time, the sector should guard against co-dependency by building autonomy and tapering support. The phrase "civvies don't understand" is often heard within military safe spaces; language like this can become a barrier shouted loudest by those avoiding help. Professionals must be culturally competent, trauma-informed and prepared to grapple with that tension.

- Confusion persists around the Armed Forces Covenant Duty, particularly the distinction between priority treatment and parity of access. Veterans will sometimes use words like ‘entitled to’ and these can create unrealistic expectations. Some advocates and frontline professionals, with the best of intentions, may unintentionally miscommunicate the scope of the Covenant. Op COURAGE reports pressures when Veterans arrive expecting preferential access based on what they’ve been told. This highlights the need for greater consistency in messaging and training, so organisations accurately represent the Covenant Duty and its implications.
- Activities are not just recreational. They provide routine, identity, skills, peer connection and an accessible bridge into more formal support. Hubs like M.A.S.H East Riding (cited as an exemplar), Tri Services’ ‘Zero to Hero in the Kitchen’ and the Battle Back programme show how activities provide a valuable structure, routine, a chance to connect, have fun and learn new skills.
- Open-ended, relationship-based support means there can always be a route back. This pathway may not result in employment or secure housing, but quality of life outcomes that stem from human connection, engagement and routine are also important, particularly for Veterans who will not return to work.
- There is uncertainty among some working age Veterans who would like to use their skills to help others but don’t know how. This suggests there is untapped opportunity to link OVA investment in Veterans’ skills and national career pathways (CTP, RBLI, Step into Health, HelpForce, etc.) more explicitly with what hubs are doing.
- Peer support remains integral and central as it is rooted in trust – and it could also be one potential pathway for Veterans. Evidence from the Welsh Peer Support Model¹ suggests there could be value in formalising the role and training to achieve consistency, supervision and clearer boundaries.

Key findings: Support for families

- Services are struggling to access families – an issue that is much larger than Thrive. The census from 2021 tells us there were in the region of 2 million Veteran families, a quarter of them with children living with them and 10% of family members were Veterans themselves.² Where are these ‘hidden heroes’³ and what would encourage them to engage?
- Families remain under-reached, in general, and particularly for non-traditional families, including bereaved partners. The families who took part in this phase of the consultation were almost all there because the Veteran already engages with a hub or because a small, independent project like Outside the Wire (led by Hambleton Community Action) has invested time in building trust and creating the conditions where family members can start to get involved for their own sake.

¹ [Source](#)

² [Source](#)

³ The name of a successful [US programme](#) by the Elizabeth Dole Foundation to raise awareness about the caregivers of wounded Veterans.

- For family members who have been reached, hubs provide a similar sense of respite and “second family” that Veterans describe. Combat Stress found that Veterans’ recovery outcomes are better when their partner or support network is involved.⁴ Crafting together demonstrated that families can benefit too.⁵ Thrive has designed programmes specifically for families, including Combat Stress, but they are all at an early stage of maturity.
- From our conversations, family members will default to talking about the Veteran first, rather than other members of the family unit. Our previous recommendation to make it very clear that family members have permission to get involved remains valid.
- Families want local, relationship-based provision, targeted awareness-raising, and activities designed with them, including for partners, children, bereaved relatives, younger families, and those living on camp. Surprisingly perhaps, face to face is still much preferred, including by those with small children.
- Even if all these steps are taken, not all families will get involved. Outside the Wire, led by a local Veteran family member who had lived on the base in question, still sat in an empty room for the first weeks until family members started to come in.
- This report recommends the future programmes establish a family reference/advisory group at programme level to provide a valuable sounding board. This group would help to test assumptions (for example, that “young people don’t want regimental associations” or “to reach young families the offer needs to be online”) and co-design offers that genuinely speak to different life stages and family types.
- Families of serving personnel highlight issues that will become Veterans’ issues later: precarious housing, constrained careers, patchy local provision, and anxiety about transition. These families did not feel heard or valued, so is it any wonder they may not choose to get involved in Veterans and family services later?

Sustainability

- Sustainability remains a challenge for the Thrive partners. Before the midway point in Thrive, organisations were already adjusting and trying to position themselves to bid for Valour contracts.⁶ This has displaced some activity and shifted the focus away from the work Thrive partners are committed to on the ground.
- Hubs like Tri Services, Stand To, MCVC and Veterans Launchpad consider themselves as the “local engine that drives everything”. Larger, regional Valour centres were regarded as potentially less effective, national charities with their additional overheads not best placed to work with Veterans on the ground.
- Partners called for a move away from short-term grants to more stable contracts, with clear expectations, outcomes and the ability to terminate if standards are not met. This could improve sustainability and accountability across the sector.

⁴ [Source](#)

⁵ [Source](#): ‘Community Reinforcement Approach and Family Training.’

⁶ [Source: https://www.gov.uk/government/news/government-spends-record-levels-to-support-our-veterans](https://www.gov.uk/government/news/government-spends-record-levels-to-support-our-veterans)

- The core ‘Thrive model’, discovery, peer-led activities, warm navigation (not signposting), partnership working, feedback and continuous improvement, provides a strong basis for commissioning and social value.

“It's great, because there is a circle, but it's not closed circle, because there's always room for more people to come in, more organisations.” (Partner Midlands)

- Thrive partners have received training on social value and can use bespoke software to help them report on SV. There is scope, at programme level, to connect local authority social value efforts and businesses that have expressed willingness to contribute with the creation of new or bigger events for Veterans and Veterans’ families, as an identified community need or gap.
- Continuing to share learning cross-sector, through case studies, video stories, podcasts and peer-led content, will continue to be crucial. Veterans repeatedly said they “[listen to their peers before anyone else](#)”; so, investing in authentic storytelling from hubs will be central to awareness-raising, trust renewal and earlier help-seeking from Veterans yet to engage.
- The blurred lines between being a staff member, peer supporter and Veteran have again been noteworthy, especially given that a significant proportion of professionals in this sector have personal experience. This dual identity is both a strength and a challenge: it brings credibility and empathy, yet can complicate boundaries, expectations and conflate participants’ experiences with their own.

Next steps

- The next phase of the consultation will pivot to consider how the innovative programmes within Thrive are developing. A second series of focus groups is planned for April-June 2026.

We now present the detailed main report. Each section on the consultation findings follows the same format; what is working well, what the likely alternative experience might have been (‘counterfactual’), the ongoing challenges, then what could be improved to sustain and extend any gains.

Anonymised quotes are used throughout to ensure that the voices that matter most are also the most prominent. Care has been taken to ensure the accuracy of these quotes, but they have been lightly edited to ensure they can be understood out of context. As noted, there is a full set of quotations and summary focus group reports available separately for anyone seeking a more granular level of detail.

2 Introduction

Thrive Together takes a partnership-based approach. Consultation is an integral part of the programme – to ensure the views of Veterans and families are regularly being listened to and heard. This report contains the results from the second phase of the consultation.

Across 10 groups (five Veterans' groups and five family groups, including families of serving personnel) we listened to **66 people**. This sample included older and younger Veterans, early service leavers, Veterans in contact with the justice system, people with complex mental and physical health conditions, those who had experienced homelessness, bereaved partners, parents and carers, and spouses currently living on base. Many described hubs like Tri Services, Stand To, MCVV and Veterans Launchpad as a “[second family](#)” or “[last chance saloon](#)”.

“It’s like you’re coming here because it’s last chance saloon in a sense, you’re not coming because you’re successful and doing really well in life. You can choose two ways where you want to go – partying and going down that road and whatever comes with that, or you could stick, give the project a chance, you know, and really take advantage of what’s available.” (Veteran, North)

This consultation builds on a previous round of consultation carried out in 2024, which helped to shape the intent and composition of Thrive Together in the Midlands and North.⁷

⁷ Building on the first round of consultation in 2024 which involved 88 Veterans and family members over 11 focus groups.

3 Method

3.1 Engagement Methods

- Focus group recruitment was led by Hubs and third sector organisations who are part of one of the Thrive Together partnerships (North or Midlands). Participating organisations and focus group participants were, by design, a mix of those involved in the previous consultation and new.
- The Veteran and family / carer groups were scheduled for the same day, with space for informal chat over lunch. Staff from DMWS were available if the discussion triggered the participant.
- A recruitment specification was shared with Hubs and a colleague from DMWS led the main recruitment process.

3.2 Focus Group Approach

The following steps were implemented to create the conditions where Veterans and their families could talk openly

- The day began with a briefing for the facilitator with the staff team to bring them up to speed with events
- Discussion subjects were shared in advance so there were no surprises
- The discussions were facilitated by a neutral social researcher, well briefed by DMWS
- Sessions were held face to face, to encourage interaction and also to allow support to be made available to participants if needed.⁸
- A separate, private space to talk – so Veterans could hear one another
- 90-minute running time to allow for depth of discussion
- Participants could take a break whenever they needed to, for whatever reason.
- Support from the Hub and DMWS available at all groups for participants triggered by the discussion
- All groups recorded, with permission, to allow comments to be captured accurately, and, if required, heard again in context.

⁸ A planned online group with younger Veterans did not take place, owing to a lack of engagement from the organisations (outside the Thrive partnership) who had initially offered to support them.

Sample

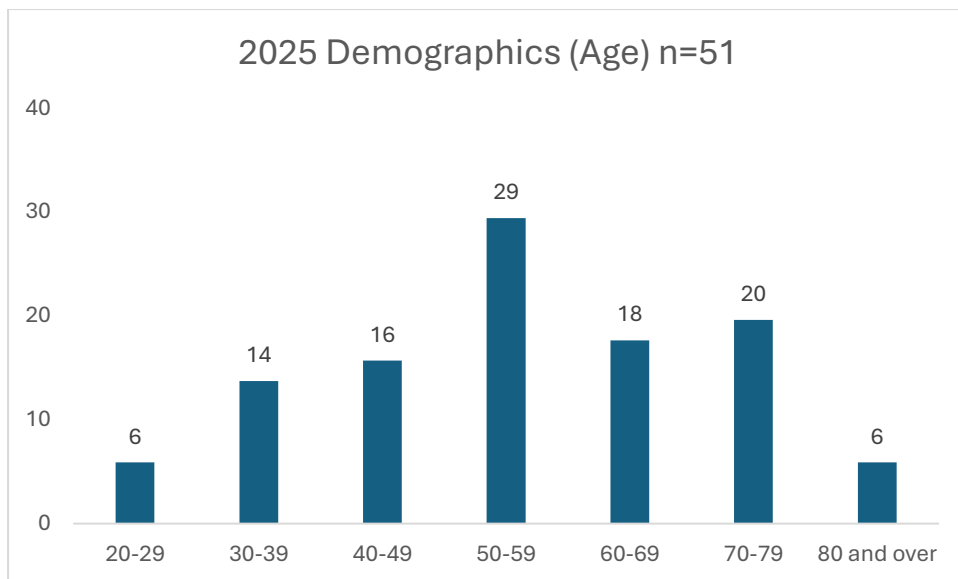
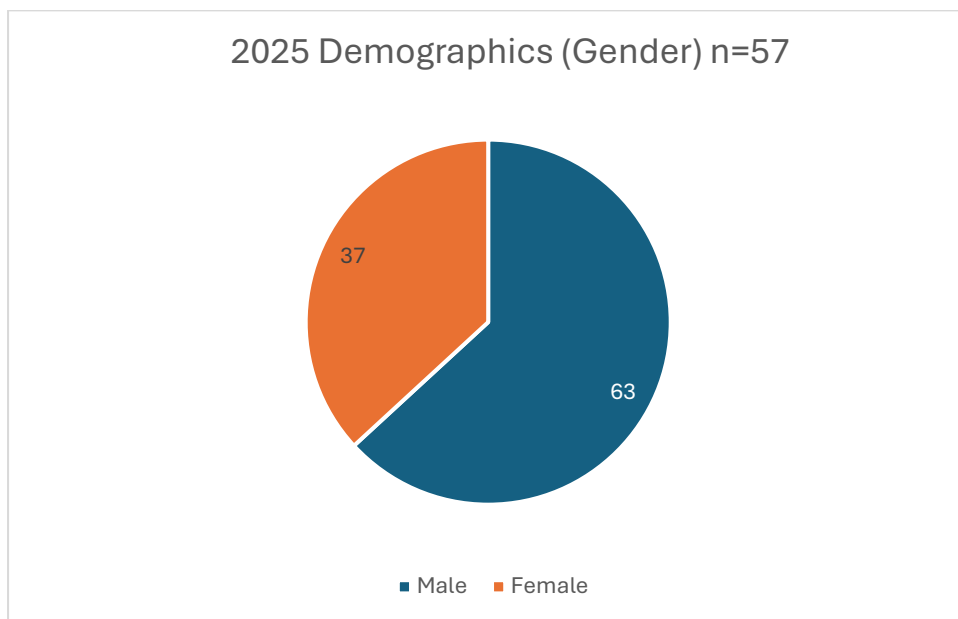
Based on the first **10 focus groups** with Veterans (5) and families (5), the total number of attendees was **66**.

Region	Focus groups (Veterans then families unless otherwise noted)	Date	Veterans attending	Families attending	Staff attending
Midlands	Tri Services (2)	14-Jul	11	4	–
Midlands	Stand To (2)	30-Jul	8	3	–
North	Veteran Launchpad (2 Veterans' groups)	29-Jul	15	0	4
North	MCVC (2)	29-Jul	7	5	–
North	Hambleton Community Action / One Vision (1 family group)	11-Nov	0	7	1
North	One Vision Uniformed Services (1 family group with a mix of Veteran and non-Veteran families)	13 March ⁹	1	5	3

Broadly a third of focus group attendees were aged under 50 and the same proportion were female.

As part of our bid to hear new voices, we spoke with a group of family members living with their serving partner on a RAF base. Their perspectives therefore come from a different place, in every sense, but also highlighted some recurring themes about permission to take part for themselves, a lack of recognition and their concerns about transition align with those from Veteran families on the other side. At the final group in Cumbria, a mix of Veteran and non-Veteran family members took part, which added another dimension on how these different worlds interact (or don't).

⁹ The delay between this final focus group and the others is due to challenges identifying suitable opportunities to meet with families.



Limitations:

- In order to consider and discuss the programme outcomes, it was decided that a qualitative approach was preferred. For qualitative research to be trustworthy, it is important for the researchers to be open and transparent about how the work was carried out.¹⁰ Qualitative research allows us to put the views of Veterans and families at the centre, in their own words, and to adapt our discussion in light of what was being said; for example to probe further into a subject the group felt strongly about or to test ideas raised in previous discussions. This approach helped to put people at ease, so in almost every session the facilitator adapted the flow of questions to preserve the conversational, informal atmosphere so participants felt able to talk openly.
- Qualitative research cannot claim to be representative or generalisable in the way a large quantitative survey can, however, by conducting multiple focus groups we took great care that our research was not skewed by a small number of strong viewpoints. Furthermore, our findings can be compared to other research studies, and to the findings from additional consultation led by DMWS and other VPPP portfolio leads.
- There is a 'hub-positive' skew to the findings, which reflects the location of the focus groups and hubs taking a lead on the majority of the recruitment. Our sample included limited input from:
 - Younger Veterans
 - BAME Veterans or family members
 - Other minority groups were not involved.
- Family groups were less well attended, but reflective of the wider programme, nevertheless, the quality of the conversation was good.
- The Veteran Launchpad group and Hambleton Community Action groups included staff members – who Veterans wanted to have in the room – but this inevitably impacted on what was discussed.

Across the 10 groups we heard from:

- **Tri Services (Midlands):** Veterans from Army, Navy and RAF, some now in policing or other public services, at different points from crisis to relative stability. A second group with family members seeing the impact of hub activity on home life.
- **Stand To Veterans and families (Midlands):** people with justice involvement, addiction histories, bereavement and long-term trauma.
- **Rotherham MCVC Veterans and families (North):** older Veterans, TA Veterans, carers and bereaved partners, with complex family histories.
- **Veterans Launchpad (North, two groups):** homeless Veterans plus staff with lived experience.
- **Outside the Wire (North):** one group with spouses of serving personnel living on camp, juggling isolation, postings and precarious housing.

¹⁰ See this [academic study](#) for a suggested 'trustworthiness framework' for qualitative research.

- **One Vision Uniformed Services:** family members and Veterans at a breakfast event and an evening group for females.

4 Key Consultation Findings

4.1. Enhanced help-seeking behaviour

Across the focus groups, we spoke with Veterans who had found the courage, or had the encouragement, to engage with either a hub or a service. The consultations highlight that while most Veterans and families still come forward only when in acute crisis, the availability of local, trusted ‘first doors’ has made the experience of seeking support a positive step.

What’s Working

The most consistent finding across all groups was that local, relationship-based hubs are working in making help-seeking possible and acceptable. The hubs’ success lies less in the number of services provided, but in the tone and nature of engagement: informal, continuous, and non-judgemental.

“Local means I can get into town. I can bring the kids. I do not have to go to some big centre miles away where I feel out of place.” (Family, North)

Above all support is typically delivered by staff and volunteers ‘who understand’. Veterans and families contrasted this with formal systems that could feel bureaucratic or transactional. For many, hubs represented the first place where they felt able to speak openly about trauma, mental health, housing or finances without fear of stigma or dismissal.

“I’m very guarded on what I say, what I do outside... I come in here, I relax instantly. You feel safe because everyone’s kind of got your back.” (Veteran, Midlands)

“MCVC does simple things well. The doors are open, the tea is on and nobody is looking at you like a problem.” (Family, North)

Reasons for seeking help

The trigger for seeking help for some was being in custody or prison.

“I was arrested and the outcome of that was Op COURAGE and lots of other agencies becoming involved in my life. Had that support been there prior to the event, it’s quite likely that event would never have happened. So, at the moment, there’s been involvement for 18 months. They reckon they’ll be in my life for the best part of another 12.” (Veteran, Midlands)

Homelessness was also a decisive factor for some.

“I was sleeping out. It was pissing down, lightning... I thought to myself, I can’t do this anymore. I need help. I had to get off the streets. Op FORTITUDE called me then put me on the train up here.” (Veteran, North)

The routine and layout of hubs and (in the example below) supported accommodation, is part of their appeal, and consequently, can become part of the Veteran’s routine.

“It’s kind of like a block when you’re in the army. The setup is not completely alien to you.” (Veteran, North)

We met one such Veteran at Stand To in Chesterfield, who came in most days, had opened up over time and even contributed artwork for the walls. The staff team were actively taking steps to ensure he wasn’t becoming over-dependent and were making connections outside of the hub that would extend his social network.

“This is just a walk in and out. You do not need an appointment. It does not matter if we have seen you 12 times this week already. It is okay for anybody to just walk in.” (Volunteer, Midlands)

A success factor at Stand To is the presence of volunteers who will go outside and encourage people to come in. Their town centre location is a real asset too, and a number of family members have registered the building then come back to talk at a later point.

Participants spoke of staff who remembered their details, checked in with them and followed through on promises, making them feel valued. This builds trust.

“I came in after two and a half months in hospital, and they said I’d been missed and kept updated about me being in. You feel valued.” (Veteran, Midlands)

“Being listened to and remembered makes you feel you matter. That’s why we trust them.” (Family, North)

“It takes months to build that trust, but once they’ve got that trust, you’ve got mutual respect.” (Staff, North)

Once trust is in place, if more support is needed, the conditions are in place for referrals, advocacy to be taken up, which brings the potential for change.

“They’ve said they’ll help and then actually followed through—calling people, sorting appointments so we’re not left chasing.” (Veteran, North)

“Help for Heroes contacted the doctors on her behalf: ‘Why isn’t A, B, and C being done?’ Things started moving.” (Veteran, Midlands)

Being in the company of peers and staff with lived experience is an aspect of hub support that is highly valued. Veterans described being ‘seen’ and understood without lengthy explanations or judgement. Family members talked about how that shared experience was able to cut through reserve and defensiveness, particularly for men reluctant to disclose vulnerability.

“Men will never talk. We brush it off and move on. You’re expected to just get on with it... I think a lot of people end up in a place like this because they’re on their arse, so to speak, and they have to ask for help.” (Veteran, North)

“It’s quite overwhelming when the doctors talk so fast and they just throw words at you. I’m not a doctor, I’m not medically trained. I struggle to get through a sentence



sometimes, for me actually being understood. So having a doctor sit there and run through a scenario or an explanation of what they believe is the problem, and then you ask that question, and they kind of belittle you, like you should know what I've just. I've just told you the answer. And it's like, 'No, you haven't though, because I don't understand.'" (Veteran, Midlands)

"You're given numbers by doctors, you phone up, and you don't know what to say, and you just, you end up giving up." (Family, Midlands)

Veterans are in turn more likely to encourage others to engage – and they are seen by staff as the “best ambassadors”.

“Now I encourage everybody else... If I can find Veterans, I tell them.” (Veteran, North)

R promotes the group through his Facebook group and makes calls to get people involved.” (Family, Midlands)

Veterans feel safe in these settings, perhaps not immediately, but the ‘kettle always on’ approach (a hallmark at Stand To for example) means anyone can come in to ‘test the water’ before they go any further.

“You’re not rushed... ‘Get your head right, take it easy, transition yourself’. They give you that kind of respect.” (Veteran, North)

“You have to trust people. There is so much pride. They will not walk into a place if they think it is going to be tick boxes and questions. Here it is the same faces, you get to know them, they get to know you. That is what makes it possible to talk.” (Family, North)

The informal nature of much of the support offered by hubs is a key ingredient – valued by both Veterans and families.

"We help each other out, even if it's just a chat or a cup of tea. That support means more than people realise." (Veteran, Midlands)

“You’re in the same room but you’re not glued together. I’ve got my five minutes and someone else to talk to that’s in the same boat.” (Family, North)

Across focus groups it was striking how often Veterans and families used family metaphors to describe how they felt.

“Support for family and carers is difficult. It’s hubs like this that provide a sort of family, an alternative family for Veterans, they make this different kind of happy.” (Family, Midlands)

“This is like a family. You walk in and people notice if you are not yourself.” (Family, North)

Support received

There were a range of examples of where staff or volunteers were able to help the Veteran or family member get the support that they had been unable to achieve for themselves. Whether a warm handover, or more overt advocacy, the support feels personal.

“All roads lead to Ann, the Armed Forces Outreach Service. She supports us with move-on and referrals.” (Veteran, Midlands)

“Christine knows which routes to direct people to, and she gets in there faster than anybody to get what they need.” (Family, North)

Peer support featured prominently in our previous report and is still important.



"But I think talking like this again, as like minded idiots, I think it's easier, and it helps."
(Veteran, Midlands)

"Having someone who's been through it themselves makes a difference. Peer support should be part of what's offered." (Veteran, North)

"The best thing is just being able to share with others who understand. It's not about fixing things, it's about being there for each other." (Veteran, Midlands)

In the more detailed examples below, a spouse describes how having an advocate made the difference in their partner getting the medical referral they needed.

"When you are already on your knees you cannot face ringing ten different numbers. A good case worker who understands Veterans and families and just says 'we will sort this' is worth gold." (Family, North)

"To go back to C, she was originally referred for counselling through the GP. We never heard anything. We called several times to discuss counselling through the GP, and then again, it's taken for us to be part of this particular service for us to have contact with Help for Heroes and the other services that they provide for them to put referrals through. The Counselling Service was called Savannah. They lost funding, so they're no longer a thing. So C didn't even get her full eight to 12 weeks of counselling, because they ended a week later. She's had to go back to the beginning of the waiting list for Help for Heroes and whatever talk therapies that they have..." (Family, Midlands)

From a staff perspective, this means people feel listened to and understood.

"We will not signpost anybody. We will take them by the hand and lead them to where they need to be, because once we've signed post them, we will offer them support throughout whatever transition they're going through, however long that takes, six months, a year, two years, we will be there for them." (Staff, North)

In some settings, such as Veteran Launchpad who operate supported accommodation in the Newcastle area, Veterans can access a range of support, which they can take at their own pace. Actually, often more slowly, as staff report that residents often have unrealistic expectations about how fast they can progress.

"Found myself homeless in London. Within a couple of days, I got picked up and put on the train. This place has been 'interesting'. I'm leaving in less than two weeks. I've got a flat down in London now and got a job." (Veteran, North)

What would likely happen instead?

As part of the conversation, if it didn't feel intrusive, the facilitator would often change tack and ask about the likely alternative scenario if this service was not available. The 'counterfactual' picture described in the focus groups was typically stark.

Most participants stated that without the hubs they would either have continued to deteriorate or needed emergency or criminal justice interventions. Homelessness, custody, and suicidal intent were common.

"I would have been gone, just another statistic. That's how bad it was before I got help."
(Veteran, North)

Instead, the outcomes have been positive. To take just one example from many.

"I've had no hospital admittance, not been arrested, not been in jail, not been a drain on the NHS. I'm fully qualified in certain things and working at a mental health recovery college doing therapeutic work. That wouldn't have happened at all. You need that kind of support to get back on your feet." (Veteran, North)

Veterans and families alike emphasised that help often came 'too late', after the situation had already reached crisis.

"The only support you get is when you have done something wrong and you have ended up on the wrong side of the law." (Veteran, Midlands)

"If I hadn't found somewhere like this, I would have been dead or in jail." (Veteran, North)

Families also described the emotional and practical consequences of delayed help. Without early intervention, relationships can fracture, dependents take on caring roles, and financial pressures mount. Several participants spoke of years lost in cycles of crisis, addiction and shame before encountering Veteran-specific community support.

The vivid example below was seen by this family focus group to be fairly representative.

"When your husband comes back, when they do eventually retire, there is that transition from retirement to wanting to stab him because you've had enough of seeing him sat there drinking and watching TV. You tell him, 'You sort the kids out'. You go to bed but he's still sat there in the morning with cans all around him. You come in from work. Kids are still in the school uniform. 'Have you ate?' And this is eight o'clock at night, and they've had cereal. 'What do you mean? You fed me kids cereal? I've been at work all day'. No structure, nothing regimented. You know, they go nuts. Yet if there's a spoon left in the sink everything's got to be in its place. If it's not in its place, 'why is it not in its place?' That regimented thinking is always there, and then when you retire, suddenly all of that's gone." (Family, North)

Challenges

While it is important to acknowledge the progress being made, barriers continue to limit timely help-seeking. The most prominent are cultural, systemic, and structural. Many Veterans continue to equate asking for help with failure, a mindset ingrained during service. This cultural legacy combines with the fragmentation of the Veteran support system, with multiple schemes, accreditations and referral routes that are difficult to navigate. Participants described frustration at being 'bounced around' between services or subjected to repeated assessments without any continuity.

"Veterans would prefer advocates rather than a signposter. People are sick of being passed around." (Veteran, North)

Participants also highlighted the weaknesses of their transition. Discharge and resettlement planning remain highly variable, with many reporting they were left to 'get on with it' with little or no guidance.

"Transition is horrible. They lose the routine. They lose the structure." (Family, North)

"It's like you're given all the kit for the job when you're in, but when it comes to leaving, you're on your own. There's nothing to help you with the real world." (Veteran, North)

"There's no handbook for civilian life. You just have to figure it out as you go along."
(Family, North)

"When I left there was no offer like this. They packed me up and just let me get on with it. I ended up for a firearms offence. I got more help in there than I did on the outside."
(Family, Midlands)

Families felt particularly unsupported, facing complex bureaucracy around pensions, housing, or health care. This can begin before the Veteran leaves. Notice how the family member below focusses more on their Veteran than the family. This is typical.

"We follow them around and then they come out, and suddenly they're a nobody. Military treats them as though they no longer exist. They're left without having that structure, not having that big team, carrying whatever they carry from whatever they've experienced. Then suddenly there're a nobody, without that military identity." (Family, North)

4.2 Holistic approach to supporting Veterans focusing on mental and physical health services and activities.

The hub and support settings for the focus groups offer a range of different activities for Veterans and, to an increasing extent, to their families. Whether informal or formal, delivered on or off site and peer or staff-led, the overall point is that activities provide purpose and are enhancing the quality of life of participants - through connection, learning new skills and enjoyment.

Activities are integral; they were described as the way support becomes accessible in the first place. Shared meals, informal social contact, creative sessions, and structured programmes like Tri-Service's Zero to Hero cooking programme (or photography, sport, outdoor and craft sessions) provide practical reasons to be present, while also creating routine, belonging, and an indirect way into conversations about trauma, mental health, housing, family pressures, and future plans. This section summarises what Veterans and families told us about what is working, what may happen without this support, challenges and opportunities for improvement.

What's Working

Low-stigma access to support

In both regions, low-pressure activities were consistently described as an effective way to enable engagement. Participants talked about the atmosphere as much as the activity: non-threatening and warm. 'A brew and a chat' in all its varieties, is the most common way to develop trust and understanding.

"I feel it's brought sunshine again back into my life. I was in a rut, really, I'd go to work, I'd got me allotment, I'd see a friend every now and then, but I've never got money to do anything else." (Veteran, Midlands)

"Sometimes it is just coming in and sitting quiet and having a cup of tea two or three times before gradually being drawn in. I put up 'the kettle is always on' and one of my members said that should be the slogan." (Staff, Midlands)

This approach also matters for families. ‘Being invited’ and included in this sort of social activity was described as a meaningful counter to isolation and a route into wider support if that was welcomed and available.

“Simple things, small, simple things work. So it’s being invited, included.” (Family, Midlands)

Activities as confidence, capability and identity-rebuilding

Activities are rebuilding confidence and capability, and adding new skills too. This is particularly the case among Veterans who experienced a loss of routine, identity and self-belief following discharge, ill-health or periods of instability.

“When I have a good day and I feel positive enough and confident enough, then it’s all about getting that confidence to get out of your own house. Yes, not about getting through this door. It’s about getting out your own house to get here.” (Veteran, Midlands)

In the Midlands, the ‘Zero to Hero’ cooking programme is an enjoyable format where Veterans can learn practical skills, experience success, and feel pride in what they have produced. In the second example below, grandchildren were the happy recipients of the dishes the Veteran was now able to prepare for the first time.

“I’m cooking with different people. I’ve just got confidence to do it. I made muffins for my granddaughter last week, I’ve made a rhubarb crumble. It’s been eye-opening to find out that I like baking.” (Veteran, Midlands)

At Veteran Launchpad, activities were helping Veterans to regroup then, when they were ready, work towards future goals. The example below shows that journey ‘in miniature’.

“I’m ex-Navy. Last year, mental health was bubbled. Couldn’t get any help through the NHS. Within a week of being here I was with ‘Veterans at Ease’. Now these have got us all the funding and I’m doing outdoor instructor courses that could lead to an RCI qualification as well.” (Veteran, North)

Activities that connect mind, body and wellbeing

Participants shared their experiences of a range of programmes that combine physical activity, peer connection and reflective work. As well as the enjoyment and satisfaction from taking part, there is often a direct or indirect link to improved mood and wellbeing. The mechanism described was twofold: activity creates a sense of safety and belonging; and it also provides a practical route to exploring emotions. This approach appears particularly valuable for those whose service culture reinforced emotional suppression.

“There’s something about doing it in a group. You’re not sat there on your own in a little cell cooking. You’re in a room together.” (Veteran, Midlands)

“They get you to open up about how you’re feeling and what’s going on in your head, but you’re doing things like rock climbing and cycling. I came back with the most positive attitude I’ve had in a long, long time.” (Veteran, North)

Choice, autonomy and non-coercive engagement

A consistent strength of these hubs is that, for the most part, Veterans do not have to take part and there is empathy for why some may be unable to attend at different times. Participants valued having control, and the agency to engage at their own pace.

“The thing I got from that Thrive course, was that ‘my life is my train’, and I’m in charge of driving it, you know, and that’s what I’ve done.” (Veteran, Midlands)

Accountability is an important element too – which is illustrated in the detailed example below.

There is an element of accountability, and it's not about pointing fingers, it's about encouraging and empowering people to encourage and empower themselves, and being proactive and thinking for themselves. And I think that a project like this is just a really amazing proving ground for that to happen. I mean, for me to make a total change from down in a hospital bed to where I'm at now, that's taken over five years, and it's hard to be that way. And I can't imagine that other people are very much different. And I think to create such a big change, whatever it is, there's the expectation that has to be done just like that, and it can't, and people keep falling because they are putting themselves or being put in a position where they're failing, yeah, because it's not a realistic approach to change. Change does take time. We get two years here, you know, I don't know how the project on a wider scale, but it's taken me five and a half year to genuinely feel like I'm no longer a cost to the system.” (Veteran, North)



The availability of different types of activities, drop-in, small group, trips, structured courses, creates a choice of entry-points and is therefore more inclusive than any single format offer. As the first quote also illustrates, where possible, activities are being adapted to make them accessible. The second quote shows that families are also aware that events need to be designed so they don't exclude.

“You have quite a lot of activities. You can choose to do them or not.” (Veteran, North)

“Some members are not as physically able to do anything. Maybe something for them, just like games night or something like that, just to make them feel like they are part of a group.” (Family, Midlands)

What would likely happen instead?

Without these low-stigma routes, many Veterans and families suggested they would likely remain at home, avoid services, or spiral further into crisis before they engaged. The qualitative evidence suggests that the counterfactual is not simply ‘less activity’, but reduced contact, less routine, weaker peer connections, and the increased risk of crisis.

“If you're just sat in your flat all day, you're not talking to anyone and thoughts get dangerous. When you can walk around, have a chocolate, even saying hello makes a massive difference.” (Veteran, North)

While the large majority of support is delivered in person, the example below also recognises the large number of online groups.

“Online groups and local gatherings where Veterans feel understood... helped those who initially avoided services and were at risk of crisis.” (Family, Midlands)

Challenges

Consistency, regularity and predictable offer

While participants were strongly positive about activity pathways, there were concerns about consistency and regularity. Some described activities as intermittent or unevenly available, still more challenging for those who rely on routine as a stabilising factor.

“I’ve been involved with the Veterans for just over a year. I help out with social media and do the photography course every now and then; it needs to be a bit more regular.”
(Veteran, Midlands)

“One week we might pay so much, another week it might be free, or then the funding runs out, and then it struggles. Sometimes just virtually shut until they get more funding.” (Veteran, North)

From the perspective of a Thrive partner, a consistent presence is a key element in setting up and running a service. In the example from Hambleton Community Action, the project lead sat by herself in the recreation centre for the first few weeks before gradually families started to come. Without Thrive funding, this persistence would not have been possible.

“We’d sit in for hours hoping someone would come. Now some weeks it’s full, then nothing the next. We need it every week so people build it into their routine.” (Partner North)

Capacity, funding and the ‘hidden’ costs of participation

A persistent barrier is the resource required to run activities well. Participants highlighted that activities need staffing, venues, materials, and transport. Several hubs are supporting people across wide geographies, and the costs of travel (and of staff time to coordinate travel) are not always visible in funding models. Where transport is not available, engagement is naturally skewed towards those who can afford to travel or who live close to provision.

“We have to dig around and beg to get funding off other organisations because we can’t afford to fund the transport. We take referrals from the whole of the country. If there was an easier way of getting funding for people to get here, that would help and take the pressure off.” (Staff, North)

For one partner, offering contracts rather than grants would be more effective, for both provider and commissioner.

“Because grant funding is only over a certain period of time. What you’re lobbying for is contracts. Because I think contract is the way ahead, because in a contract, you can terminate the contract if you’re not providing the service. I think that would catch lots of charities out if it’s a contract.” (Staff, North)

Accessibility and inclusion in practice

The focus groups affirm that simply ‘having activities’ is not sufficient; they should be accessible to people living with pain, disability, poor mobility, fluctuating mental health, caring responsibilities, or childcare barriers. Veterans described needing alternatives to highly physical activity, while families of serving personnel highlighted the barriers of location, transport, and reduced local provision.

“I have really bad knees. I could not do a climbing wall and a 12-mile hike at the end of it. They are now looking at what they can do like Battle Back for the people that cannot do physical activities, so people like me can go.” (Veteran, North)

“I've seen this place, pre covid, I've seen it post covid. Before there was something in this centre every day for the little ones to do. I think a lot of companies, namely the council, used COVID as an excuse not to restart. There was a lovely singing group, but that stopped. There was a midwife who did baby weighing sessions so new mums could get together and see what was available for them. That didn't restart, you have to go off the camp for that, if you drive that it as there aren't regular buses.” (Family, North)

What can be improved?

Strengthen the progression pathway from 'activity' to 'support'

Participants' accounts suggest that the strongest activity models are those that offer the potential for progression: from social contact to relationship-building, to disclosure, and then onward into tailored practical or clinical support. In two of the focus groups, Veterans expressed a desire to work with their peers.

“In the future, I'd like to see a more peer run service. Someone like us would be able to take a new resident on our wing, be a positive influence and show them how you got where you are.” (Veteran, North)

“Within the project it would be nice to take what skills that I've gained and be an advocate. To have the opportunity to be employed or to be a therapeutic enabler within something like this. We've got a multitude of talent in this place.” (Veteran, North)

There may be limited awareness of the OVA's pathways for Veterans to progress to work with other Veterans (see conclusions).

Increase regularity and breadth of offer, including non-physical and family-inclusive options

The evidence indicates that a diverse set of offers are important, because needs and preferences vary widely. Strengthening the timetable of predictable, regular activities, alongside flexible drop-in contact, would particularly benefit those who depend on routine and those who are building confidence over time. Participants also emphasised the importance of offers that include people with limited mobility, those who dislike groups, and families with children.

“The breakfast club is brilliant. It is just bacon sandwiches and chat, but that is where people open up. You sit next to someone, you talk about football and grandkids and then the other stuff comes out.” (Family, North)

Improve visibility and practical access (local promotion)

Several participants suggested that improving participation hinges on making sessions accessible. Clearer local promotion was a recurring theme. Participants suggested promoting the programmes on buses, bus stops and train stations.

“Put it on the back of buses. Put it in the train stations. Put it in with the Veterans Card when people leave. If you want to join things up you have to tell people it exists.” (Family, North)

“I don't know that it's advertised, I don't know where you find out about it. You find out about it by chance.” (Veteran, Midlands)

One group suggested that the different local organisations working with Veterans join up to carry out joint promotion rather than each trying to undertake advertising piecemeal.

Enhanced help-seeking behaviour: what is missing in terms of holistic support

Across the focus groups, 'holistic' was understood in a very practical sense. This time around no one confused the term with alternative medicine. Veterans and families talked about support that recognises how mental health, housing, benefits/finance, addiction, family stress and (for some) justice involvement are often interconnected, so support that treats them as a whole person rather than an amalgam of separate issues is strongly preferred.

A genuinely joined-up pathway, rather than fragmented schemes and repeated hand-offs

Participants were not calling for more programmes; rather about joining up and making what is already there clearer and more coherent.

"You should have a service like the Americans have the VA. You've got all these operations of such and such. Stick them all under one roof so you can talk to each other and it's joined up, properly thought through. Maybe then you wouldn't have to rely on charities to do the hard work." (Veteran, Midlands)

"Without it [holistic support], without this, they'd be so lost." (Family, North)

Whole-person triage and ongoing support that sees "the person", not a single issue

Holistic help-seeking starts with a sympathetic, listening ear, with the aim to understand and build trust and not to diagnose (Thrive partners recognise for example the grey areas around diagnosing PTSD)

"Obviously the people here, they help. One of the good things is you've got access to other charities or organisations that we can signpost to, because you can't do everything, but you can actually sit and have a chat and work out what's going on." (Veteran, Midlands)

"Holistic support means looking at the whole person. It's about physical health, mental health, social connection, and having things to look forward to." (Family, North)

Wrap-around navigation that keeps momentum across multiple needs

Participants valued someone being there for them as they made their way through forms, calls, appointments and decisions, especially when they are overwhelmed or in crisis and persisting even when faced with rejection. They distinguish between 'support' and 'signposting'.

"People are sick of being signposted. A phone number and a leaflet is not support." (Family, Midlands)

"Wraparound support is what's needed. People have different needs at different times, and services should be flexible enough to respond to that." (Veteran, Midlands)

"There are people here who will sit with you and go through the forms. They will say we will do this together. That is huge." (Family, North)

Capacity issues across the entire system make this challenging. Without volunteers, hubs would likely soon cease to function effectively. Including families, whether to better support the Veteran or to help family members in their own right could also be seen as part of a holistic

approach. Dedicated support for family members is a new pillar of activity in this final phase of Thrive, and that is the subject of our next chapter.

4.3. Support for Carers and Families

How can we find and support more families is a question that has often been heard from Thrive partners.

As with our previous consultation, support for carers and families was a clear priority and a complex delivery challenge. Participants consistently described families as carrying an ‘invisible’ burden: living with the long-term impacts of service-related trauma, managing instability through transition, and, in some cases, taking on substantial caring responsibilities.

Where families engaged with Thrive hubs, they described relief, feeling accepted, improved coping and connection, and a reduction in household stress. However, the evidence also indicates that family support remains uneven, often harder to access than Veteran-facing provision, and shaped by additional barriers (awareness, permission, time pressures and childcare).

What’s Working

A trusted space that legitimises families’ needs

Across both regions, families valued spaces that treat their needs as legitimate in their own right, rather than as secondary to the Veteran’s journey. When hubs have also created a welcoming environment for partners, carers and bereaved family members, participants described feeling understood without having to explain or justify their presence or minimise the impact of service on home life.

“Sometimes it is just the simple act of coming in and sitting quiet and having a cup of tea two or three times before gradually being drawn in. I put up that the kettle is always on and one of my members said that should be the slogan. It is just having time to let someone know that they have been listened to.” (Family, Midlands)

“Families can be very isolated during service and after. They think [hubs] are not for them and they are busy. It is our right to be private. Coming somewhere like this is a big step, so it helps that it does not feel like a big official building.” (Family, North)

Respite, connection and improved household climate

When family members did engage, they frequently described hubs as providing respite and a sense of community. In the North, bereaved partners described how connection to others reduced loneliness and removed the emotional effort of repeatedly explaining their circumstances. In the Midlands, family members similarly shared their relief in being listened to and having space to talk about pressures they may not be able to share elsewhere.

“When he died, I felt like the military had gone and I was just on my own. Coming here I felt like I had acquired a second family. It is the first place where people just understood without me having to explain everything from the start.” (Family, North)

“This place has been my saving grace.” (Veteran, North)

This evidence suggests that family-inclusive support can create indirect benefits for Veterans and the wider household: reduced conflict, more stable routines, and a shared sense that support is available. The family member is often the person sustaining day-to-day coping; therefore, even small reductions in stress or isolation can have disproportionate impacts on overall stability.

What would likely happen instead?

When discussing what would likely happen without hub-based support, families described a counterfactual characterised by isolation.

The impact felt by some families when a Veteran leaves was vividly described in one of the focus groups from the North.

For some, the absence of family support compounds existing trauma and creates a situation in which households 'carry on' until something breaks.

"If they took these, this service away, a lot more people, and especially the partners would suffer, because there'd be more mental health. There really would, because this is our life escape." (Family, Midlands)

"Without the support that is given, I think there would be a lot more abuse cases, a lot more suicides. I know suicide is still a big number, both in men and women but I think suicide would be bigger as well. I think everything would just be escalated more without the services here." (Family, Midlands)

The next quote shows how family peers are supporting one another.

"If MCVV wasn't there. Where would T have gone? She would have had nowhere to go. P hasn't got much family left either. So, at the minute, E got issues. She's phoning me every night. It's we're all there for each other. It's like an extended family here, isn't it." (Family, North)

Challenges

Families' long shadow of service and trauma

A central challenge is that families experience the long shadow of service-related issues, often over decades, with limited recognition or specialist support.

"Twenty-nine years ago I lost a partner to PTSD. He took his own life. I was three months pregnant." (Family, Midlands)

"My husband was in the army 28 years. I enjoyed the army, moving around and everything, meeting different people, different places, but since he's come out, the reason we came to the Veterans hub was because we both needed support, because my husband's got Alzheimer's, Parkinson's, and we're just waiting to see if he's got cancer. You know, you have your good days and your bad years. You're treading on eggshells these bad days. Yeah, it is hard." (Family, Midlands)

Families have adapted to dealing with frequent, sometimes extended absences.

“For advice, to be honest, you've got to be comfortable with the uncomfortable because this life is not comfortable at all. There is stuff in it that that's so hard. You don't know where your partner will go, or where your house will be when you get posted next. There's so much you need to get comfortable with that's uncomfortable.” (Family, North)

"You're used to running your house your way, and then they come back and say, 'I don't fit anymore'. You have to allow yourself two weeks to a month for them coming home for them to slot back in." (Family, North)

"It's annoying. It's because when you move every two years, you don't accumulate stuff because you've got to fling it away. Don't get attached to it. Some things are not sentimental, but when it's when it belongs to your children. So, when he left the military I went absolutely nuts, I bought loads of shit, put it everywhere in the house, and it would drive him mad." (Family, North)

Participants described bereavement, exposure to suicide, and traumatic episodes at home that have lasting impacts on partners and children.

“Families have a hard time. There has not been anything, there is not perceived to be anything for Veterans' families going on until what Stand To is trying to do getting started up.” (Family, Midlands)

This theme is linked to a wider structural issue raised repeatedly in the Midlands: a perception that institutions ‘walk away’ once service ends, leaving families to manage the consequences.

Practical and cultural barriers to family engagement

Families talked about practical constraints include childcare, work patterns, transport and location. Serving families in particular highlighted the restrictive geography of camp life and the reduction of on-site activities. Challenges include a lack of information, fear of stigma, and a sense that seeking support might be interpreted as disloyalty or ‘making a fuss’.

“Families say they want things on the camp, but they won't leave the house. There are no wives' groups. This camp is closed and it's so isolated, just so, so isolated.” (Family, North)

Information is all routed through the serving partner, who may not always share or pass on the necessary details.

Housing is a significant issue for Veterans and families.

Families of serving personnel talked about feeling powerless and vulnerable. One of the group had recently had to leave when her partner announced he no longer wanted to be in the relationship. Another had received an eviction notice one week after their partner had returned from overseas when an administrative error classed him as single.

“We've all had a friend recently that was in a really vulnerable situation, and the MOD hasn't really seemed to help the spouses. And I think it reflects that actually, it is their house, it is their post, and it is their job. You're just moved around. And actually, if they don't want you it's quite a vulnerable position.” (Staff, North)

“It's not as easy as it appears from the outside. ‘Oh, you're in the military. You're looked after, you get a house’. Well, the house, is it not your house. I said to T, I'm a lodger in your house and he said ‘no you're not’. But this isn't our home. It is a building that you get

because of your job. We can't do anything to it. We can't make it home now, it's all to their rules, and if they want to, we're out. Tom came home from Iraq last year, they messed up his JP so he came back single with no children on his system. So, they straight away called. We weren't entitled to stay and then they sent a letter wanting us out." (Family, North)

This experience is also being seen elsewhere in the country. DMWS's case workers report that military families are receiving conflicting information from local authorities which may not be in the best interests of the family. Some family members are being told to stay in service accommodation until formally evicted once they transition, otherwise they are seen as 'intentionally homeless' and lose their priority status. However, being evicted will make it very difficult for them to secure accommodation in the future.

Gaps in understanding and in 'early warning' capacity

A further challenge concerns families' ability to recognise deterioration and respond early. Families asked for more practical education both for themselves and for frontline professionals, about trauma, PTSD and the behavioural consequences of distress. They described situations in which they did not know what they were seeing or how to respond, and worried that professionals misinterpret trauma-related behaviour as 'attitude' rather than a signal of need.

"It is education. Just because you cannot see it does not mean it is not real." (Family, Midlands)

"It is hard for Veterans to seek help. Some of them will never come until it is very bad. Suicides will continue, sometimes even when there has been help. We need families to be supported so we can see the signs earlier and know what to do and who to ring." (Family, North)

Economic pressures and transition

Across the North groups in particular, families also told us about the economic pressures associated with transition. Participants described a need for earlier and more coherent support to families on financial planning and employment. Families are impacted in transition but not involved.

"Financial advice for families. They (the Veteran) get the forms and the advice. We need it sooner, because I might need to retrain to get a job on civvy street and it's no use if it's just, you know, dumped on them" (Family, North)

The transition can also be a time of great change for the family dynamics. Having revolved around the serving partner, transition can hold out the promise of the spouse resuming or starting a career.

"If I can, I will have my own horse, they are like my bubbles of happiness. And he's like, what a waste of money. And I'm like, 'Oh no, I've given up everything to follow him around. Obviously, he's looking to come out next year. I don't want to do any job that requires him going away because I gave up my job. When you come out, it's our choice, not your choice. We wouldn't have been able to have a horse while he's in, but afterwards, that's my time." (Family, North).

What can be improved?

Create clearer, more visible family pathways within Thrive hubs

Participants' evidence indicates that family support is most effective when it is integral rather than incidental. A practical improvement is to make it clear that families are welcome and how families can engage even if the Veteran is not ready. As families default to talking and thinking about their Veteran first, there is a strong likelihood they will assume support is only for the Veteran too.

Expand dedicated provision for partners, carers and children

Families asked for provision that recognises different needs. This includes spaces for partners and carers, opportunities for children, and activities that make participation feasible and appealing – mindful that many families are working. In the Midlands, participants suggested family-focused sessions that do not require joining mixed groups if that feels exposing. These recommendations align with the wider evidence that engagement increases when activities feel safe and relevant.

“Maybe have a day or an afternoon where it is for partners and children rather than everyone together.” (Family, Midlands)

Representation and reach

Younger Veterans and families will not necessarily recognise themselves in current imagery or offers which is seen as ‘older men with mugs of tea’.¹¹

“I am the only civilian and family member, but I have been really welcomed by the guys and girls and I absolutely love this place.” (Family, Midlands)

Strengthen education, early intervention and professional capability

Families' call for education and early intervention suggests the potential to develop a family toolkit (akin to the ‘Engaging Female Veterans’ toolkit).¹²

Offer flexible and digital routes to engagement

Finally, the evidence indicates that digital or blended formats *may* be important for reaching families who cannot easily attend in person – but views were divided on this. This is particularly relevant for serving or working families and those with caring responsibilities. Hubs could explore how technology, like MCVC below - could support younger people and broaden their reach. Developing online peer sessions, short webinars, and moderated support groups could offer a route into connection while maintaining confidentiality and choice.

“They’re asking for input for younger people getting technology, using technology.” (Family, North)

¹¹ Multiple studies (e.g., from Forces in Mind Trust and Help for Heroes) describe how younger veterans and family members may hesitate to engage with veterans' hubs because of perceptions that they are male dominated, aimed at older veterans, or socially outdated. However, this is a perception barrier, and broader research indicates that veterans and families tend to view hubs positively once involved.

¹² [Source](#). Also, Low barrier digital access for female Veterans to cognitive behavioural therapy using an app is also being piloted. [Source](#)

Overall, families' contributions show that Thrive hubs are well placed to be part of a broader offer for families, if families are involved in the design of support and there is sufficient capacity and of course, funding.

4.4. Learning and Improvement

This chapter draws together what the 10 focus groups reveal about learning and improvement within Thrive: what appears to be working as a delivery model, where the system still fails Veterans and families, and what practical changes participants believe would strengthen outcomes. Participants did not talk about 'learning' as an abstract concept; rather, they described the concrete conditions that enable progress—trust, time, consistency, culturally competent staff, and practical advocacy and the risks that arise when capacity, coordination and visibility are weak. The evidence also highlights that hubs are not only support spaces but preventive infrastructure: participants linked them to reduced crisis escalation, reduced offending and lower demand on statutory services.

What's Working

Trust-first engagement: time, continuity and the right people

Across both regions, the strongest 'what works' message relates to the model of engagement itself. Participants repeatedly contrasted Thrive hubs with larger or more formal services, emphasising that help is unlocked through relationships built over time. Continuity, the ability to see the same faces, to be remembered, and to speak without repeating one's story, was described as essential. This appears to function as a foundational enabling factor: without trust, other interventions (housing advice, mental health support, employment support) are less likely to be accessed or sustained.

"Why does it work that they sit and listen more compared to bigger centres? It's time. The critical thing is time. If you're in a bigger centre, you wouldn't know anyone, wouldn't see the same person twice." (Family, Midlands)

Participants also described the importance of culturally competent staff and peer presence. When people feel 'seen as a person' rather than as a case or label, engagement becomes less guarded and more consistent. This point is particularly relevant for Veterans who have experienced repeated assessment processes and service thresholds that feel depersonalising.

"The staff get to know you as a person. You're not a Veteran, you're a person." (Veteran, North)

Practical advocacy

A second major learning point is that effective support is rarely a linear pathway. Participants described bureaucratic friction, forms, eligibility rules, waiting lists, and disjointed services—as barriers that can cause drop-out or relapse. Hubs mitigate this by 'walking alongside' people, providing practical advocacy and reducing cognitive burden. This is a delivery mechanism that hubs have developed through practice and iteration: it reflects a clear understanding that, for many participants, navigation itself is the problem.

Prevention and social value

Participants framed Thrive hubs as preventive infrastructure. The focus groups repeatedly linked hubs to reduced crisis escalation, less reliance on A&E, fewer acute mental health crises, and (particularly in the Midlands) reduced offending and reduced return to custody. The system

value is therefore not only in ‘support offered’ but in crises avoided. This is significant because it aligns with the programme’s strategic intent: earlier, local, human support that reduces costly statutory interventions.

Learning about reach: who engages and who is still missing

Finally, participants offered a clear message about reach and representation. In the North, several described how public perceptions of ‘Veteran spaces’ can deter younger Veterans and families. In the Midlands, participants also reflected on inclusion and how welcome—made explicit—can broaden participation beyond the stereotypical image. This is a learning point for practice and communications: if the offer looks like it is for ‘someone else’, people will self-exclude.

“I have been on a few walks now. I did Mam Tor last week. I am the only civilian and family member, but I have been really welcomed by the guys and girls and I absolutely love this place.” (Family, Midlands)

“A lot of people think it is just older men. Older men at tables with mugs of tea. That is what they picture. If you want younger ones and families, you have to change that. Show the kids, show the women, show the younger lads and lasses.” (Family, North)

What would likely happen instead?

Participants’ counterfactual accounts suggest that without the relational and advocacy-based model, many would continue to experience support as fragmented, late and crisis-driven. For Veterans with justice involvement or high levels of trauma, the likely alternative is continued disengagement until escalation: homelessness, custody, acute mental health crisis, or emergency service contact. For families, the counterfactual is sustained isolation—coping privately until stress becomes unmanageable—and a reduced ability to prompt early help-seeking. From a system perspective, the counterfactual is higher demand on statutory services and higher costs associated with crisis response.

Challenges

Capacity and sustainability

The most persistent delivery challenge raised by participants concerns capacity and sustainability. Hubs are expected to provide high-touch relational support, advocacy, and activities—often to individuals with complex needs—yet funding and staffing can be precarious. Participants recognised that without stable resource, hubs cannot maintain the continuity that makes them effective. This creates a risk of drift towards shorter, more transactional models—precisely the approach participants described as less effective.

“They need more recognition and more finance. The government needs to respond to this so they have got money coming in and then they can do so much. They could advertise more and support the Veterans more by doing more activities properly.” (Family, Midlands)

Fragmentation and ‘badge’ culture

A further challenge is that hubs operate within an external system that participants described as fragmented and sometimes performative. Accreditation and branding were criticised where they do not translate into practice change. This matters because it shapes trust: repeated

experiences of ‘badges without substance’ can discourage engagement, and push people back toward crisis-only contact.

“My doctor’s ‘Veteran accredited’. It’s got the tick box saying, yes, we understand, we look after Veterans. I’ve spent the last year and a half trying to get them to understand what the programmes are. It’s a tick box exercise. It’s a badge. That’s it. It’s a badge to say, ‘we do this, look, we’re awesome’.” (Veteran, Midlands)

Visibility and uneven reach

Participants emphasised that many Veterans and families discover support too late, by chance or during crisis. This remains a challenge for programme effectiveness: prevention depends on earlier contact. Where the offer is not visible, or where people assume it is ‘not for them’, hubs miss individuals who could benefit most from early, low-stigma engagement.

What can be improved?

Share learning: cross-hub learning, reflective practice and feedback

The evidence gathered through the focus groups, and by attending partner meetings suggests Thrive partners are continuing to adapt and learn through practice. Strengthening this further could include more structured cross-hub learning sessions (sharing what works on engagement, transition, advocacy and family support and light-touch reflective practice for staff). This would be in addition to the participant feedback mandated by the commissioner’s Impact Hub or its successor. and systematic participant feedback mechanisms that do not feel burdensome.

Invest in advocacy capacity and ‘warm handover’ roles

Participants repeatedly told us that advocacy is a key enabling factor. A practical improvement is to formalise and resource this function through further dedicated advocate or peer navigator roles. The programme leads have been inspired by the Welsh Model, whereby volunteers can access free online accredited learning which “[offer practical, trauma-informed ways to listen, guide, and encourage others safely and effectively.](#)”¹³ These opportunities have been disseminated through the partnership.

Improve reach through modernised representation and targeted communications

Participants offered direct, practical suggestions for improving reach: use everyday channels and embed information earlier in the transition journey. Alongside this, communications should represent the diversity of the Veteran community and show family-inclusive participation, to avoid reinforcing narrow stereotypes.

¹³ Source: <https://www.facebook.com/Adferiad/posts/-free-training-opportunities-for-veterans-family-members-carers-support-workers-/1164354105870614/>

4.5. Veteran Views on National Ops and Valour

When the majority of the focus groups were taking place, there was considerable uncertainty about what form the proposed Valour would take. Whenever time allowed, Veterans and families were asked about their perceptions of the existing and new ops in relation to the support they were currently receiving.

This qualitative evidence suggests Veterans and families want national programmes to strengthen, not displace, local, relationship-based hubs. Where national initiatives deliver rapid, joined-up outcomes (particularly for housing), they can be life-changing. However, in other areas participants described national systems as likely to be slow, inconsistent, and at risk of becoming ‘badge-led’.

What’s Working

When national Ops respond quickly, they can be life-changing

Participants’ most positive accounts focused on situations where national schemes responded quickly and delivered an immediate, practical outcome. In the North, there were several examples of where Op FORTITUDE had worked ‘as intended’ by enabling rapid triage and an immediate route into safe accommodation. The key ingredients in these accounts were speed, clarity, and follow-through.

“I called Op FORTITUDE on the day my prison-provided accommodation expired and I had nowhere to go. It was within less than an hour, maybe two hours, and I had a place here.” (Veteran, North)

In the Midlands, participants acknowledged that national routes and statutory partners can be helpful when they are accessible and when response times match the realities of crisis. The issue, however, is variability.

A clear desire for joined-up, whole-household support

Families in particular framed national ‘Ops’ as most effective when they translate into joined-up support at local and county level that is open to families. This reinforces a key theme across the report: support is most effective when it recognises the household and does not treat families as peripheral.

This expectation of joined-up provision is relevant to Valour’s stated intent to improve coordination. Participants’ evidence suggests that success will be judged by whether the initiative makes pathways simpler, faster, and more coherent for both Veterans and families.

In two of the focus groups in the North, there was anger at migrants being housed in hotels, while Veterans struggled with long waiting lists for housing.

“Why can we not have Veterans’ hotels?” (Veteran, North)

“When I started three years ago, I would ring them on a Monday and have an acknowledgement on a Wednesday, they would be seeing you the following week. Now it is a 12 to 14 week waiting list in the Midlands... and then you see a psychotherapist in two years’ time. It is an absolute waste of time, is it not?” (Staff, Midlands)

Challenges

'Badges' and accreditation without meaningful change

A prominent challenge raised in the Midlands was scepticism about accreditation and 'badge' culture. Participants described 'Veteran accredited' schemes and high-level commitments as insufficient unless they translate into tangible differences in access and treatment. This concern was not ideological; it was grounded in experience of services that appeared to signal Veteran-friendliness while delivering little practical prioritisation or understanding in reality.

"I remember when that Veterans thing came in. The head nurse of the NHS stood up and said it will make no difference, we prioritise people by need, it doesn't matter about whether you're a Veteran. It's policy on one side saying, 'look, we do this, aren't we amazing'." (Veteran, Midlands)

A gap between national intent and local experience

In the North, participants made parallel points about the Armed Forces Covenant: it is valued as a promise in principle, but questioned in practice when displayed symbolically without consistent delivery. This reflects a broader trust issue: Veterans and families judge commitments by outcomes, speed of response, quality of interaction, and whether barriers are removed.

"The Armed Forces Covenant is a promise and that needs to change. It's not legally enforceable. So you get councils that signed into it, but it means nothing. Companies get a lot of respect for displaying it on their banners, but it has to mean something." (Family, North)

Geographic inequity and the risk of centralisation

A second challenge is uneven geographic reach. Participants expressed concern that a 'regional hub' model could centralise provision and inadvertently leave gaps, particularly in areas already perceived as underserved. The language used conveys a fear that national restructuring could make support less accessible for those who are not close to major centres.

"There is a big black hole around the West Midlands. There are very, very few events here. If it becomes this big super hub thing, we are going to get forgotten." (Veteran, Midlands)

"The small local hubs are the engine that's driving things, ideally, albeit on a shoestring." (Volunteer, Midlands)

This concern has direct implications for Valour: if the model is interpreted as centralising resources into fewer sites, it risks undermining the local reach that participants described as essential for early help-seeking, particularly in the interim period when they are setting up and getting established.

What can be improved?

Make Valour (and other national Ops) a coherent 'bridge' into local hubs

Participants' evidence suggests that the most constructive role for national initiatives is to function as a coherent bridge into local, relationship-based hubs. This includes reliable triage, clear eligibility, and warm handovers between organisations. In practice, this means national routes should reduce the number of steps a Veteran or family must take alone, and should confirm that a local connection has been made rather than merely advising someone to contact another service.

Improvement, therefore, is not primarily about introducing additional branded schemes. It is about creating a consistent standard of navigation support, ensuring that national pathways connect people to local provision quickly and with follow-through.

Prioritise plain-English communications and earlier awareness

A recurring improvement request was earlier, clearer awareness before crisis. Participants offered specific suggestions for normalising and publicising national and local support routes through everyday channels and transition touchpoints. This is aligned with the wider report finding that many Veterans discover support by chance or during acute crisis; improving visibility is therefore a preventive intervention in its own right.

“Valour, what does it do? If I was working in the NHS and I don't really know much about it, Valour, what's that? It doesn't tell me anything about what it's doing. By calling it stuff like that, you make it hard for people.” (Veteran, Midlands)

Protect local reach and address perceived 'black holes'

Participants' concern about geographic gaps suggests a clear design requirement for Valour: it must strengthen local coverage, not consolidate it. A practical approach would be to recognise and resource local hubs as part of the 'Valour' network, with clarity on roles, referral routes, and accountability. Without this, the new programme risks reinforcing perceptions that those living in areas outside major centres will be forgotten.

Ensure commitments translate into practice change

Finally, participants' scepticism about badges and symbolic commitments indicates that implementation needs to focus on observable practice change. For health and public services, this could include measurable expectations around responsiveness, staff understanding, and continuity.

Overall, Veterans and families are open to national initiatives where these add speed, clarity, and accountability, particularly in critical domains such as housing. However, the dominant message is pragmatic: national 'Ops' should simplify pathways, enable warm handovers into local hubs, and protect local reach.

5 Conclusions

The blurred lines between being a staff member, peer supporter and Veteran are particularly noteworthy, especially given that a significant proportion of professionals in this sector have personal experience. This dual identity can serve as both a strength and a challenge: it brings authenticity, empathy and credibility, yet can complicate boundaries, expectations and conflate experiences with their own. Peer support remains integral and central as it is rooted in trust. Evidence from the Welsh Peer Support Model suggests there is value in formalising the role and training to achieve consistency, supervision and clearer boundaries.

Early help seeking

Transition continues to loom large in our conversations. Younger cohorts of service leavers, particularly early service leavers, are likely to have a different experience and face different challenges than most of those involved in our consultation; “better transition will lead to better engagement later.” For those medically discharged, support exists but may not be taken up owing to their mental and physical state. Help is mandatory for these groups, but readiness isn’t guaranteed.

Help-seeking is often late. Many group members talked about attending funerals of Veterans who had taken their own lives; Veterans are continuing to reach crisis point before reaching out. This does not negate the need for the Thrive programme, since without it and allied interventions, there would be more illness, more isolation, more cases of abuse and more lives lost. It does raise the question of how can services intervene proactively? How will Valour manage this at scale? Once again, part of the solution may lie in transition and ensuring those leaving service know that support is available should they require it later.

Veterans are very aware of the difference between signposting and empowering people to take ownership of their recovery journey. Veterans would prefer advocates rather than a signposter. This makes them feel valued, with the onus on ‘the right people’ being able to help them to achieve fast-track referral that they haven’t managed for themselves. At the same time, the sector has to guard against creating dependency by building autonomy and tapering support. The phrase “civvies don’t understand” is often heard within military safe spaces; language like this can become a barrier shouted loudest by those avoiding help. Professionals must be culturally competent, trauma-informed and prepared to work through that tension.

Confusion persists around the Armed Forces Covenant Duty, particularly the distinction between priority treatment and parity of access. Veterans will sometimes use words like “entitled to” and these can create unrealistic expectations. Some advocates and frontline professionals, with the best of intentions, may unintentionally miscommunicate the scope of the Covenant. Op COURAGE reports pressures when Veterans arrive expecting preferential access based on what they’ve been told. This highlights the need for greater consistency in messaging and training so organisations accurately represent the Covenant Duty and its implications.

National Op Services emerge from this round of consultation more positively than before (although partners have needed to turn some of the focus away from delivery to bid for Valour), with several examples of swift and appropriate support being accessed; however, a positive outcome depends on local capacity, which is impacted by short-term funding.

Awareness-raising and information sharing need a multi-channelled, consistent approach and ideally joined up in a locality. Negative first impressions from 10-20 years ago linger, so trust renewal should be explicit rather than assuming the current offer speaks for itself. Help for Heroes are regarded by the partnership as particularly good at advertising and promotion and there is existing funding allocated for video content. For example, MCVC (where the author heard for themselves a number of fine storytellers) are producing videos gradually so Veterans can get used to the process. Veterans will listen to their peers before anyone else, so this collateral is likely to be important.

Holistic support

Activities are more than merely fun and recreational; they can build trust and provide structure, purpose and a socially safe environment for Veterans reluctant to seek formal help. Outside of Thrive, M.A.S.H East Riding has been identified as a strong exemplar for using activities as community hooks. A programme of voluntary activities is a good fit for Veterans who have lost their sense of purpose, reinforcing a strengths-based approach and acting as a low-stigma bridge towards formal support and recovery. In the Midlands, "Zero to Hero in the Kitchen" is a programme offered by Tri-Services which has proven popular, social and a source of improved nutrition. 'Pay As You Dine' while serving has, for some, shaped poor nutrition habits, with real implications post-discharge.

Quality of life is a key driver and outcome, particularly for Veterans who won't be able to return to work. Holistic support should be open to outcomes such as improved wellbeing and improved family relationships. This sample of Veterans typifies how much they have to offer in skills, experience and work ethic, raising the question of how these could be better deployed for mutual benefit. There has been significant OVA investment into building Veteran skills; the extent to which this is effectively communicated remains a live issue. Offers include MOD CTP Career Transition, RBLI for those medically discharging through personnel recovery centres, Step into Health and HelpForce, with a new Covenant three-year strategy and Valour also focusing on this.

'Think Family'¹⁴

Services are struggling to access families. Families are likely finding it hard to get support, either for their Veteran and particularly for themselves. Families consulted have typically come as a result of the Veteran accessing a hub, so are likely to be the minority. For these families, hubs offer a similar respite to that described by Veterans – access to those who get it.

It is interesting that family members tended to focus on the needs of the Veteran rather than their own needs. This is the default. Combat Stress found that Veterans' recovery outcomes are better when their partner or support network is involved.¹⁵ Crafting together demonstrated that families can benefit too.¹⁶ Thrive has designed programmes specifically for families, including Combat Stress, but they are all at an early stage of maturity and would benefit from further co-design with families.

Families prefer local provision, call for targeted and deliberate awareness-raising, and also spoke about having activities designed for them. Would a group of younger family members

¹⁴ A call from [Living in our Shoes, Phase One Revisited](#) (2026)

¹⁵ [Source](#)

¹⁶ [Source](#). 'Community Reinforcement Approach and Family Training'

come up with the same ideas as older hub members? To what extent can technology increase access or will it also reinforce isolation? The evidence is still emerging.

We recommend that a family reference/advisory group is established to provide a critical sounding board. The family members of serving personnel supported by Hambleton Community Action Group proved a valuable source of current insight. Provision planning needs to include and take account of groups we haven't reached yet. Reservists for example, early service leavers and their families. It will be important to test the working assumption that "young people don't want regimental associations." Perhaps technology can be part of the answer.

Finally, there are social value opportunities. Thrive partners have received training on social value, but there is scope, at programme level, to connect local authority social value efforts with the creation of new or bigger events for Veterans and Veterans' families – responding to a community need or gap.

Sustainability is vital, but in the short term remains an active threat to Thrive. Efforts are already being displaced or affected as organisations seek to position themselves for Valour contracts. The Thrive 'Loop model' (Discovery, peer-led activities, 'warm navigation' (not signposting), evidence, feedback and continuous improvement) should find a place in the new structure, especially since provision is scattered and there are many gaps. Across the programme, continuing to sit and listen is the beating heart of the programme, meaning support can be genuine and authentic. In the sustainability phase, the programme should increase its work to share learning cross-sector through case studies, video stories and podcasts.

6 Technical Annex

6.1 Context

This annex compares recent focus group findings from the Thrive Together Veteran support programme (2025) with contemporary UK research (2024–2025) on Veterans and their families. Artificial intelligence was used to rapidly identify and appraise relevant publications.

This context review highlights where Thrive’s insights converge with broader evidence and where they diverge, and outlines potential implications for Thrive Together and the Office for Veterans’ Affairs (OVA). The focus group discussions focussed on themes of help-seeking, peer support, activity-based engagement, and family inclusion. These are examined against UK-wide studies, government reports, and evaluations to ensure the recommendations above are evidence-based.

During this consultation period, three national developments reinforce the relevance of the Thrive findings. First, the Armed Forces Covenant Annual Report 2025 explicitly frames Valour as a mechanism for scaling what works locally, with data and evidence playing a key role, based on the premise that data standards and evaluation practice improves across the sector. Second, the Armed Forces Bill 2026 signalled an extension of the Covenant Duty, increasing the number of policy areas and public bodies within scope and raising the importance of consistent implementation, awareness and monitoring. Third, the Government’s ‘National Plan to End Homelessness’ (Dec 2025) includes specific commitments for Veterans: further investment to reduce Veteran homelessness, continued support for Op FORTITUDE as a referral pathway, and an emphasis on Valour as the mechanism to coordinate local delivery and gather data.

Taken together, these developments strengthen the case for Thrive’s “Loop model” (warm navigation, trusted local provision, and continuous learning) as an approach that is both relevant and policy-aligned.

Enhanced Help-Seeking Behaviour

Both the focus groups and recent research point to the critical need to improve Veterans’ willingness and ability to seek help for health and welfare issues. Key points of convergence include the importance of cultural understanding and trust in service providers, and the need to reduce stigma and practical barriers to care:

- **Reluctance to Seek Help:** Focus group participants reported that many Veterans delay seeking support until reaching a crisis point (often noted in tragic contexts like suicides or funerals). This pattern is echoed by research showing that a significant proportion of Veterans struggle to ask for help, around 60% of Veterans in a 2022 NHS survey said it was difficult to speak up about mental health problems. Moreover, a joint RCGP-OVA survey found 1 in 7 Veterans had not sought help for health issues, often preferring to “manage alone” or fearing a civilian professional “would not understand” their experience. This fear of being misunderstood is a major barrier, reinforcing what focus group members voiced as the ‘civvies don’t understand’ sentiment.
- **Role of Trust and Veteran-Friendly Services:** Both sources agree that fostering trust through Veteran-aware services and peer support can markedly improve help-seeking. One Guardian-reported survey found 63% of Veterans would be more likely to seek help if they knew their GP was accredited as “Veteran-friendly” indicating that Veterans are

far more willing to engage when they sense cultural competence and understanding in providers. Similarly, the NHS's Op COURAGE mental health service attributes its success to employing staff with military backgrounds or training, which helps build a non-judgmental, understanding rapport. Focus group Veterans likewise emphasised the value of "the right people" – ideally fellow Veterans or knowledgeable advocates – to guide them through the system, rather than generic signposting. In short, peer-led or Veteran-informed support builds credibility and encourages earlier engagement, a point strongly supported by both the grassroots perspective and formal evaluations.

- **Signposting vs. Advocacy.** A focus group insight was dissatisfaction with signposting. Veterans preferred advocacy: someone who can help them make sense of options, and follow through so they do not fall through gaps. Recent evidence from a bespoke Armed Forces Community social prescribing scheme in Cornwall helps explain the mechanism behind this. In that evaluation, the link workers were themselves Veterans, and this shared background was crucial for establishing trust quickly, without service users having to explain military culture or re-tell experiences. Referrals covered mental health and social isolation, but also interconnected issues such as housing, finances, physical health and domestic abuse. Service users reported improvements in living conditions and mental health, stronger connection to other people, and renewed hope and optimism. This strengthens the case for Thrive's emphasis on warm navigation and the recommendation to consider the applicability of the Welsh peer support model where Veterans are trained to take peer support further.
- **Divergence:** One area of slight divergence is in emphasis. The focus groups highlighted potential confusion around the Armed Forces Covenant Duty – some Veterans believed they were 'entitled' to preferential treatment such as a council home, leading to unmet expectations and discontentment. The implication is that OVA and service providers should standardise messaging and training about what the Covenant guarantees to manage expectations.

Veterans' stories reinforce research calls and those of Thrive partners for more consistent definitions of 'crisis' for Veterans to help them self-identify struggle earlier or for services to better manage those at high risk. The academic literature does not capture this.

Implications – Thrive Together and OVA: The convergence here suggests that grassroots support should continue investing in peer-led, trust-building approaches to outreach, as these are validated by broader studies. Future programmes could formalise roles for Veteran 'navigators' or advocates to guide peers to services, working in tandem with initiatives like Valour.

For the OVA, the findings affirm policies to expand Veteran-friendly accreditation in healthcare and to publicise existing help pathways. Efforts should also be made to train staff (civilian or Veteran) in cultural competence and clear communication, addressing any misconceptions about entitlements under the Covenant. Overall, reducing the psychological and practical obstacles to help-seeking, by making support feel accessible and safe, is a priority area.

Enhanced Early Help-Seeking and Transition Support

Early intervention – particularly around the transition from military to civilian life – emerged again as a critical theme. The focus groups repeatedly noted that dealing with issues at transition and better early support could prevent larger crises later. UK research broadly corroborates this, identifying transition as a vulnerable period for both Veterans and families:

- **Transition Challenges for Newer Veterans:** The focus group participants stressed that younger Veterans and early service leavers (including those who leave after only a short service or those medically discharged) often face distinct and acute challenges. Many do not fully absorb or act on the support offered at point of discharge – “readiness isn’t guaranteed” when someone is coping with a medical board or the shock of leaving service. This resonates with findings from the first UK-wide Veterans’ Survey and family survey (2022–23), where “*transition from military to civilian life*” was among the top three areas family members felt lacking in support. Common transition-related problems reported by Veteran partners and children include mental health difficulties, financial strain, relationship stresses and social isolation. In the UK Veterans Family Study, over three-quarters of Veteran partners and adult children surveyed recalled at least one major issue during or after their loved one’s transition. These data confirm the focus group’s view that transition is a flashpoint: a smoother transition (with better guidance, education, and follow-up) leads to better long-term engagement and wellbeing, whereas a rocky transition can set Veterans back significantly.
- **Delayed Help-Seeking Until Crisis:** Both sources acknowledge that help is often sought “late” and rarely early enough. In the focus groups, Veterans spoke of only seeking help at “last chance” moments or not realizing they were in serious trouble until very late. Academic research bears this out, a recent profile of Veterans in crisis noted that many only present for mental health care when a crisis is imminent or underway. This study, from NHS High Intensity Services, observed that by the time Veterans came forward, over 85% were already experiencing suicidal ideation and other severe crisis factors. The implication is that traditional transition briefings or signposted services are not enough to spur early help-seeking. In fact, preventive engagement needs to happen well before a Veteran reaches breaking point. The NHS England survey cited earlier reinforces this: even among those aware of services, a majority did not feel comfortable seeking help until things deteriorated. Both Veterans and policymakers are asking “how do we get people to seek help sooner?”. The emerging consensus is that earlier interventions should be proactive and persistent, for example, routine mental health check-ins post-discharge, peer mentors reaching out to recent leavers, and lowering the threshold for accessing support (so Veterans don’t feel they must qualify by being in dire straits).
- **Improving Awareness and Accessibility:** A consistent message is that many Veterans (and families) simply don’t know what help is out there until they desperately need it – and by then, as one Veteran put it, “until you’re looking, you’ll never see it.” Focus group members noted that younger Veterans in particular might be missing out on support due to poor communication channels. UK-wide efforts are underway to address this: Operation Valour’s design, for instance, explicitly aims to make support more visible and consistent, regardless of geography. Plans include one-stop regional hubs and outreach officers to ensure no one leaving the Forces falls through the gaps of a fragmented system. Additionally, Veteran charities and the OVA have focused on awareness

campaigns, from NHS England's new Op COURAGE publicity drive to Help for Heroes and local hubs producing videos and peer testimonials to engage those who may not respond to traditional adverts. Both the focus group narrative and national strategy stress meeting Veterans 'where they are', whether that means on social media, at community events, or through personal networks – long before they reach a crisis. Early engagement also means demystifying what "counts" as a crisis or a valid reason to seek help. Clear, plain-English definitions and examples (as suggested in the focus groups) could empower Veterans to reach out at earlier signs of trouble, rather than soldiering on.

Convergent Findings: There is broad agreement that early, proactive support during transition can prevent later problems. Both Veterans on the ground and research/policy voices call for structured transition programmes that address employment, health, housing, and social connectivity as a package. Notably, families in the ONS Veterans' Family Survey also identified transition support as a critical gap affecting not just Veterans but the family unit. This convergence underlines a need for holistic transition services – for example, better handover from the military to NHS and civilian services (as embodied by programmes like the MOD's Career Transition Partnership and NHS's Transition, Intervention and Liaison services). Additionally, both perspectives emphasise the role of peers in early intervention: many Veterans will "listen to their mates before anyone else," suggesting that peer networks (such as regimental associations, online forums, or hub alumni groups) could be leveraged to check in on recent leavers and signpost them to help without stigma.

Divergent Findings: The main differences lie in what aspects of early support are highlighted. The focus groups, given their composition, spoke less about practicalities like finances or housing in transition, whereas the national surveys and studies show these are major areas of need. For example, family members frequently mentioned finances and navigating benefits/pensions as a sphere needing improvement, something not deeply discussed in the Veteran-centric focus groups. Another divergence is optimism: policy announcements (e.g. Valour) strike an optimistic tone about "fixing" the fragmented system, whereas focus group Veterans voiced cautious scepticism (some reacted negatively to the idea of larger, centralised hubs replacing local ones). This highlights a perception gap, while a joined-up system promises fewer postcode lotteries, Veterans fear losing the personal touch of small, familiar support settings. Managing this change will require careful implementation so that consistency is achieved without sacrificing the trust and camaraderie of local networks.

Implications – Thrive Together and OVA: For Thrive Together, the implication is to strengthen its transition outreach and early transition engagement. The programme could collaborate with military resettlement services and the OVA to identify recent service leavers and offer them low-pressure, welcoming points of contact (peer drop-ins, newcomer briefings at hubs, etc.). Ensuring that Veterans know "the kettle is always on" from day one of civilian life could mitigate the last-chance scenarios later. The OVA, on its part, should continue to drive initiatives like Valour and the Veteran Champions in GPs, but must do so in close partnership with community organisations. The focus group findings are a reminder to policymakers that top-down solutions must incorporate bottom-up trust. As such, OVA might support hybrid models where national resources (e.g. funding, unified referral systems) empower local Veteran groups rather than replace them. Early help-seeking will improve when every Veteran, regardless of when and how they leave service, feels that there is an obvious, approachable place to turn – something both Thrive and OVA can work together to create.

Veterans on a justice pathway (prevention and earlier intervention)

Although the focus groups included Veterans who had been in contact with the criminal justice system (CJS), this is an area where recent UK evidence adds useful depth about what happens before custody and where earlier support could possibly change these trajectories. A supplementary report commissioned by Forces in Mind Trust (February 2026) draws on interviews with 104 ex-service personnel (the majority in prison, with a smaller community sample) and describes a picture in which early trauma and adversity, earlier low-level CJS contact for some, and later challenges in service and transition accumulate over time. The report highlights how difficulties maintaining relationships and networks, alcohol and substance misuse, poor mental health, and reluctance to seek help can be present well before justice contact. It also shows that transition from the Armed Forces can be particularly precarious, with the loss of identity and support networks, regrets about leaving, financial strain, isolation, and low readiness to engage with civilian services.

‘Journeys to Harmful Behaviour’ implementation report (January 2026) translates earlier research into practical improvement priorities across six areas:

- Greater awareness of the severe challenges some recruits may be seeking to leave behind
- Access to counselling and wider support for those struggling with the impact of military life on behaviour or relationships
- Confronting harmful alcohol culture
- Addressing misogyny/sexualisation of women in some contexts
- Funded pathways for individuals required to leave service due to behavioural issues
- Increased training for the justice sector and wider caring agencies.

Importantly for Thrive, the implementation work also emphasises the need for cross-agency coordination (police, prisons, probation, health and the third sector) and highlights gaps for individuals leaving military detention / discharge where statutory supervision may not apply.

Implications for Thrive Together and OVA:

These findings also support the value of a prevention and early-intervention model like Thrive, i.e. earlier intervention as well as post-crisis support. Practically, this suggests (i) making Veteran support visible and available to Veterans before they offend (e.g., through probation/Op NOVA relationships, hub outreach to those at risk, and clear routes for families), (ii) building trauma-informed practice and substance-misuse-aware pathways into hub support, and (iii) continuing Care After Combat training as part of Thrive’s learning and sustainability offer.

Person-Centred Activity Design (Peer Support and Holistic Activities)

In different ways, all the focus groups supported the need for Veteran / family-centred activities to support engagement, recovery and improved wellbeing and in the longer-term quality of life. Veterans described activity-based peer groups as providing structure, purpose, and a socially safe environment for those who might be reluctant to seek formal help. UK research and best-practice literature strongly validates this approach, showing that meaningful activities and peer-led support can improve wellbeing and act as a gateway to further care:

- Activities as hooks to engagement. In the focus group narratives, Veterans highlighted group activities, cooking classes, sports, volunteering projects were more than

recreational; they also build routine, camaraderie and trust. Research during and after the pandemic found that strong social networks are associated with better mental health among Veterans. Conversely, loneliness or loss of the military community can drive poor outcomes. By designing activities that resonate with Veterans' identities (teamwork, skill-building, serving others), programmes could be seen to re-create a sense of mission and belonging. Academic evaluations of Veteran peer networks found they reduced isolation and stigma, and served as a bridge into treatment. For example, one study of a UK peer support service showed it helped Veterans engage with clinical services and boosted treatment completion rates. Both the focus group evidence and research align that informal, peer-led activities can be more effective than official invitations.

- **Peer leadership and authenticity.**

Peer Leadership and Authenticity (mechanisms that make peer support work): Recent synthesis evidence helps specify the interpersonal “conditions” that make peer support effective. A realist-informed qualitative meta-synthesis (Dec 2025) identifies five contextual factors that together form the APPEAR framework: Accepting, Personalised Practice, Empowering, Available, and Reciprocal. In combination, these conditions create the space for recovery-related outcomes such as greater self-acceptance, confidence, hopefulness, self-expression, improved relationships, and new knowledge/skills. Peer support is most powerful when it feels non-judgemental, tailored to the individual, oriented toward agency (not dependency), consistently accessible, and based on mutuality rather than hierarchy.

- Practical design features that follow from APPEAR include role clarity (peer vs staff), training and reflective supervision, agreed escalation routes, and ensuring peer supporters themselves have support to prevent burnout or blurred boundaries (also noted by the Thrive team).
- The focus groups noted that the majority of staff and volunteers in these programmes are ex-Forces, which can blur the lines between ‘professional’ and ‘peer’, bringing authenticity but can also complicate boundaries and roles. The importance of peer leadership is heavily emphasised in the literature as well, with peer support described as “the entry point and the glue” for many successful Veteran programmes. A 2024 evaluation of Combat Stress’s Veteran peer support service found it to be well-received by both Veterans and clinicians, with peer workers adding value through their lived experience. Veterans in that study reported that the presence of Veteran staff improved their motivation to engage in treatment and reduced the negative stigma they carried from military culture. The evaluation flagged the need for training and clear boundaries for peer supporters.
- The Thrive team have been inspired by a Welsh peer support model that formalises training, supervision and role definitions – which is corroborated by the Combat Stress study’s action plan which includes ‘further training on professional boundaries’ for peer workers. The convergence is that peer support should be intentionally structured and allow for Veterans or family members who wish to develop their skills in this area (through training, monitoring, and support for the peer mentors themselves).

Holistic approaches. Both the evidence base and consultation advocate taking a broader view of Veterans' or family members' needs, not only through a clinical or employment lens, but in terms of overall quality of life.

- Focus group participants spoke of hubs as 'like family'. This type of atmosphere allows Veterans to pursue goals at their own pace, whether that is improving fitness, learning a hobby, or rebuilding confidence to socialise. This holistic approach aligns with recommendations for 'broad-spectrum, whole-person wraparound care' in addressing Veterans in crisis. Activities that can provide multiple benefits, for example giving a sense of purpose, improving physical health (e.g. nutrition, as noted with the Pay-As-You-Dine military feeding issues that led to poor eating habits post-service), and social support. Research from the King's Centre and others has consistently found that social, physical, and mental health in Veterans are interlinked – for example, physical health issues often overlap with mental health challenges, and both can be alleviated by strong supportive relationships or structured routine. The focus on quality of life as an outcome (mentioned in the groups) is also supported by policy trends; OVA's Strategy for Veterans emphasises not just employment and health, but overall wellbeing, with life satisfaction, stable relationships, and community involvement important measures of success.

Implications – Thrive Together and OVA: The evidence base affirms Thrive Together's existing model of peer-led, activity-oriented engagement that can support multiple potential outcomes for those who engage. The programme should continue to develop varied activities driven by participant interests, knowing this is both empowering for Veterans and supported by mental health research.

For the OVA, the success of these grassroots approaches contains lessons for national strategy. It suggests that funding and policy support should flow toward community hubs and groups that foster camaraderie and purpose. Expansion of programmes like Op COURAGE and Valour hubs should include spaces for non-clinical, Veteran-run activities that build trust (One of the Thrive North partners summed up their approach as [“trust first, then everything else.”](#)) Additionally, OVA could facilitate knowledge sharing, for example, collating case studies of successful local initiatives and disseminating these as models that other regions can adapt.

Support for Carers and Families

The family focus groups acknowledged that families of Veterans are often the 'hidden heroes' fulfilling a pivotal role in Veterans' wellbeing but often under-supported. The discussions (in both what was said and what was not said) revealed that family members often put the Veteran's needs first, sometimes to the detriment of their own, and that more could be done to engage and assist families. Research from 2024–2025 reinforces these points: there is growing recognition in the UK that support for Veteran families is an essential component of Veteran care, and that family members have distinct needs and challenges that deserve attention.

- **Families' Needs and Barriers:** According to the Veterans' Family Survey 2022, a majority of family respondents (90%) identified gaps in support available to them. The top themes they cited were improved mental health support (for both Veterans and family members), financial and pension advice, and better transition assistance. This was echoed by our consultation with the family members of serving RAF personnel.

- A significant finding was that over a quarter of family members mentioned difficulties in accessing or understanding services intended for them. They called for simpler, more accessible information and processes. This resonates with focus group anecdotes that families often don't know where to turn until they reach a breaking point. Additionally, families felt their role is often forgotten: one Veteran's spouse in the focus group described the peer support group as ["your little escape as well, a bit of respite,"](#) showing that families need relief and peer connection just like Veterans. Academic research from the UK Veterans Family Study also found this: family interviewees reported a lack of services addressing family needs specifically, and noted they often felt like an 'appendage' to the Veteran rather than important in their own right. Psychological barriers such as stigma and prioritising the Veteran (by both families and providers) were also identified. This report calls for future programmes to establish family reference groups to ensure that solutions are informed by, and ideally co-created with family members.
- **What works for families.** The focus groups suggested that when families do engage and do not drop out prior, they also benefit. As well as formal programmes like the Warrior Programme, joint craft sessions or family activity days were mentioned as positive examples. However, partners repeatedly mentioned that family attendance was low. Research confirms that targeted, family-inclusive approaches are needed. For instance, the family survey respondents explicitly requested ["family-specific training on how to manage Veterans' mental health"](#) (which was also a finding from Thrive's 2024 consultation, albeit more specific to managing PTSD) and more community support services that include peer support for Veterans and families.
- Moreover, evidence from charities providing clinical support (like Combat Stress) indicates that involving family in a Veteran's treatment can improve outcomes for the Veteran.
- The UK Veterans Family Study found partners and adult children favoured informal support like coffee mornings or mentoring rather than purely recreational fun days. Our consultation would say 'as well as'. This suggests that to engage families, programmes should create dedicated spaces (physical or virtual) where family members of Veterans can meet, share experiences, and access information in a supportive, non-official environment.
- **Convergent Findings:** Both the evidence base and Thrive's primary research agree that family members often feel undervalued and under-supported, and that addressing this is a key area for improvement. The research recommendation to avoid language that subsumes families under Veterans highlights the need for agencies to view family members as individuals with their own needs, not only as support tools for the Veteran. Both sources also see value in integrating families into the Veteran's journey in a healthy way by empowering them with knowledge and coping strategies and also to ensure they too have access to mental health or social support. Peer support for families (spouses meeting each other, for example) replicates the trust factor that works for Veterans.
- **Divergence.** The 2021 Census identified approximately 2 million members of the Veteran community's families in the UK. An issue raised in both the focus groups and research is the visibility gap. Many families of Veterans are effectively hidden, especially younger spouses or those not already connected to Veteran services. Divergence

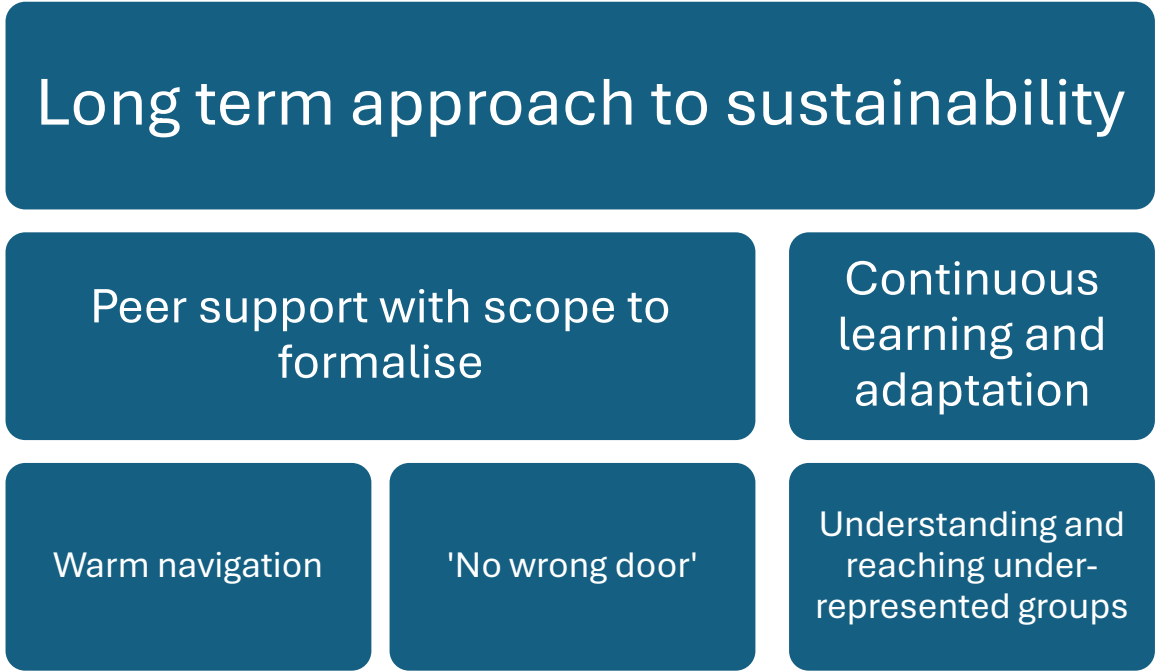
appears in what solutions are proposed. The focus group participants put forward practical ideas like running targeted awareness campaigns with imagery that includes spouses, children, and female Veterans, and experimenting with family-friendly event formats (e.g. family days, women-only groups, parent-child activities). The literature points to structural asks from families: better information on existing services, Veteran ID cards with benefits that indirectly help families, and financial support like improved access to military pensions. Both are likely required.

Implications – Thrive Together and OVA: Both Thrive and the OVA should build on the foundations from VPP to continue to develop the maturity of family support available. For Thrive Together partners this could mean setting specific targets for family inclusion and ensuring families are visible in the offer going forward. Another option is recruiting or training a Family Liaison to lead this work and ensure that the family perspective is represented in service design. A family reference group would provide ongoing feedback to keep services relevant to families' evolving needs.

For the OVA, the implication is to incorporate family measures as the default into Veteran initiatives. This might involve funding streams dedicated to family services (e.g., grants for childcare at Veteran events, counselling for partners, or peer groups for Veteran children). Given the survey evidence, OVA might also consider improving communication of pension and financial support to families, and working with other departments (education, employers) to mitigate the disadvantages that military families face (as per the Armed Forces Covenant's intent to prevent service-related disadvantage).

Learning and Improvement: Comparing Recommendations and Next Steps

In reviewing the focus group conclusions alongside wider research and programme evaluations, several cross-cutting lessons emerge. Many of the Veterans' grassroots suggestions align with recommendations from other studies and expert reviews, showing consensus on key actions that would improve Veteran and family support. Below is our initial synthesis of how the Thrive Together insights compare to broader recommendations, and what this could mean. These are summarised below.



In conclusion, this set of focus groups largely reinforces the direction of recent UK research and policy, affirming that trust-based peer support, early intervention, holistic activities, and family inclusion are the right priorities. The focus groups offer an honest scepticism about new initiatives which policy makers should take note of.

For Thrive Together, the key as partners move into the sustainability phase will be to maintain fidelity to its community-driven ethos while transitioning to the new OP Valour landscape. For the OVA, integrating grassroots insights into the execution of national strategy (like Valour’s rollout, NHS services, and Covenant commitments) will increase the likelihood of success.

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ⁱ Demographics were not captured at the Hambleton Community Action group as this session had a more informal start and end than the other groups. However, all were female partners of serving Veterans aged under 50.

7. Contact Details

We welcome your feedback, comments and questions.

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