

This protocol has regard for the HRA guidance and order of content

TITLE OF THE STUDY

Assessing feasibility and acceptability of the Veteran Connection Programme (and trial), designed to enhance mental health amongst military veterans through social connectedness

SHORT STUDY TITLE / ACRONYM

VCP - Testing Feasibility of the Veteran Connection Programme

PROTOCOL VERSION NUMBER AND DATE

2.0, 10/08/2026

RESEARCH REFERENCE NUMBERS

IRAS Number:	355035
SPONSORS Number:	25-26-37
FUNDERS Number:	NIHR209840
MODREC ID:	2511/MODREC/26
UoE REC ID:	5426272

SIGNATURE PAGE

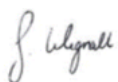
The undersigned confirm that the following protocol has been agreed and accepted and that the Chief Investigator agrees to conduct the study in compliance with the approved protocol and will adhere to the principles outlined in the Declaration of Helsinki, the Sponsor's SOPs, and other regulatory requirement.

I agree to ensure that the confidential information contained in this document will not be used for any other purpose other than the evaluation or conduct of the investigation without the prior written consent of the Sponsor

I also confirm that I will make the findings of the study publicly available through publication or other dissemination tools without any unnecessary delay and that an honest accurate and transparent account of the study will be given; and that any discrepancies from the study as planned in this protocol will be explained.

For and on behalf of the Study Sponsor:

Signature:



Date:

02/06/2026

Name: Suzy Wignall

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Position:

Senior Clinical Research Governance Manager

Chief Investigator:

Signature:



Date:

1/6/2026

Name: Dr. Stefan Schilling

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KEY STUDY CONTACTS

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Joint-sponsor(s)/co-sponsor(s)	n/a
Funder(s)	National Institute for Health and Care Research (NIHR), Research for Patient Benefit (RfPB) Programme (reference NIHR209840) Programme Manager Louisa Fox, louisa.fox@nihr.ac.uk
Key Protocol Contributors	Dr. Juliet Wakefield, Senior Lecturer, Nottingham Trent University, juliet.wakefield@ntu.ac.uk , Dr. Summer Bedford, Trial Manager/Postdoctoral Researcher Veteran Connection Programme, University of Exeter, s.l.bedford@exeter.ac.uk , 07597 674963 Additional Contributors: • Prof. Obi Ukoumunne – Co-investigator statistical oversight • Prof Antonieta Medina-Lara – Co-investigator health economics input • Dr. Jane Smith – Co-investigator, Implementation and Evaluation • Prof. Mark Tarrant – Co-investigator, Feasibility and Fidelity • Chris Hayward, Co-investigator, CTU involvement • Stacey Denyer, Co-investigator, PPIE involvement • Dr. Tarli Young, Co-Investigator, Facilitator Training
Committees	Trial Steering Group: Independent Chair: Dr Mary Keeling (CPsychol) [she/her] Deputy Director, Centre for Evidence for the Armed Forces Community. Contact: mkeeling@randeurope.org +44 1223 353 329 Stakeholder and PPI Advisory Group (SPAG): Chair: Stacey Denyer Contact: s.denyier@exeter.ac.uk

STUDY SUMMARY

Study Title	Assessing feasibility and acceptability of the Veteran Connection Programme (and trial), designed to enhance
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	mental health amongst military veterans through social connectedness.
Internal ref. no. (or short title)	VCP - Testing Feasibility of the Veteran Connection Programme
Study Design	18-month feasibility/acceptability study comprising a two-arm randomised controlled trial incorporating a process- evaluation and work to underpin and inform a future definitive trial and economic evaluation. Eighty participants will be randomly allocated in a 1:1 ratio to either the intervention (VCP) or control arm. Control participants will receive a leaflet listing support services. Informed consent for participants in the VCP arm will be obtained prior to participation in the intervention (i.e., T0) via an online form.
Study Participants	Veterans (British/Commonwealth nationals) who will be between six months from leaving and 10 years post-leaving the UK military. From this population, eighty participants (40 intervention/40 control) will be recruited through four pathways: Primary care; Military resettlement (Ministry-of-Defence; Veteran-facing VCSE (voluntary) organisations; social media/self-recruitment
Planned Size of Sample (if applicable)	80 (40 intervention/40 control)
Follow up duration (if applicable)	3 months
Planned Study Period	Start date of funding: 01/04/2026 Start date of study: 01/07/2026 Planned end date: 30/09/2027
Research Question/Aim(s)	RQ1: Are study procedures and the intervention suitable for and acceptable to service-leavers across different subgroups (females/early service-leavers/LGBTQ+/minoritised/rural/coastal-living)? RQ2: Can we recruit appropriate participants through the suggested recruitment pathways (NHS, voluntary-organisations, Ministry-of-Defence (MoD), self-referral)? RQ3: How appropriate are the trial and data collection procedures e.g., for data-collection procedures and outcome measures)?

FUNDING AND SUPPORT IN KIND

FUNDER(S) (Names and contact details of ALL organisations providing funding and/or support in kind for this study)	FINANCIAL AND NON FINANCIAL SUPPORT GIVEN
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National Institute for Health and Care Research (NIHR), Research for Patient Benefit (RfPB) Programme (reference NIHR209840) louisa.fox@nihr.ac.uk	£308,334.93
Royal Air Force Resettlement Support Ian Nugus, SO1 Resettlement D People Gd floor, Hurricane Block 1-Site, RAF High Wycombe Teams Business Tel: 0303 383 6948 Email: Ian.Nugus258@mod.gov.uk	RAF Resettlement is providing recruitment support through their RAF 15 Resettlement Officers and RAF sites.

ROLE OF STUDY SPONSOR AND FUNDER

The University of Exeter is the study sponsor, assuming overall responsibility for the initiation, management, and conduct of the study. The sponsor has no role in data analysis, interpretation, or manuscript writing, and does not control decisions regarding publication or dissemination of results.

The study is funded by the National Institute for Health and Care Research's Research for Patient Benefit (NIHR RfPB) programme (grant ref: NIHR209840). The funder has no influence over study design, data collection, analysis, or interpretation. All publications must acknowledge NIHR funding and include the standard disclaimer that views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care. NIHR retains the right to review publications prior to submission in accordance with grant conditions but does not hold editorial control over the content or conclusions of publications arising from the study.

ROLES AND RESPONSIBILITIES OF STUDY MANAGEMENT COMMITTEES/GROUPS & INDIVIDUALS

Core Research Team and Day-to-Day Management

Day-to-day operational management is led by the core research team: Dr. Stefan Schilling (PI, University of Exeter), Dr. Juliet Wakefield (Co-PI, Nottingham Trent University), and Dr. Summer Bedford (Trial Manager/Postdoctoral Researcher, University of Exeter). The team meets weekly, chaired by Dr. Schilling, to monitor progress, troubleshoot delivery issues, review timelines, and ensure alignment with the project plan. The Management Group (MG) comprises senior co-investigators with specialist responsibilities. Its role is to provide expert oversight of methodological rigour, ensure integration across workstreams, and review emerging data. The MG will flag risks or deviations from protocol and advise on mitigation strategies. It is not independent of the study team.

Study Steering Groups

The Trial Steering Committee (TSC) provides independent oversight of the study. It is chaired by an independent chair (Mary Keeling) and includes two independent medical officers (GPs), an independent statistician, and a lay member. The TSC will meet three times during the project. Its responsibilities include assessing progression criteria, advising on trial progress and protocol adherence, reviewing participant safety, and considering proposed amendments to the protocol. The TSC operates independently of the sponsor and investigator team. Terms of Reference for the TSC will be established prior to the first meeting.

Stakeholder and PPI Advisory Group

The Stakeholder and PPI Advisory Group (SPAG) is chaired by Stacey Denyer (peer facilitator and PPIE lead) and meets quarterly throughout the study. The SPAG is not independent — it is a stakeholder and public involvement body whose role is to provide continuous feedback on intervention delivery, inclusivity, and relevance. Membership includes veterans from diverse backgrounds (female, minoritised, LGBTQ+, early service leavers, rural/coastal) and stakeholders across referral pathways, including GPs, link workers, veteran charities (RAFA, Royal Marines Association, Royal Air Force resettlement services), NHS Integrated Care Boards, MoD representatives, and VCSE organisations. The SPAG advises on recruitment, participant experience, and dissemination strategy, and contributes to refinement of the intervention and study materials throughout the trial. Terms of Reference for the SPAG will be established prior to the first meeting.

Patient and Public Involvement

Public and patient involvement is embedded throughout the study. VCP was co-developed with veterans and peer facilitators, and PPI has informed study design, recruitment materials, outcome selection, and safeguarding procedures. Ongoing PPI is coordinated through the SPAG. Participants and PPIE contributors will receive a plain-language summary of findings at the end of the study.

PROTOCOL CONTRIBUTORS

The University of Exeter, as the sponsor, holds overall responsibility for the initiation and management of the study but has no role in data analysis, interpretation, or manuscript writing, and does not control decisions regarding publication or dissemination of results.

The study is funded by the National Institute for Health and Care Research's Research for Patient Benefit programme (grant ref: NIHR209840). The funder has no influence over study design, data collection, analysis, interpretation, or publication. All publications must acknowledge NIHR funding and include the standard disclaimer that views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

Study Investigators

Dr. Stefan Schilling (PI, University of Exeter) is a social and organisational psychologist with expertise in group-based interventions, social identity, and military-to-civilian transition. Trained in both psychology and security studies, he has worked in and researched military environments for over a decade. He leads day-to-day project management, trial delivery, stakeholder engagement, and oversight of all study elements.

Dr. Juliet Wakefield (Co-PI, Nottingham Trent University) is an experienced social psychologist with 18 years of expertise in the Social Identity Approach and its application to health. She leads the mixed-methods components of the study, oversees policy-related aspects, and co-leads intervention development and facilitator training.

Dr. Summer Bedford (Postdoctoral Researcher, University of Exeter) is responsible for co-delivering the intervention, collecting qualitative and quantitative data, supporting analysis, and day-to-day operational coordination. Her PhD focused on social identity and prosocial behaviour. As the spouse of a Royal Marine Commando, she brings lived experience of military family life to the study.

Professor Mark Tarrant (Co-Investigator, University of Exeter) leads the evaluation of fidelity and stop/go criteria. He is an expert in developing and evaluating group-based behaviour change interventions informed by the Social Identity Approach to Health and has led several NIHR-funded trials including the PROGROUP trial.

Dr. Jane Smith (Co-Investigator) leads the process evaluation and mentors the PI and Co-PI on trial design. She co-developed the MAGI Framework (Mechanisms of Action in Group-Based Interventions), which is applied in this study, and has received NIHR funding for multiple relevant projects.

Professor Antonieta Medina-Lara (Co-Investigator, University of Exeter) oversees the health economic component of the study, including the feasibility of collecting resource utilisation and health-related quality-of-life data and the development of the cost-effectiveness framework for a future trial.

Professor Obi Ukoumunne (Co-Investigator, University of Exeter) leads all statistical aspects of the study, including trial design, sample size calculation, randomisation, the statistical analysis plan, and data analysis. He is an expert in the design and statistical analysis of clustered and individually randomised trials for group-based interventions and mental health outcomes.

Chris Hayward (Co-Investigator, Exeter Clinical Trials Unit) is Director of Operations of the Exeter CTU. He will support evaluation of the progression criteria and provide expert guidance on full trial preparation.

Dr. Tarli Young (Co-Investigator, University of Queensland; uncosted) co-developed VCP with Schilling and Wakefield and has delivered VCP pilot workshops in Australia. She leads development of the facilitator training workshop and materials, drawing on her expertise in the Social Identity Approach to Group Therapy Leadership.

Patient and Public Involvement

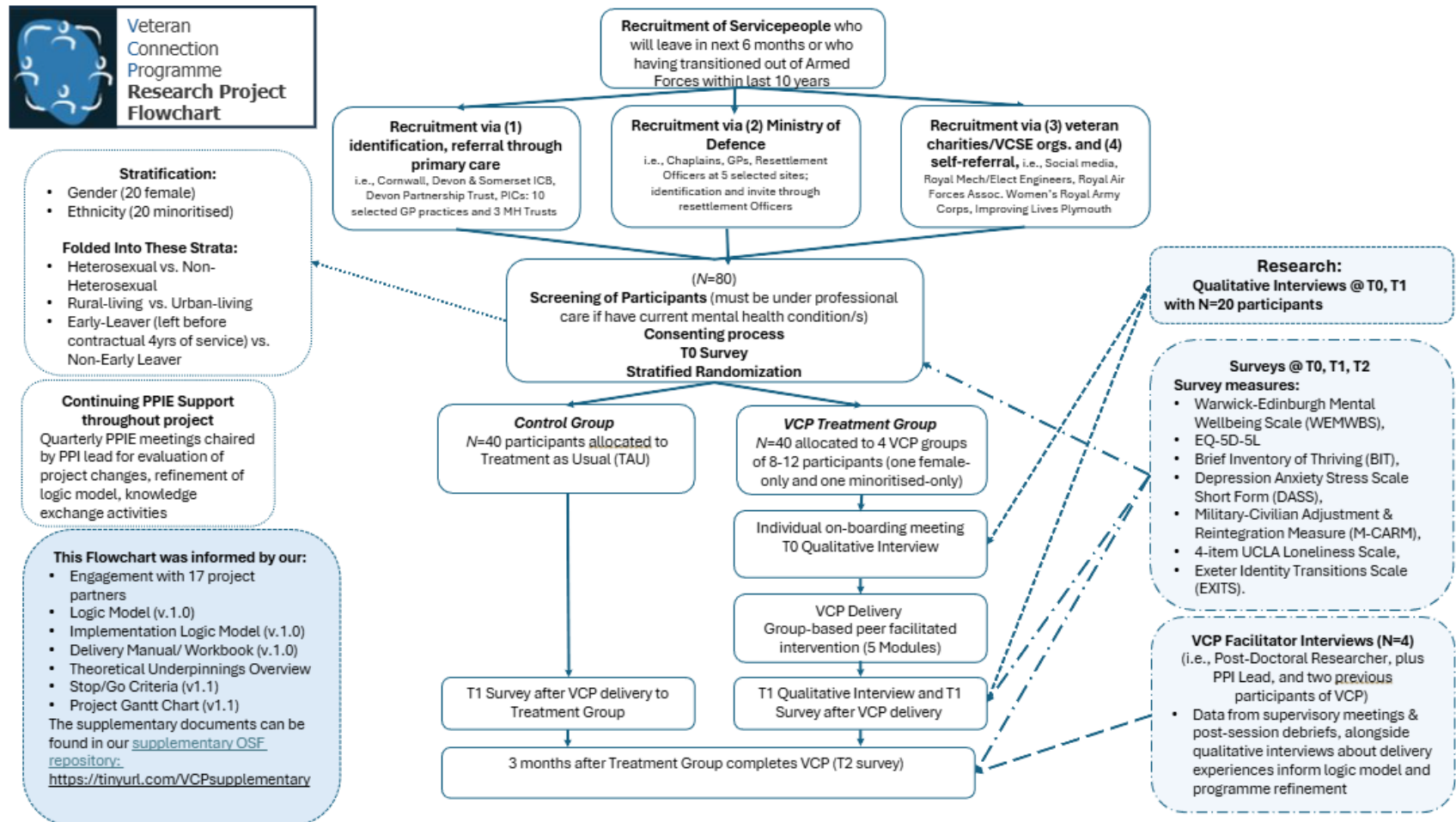
Stacey Denyer (PPI Lead and SPAG Chair) is a veteran peer facilitator with direct lived experience of military-to-civilian transition. She leads PPIE activities within the study, chairs the Stakeholder and Public Advisory Group, which meets quarterly throughout the study, and ensures that intervention materials and study delivery are culturally competent, inclusive, and grounded in the lived experience of the veteran community.

PPIE has been embedded in the development of VCP from inception. Veterans and peer facilitators were involved in the co-development of VCP's core materials, participated in the proof-of-concept trial, reviewed participant-facing documents, and produced social media testimonials to support recruitment. Stakeholder consultation events and a stakeholder survey (2025) directly informed the implementation plan, recruitment strategy, and logic model. Ongoing PPI is reported using the NIHR PPI log and the GRIPP2 checklist.

KEY WORDS:

- Veterans
- Mental health
- Social connectedness
- Feasibility study
- Group intervention
- Military transition

STUDY FLOW CHART



STUDY PROTOCOL

Title: Assessing feasibility and acceptability of the Veteran Connection Programme (and trial), designed to enhance mental health amongst military veterans through social connectedness

1 BACKGROUND

Approximately 15,000 individuals leave the UK Armed Forces each year. For many, the transition from military to civilian life — often referred to as military-to-civilian transition (MCT) — is a significant and challenging life event. While some service leavers adapt successfully, a substantial proportion experience difficulties that affect their mental health, social functioning, and long-term wellbeing.

Over half of UK veterans experience mental health problems (55%, compared to 35% in the general population), including elevated rates of depression (26%), post-traumatic stress disorder (PTSD; 8%), psychosis (14%), and alcohol misuse (14%), with suicide rates two to three times higher than the general population (Rodway et al., 2022; Williamson, Palmer, et al., 2023). The societal cost of problematic transitions has been estimated at £258 million annually (Galley & Slapakova, 2025).

Many of these difficulties are compounded by the loss of identity and social connection that accompanies leaving military service. While serving, military personnel develop a strong, self-defining military identity supported by tight-knit social networks, shared purpose, and a clear sense of belonging (Keeling, 2018; Wakefield et al., 2024). Upon discharge, this identity and the accompanying group memberships and psychological resources are often lost abruptly, and many veterans struggle for years to regain a sense of who they are and where they fit in civilian life (Keeling, 2018). This identity disruption is compounded by loneliness: approximately two-thirds of veterans report feeling lonely (Williamson, Wickersham, et al., 2023), with those who are economically active at heightened risk. Civilian research consistently links loneliness to heightened risks of anxiety, depression, cardiovascular disease, and premature mortality (Hawkley & Cacioppo, 2010; WHO Commission on Social Connection, 2025). Stigma and unfamiliarity with civilian services further hinder help-seeking, with many veterans relying on peer and family support and only seeking professional help around two years post-transition, often at crisis point (Hitch et al., 2023).

These challenges are compounded for underserved veteran subgroups, who face additional barriers to support and poorer post-service outcomes due to systemic inequalities and differing needs, including female veterans, who are less likely to access employment support (Godier-McBard et al., 2023; House of Commons Defence Committee, 2021), medically discharged veterans, who face greater identity disruption and economic instability (Office for National Statistics & Office for Veterans Affairs, 2024) and minoritised veterans, who often contend with cultural stigma and institutional distrust (Pearson et al., 2022). Consequently, veterans consistently report valuing peer-facilitated interventions that normalise mental ill-health and draw on shared experience (Aitken & Kinane, 2024). These patterns highlight the need for more tailored, inclusive peer-led transition support that acknowledges the diverse experiences of those leaving the Armed Forces.

Limitations of Existing Support

Current transition support for service leavers overwhelmingly focuses on mental health treatment or practical assistance with accommodation and employment. Although 88% of service leavers who use the Career Transition Partnership are reportedly employed six months after discharge (Ministry of Defence, 2025) internal data suggest that many leave these positions within four months (Fisher et al., 2021), pointing to unmet social and psychological needs. Systematic review evidence shows that in-person interventions targeting loneliness are rarely tailored to diverse subpopulations, are generally low quality, and few report cost-effectiveness or process outcomes (Welch et al., 2024). Existing veteran-specific programmes are often already stretched, and many veterans whose needs do not align with

Talking Therapies or Community Mental Health Services fall through the gaps (Powell et al., 2024). The MeT4VeT app, for example, neglects the social identity issues that amplify veterans' mental health problems and lacks the group-support processes veterans prefer (Parkes et al., 2023). Veterans themselves consistently report valuing peer-facilitated support that normalises mental health difficulties and draws on shared experience (Aitken & Kinane, 2024).

Our Intervention – The Veteran Connection Programme (VCP)

VCP is a veteran co-designed, group-based, peer co-facilitated psychosocial intervention developed specifically to address the social identity and loneliness challenges faced by service leavers and veterans. Theoretically based on the Social Identity Approach to Health (SIAH), our work shows that being a member of the Armed Forces is associated with a strong sense of group belonging, anchored in their 'oppos' and 'mates', which provides social support, purpose and meaning (Heward et al., 2024). However, losing important group memberships, as commonly occurs during life transitions such as MCT, has demonstrable negative effects on mental health, across various life transitions, including becoming a parent (Seymour-Smith et al., 2017; Seymour-Smith et al., 2021) a retiree (Haslam et al., 2019; LaRue et al., 2022; La-Rue et al., 2023), or a veteran (Wakefield et al., 2024). On the contrary, maintaining existing memberships and forming new ones has a protective effect (Haslam et al., 2020).

In fact, group-based interventions grounded in SIAH principles have demonstrated reductions in loneliness, depression, and social anxiety comparable to Cognitive Behavioural Therapy (Cruwys et al., 2022; Haslam et al., 2025), with effects enhanced when participants identify with the group (Steffens et al., 2021). No such programme has previously been developed or tested specifically for veterans, who have distinct social identity needs and a strong preference for peer-facilitated delivery (Aitken & Kinane, 2024).

VCP builds on this work and is the first programme deliberately facilitated by a psychologist and a trained veteran peer facilitator across a one day workshop, which covers the effect of social groups on wellbeing, encourages participants to map their social connections, explores how their identity has changed through transition and aids them in expanding their social networks by forming new group connections aligned with their current goals and values.

The Proposed Study

This study is a two-arm feasibility randomised controlled trial (RCT) designed to test the feasibility and acceptability of VCP for UK military service leavers and veterans. The trial will recruit 80 participants (40 VCP, 40 treatment as usual) across sites in the Southwest and Northeast of England. The primary aim is to determine whether a full-scale efficacy RCT is warranted and feasible, by assessing recruitment, retention, intervention fidelity, and the acceptability of outcome measures. Secondary aims include generating preliminary estimates of VCP's effect on wellbeing, loneliness, and social connectedness, and assessing implementation pathways for future delivery through NHS, MoD, and third-sector organisations. The question for the future definitive trial is defined using the PICO framework (Population, Intervention, Comparison, Outcomes):

Population: 80 British and Commonwealth Service leavers (within six months of leaving the forces) and Veterans up until 10 years post-leaving the UK military) will be recruited into a treatment and control group (40 each) through four pathways:

1. NHS Primary care;
2. Military resettlement (Ministry-of-Defence)
3. Veteran-facing VCSE (voluntary) organisations;
4. social media/self-recruitment.

Intervention: The Veteran Connection Programme (VCP) – a psychoeducational, group-based intervention focused on improving social connectedness, identity continuity, and mental-wellbeing.

Comparison: Control (Treatment-As-Usual; TAU), defined as access to existing transition/resettlement/NHS/VCSE support services, but not access to VCP participation during the trial period.

Outcomes: are assessed at three timepoints (pre-intervention, immediately post-intervention, and three-month follow-up), with the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) as the provisional primary outcome, and secondary outcomes including the UCLA Loneliness Scale, Brief Inventory of Thriving (BIT), Depression Anxiety and Stress Scale (DASS), Military-Civilian Adjustment & Reintegration Measure (M-CARM), Exeter Identity Transition Scales (EXITS), and Health-Related Quality-of-Life Scale (EQ-5D-5L).

2 RATIONALE

Despite the well-documented mental health burden associated with MCT and the clear role of identity loss and social disconnection as drivers of poor outcomes, no group-based, peer co-facilitated psychosocial intervention grounded in social identity theory has been developed and rigorously tested for UK veterans. Existing provision focuses predominantly on employment, accommodation, and clinical mental health treatment, leaving a significant gap in preventative, psychosocially-focused support — a gap consistently identified by veterans, service providers, and clinicians as a priority.

The study directly addresses two DHSC research priorities (i.e., prevention and reduction of compound NHS pressures) and aligns with NHS England's 2024/25 operational priorities around improving access to mental health services, increasing preventative healthcare availability, and reducing health inequalities (NHS England, 2024; DHSC, 2024). It further supports VALOUR, the £50 million MoD and Office for Veterans' Affairs initiative to improve coordination and accessibility of veteran services through regional hubs, by filling critical gaps in psychosocial provision and building workforce capability (Ministry of Defence & Office for Veterans Affairs, 2025).

Stakeholder and PPI consultation conducted prior to this application confirmed that VCP addresses a genuine and currently unmet need. Veterans, GPs, link workers, and VCSE partners during interviews and stakeholder workshops described existing provision as inadequate for veterans whose primary difficulties are psychosocial rather than clinical, and endorsed VCP's focus on identity, self-efficacy, and social connection as novel and promising. Stakeholders also identified key barriers to participation (e.g., including travel, childcare) which have been incorporated into the study design and recruitment strategy.

Our proof-of-concept trial conducted in 2024/25 across five UK and Australian cohorts (N=33) demonstrated promising preliminary findings. Participants showed a reduction in loneliness and improvements in thriving, social group gain, self-efficacy, and military-to-civilian adjustment. Qualitative feedback highlighted the value of the peer-facilitation model, the normalisation of mental health difficulties, and the development of new social connections. Participants consistently emphasised the importance of early, preventative delivery to support veterans before difficulties become entrenched.

However, while these results are promising, critical questions about recruitment pathways, retention, fidelity of delivery, and acceptability of outcome measures and potential for implementation and scalability must be answered before a fully powered efficacy trial can be designed with confidence.

This study is designed to provide exactly that evidence base. The design includes process indicators, implementation outcomes, and personalisation across subgroups and, in-line with NHS/DHSC priorities, can be delivered preventatively and/or alongside clinical treatment. As a group-based, peer co-facilitated interventions (GBPCI), **VCP** attracts lower levels of stigma and is likely to cost less than medicalised interventions (Cruwys et al., 2022; Haslam et al., 2025; Steffens et al., 2021).

3 THEORETICAL FRAMEWORK

VCP is grounded in the Social Identity Approach to Health (SIAH), which proposes that belonging to social groups – and identifying with them – is a fundamental determinant of mental health and wellbeing (Haslam et al., 2020). The SIAH is particularly relevant to MCT: military service provides a chronically salient, shared identity and dense social networks that are often lost abruptly upon discharge, at precisely the point when social support is most needed (Wakefield et al., 2024).

In general terms, the SIAH demonstrates that identification (or a sense of belonging) with meaningful social groups provides access to psychological resources such as support and agency, which in turn protect mental and physical health (Haslam et al., 2020). Within the SIAH, life transitions are defined as identity transitions, since they involve losing one or more social group/s (e.g., membership of the military). This process is understood via the Social Identity Model of Identity Change (SIMIC), which posits that the stress created by this group membership loss can be buffered by maintaining some old group memberships during the transition, and gaining new group memberships during/after the transition. Research across various life transitions, including becoming a student (Iyer et al., 2010), a parent (Seymour-Smith et al., 2017; Seymour-Smith et al., 2021), and a retiree (Haslam et al., 2019; LaRue et al., 2022; La-Rue et al., 2023), shows that positive effects from group membership maintenance and gain enhance physical-health, longevity, mental-health, and general well-being. Our research has shown that the same theoretical processes are relevant in veterans (Wakefield et al., 2024), although these mechanisms have not been systematically embedded within UK veteran transition programming. The principles of SIMIC were applied to develop the intervention GROUPS4HEALTH (G4H), which has been extensively tested in clinical populations, and has shown to be acceptable, feasible, and effective (Cruwys et al., 2022; Haslam et al., 2025).

VCP's theory of change was developed using the Mechanisms of Action in Group-based Interventions (MAGI) framework (Borek et al., 2019) and operates at three levels: group-level processes (identification, engagement), interpersonal processes (peer support, motivation, experience-sharing), and intrapersonal processes (self-efficacy, barrier identification, skills practice). Two interrelated models specify how these mechanisms translate into behaviour change. The Social Identity Model of Behaviour Change (SIM:BC; (Tarrant et al., 2020)) proposes that building a shared group identity within an intervention amplifies its effectiveness, as the group itself becomes a source of psychoeducation, motivation, and social resources such as connection, norms, and agency (Steffens et al., 2021). Complementing this, the Social Identity Approach to Group Therapy Leadership (Cruwys et al., 2023; Robertson et al., 2023) proposes that facilitators who actively foster group identification enhance engagement, promote health-supporting norms, and strengthen therapeutic relationships. VCP builds on this by combining the theoretical and empirical learnings of the SIAH and the social identity principles of effective therapy delivery to adapt a proven group-based intervention framework specifically for the psychosocial needs of UK veterans navigating military-to-civilian transition.

4 RESEARCH QUESTION/AIM(S)

Our pre-existing work identified various questions to be answered in this proposed research, including VCP feasibility/acceptability to veteran subgroups, appropriateness of identified recruitment and referral pathways, and evaluation of proposed outcome measures and data collection procedures for use in a future definitive trial (Orsmond & Cohn, 2015). The research is therefore guided by three main questions:

RQ1: Are study procedures and the intervention suitable for and acceptable to service-leavers across different subgroups (females/early service-leavers/LGBTQ+/minoritised/rural/coastal-living)?

RQ2: Can we recruit appropriate participants through the suggested recruitment pathways (NHS, voluntary- organisations, Ministry-of-Defence (MoD), self-referral)?

RQ3: How appropriate are the trial and data collection procedures e.g., for data-collection procedures and outcome measures)?

4.1 Objectives

The aims of this feasibility trial are to establish:

- Feasibility of VCP as a one-day format to service-leavers/veterans, collecting evidence of participants' experiences/responses to VCP
- Feasibility of recruitment pathways, measuring recruitment/retention rates/follow-up.
- Identification of definitive outcome measures and estimation of outcome standard-deviations to inform the sample size for definitive trial.
- Appropriateness of the trial processes including randomisation/data collection/data-management procedures for subsequent definitive trial.
- Feasibility and adherence to procedures.
- Feasibility of collecting resource utilisation and health-related quality-of-life data, to estimate the cost of the intervention.
- Evaluation of VCP implementation plan and scalability to inform effective delivery in real-world settings.

4.2 Outcome

The broad outcomes of the study therefore fall into two categories. First, feasibility and process outcomes, including recruitment and retention rates across pathways, intervention fidelity, and the acceptability of randomisation and data collection procedures. These will determine whether and how a definitive trial should proceed. Second, clinical and psychological outcomes, including mental wellbeing, loneliness, thriving, psychological distress, military-civilian adjustment, and identity continuity, assessed using validated self-report measures. These are treated as provisional outcomes for the purposes of this feasibility study; their primary function is to estimate variability, assess data completeness, and identify the most appropriate outcome battery for a definitive trial. Health-related quality-of-life data will also be collected to support future cost-effectiveness modelling.

5 STUDY DESIGN AND METHODS OF DATA COLLECTION AND DATA ANALYSIS

This is an 18-month, two-arm mixed-methods feasibility randomised controlled trial incorporating a process evaluation and health economic analysis. Eighty participants (40 VCP intervention; 40 treatment-as-usual control) will be randomly allocated in a 1:1 ratio, stratified by gender and ethnicity. The study is conducted across Southwest and Northeast England. The mixed-methods design integrates quantitative survey data with qualitative interview data to assess feasibility, acceptability, and implementation, and to inform the design of a future definitive trial.

Data Collection

All participants complete self-report questionnaire batteries at three timepoints: baseline (T0), post-intervention (T1), and three-month follow-up (T2). Surveys are administered online via Qualtrics, which is GDPR-compliant and accessible via the University of Exeter's single sign-on infrastructure. The survey battery includes validated measures of mental wellbeing (WEMWBS), loneliness (UCLA Loneliness Scale), thriving (BIT), psychological distress (DASS), military-civilian adjustment (M-CARM), identity continuity (EXITS), health-related quality of life (EQ-5D-5L), and self-reported comorbidities and healthcare utilisation. Survey data are collected, managed, and stored by Dr. Summer Bedford under

the oversight of the PI. Quantitative data will be managed in Microsoft Excel and analysed using SPSS and R.

Twenty purposively sampled VCP participants, representing diverse veteran subgroups (female, minoritised, LGBTQ+, early service leavers, rural/coastal), will participate in semi-structured interviews at T0 and T1. Interviews will be conducted online via a secure video platform. Interview topic guides will be developed by the research team in consultation with the SPAG, drawing on the process evaluation framework and the Implementation Research Logic Model. Interviews will be conducted by Dr. Summer Bedford and audio-recorded with participant consent. Facilitators and selected PPIE-Stakeholders will also be interviewed post-trial to assess delivery experience, mechanisms of change, and implementation considerations.

Audio recordings will be transcribed professionally and verified by the research team. Transcripts will be de-identified during transcription by removing names, units, locations, and other potentially identifying details. Audio recordings will be deleted immediately following transcription and verification. Transcripts will be coded and analysed by Dr. Summer Bedford and Dr. Juliet Wakefield. Quantitative data will be cleaned and managed by Dr. Summer Bedford under the oversight of Professor Obi Ukoumunne.

Process and Implementation Measures

Intervention fidelity will be assessed using a structured fidelity checklist completed by facilitators and independent observers for each VCP session, covering content adherence, delivery style, and session completeness. Implementation logs will record site-level data including venue suitability, referral and attendance rates, and administrative burden.

Analysis

A CONSORT diagram (CONSolidated Standards of Reporting Trials) will illustrate participant flow from each recruitment source. Feasibility parameters (recruitment rates, retention, follow-up rates, fidelity) will be reported with 95% confidence intervals. Participant characteristics will be reported by trial arm using means and standard deviations or medians and interquartile ranges for continuous variables, and frequencies and percentages for categorical variables. Potential effectiveness of VCP at T1 and T2 will be estimated using mixed-effects models with arm, time, and their interaction as fixed effects, adjusting for baseline scores and stratification variables. Effect sizes with 95% confidence intervals will be reported to inform the sample size calculation for a definitive trial. Health economic analysis will estimate intervention costs on a per-participant basis and assess the feasibility of health-related quality-of-life data collection using the EQ-5D-5L.

Qualitative data will be analysed using framework analysis, consistent with the process evaluation approach and guided by the Implementation Research Logic Model. Coding will be conducted in NVivo. Findings will be integrated with quantitative feasibility data to produce a comprehensive account of intervention delivery, acceptability, and implementation across pathways and subgroups.

Data Storage, Transfer, and Archiving

All data will be handled by the research team, in accordance with UK GDPR and the Data Protection Act 2018. All data are stored on the University of Exeter's SharePoint platform within the European Economic Area. Pseudonymised quantitative datasets and anonymised qualitative transcripts will be archived with the UK Data Service or the University of Exeter's Open Research Exeter repository following study completion, in accordance with the Data Management Plan.

6 STUDY SETTING

This is a multicentre feasibility trial conducted across two regions: Southwest England (lead site) and Northeast England. The two-region design reflects the need to assess recruitment and delivery feasibility across geographically and demographically distinct veteran populations, including rural and coastal communities that are historically underserved by veteran support services.

Participant identification and recruitment

Participants will be identified and recruited through four pathways, each operating across different settings:

- **Primary care:** Eligible veterans will be identified by NHS Integrated Care Boards and selected GP practices and Mental Health Trusts across Cornwall, Devon, and Somerset, including specifically identified rural and coastal practices. Referral will also occur via social prescribers, health coaches, care coordinators, and mental health therapy providers within Southwest NHS Trusts. Recruitment at primary care sites involves identification from practice records and outreach via text message. Posters will be placed in participating sites.
- **MoD (Ministry of Defence) resettlement:** Participants will be identified and recruited via resettlement teams and transition officers, resettlement websites. Peer facilitators will deliver promotional presentations at selected military sites (including RNAS Yeovilton, HMS Devonport, RM Norton Manor, RAF Brize Norton, MOD Lyneham, and MOD Warminster, Catterick Garrison). Posters will be hung up in military primary care practices and mess halls.
- **VCSE (Voluntary, Community, and Social Enterprise) organisations:** Participants will be identified and invited via supporting military charities and veteran-facing VCSE wellbeing hubs, including designated rural and coastal delivery partners. Posters and flyers will be disseminated.
- **Social media and self-referral:** Social media advertisements using participant and facilitator testimonials will be disseminated through partner networks. Posters and flyers will be placed in garrison pubs and gyms.

Intervention Delivery

VCP workshops will be delivered face-to-face at four participating research sites. Sites are selected on the basis of existing relationships with veteran populations, accessible physical space for group sessions of 8–12 participants, and capacity to support trial processes. Delivery sites on military installations are excluded. One dedicated workshop will be delivered for female veterans and one for minoritised veterans respectively, at appropriately selected venues.

Follow-up sessions (T1 virtual session and T2 follow-up) and all qualitative interviews will be conducted online via a secure video platform, removing geographic barriers to participation for rural and coastal veterans.

Site-specific Requirements

Primary Care Sites (PICs) are required to have existing relationships with veteran populations, capacity to identify and refer eligible veterans, and staff willing to engage with the study team. Delivery sites must have accessible indoor space suitable for group workshops and must not be located on or adjacent to military installations. All participating sites will complete a site initiation process prior to commencing study-related activities.

7 SAMPLE AND RECRUITMENT

7.1 Eligibility Criteria

7.1.1 Inclusion Criteria

Inclusion criteria include:

- Aged 18+ until 55 (standard retirement age for most military personnel)
- Currently serving or having served in the UK Regular Armed Forces
- In resettlement (6 months prior to leaving the military) up until 10 years post-service
- Able and willing to attend a face-to-face one-day group workshop and two brief virtual sessions
- Have sufficient English proficiency to participate in group discussions and complete study assessments
- Able to provide informed consent

7.1.2 Exclusion Criteria

Exclusion criteria include:

- Currently receiving intensive or crisis mental-health care (e.g., hospitalisation/acute risk-management)
- In the military but not in resettlement (i.e., not within 6 months of leaving)
- Experiencing unmanaged severe mental illness (e.g., personality disorder/psychosis/bi-polar disorder/moderate to severe suicide risk) or significant cognitive impairment that would prevent group participation
- Pose a current unmanaged risk to others (based on self-report and/or referrer indication).

7.2 Sampling

The population is service leavers and veterans (British/Commonwealth nationals) who are between six months from leaving and 10 years post-leaving the UK military. From this population, eighty participants (40 intervention/40 control) will be recruited through four pathways:

- Primary care;
- Military resettlement (Ministry-of-Defence, RAF, RN, RM);
- VCSE (voluntary) organisations (e.);
- social media/self-recruitment.

These pathways have been selected through discussion with stakeholders and veterans. This sampling technique was justified through stakeholder consultations and preliminary feasibility assessment through partner organisations (e.g., five NHS-selected GP practices identified 493 eligible veterans, while our RAF partners can identify and target 3000 eligible service leavers at any given time). This sampling volume is justified through in-depth discussions with the medical statistician on the research team.

7.2.1 Size of Sample

While this feasibility/acceptability study is not powered to determine intervention effectiveness, it is designed to generate critical evidence on VCP's viability/acceptability/scalability, particularly across diverse veteran populations and delivery contexts. Eighty participants are enough to estimate: (i) a follow-up rate of 80% with a 95% confidence interval (70-88%) ; (ii) standard deviations for continuous outcomes to within 18% of their true value at baseline and to within 21% of their true follow-up value based on the upper-bound of the 95% confidence-interval. The 64 participants that provide follow-up data are enough to estimate a correlation of 0.7 between baseline and follow-up outcome scores with a 95% confidence interval (0.69-0.87). The 40 participants in the intervention arm are enough to estimate the percentage that complete the intervention with a margin of error no wider than +/- 16 percentage points based on the width of the 95% confidence interval.

7.2.2 Sampling Technique

Participants are recruited using a mixed sampling strategy combining convenience and purposive sampling. The broader recruitment approach is opportunistic, drawing on established referral networks across four pathways (i.e., NHS primary care, MoD resettlement services, VCSE organisations, and social media/self-referral) to maximise the pool of eligible veterans during the recruitment window. Within NHS primary care, eligible veterans are identified via SNOMED CT codes.

Purposive sampling is applied to ensure representation of historically underserved subgroups: female veterans, minoritised veterans, LGBTQ+ veterans, early service leavers, and those living in rural or coastal areas. This reflects the study's theoretical framework, which holds that the health impacts of military-to-civilian transition are shaped by intersecting social identities, and the practical need to assess whether VCP is feasible and acceptable across diverse groups ahead of a definitive trial.

Recruitment pathways were selected following stakeholder consultations and preliminary feasibility data indicating their reach into different veteran subgroups. Stratified randomisation by gender and ethnicity (i.e., targeting 20 female and 20 minoritised veterans within the 80-participant sample) ensures the trial can generate initial feasibility and acceptability data for these groups specifically, informing subgroup-specific recruitment strategies for a future definitive trial. Following eligibility screening and consent, participants are randomly allocated to intervention or control arms using a sealed-envelope randomisation service.

7.3 Recruitment

Recruitment will take place across two regions (Southwest England (lead site) and Northeast England) via four pathways: NHS primary care, MoD resettlement and military primary care, VCSE organisations, and social media/self-referral. The multi-pathway approach is necessary to reach the breadth of the service leaver and veteran population, including those who do not engage with NHS services, and to assess the feasibility and relative effectiveness of each recruitment route. Recruitment will open following receipt of all required ethical and regulatory approvals and NHS management permissions at each site.

7.3.1 Sample identification

Potentially eligible participants will be identified through four pathways:

- 1) **Primary care:** Within NHS primary care, eligible veterans will be identified by members of the existing clinical care team using SNOMED CT codes:

- Military Veteran: 753651000000107;
- Army Veteran: 986751000000107;
- Royal Navy Veteran: 986811000000103;
- Royal Air Force Veteran: 986811000000103

via Southwest Integrated Care Boards and selected GP practices and Southwest Mental Health Trusts. Identified individuals will be contacted by their clinical care team via text message and invited to express interest. Direct referrals will also be accepted from GPs, social prescribers, health coaches, care coordinators, and mental health therapy providers. Access to patient records for identification purposes is restricted to members of each participant's existing clinical care team.

- 2) **MoD resettlement and military primary care:** Participants will be identified and recruited via MoD resettlement teams (RAF and Royal Navy, Royal Marines) and the RAF resettlement website. Peer facilitators will deliver promotional presentations at selected military sites. Posters will be displayed in DMPC practices and mess halls.
- 3) **VCSE organisations:** Participants will be identified and invited via supporting military charities and veteran-facing VCSE wellbeing hubs, including designated rural and coastal delivery partners. Peer facilitators will deliver promotional presentations at partner organisations. Recruitment info will contain a QR code to our website and the study sign up.
- 4) **Social media and self-referral:** Participants will self-identify in response to social media advertisements using testimonials from participants and facilitators, disseminated through partner networks, research team podcast appearances alongside peer champions, and posters in garrison pubs and gyms. Recruitment info will contain a QR code to our website and the study sign up.

Initial eligibility screening is then conducted by the research team using the study screening protocol prior to enrolment.

Payments and incentives

Participants in the VCP intervention arm will receive a £150 voucher on completion of the study, in recognition of the time commitment involved in attending the one-day workshop and follow-up sessions. Participants in the control arm will receive £50 on completion. All participants will be reimbursed for reasonable travel and accommodation costs, and childcare costs where applicable, to remove practical barriers to participation. These arrangements are in line with NIHR guidance on payments and incentives in research.

7.3.2 Consent

Informed consent will be obtained from all participants prior to any study-specific activity. The consent process is designed to ensure that participation is fully voluntary and that participants have sufficient time and information to make an informed decision.

Potentially eligible individuals will receive a link to the Participant Information Sheet (PIS) via email, newsletter, or the study website. The PIS is hosted on Qualtrics, which is GDPR-compliant and accessible via the University of Exeter's single sign-on system. The PIS outlines the purpose and nature of the study, all procedures involved, potential risks and benefits, confidentiality arrangements, data handling procedures, and the right to withdraw at any time without consequence. Participants will be

given up to two weeks to consider whether to participate following the initial invitation, and members of the research team are available to answer questions prior to consent being given.

Written informed consent will be obtained online prior to intervention participation. Separate consent will be obtained for survey participation and for audio-recorded qualitative interviews.

8 ETHICAL AND REGULATORY CONSIDERATIONS

The study will be conducted in accordance with the ICH Good Clinical Practice (GCP) guidelines, the UK Policy Framework for Health and Social Care Research, and the Sponsor's Standard Operating Procedures. Ethical approval has been obtained from the University of Exeter Psychology Research Ethics Committee (Ref: 5426272) and a favourable opinion received from the RAF Scientific Advisory Committee via MODREC (Ref: 20263012). NHS HRA/REC approval will be obtained prior to commencement of any NHS site activity.

8.1 Assessment and management of risk

The study involves delivery of a psycho-educational group intervention to veterans and service leavers, a population that may be considered potentially vulnerable due to elevated rates of mental health difficulties. The following ethical considerations have been identified, alongside mitigation procedures:

- **Psychological Distress.** Discussion of identity, transition experiences, or military service may elicit emotional distress. Although VCP is a low-risk psycho-educational intervention, facilitators will be trained in safeguarding, risk recognition, and escalation procedures. A structured safeguarding screening process will be used to exclude individuals experiencing acute crisis or active suicidality, who may be a risk to themselves or to others. These individuals will instead be signposted to appropriate clinical services. During workshops, facilitators will monitor participant wellbeing and offer individual check-ins where required. Clear referral pathways to NHS, military primary care, and relevant veteran services will be available.
- **Confidentiality in Group Settings.** Because VCP is delivered in small groups, confidentiality cannot be absolutely guaranteed between participants. At the start of each workshop, group agreements regarding confidentiality and respectful conduct will be established. Participants will be reminded not to disclose personal information shared within the group outside the workshop setting.
- **Data Protection and Confidential Data Handling.** All data will be handled in accordance with UK GDPR and the Data Protection Act 2018. Identifiable information will be stored separately from research data using secure, encrypted University servers. Only authorised members of the research team will have access to identifiable data. Interview recordings will be transcribed and anonymised prior to analysis. Data will be retained and destroyed in accordance with University and Sponsor policies.
- **Conflicts of Interest.** Where recruitment occurs via Ministry of Defence or affiliated resettlement pathways, care will be taken to ensure that participation is entirely voluntary and not perceived as linked to career progression, resettlement support, or access to services. Facilitators will not be in a line-management relationship with participants. The voluntary nature of participation will be clearly emphasised in all materials.

- **Inclusion of Potentially Vulnerable Individuals.** Veterans and service leavers may have co-morbid mental health conditions. Eligibility criteria and screening procedures will ensure that individuals requiring immediate clinical intervention are not enrolled. The intervention is not a substitute for formal psychological therapy, and this will be clearly communicated.
- **Equity and Inclusion.** The study actively seeks to include underserved subgroups, including female veterans and minoritised veterans. Care will be taken to ensure that materials are inclusive and that participation does not inadvertently exclude individuals based on geography or background. Where necessary, travel support or local delivery arrangements will be used to reduce access barriers.
- **Right to Withdraw and Use of Data.** Participants may withdraw from the study at any time without affecting their access to services. Where data have already been anonymised and included in analysis, withdrawal of those specific data may not be possible, and this will be explained clearly in advance.

8.2 Research Ethics Committee (REC) and other Regulatory review & reports

Prior to the commencement of the study, favourable opinions will be sought from the following bodies for the study protocol, participant information sheets, consent forms, and all relevant supporting documents:

- NHS Health Research Authority (HRA) / NHS Research Ethics Committee (REC): As the study involves recruitment through NHS pathways and participants who may be NHS service users, NHS REC review is required. A favourable opinion from an NHS REC will be obtained before the study commences at any NHS site.
- Ministry of Defence Research Ethics Committee (MODREC): Given recruitment through MoD resettlement pathways and the involvement of currently serving personnel, MODREC review is required. A favourable opinion has been received from the RAF Scientific Advisory Committee (SAC) (Ref: 20263012).
- University of Exeter Psychology Research Ethics Committee: Institutional ethical approval has been granted (Ref: 5426272).

The study will not commence at any site until all required approvals are in place.

Regulatory Review and Site Approvals

Before any site commences enrolment, Dr. Stefan Schilling or designee will ensure that all required approvals from participating organisations are in place. For NHS sites, NHS management approval via the HRA Approval process must be confirmed before recruitment begins. Non-NHS pathways (MoD resettlement, VCSE organisations) will be managed in accordance with the relevant organisational requirements and the University of Exeter's sponsor procedures.

Modifications

The decision to modify the protocol rests with Dr. Stefan Schilling as CI, in agreement with the University of Exeter as sponsor. The CI is responsible for determining whether any proposed change constitutes a substantial or minor modification in accordance with HRA guidance.

For substantial modifications, the sponsor will submit a valid notice of modification to the NHS REC for review. The REC will respond within 35 days of receipt. Substantial modifications will not be implemented at any site until REC approval and, where required, updated NHS management approval

is in place. MODREC and the University of Exeter REC will be notified of modifications in accordance with their respective procedures.

Minor modifications that nonetheless affect NHS management permission e.g., changes to funding arrangements, will be notified to the relevant NHS R&D office(s) even where REC submission is not required. All modifications will be communicated to the R&D offices and local research teams at all participating sites, who will assess whether the modification affects local NHS permission. Where other specialist review bodies have provided an opinion on the study, they will be notified of any substantial modification that may affect that opinion.

All protocol versions will carry a version number and date. A modification history log will be maintained by the Trial Manager (Dr. Summer Bedford) to ensure the most current approved version is always identifiable. All correspondence relating to modifications will be retained by the CI.

Annual reporting and end of study

The end of the study is defined as the date on which the last data item is collected from the last participant — that is, completion of the final T2 follow-up survey, or the final post-intervention interview, whichever occurs later.

The Chief Investigator (Dr Stefan Schilling) is responsible for submitting an Annual Progress Report to the Research Ethics Committee, via the Sponsor, within 30 days of the anniversary of the date on which the favourable opinion was granted, and annually thereafter until the study is formally declared ended. The Chief Investigator will notify the Research Ethics Committee in writing within 90 days of the end of the study, and will submit a final report, including results and any publications or abstracts arising from the study, within 12 months of the end of the study. If the study is ended prematurely, the Chief Investigator will notify the Research Ethics Committee within 15 days, including the reasons for early termination.

Equivalent reporting obligations to MODREC and the University of Exeter REC will be fulfilled in accordance with the requirements of those bodies.

8.3 Peer review

The protocol has gone through independent, expert, and proportionate peer review:

The study protocol was subject to rigorous independent peer review by the NIHR Research for Patient Benefit (RfPB) Programme (reference NIHR209840) prior to funding being awarded. This included review by independent scientific experts, clinicians, and patient and public involvement representatives. The study design, methods, outcome measures, and analysis plan were all reviewed and approved through this process. The trial design and outcome measures were developed in collaboration with the Exeter Clinical Trials Unit, ensuring methodological rigour and adherence to good clinical practice guidelines.

The protocol has additionally undergone scientific review by the RAF Scientific Assessment Committee (RAFSAC), reference: SP2602 and the University of Exeter Faculty of Health and Life Sciences Psychology Ethics Committee, which granted a favourable opinion in November 2023 (Ethics Application ID: 5426272).

8.4 Patient & Public Involvement

Public and patient involvement has been embedded in VCP from inception and will continue throughout the study. PPI activities are coordinated by Stacey Denyer (PPI Lead and SPAG Chair), a veteran peer

facilitator with direct lived experience of military-to-civilian transition. PPI is reported using the NIHR PPI log and the GRIPP2 checklist.

Acceptability and design

Over 70 individuals across the veteran community and wider system have been engaged during the development of this proposal, including veterans, currently serving and MoD resettlement personnel, GPs, social prescribers, veteran-facing VCSE providers, and policy stakeholders. Veterans with lived experience of military-to-civilian transition were involved in the co-development of VCP's core materials and participated in the proof-of-concept trial. Their feedback directly shaped the programme content, delivery structure, and tone. A stakeholder survey (March/April 2025) and two online consultation events (June/July 2025) with 12 PPI representatives were used to identify implementation barriers and refine the logic model. PPI input led directly to the inclusion of dedicated workshops for female and minoritised veterans, and to the design of the recruitment strategy and practical access arrangements (travel reimbursement, childcare provision).

Management of the research

The Stakeholder and PPI Advisory Group (SPAG), comprising of veterans from diverse backgrounds (female, minoritised, LGBTQ+, early service leavers, rural/coastal) and stakeholder representatives from referral pathways (GPs, link workers, veteran charities, NHS ICBs, MoD, VCSE organisations), meets quarterly throughout the study. SPAG members have active decision-making roles, including advising on emerging findings and contributing to interpretation of results.

Undertaking the research

VCP is co-delivered by a psychologist and veteran peer facilitators. Training and support, including NIHR PPI training via PenARC, will be provided. PPI members are reimbursed for their time and travel in line with NIHR guidance.

Analysis and dissemination

SPAG members will contribute to the interpretation of study findings to ensure conclusions are meaningful and accessible to the veteran community. Findings will be shared with participants and PPIE contributors via a plain-language summary on study completion. Wider dissemination to stakeholder organisations will take place through the quarterly SPAG meetings, stakeholder newsletters, and a dedicated end-of-project Knowledge Exchange workshop hosted by Devon Mental Health Alliance.

8.5 Protocol compliance

All investigators and site staff are required to conduct the study in accordance with the approved protocol, the study procedures manual, and the UK Policy Framework for Health and Social Care Research, and in accordance with ICH GCP guidelines.

This study will conform to the University of Exeter's code of practice for research and the UK Policy Framework for Health and Social Care Research. Dr. Stefan Schilling, as CI, is responsible for ensuring protocol compliance across all sites and will provide updates to the University of Exeter Research Governance, Ethics and Compliance team and raise any concerns as required. Day-to-day monitoring of compliance is the responsibility of Dr. Summer Bedford as Trial Manager, under the oversight of the CI.

Accidental protocol deviations can occur at any time. All deviations must be documented on the relevant forms and reported to the CI and the University of Exeter as sponsor immediately. The CI will assess each deviation for its impact on participant safety, data integrity, and ethical compliance.

Deviations that recur frequently are not acceptable and will require immediate remedial action. A pattern of recurring deviations may be classified as a serious breach and will be escalated to the sponsor and the relevant Research Ethics Committee.

In the context of this feasibility trial, departures from planned intervention delivery are not classified as protocol breaches but are recorded systematically as fidelity data and constitute core feasibility outcomes, reported descriptively in the final study report.

8.6 Data Protection and Patient Confidentiality

All investigators and study site staff must comply with the requirements of the Data Protection Act 2018 and the UK General Data Protection Regulation (UK GDPR) with regard to the collection, storage, processing, and disclosure of personal information, and will uphold their core principles throughout the study. A Data Protection Impact Assessment has been conducted (Ref: IG24-0311).

Study data and personal data are kept in separate, password-protected electronic databases linked via a unique participant identification number (PIN). During data collection the PIN takes the form of a randomly assigned alphanumeric code enabling participants to identify their own records and facilitating data deletion on request. Upon completion of data collection, the PIN is replaced with a fully anonymised participant ID (PID), and the linking file connecting PIN to personal identifiers is permanently deleted. All study data are stored on the University of Exeter's Microsoft SharePoint platform, with physical servers located within the European Economic Area, accessible only to named research team members via university-authenticated accounts. Personal data required for study conduct (contact details, scheduling information, incentive distribution) are stored separately on SharePoint in password-protected files. No raw, unidentified data are shared with any collaborator. Audio recordings from interviews are deleted immediately following transcription and verification.

Where pseudonymised data must be shared with collaborators (Nottingham Trent University, Queensland), access is granted via a controlled SharePoint library invitation, with no raw or unidentified data are transmitted externally. Where particularly sensitive files require sharing, these are encrypted using an appropriate compression tool and the password communicated in person. No personal data are transmitted by unencrypted email. Access to identifiable data is restricted to the CI (Dr. Stefan Schilling) and the Trial Manager (Dr Summer Bedford). External collaborators receive access only to pseudonymised data during the active research period. Regulatory bodies and the sponsor may access data for audit and inspection purposes as required. Consent forms will be retained for 10 years following study completion for audit purposes. Personal contact details will be destroyed within one year of study completion. All other research data will be retained in accordance with the study Data Management Plan, with a planned end date of 31 December 2030, after which data will be securely destroyed or, where appropriate, archived in anonymised form with the UK Data Service or the University of Exeter's Open Research Exeter (ORE) repository.

The data custodian the CI (Dr. Stefan Schilling s.schilling@exeter.ac.uk) is responsible for ensuring data are stored securely, that appropriate access controls are maintained, and that backup copies of all study data are created and retained in accordance with the Data Management Plan and the University of Exeter's data governance policies.

8.7 Indemnity

The University of Exeter, as study sponsor, holds insurance to cover legal liabilities arising from the management, design, and conduct of this research. The University of Exeter has insurance in place to cover legal liabilities arising from the management, design, and conduct of the research.

NHS indemnity arrangements apply to NHS staff acting within the scope of their NHS employment. Participant-facing activities by participating research sites are covered under NHS indemnity. Participants will be informed of the indemnity arrangements in the Participant Information Sheet.

The University of Exeter, as sponsor, has not made specific arrangements for no-fault compensation in the event of harm where no legal liability arises.

8.8 Access to the final study dataset

Only members of the Research team will have full access to the dataset, with data sharing agreements in place. Site investigators and SPAG members do not have access to the full dataset. The independent statistician appointed to the Trial Steering Committee will have access to aggregated and pseudonymised data as required for their oversight role, but will not routinely hold a copy of the full dataset.

Results will not be disclosed publicly by any individual site or investigator prior to agreement with the PI and completion of the primary analysis. Access to the dataset for secondary analysis purposes may be requested by any qualified researcher following study completion. Any such request must be submitted in writing to the PI, describing the proposed analysis, and will be considered on a case-by-case basis. Secondary analysis is permissible only where participant consent covers the proposed use. Participants' consent forms and the Participant Information Sheet explicitly state that anonymised data may be used in future ethically approved research.

Following study completion, the pseudonymised dataset will be archived with the UK Data Service or the University of Exeter's Open Research Exeter (ORE) repository, in accordance with the study Data Management Plan, with an anticipated retention period to 31 December 2030.

9 DISSEMINATION POLICY

9.1 Dissemination policy

Data arising from this study are owned by the University of Exeter as study sponsor. On completion of the study, data will be analysed, tabulated, and a Final Study Report prepared. The Final Study Report will be submitted to the National Institute for Health and Care Research (NIHR) in accordance with the Research for Patient Benefit (RfPB) programme requirements, within the timeframe specified in the grant agreement.

All members of the named research team have rights to publish study data in peer-reviewed journals and to present findings at academic and clinical conferences, subject to agreement with the PI. Any proposed publication or public presentation of study findings must be reviewed by the PI prior to submission to ensure consistency with the primary publication and to avoid premature disclosure of

results. There is no requirement for site-level embargo beyond this. All publications must acknowledge NIHR RfPB funding (grant reference NIHR209840) and include the standard NIHR disclaimer: "The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care." NIHR retains the right to review publications arising from this grant prior to submission; authors are required to comply with NIHR's open access policy, which mandates that all peer-reviewed publications are made freely available via an open access route. All publications will be deposited in the University of Exeter's Open Research Exeter (ORE) repository to ensure open access compliance. The study protocol will be published in an open access peer-reviewed journal prior to or concurrent with study completion.

Participant notification

Participants will be informed in the Participant Information Sheet that they will receive a summary of the study findings on completion of the research. A plain-language summary of the overall results will be prepared and distributed to all participants who have not withdrawn consent and for whom contact details are available at the time of dissemination. Findings will also be shared through the website, with SPAG members and relevant stakeholder organisations (including service charities, NHS Integrated Care Boards, and MoD resettlement services) through the quarterly SPAG meetings and/or a dedicated lay summary document. Participants may request further information regarding the study results directly from the PI at any time following publication of the Final Study Report.

Open data and code

The pseudonymised participant-level quantitative dataset and the statistical code used to generate the primary results will be archived with the UK Data Service and/or the University of Exeter's Open Research Exeter (ORE) repository following study completion, in accordance with the study Data Management Plan. Archived data will be made available to bona fide researchers under standard UK Data Service access conditions. Qualitative data (interview transcripts) will be fully anonymised prior to archiving; given the sensitivity of the participant group (military veterans and service leavers), any residual risk of identification will be assessed prior to deposit and data sharing will be restricted accordingly. Retention of all study data is planned to 31 December 2030.

9.2 Authorship eligibility guidelines and any intended use of professional writers

Authorship eligibility will be determined in accordance with the 2017 Statement of Policy on Authorship and Publication Credit of the British Psychological Society and the recommendations of the International Committee of Medical Journal Editors (ICMJE). To qualify as an author, individuals must meet all four of the following criteria: making substantial contributions to the conception or design of the work, or to the acquisition, analysis, or interpretation of data; drafting the work or revising it critically for important intellectual content; providing final approval of the version to be published; and agreeing to be accountable for all aspects of the work, including the accuracy and integrity of any part of the work.

Individuals who contribute to the study but do not meet all four criteria will be acknowledged in publications but will not be listed as authors. No professional medical writers will be used in the preparation of publications arising from this study.

10 REFERENCES

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11. APPENDICES

11.1 Appendix 1- Required documentation

List here all the local documentation you require prior to initiating a participating site (e.g. CVs of the research team, Patient Information Sheet (PIS) on headed paper etc.).

11.2 Appendix 2 – Schedule of Procedures (Example)

Procedure	Total number per participant	If routinely given to participants as their care outside of research, how many of the total would be routine?	Average time taken per procedure	Who will conduct procedure?
Seeking consent	4	0	5mins	Consent will be sought for the intervention via an online form. Consent will also be sought for each survey participants complete (T0, T1, T2) on the first page of the online surveys
Surveys	3	0	20mins	Participants complete three online surveys: at baseline, before the intervention (T0), post-intervention (T1), and three months post-intervention (T2).
VCP Workshop: in-person, group-based,	1	1	7hours	The Post-Doctoral

co-facilitated by peer facilitator and psychologist/wellbeing practitioner/link worker (1 day or 2 half-days)				Researcher will co-deliver the intervention with a trained service-leaver/veteran advocate (PPIE). It will take place in a non-clinical, non-military setting, e.g., community centres, equipped university buildings, etc.
Online VCP follow-up session	1	1	1hour	The Post-Doctoral Researcher and trained service-leaver (PPIE) will facilitate the group follow-up in an online meeting
Online interviews	2	0	1hour	The Post-Doctoral Researcher will conduct individual interviews with a sub-group of 20 participants in an online Microsoft Teams meeting and baseline (T0) and post-intervention (T1).

13.3 Appendix 3 – Amendment History

Amendment No.	Protocol version no.	Date issued	Author(s) of changes	Details of changes made

List details of all protocol amendments here whenever a new version of the protocol is produced.

Protocol amendments must be submitted to the Sponsor for approval prior to submission to the REC.