



Developing a Model of the Restorative Approaches Veteran Family Service

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1. Executive Summary

1.1 Background

Veterans of the UK Armed Forces can experience higher levels of mental health illness and lower positive responses to mental health treatments than peers without a history of Military Service. The NHS and Ministry of Defence have responded to this situation over recent years by developing the mental health services available for veterans. Time has also increased recognition that families can be negatively affected by a veteran's poor mental health, with resultant difficulties leading to additional adverse impacts on the psychological state of the veteran. Despite this knowledge there is, at present, little information of effective ways to support veteran families and thereby prevent or ameliorate this situation.

The Veterans NHS Wales (VNHSW) service has been providing a psychological support service for veterans in Wales with Service-related mental illnesses for over 10 years. While VNHSW therapists recognised that providing support for veteran families was likely to complement the therapy provided, the service lacked the resources to offer such support. TGP Cymru, a charity working with children, young people and families in Wales have been delivering family services for many years. When providing this support TGP Cymru employ a Restorative Approach (RA), an ethos and process that addresses problems and conflicts in communities and groups by focusing on repairing, building, and maintaining relationships, as a service delivery framework. To date, a Restorative Approach has proved effective in varied settings but is little explored in family contexts. In collaboration with VNHSW, TGP Cymru developed and implemented a new service: the Restorative Approach Veterans Family Service (RAVFS). RAVFS provides a restorative family support service to VNHSW veterans and their families with the intent of having an additional positive impact on veteran mental health by improving family relationships.

1.2 Study

This study is concerned with the development and implementation of the RAVFS, the key aim being to construct and refine an acceptable and deliverable model of the service. A secondary study aim was to test the feasibility of assessing the impact of RAVFS on veterans and their families.

To achieve this, the study team undertook a 3-year process evaluation with two distinct phases. The first phase explored the development of the service by RAVFS and VNHSW during the three months before implementation. This allowed an original service model to be developed. The second phase followed the implementation of the service model for the following 2 years 9 months with interest in facilitators and barriers of service delivery and receipt. This phase of the study led to refinement of the original service model.

Data for both phases was collected at seven time points. Qualitative data was collected from two RAVFS service providers at four time points, and two VNHSW staff at three time points. Data was also collected from veterans and family members (n=13) linked to a veterans' charity, veterans and family members who took part in RAVFS (n=14), and four veterans who had used VNHSW but declined RAVFS referral. Quantitative data was collected pre and post RAVFS service and focused on the potential impact of the RAVFS on the relationships within veteran families. This was used to assess the potential for further evaluation of service efficacy in the future.

1.3 Findings

1.3.a Original Model

TGP Cymru anticipated that use of a Restorative Approach as a service framework would have a positive effect on RAVFS acceptability, family dynamics and veteran psychological health. A RA operates through a process that facilitates communication, increases understanding of how all individuals involved have been affected by the presenting problem, supports collective consideration of what needs to change to resolve matters, how this will be achieved and what is needed to facilitate the change. It was theorised this would be achieved through several processes. First, VNHSW would identify the veterans in need of family support during initial VNHSW assessments or in later therapy and refer the case to RAVFS. If RAVFS endorsed the referral veterans would be given information about RAVFS and encouraged to discuss service use with family members. Veterans and/or family members who decided to take part would first meet with the RAVFS practitioner on a one to one or small group basis thus giving the practitioner insight into family problems and challenges from multiple family perspectives. Following this, where safe and possible, fuller family meetings would be held with the practitioners' skills and tools utilised to facilitate the RA process. As part of this, VNHSW therapists would attend some meetings to deliver mental health information in order to increase family understanding of mental health illnesses and possible impacts on behaviours, thereby increasing levels of empathy. Service closure was anticipated to be led by family needs or family and/or veteran disengaged. Throughout these processes, integration of the VNHSW with RAVFS also involved extending veteran consent to RAVFS to allow on-going data sharing.

1.3.b Implementation Findings

During implementation, the mechanisms within the RA framework were found to work as expected in the context of a providing a support service for veteran families. Most families and service providers described how RAVFS use had built more positive relationships between family members as well as with the RAVFS practitioner and how this formed a strong base for higher levels of positive family communication, understanding, empathy and motivation to change.

Further key findings suggested that changes in the original RAVFS model would increase service acceptability and receipt. Specifically, the findings called for:

- Time to be given during implementation for VNHSW therapists to become familiar with RAVFS, relate the service to veteran needs and become confident enough in the service to make referrals.
- An expansion of VNHSW assessments to allow greater consideration of family issues and the potential benefits of RAVFS on the veteran's mental health.
- The inclusion of the RAVFS practitioner in weekly VNHSW meetings to allow collaborative consideration of whether the veteran and family may benefit from RAVFS.
- The provision of greater information about the aims and nature of the service on referral to allay possible veteran/family fears that RAVFS is a therapy, may lead to secondary family trauma, is a criticism of parenting or is linked to statutory social services.
- Greater use of more informal methods of service delivery.
- The 'psychoeducational' component of the RAVFS which offers families knowledge of the link between problem behaviours and mental ill-health should be offered at an early point in service use.

Other findings drew attention to the mental health needs of veterans who either did not meet VNHSW criteria or had not yet sought support, and the negative impact of this on family functioning and relationships. There was further recognition of how wider practical concerns faced by many veterans and families when transitioning out of the Armed Forces can impact negatively on the mental health of veterans.

1.4 Recommendations

The positive impact of RAVFS on the functioning and wellbeing of the veterans and families that used the service, led to the following recommendations:

- The positive effect of the RAVFS on UK Armed Forces veterans with Service-related mental health illnesses and their families, as evidenced by better family communication, understanding and empathy demonstrates the positive potential of the service and calls for a wider roll out, perhaps to the VNHSW population across all Welsh Local Health Boards in order to test the service on a larger sample.
- When developing an integrated veteran/veteran family support service, time must be given for the constituent agencies to understand the process and intent of all services involved and to build positive relationships.
- While delivering RAVFS in tandem with a service such as VNHSW has positive effect, many veterans with mental health difficulties do not qualify for such services. There is therefore a need for a service such as RAVFS for a wider cohort of veterans and families such as those using veteran charities for support.
- Support provided for veterans and families affected by mental health issues must extend to support for practical matters such as housing and finances as these can have additional detrimental effect on mental health.

1.5 Report Structure

To help guide the reader through the report a report structure explaining each section is given below.

1. Background – Service-related mental illness in the Armed Forces.
2. Introduction - The context and rationale for RAVFS.
3. Methods – How the evaluation was conducted.
4. Findings – The results for each of the research questions posed by the evaluation.
5. Discussion - The implications for services offering support to veterans and families.

2. Background

2.1 Mental health and military veterans

Military personnel can be exposed to trauma and other sources of stress while in service. While some stressors may mirror those found in typical workplaces, others are more specific to military service careers (Campbell & Nobel, 2009). Despite this, the levels of common mental health illnesses in the UK Armed Forces are generally reported as low compared to civilian populations (NICE, 2011, MoD, 2020). While this has been viewed positively, there is suggestion that mental illness levels within the military population varies, with evidence that deployed reservists are more likely to report mental health disorders than deployed regulars or non-deployed reservists (Fear, 2010; Samele, 2013). More recently, Goodwin et al. (2015) found a higher incidence of common mental disorders in the military when compared to civilians, while military veterans with combat experience are more likely to report Post Traumatic Stress Disorder (PTSD) and common mental health illnesses than non-veterans (Palmer et al, 2021).

The high levels of deployment of UK Armed Forces to arenas of combat and peacekeeping in relatively recent times makes the prevalence of Post-Traumatic Stress Disorder within the wider category of all mental health problems of key interest. Historically, the prevalence of PTSD in UK military personnel returning from combat has also been deemed low, with levels between 4–6% reported (Stevelink et al, 2019; Fear et al., 2010; Sundin et al. 2010) and this may be partially explained by an Armed Forces culture which perceives physical or mental ailments as weaknesses (Weiss & Coll, 2011). While recent figures suggest stable rates of probable PTSD to date, associated findings show increased rates of PTSD in UK military veterans irrespective of whether they were deployed or not while serving (Stevelink et al. 2018). This knowledge highlights the mental health needs of ex-Service personnel.

While mental health problems may be evident whilst military personnel are still serving (Freidman et al., 1994; Jones & Wessely, 2005; Iverson et al., 2009) many Service men and women only experience or become aware of mental difficulties after they have left the Armed Forces (Kulka et al., 1990; Lee et al., 1995; Boscarino, 2006; Iverson et al., 2009, O'Toole et al., 2009; Goodwin, et al. 2012). The prevalence of mental health disorders among UK veterans is difficult to estimate as the population disperses on leaving services and individuals do not have to declare their veteran status in civilian life (Burdett et al., 2014). Moreover, measuring levels of specific mental health disorders can be difficult due to comorbidity, symptom overlap and the reluctance of military veterans to seek help (Gros et al., 2012; Williamson et al, 2019).

Responsibility for the physical and mental health of veterans lies with the NHS. While care and support for military veterans with mental health disorders has improved lately (Gov.UK, 2016; Murphy & Wessely, 2013), historically, the health system has been criticised for not meeting the extent of mental health needs of veterans, as these tended to be beyond primary health care but not sufficient for secondary level intervention (Macmanus & Wessely, 2013). This systems failure has been further complicated by the high levels of resistance and poor response to treatment displayed by the veteran population when compared to civilians (Kitchiner et al. 2012, Kitchiner et al, 2019), and knowledge that around a quarter of veterans with PTSD prove resistant to trauma-focused therapies (Murphy & Smith 2018; Kitchiner et al, 2019).

3. Introduction

3.1 Veterans NHS Wales

In Wales, psychological support for veterans living with Service-related mental health illnesses is supplied by Veterans NHS Wales (VNHSW). VNHSW has been operating in Local Health Boards (LHBs) across Wales for more than 10 years and currently works with over 600 veterans per year. The aim of VNHSW is to improve the mental health and wellbeing of veterans who live in Wales, have served in any of the UK Armed Forces as a regular or a reservist for at least one day, and have a Service-related treatable mental health illness (termed by VNHSW 'psychological injury') (VNHSW Annual Report April 2016 – March 2017).

VNHSW has a set of key objectives related to programme efficacy and reach. Specifically, the service seeks to:

1. Build and sustain military links to facilitate early identification and intervention.
2. Provide a usable service that meets Service-related mental health needs of veterans in Wales.
3. Ensure veterans receive full and accurate assessment of psychological/social needs.
4. Provide brief psychosocial interventions to meet psychological needs.
5. Help veterans and carers develop management plans that meet with family needs and surroundings.
6. Signpost veteran families to appropriate services if needed.
7. Signpost and/or refer veterans to other services including those for physical needs.

(Adapted from Veterans' NHS Wales website <https://www.veteranswales.co.uk/>)

While most of these objectives are concerned with the wellbeing and health of the veterans, some focus on support for the families of veterans. Family members often take on the role of primary carer for military personnel or veterans with medical problems, and this role can have a negative effect on the wellbeing and mental health of the care giver (Thandi et al., 2018). Relationships within the family can also suffer as veterans living with PTSD and other mental health illnesses may display hostility, domestic violence, and physical aggression (Carroll et al. 1985; Jordan et al. 1992; Calhoun et al. 2002; Kwan et al., 2017) which have been linked to decreased family functioning (MacDonald et al., 1999; Evans et al., 2003). While VNHSW were aware of the need for further support for the families of veterans using their service, until recently no capacity to extend services to meet this need existed.

3.2. Support for the families of military veterans

The mental health and wellbeing of the families of veterans is an important and complex issue. Evidence has shown a circle of interdependence in that the wellbeing of those providing care impacts on recipient recovery via the quality of the care provided (Al-Janabi et al., 2019), while the mental health of those providing care can deteriorate if the care recipient's progress is poor or their condition worsens (Newbronner et al., 2013; Piquart and Sorensen, 2003; Donaldson et al., 1997). This knowledge focuses attention on the wellbeing of the family and the support available for the families of injured military veterans. A recent review by Turgoose & Murphy (2019) considered a range of support mechanisms: group-based work, couples therapy, family-based interventions, residential retreats, and online resources. Within these, the effective mechanisms identified centred on the psychoeducation provided to increase carer's knowledge of mental health illness, and interventions that helped families adapt to the problematic behaviours linked to mental illness. Authors also noted the paucity of knowledge in this area and called for more evaluation of interventions, especially in countries such as the UK where little such work has been done. Collectively, present knowledge suggests that providing services capable of supporting the families of veterans with psychological injuries is of utmost importance. The following section considers family support services in the UK and the models of service provision that may best meet the needs of military veterans with psychological injuries and their families.

3.3. Family support services in the UK

Local authority family services in the UK provide families with support additional to that offered by universal state services (Dolan et al., 2006). Over time, the nature of effective services in the UK and beyond have been explored with evidence suggesting that to be effective services should be introduced early, of high quality, multi-agency, and consistent (Frost et al., 2015) with good communication, integration, collaboration, accessibility and flexibility (Dahl et al., 2005; Howarth & Foreman, 2006; Spicer and Smith, 2006). Use of positive, empathetic, family-focused, strengths and relationship-based ways of working are also advocated (Dunst et al., 2007; Morris et al., 2008; Featherstone et al., 2014; Forrester et al., 2016). As noted by Williams (2019) attempts made to incorporate such factors in UK family support services have proved challenging. However, recent work has suggested that use of family support services embedded in a Restorative Approach holds potential as it promotes use of collaborative, inclusive, flexible services delivered using

strengths and relationship-based whole family approaches (Mason et al, 2017; Williams & Segrott, 2017; Williams et al., 2018). There are further indications that delivering family support using a Restorative Approach has a positive impact on family relationships (Williams, 2019; Williams & Scourfield, forthcoming).

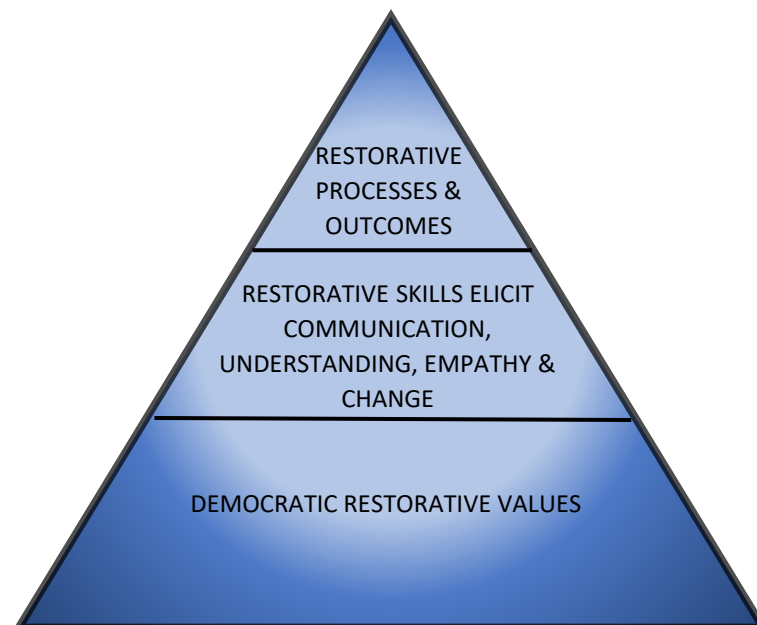
3.4. A Restorative Approach

A Restorative Approach is an ethos and process built on a set of values such as honesty, trust, respect, collaboration, transparency, and fairness, focused on repairing, building, and maintaining relationships (Braithwaite, 2000). Advocates of a Restorative Approach perceive it as a democratic, partnership-based, inclusive approach that shares power fairly between state, family, and community representatives (Burford & Hudson, 2000).

A Restorative Approach stems from Restorative Justice; a practice drawn from ancient tribal methods that dealt with problems affecting their society through collaboration and mediation (Zehr, 2002). These principles informed Restorative Justice and the associated process developed in the 1970's for use in criminal settings which draws together offenders, victims and others involved to take part in mediated sessions. The sessions are focused on admission of responsibility for the offence, discussion, and appreciation of the effects on all involved, and consideration of how resultant harms can be addressed and repaired as far as is safe, possible and acceptable to all (Hopkins, 2004, 2009; Gavrielides, 2007; Wachtel, 2013).

While a Restorative Approach has similar roots, it differs as it operates in community and organisational contexts on a proactive as well as a reactive level (Williams & Segrott, 2017; Hopkins, 2004, 2009). Proactively, the approach uses the underlying value base to shape interactions in everyday settings and thereby build strong positive relationships and environments. Reactively, a Restorative Approach reflects the process used in Restorative Justice but with the focus on the problem and how to repair relationships rather than apportioning blame. Both levels can be found in a restorative continuum created by Costello et al. (2010) which encompasses "informal" adherence to its principles in everyday life to generate and sustain positive relationships and atmospheres, through to use of more formal restorative circles, mediation, and restorative conferences needed to address and resolve difficulties. Hopkins (2004; 2009) presents the theory and practice of a restorative approach as a pyramid of restorative values, skills, and outcomes (Figure 1). In this, the base consists of restorative values which shape, inform, and direct the restorative skills such as good communication, non-discrimination and the creation of a safe environment found on the next level. Factors in both levels support the top level which consists of a set of restorative outcomes, specifically better interactions, relationships, and an atmosphere likely to elicit change.

Figure 1: The Restorative Pyramid



In the UK, a Restorative Approach is being increasingly adopted, firstly as an ethos in which family and children’s services in the UK can be embedded, and secondly as a framework for service delivery (Kay, 2015; Finnis, 2016). When considering this, Williams & Segrott (2017) contend that adherence to restorative values such as those cited above would lead to family-focused, strengths-based relationship-based forms of practice more likely to engage families in service use. Furthermore, the good relationships built with families by use of restorative principles are likely to provide a strong foundation for the restorative process which consists of

1. Facilitating and mediating communication with and within families.
2. Eliciting descriptions of the family problem and how it has affected family members.
3. Building empathy and motivation to change.
4. Collaborative family discussions of what to change and support needed to achieve them.
5. Reviews of changes made, and further support needed.

Although little robust evidence of the process or effect of a Restorative Approach in family service settings is yet available, that which does exist is encouraging. Training in its use led to significant increases in practitioner confidence in developing positive relationships with service users, communicating with families, identifying service user needs/goals, and facilitating change (Williams et al., 2018). As a family service delivery framework, a restorative approach has also been found to promote use of systematic strength and relationship based whole family approaches (Williams, 2019) and achieved reductions in

family conflict (Williams and Scourfield, forthcoming). Furthermore, use of a Restorative Approach at different levels within a local authority has been linked to statistically significant reductions in the number of children in need (@640 –550), child protection plans (@640-550) and children looked after (80 –76/10,000 population of children aged under 16 years) over a period of 16 months (Mason et al., 2017, p.54 -55).

3.5. A restorative family support service for the families of military veterans

As observed, VNHSW believed that a service capable of recognising and addressing the needs of veteran families would complement the therapy provided for military veterans with psychological injuries. TGP Cymru is a Welsh charity that works with children, young people and families that has long delivered family support embedded in Restorative Approaches. Aware of VNHSW, TGP Cymru also recognised the need for and potential of a service to support veteran families and thereby positively affect the recovery of the veteran and the wellbeing of the family. A successful application for funding to allow TGP Cymru to develop and implement a restorative family support service: 'The Restorative Approaches Veterans and Family Service (RAVFS) was made to the Forces in Mind Trust.

The funding offered was sufficient for a period of three years during which the RAVFS would be developed and implemented. With the funders and TGP Cymru aware of the exploratory nature of the new service, the funding application included a sum for an evaluation of the service. The research team conducting the evaluation have been in place since the development of the successful bid and have therefore been able to follow the whole process of RAVFS evolution with interest in the construction and refinement of a model of the RAVFS service.

4. Methods

This section sets out the research aims, objectives, questions, data sources, collection processes and analytical framework (see Table 1 for a summary). Ethical Approval for the study was obtained from the Research Ethics Committee of the School of Social Sciences, Cardiff University

4.1. Research aims, objectives and questions

The core research aim was to identify and construct the most acceptable and deliverable model of RAVFS. The study was also interested in the feasibility of assessing the impacts of RAVFS on veterans and their families. To achieve this the research was conducted in two distinct phases: The first explored the development of the service model before implementation (initial 3 months); the second followed service implementation (proceeding 2 years 9 months) to identify service use barriers and facilitators and refine the original model. To achieve this the research had the following objectives:

- To explain the development of the initial service model
- To explore the recruitment of veterans and families to the RAVFS service.
- To assess the delivery of implementing the RAVFS services with veterans and families in the current context.
- To identify and assess the underlying programme theory of the RAVFS service.

Each objective linked to a specific question:

1. What was the process of developing the initial theoretical model of the integrated VNHSW and RAVFS services?
2. What are the barriers and facilitators to recruitment to the RAVFS service?
3. How feasible was it to implement the RAVFS service?
4. Did the restorative process work as intended with veterans and their families?

This process evaluation was achieved through a mixed-methods study which took an action research approach that allowed the research team to feedback on-going results to TGP Cymru and VNHSW so they could reflect and make changes as they felt appropriate.

The study was conducted by researchers from Cardiff University. The sensitive nature of the project raised ethical issues as it was recognised that veterans and families taking part in the study interviews would be talking about difficult family situations as well as RAVFS use, and that this could cause distress. To minimise or address this possibility it was agreed that researchers would consult the RAVFS practitioner before contacting the veteran or families to find out whether the professionals felt that the veterans/family were in a suitable psychological state to take part in study interviews. Further, veterans and families would be given a choice of where the interview took place including use of a veteran and family support house where further sources of support were available. It was also decided that if any participants became upset the interview would be terminated and all veterans and family members would be offered leaflets with details of wider sources of support including ChildLine for children and young people.

4.2. Data sources and collection

Mixed methods were employed for the process evaluation.

4.2.a Qualitative data

The qualitative data was collected via interviews and focus groups at different phases/time points in the study (see table 1). Below is a narrative description of what was collected and how.

To explore the independent models of VNHSW and RAVFS before the new service became operational, interviews were held with VNHSW therapists and the RAVFS manager and practitioner during the three months of RAVFS development before service implementation. These were supplemented by a focus group involving all such staff which explored the integrated model of service delivery.

Nine months into service implementation, interviews and focus groups with service professionals were repeated. As early take-up of the new service had been slow and this

phase was primarily concerned with barriers and facilitators of RAVFS' use, data was also collected in interviews with three veterans who had used VNHSW before RAVFS was operational; a focus group of five partners of military veterans, two of whom had used VNHSW; a focus group with five veterans with experience of mental health illness. This cohort of veterans and family members were using a local veteran centre. Recruitment was undertaken by centre staff who provided information about RAVFS and the associated evaluation before arranging interviews and focus groups with those willing to take part.

Over the subsequent year, data collection centred on interviews with veteran families who had used RAVFS, and veterans who had used VNHSW but refused referral to RAVFS. Early in the year (study year two) family interviews were conducted in participants' homes, which allowed veterans, partners, and children to take part. Later family interviews were affected by the COVID-19 pandemic national lockdown and consequently took place by telephone. In all, eight families participated and ten interviews including six veterans, six partners and two children took place. Initial recruitment for this arm of the study was undertaken by the RAVFS practitioner who told families of the study and passed on the details of those interested to the research team. While early interviews were solely with veterans and families who had used VNHSW and RAVFS in the Local Health Board where the family service was first implemented, as RAVFS expanded to two other Local Health Boards, some interviews were with participant families and veterans from these areas.

Interviews were also conducted with four veterans who had used VNHSW and had seemed likely to benefit from RAVFS but refused referral. The details of these veterans were passed to researchers who made contact by phone, provided information about the study, and invited the veterans to take part. COVID measures meant all these interviews took place by phone.

In all cases, families and veterans were given additional information about the study and its purpose immediately before data collection. Consent was obtained in hard copy when possible but recorded before the interview in cases where COVID measures dictated that data be collected through telephone interviews.

4.2.b Quantitative data

The study extended to interest in the feasibility of evaluating the impact of the service on the veterans and veteran families. To explore this, quantitative data measured changes in families over the time of use of RAVFS through use of the validated measure of SCORE 15 (Stratton et al. 2010) a self-report measure. SCORE 15 consists of 15 Likert scale items, which measure three variables that indicate: family communication, family difficulties and family strengths/adaptability before and after service use. Collectively these three sub-constructs gave good measure of family relationships.

The SCORE 15 was administered by the RAVFS practitioner pre-service use and immediately post-service for each family worked with.

After analysis of the qualitative and quantitative family and veteran data was complete, findings were presented to RAVFS and VNHSW staff in a final interview with RAVFS manager and practitioner, and a focus group attended by RAVFS and VNHSW staff.

4.3. Data analysis

Focus group and interview data underwent independent transcription. The resultant documents were stored in password-protected university computers. Framework analysis was done in NVivo 12 using framework matrices. Initially the analytic focus was on the services provided by VNHSW, the concept and process of RAVFS and how this would facilitate change, the integration of the two services and adaptations demanded. This phase allowed the construction of three models: the VNHSW therapeutic service before RAVFS; RAVFS as a family support service delivered through a restorative framework; and an integrated service model of VNHSW and RAVFS working collaboratively to deliver a family support service to veterans using VNHSW and their families.

With the aim of developing and refining the initial integrated model, analysis of subsequent staff interviews and focus groups and all family and veteran data centred on the feasibility of the RAVFS service with key interest in the barriers and facilitators of service implementation. Using an action research approach, findings were considered in later RAVFS and VNHSW interviews and in focus groups. In these and in line with a restorative approach, any barriers to service use were discussed collaboratively, possible solutions identified and changes to achieve them identified. Accepted changes were then applied to the existing integrated model. This process was conducted nine months after service delivery began, and again a year later.

Further analysis continued to explore the barriers and facilitators to RAVFS implementation but also explored the potential to collect outcomes data on veteran and family wellbeing and psychological health. This phase began by exploring family and veteran backgrounds, the nature of the psychological injury and the pathway that led to VNHSW. Using knowledge of a Restorative Approach, analysis turned to the process of RAVFS, how well this aligned with restorative values, the extent to which the service recognised and addressed veteran and family needs, and the impact of service use on veteran mental health and veteran and family wellbeing.

The feasibility of collecting quantitative data using SCORE 15 data was limited to using the measure with 12 families. This resulted in 22 before and after SCORE measures that were completed by nine veterans, ten partners and three children. The data was entered into and analysed using SPSS 26, the latest version of a statistical software platform. The small numbers of SCORE 15 measures called for a test of normality of scores before the appropriate tests could be conducted. The three variables assessed showed normal distributions using both Kolmogorov-Smirnova and Shapiro-Wilk; statistical tests of normality (Razali & Wah, 2011). With the normal distribution of the data confirmed, statistical analysis of family strengths/adaptability, difficulties and communication were conducted.

Time (Phase) of Data Collection	Data Source	Informant	Data Collection Procedure	Analysis	Research Domain
March 2018 (1)	Paired/Individual Interviews (service specific) followed by combined Focus Groups	TGP and VNHSW staff (n=4)	Interviews led by study team	Thematic Analysis and Logic Model Development	Feasibility
January 2019 (2)	Paired Interviews (service specific) followed by combined Focus Groups	TGP and VNHSW staff (n=4)	Interviews/Focus Groups led by study team	Thematic Analysis and Refinement of Logic Model	Feasibility and Acceptability
July 2019 (2)	Interviews and Focus Groups	Veterans and family members not part of RAVFS service (n=13)	Interviews/Focus Groups led by study team		Feasibility and Acceptability
Dec 19 (2)	Paired Interviews	TGP staff (n=2)	Interviews/Focus Groups led by study team	Thematic Analysis and Final Logic Model	Feasibility and Acceptability
Nov 19- Aug 20 (2)	Paired and Individual Interviews	RAVFS Family Interviews RAVFS (n=14)	Interviews/Focus Groups led by study team		Feasibility, Acceptability, and Impact
June-Aug 2020 (2)	Individual Interviews	Veterans who had used VNHSW but refused RAVFS referral (n=4)	Interviews led by study team		Feasibility and Acceptability
Sept 2020 (2)	Paired Interview with RAVFS staff and combined focus group with VNHSW and RAVFS	TGP and VNHSW staff (n=4)	Interviews/Focus Groups led by study team		Feasibility and Acceptability
Pre & Post RAVFS Service Use (2)	Baseline and Post Intervention Questionnaires	RAVFS Veteran and Family Members (n=22)	SCORE 15 administered by RAVFS practitioner pre & post service.	Paired t tests, family communication, difficulties, strengths	Impact

Table 1: Summary of evaluation

5. Findings

This section presents findings related to the RAVFS model. The first part is concerned with the development of the service model before implementation and concludes with the initial integrated model of VNHSW/RAVFS service provision. The second part reports on the implementation of the initial model and associated changes applied to the model producing the service now in operation. Lastly, there is a section of further recommendations for change in services for veteran families affected by Service-related mental health disorders that can be considered by organisations implementing RAVFS.

5.1. Study Phase 1

5.1.a Initial service model development: the RAVFS

RAVFS is provided by TGP Cymru, a charity with extensive experience of delivering family support using a restorative framework. Their experiences of using this approach suggested that working with families restoratively would help by building skills that allowed families to communicate fully and transparently. In turn, this would promote mutual empathy of how family difficulties affected family members in different ways and understanding of how this impacted negatively on individual and family wellbeing.

Conflict in relationships will always exist, simply because we're all different and don't always agree, but life pressures in families can cause that to intensify and so if we support them by giving them the tools to listen to each other, look at each other's needs and respond differently, then that gives them a good chance of getting a more positive outcome. (RAVFS manager)

Despite this previous experience, TGP Cymru were aware that RAVFS, the service they were instigating, would work with a new cohort of service users: military experienced families that included a veteran with Service-related mental health difficulties. This new setting called for adaptation of previous service delivery models. Moreover, to allow the integration of RAVFS with VNHSW, the new service was developed in knowledge of the VNHSW process.

5.1.b The process of VNHSW service use

Referral to VNHSW can be made by clinicians, other agencies or by self-referral. A veteran can also be referred by the Department of Community Mental Health Service on leaving the Armed Forces. When receiving a referral, VNHSW administrative staff identify the correct Local Health Board (LHB) clinic across Wales and forward the details. The appropriate clinic sends out an information pack along with requests for the veteran to explicitly opt-in to service use and give consent for VNHSW to gain access to military medical and service notes. An appointment for an assessment is then offered within 28 days.

Assessments are comprehensive. They draw on a full medical history and additional self-report clinical measures of the veteran's psychological state. Links between Military Service and the mental health problems, one of the criteria for VNHSW use, are established. Information about the family and social support is collected. Veterans found to have a recognised and treatable Service-related psychological problem are placed on

the VNHSW out-patient waiting list. While waiting, the veteran may receive support from a peer mentor who works to identify and address practical issues that may be impacting on the veteran's mental health, although resources mean this service is not always available.

VNHSW therapy involves Trauma-focused Cognitive Behaviour Therapy (TFCBT) and Eye Movement Desensitisation and Reprocessing (EMDR); a psychotherapeutic approach that seeks to ameliorate the physical and psychological consequences of distressing events by addressing inappropriately processed memories of traumatic experiences (Shapiro, 2010). VNHSW therapy tends to consist of 16 one hour long weekly sessions, although this can vary, with more sessions offered if it is felt that further work could lead to additional improvement. On occasion, therapists refer veterans elsewhere for more intensive support from community health teams and veteran support organisations. When veterans finish using their course of out-patient therapy they are asked to complete another set of psychological measures again at one and six months. Figure 1 sets out the complete process of VNHSW use.

VNHSW is focused on the Service-related mental health injuries of the veteran. There is an option for couples therapy using cognitive behavioural conjoint therapy to treat the veteran's PTSD, however this is not routine and does not extend to the wider family. Clinicians working for VNHSW had been aware of how a veteran's mental health can impact negatively on the family,

'We see a lot of people who have come on the back of their relationship being in crisis, yeah, just, just, just the fallout, I think is kind of huge. I think, I would think probably about half my current caseload of people where the relationships currently are more, you know, quite recently been really struggling. So, so yeah, it's not just couples is it, it's the family..... (Therapist 1) You know, or mums, suffering mums for the younger life. (Therapist 2) Maybe they're still going back to live at home, with parents. (Interviewer) Yeah, they're drinking and taking drugs, gambling.' (Therapist 2)

Such experiences support links between veteran mental health illness and family difficulties, particularly psychological problems of family members that stem from experiences of caring for and coping with the veteran's illness (Sayer et al., 2009; Dekel and Mosoon, 2010). VNHSW had long believed that supporting the family would have positive effect on veterans and families by addressing,

'All those subtle things that we can't do, from an office here... Give information to the partner, the kids, work with them, improve communication between the whole family unit and pull in other family members.' (Therapist 2)

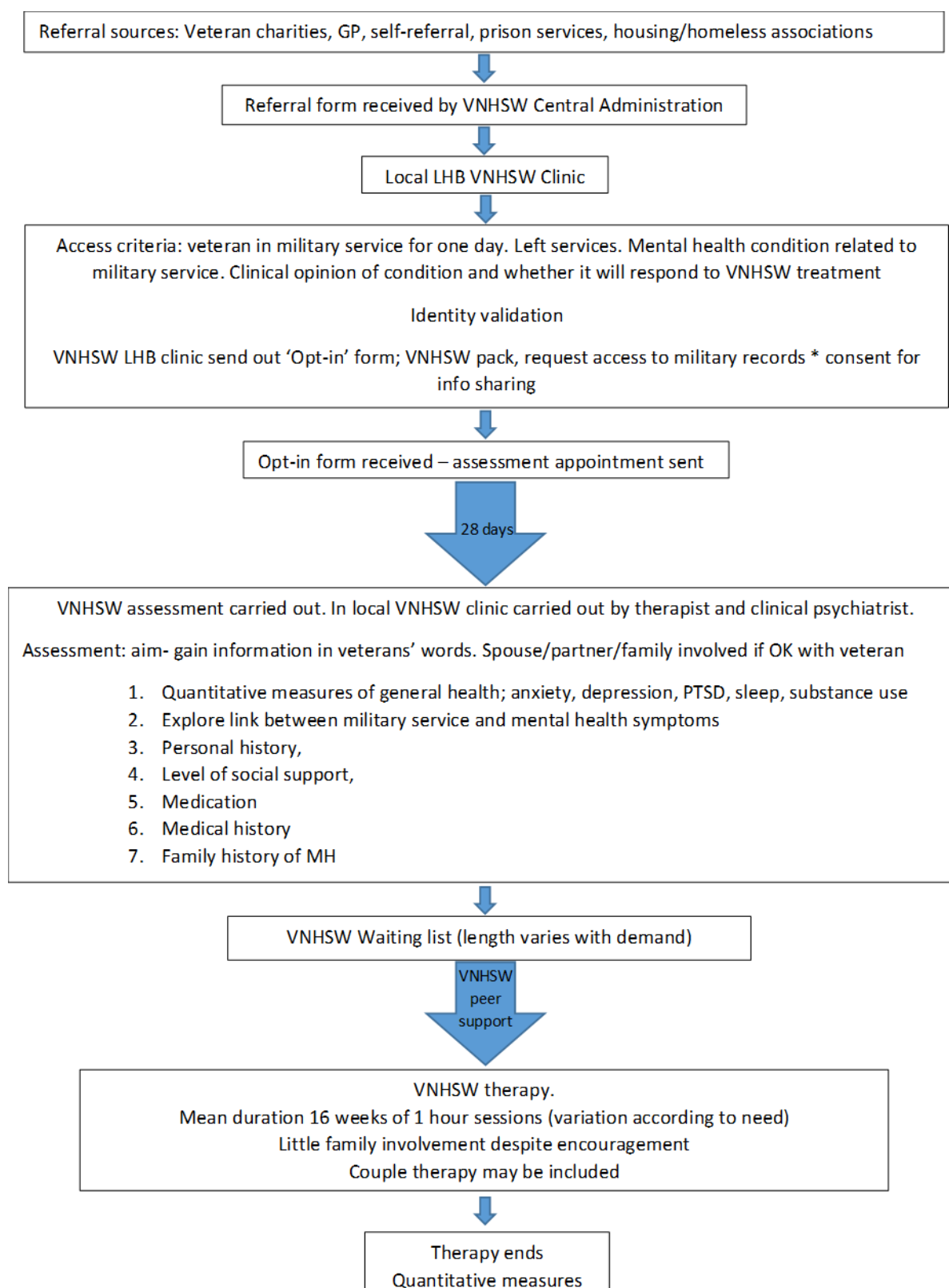


Figure 2: The process of referral and use of VNHSW

5.1.c The process of RAVFS use

As reported above RAVFS is delivered by staff from TGP Cymru, an agency experienced in delivering family services using a Restorative Approach.

Drawing on the principles and procedures underlying a Restorative Approach, RAVFS was envisaged as a series of meetings between the RAVFS staff, the veteran, and the veteran family. In addition, the RAVFS manager would provide regular supervision for the RAVFS practitioner and take part in family meetings if needs proved complex. The manager and practitioner would also hold regular case meetings to discuss family referrals from VNHSW and the progress of families already engaged in service use.

This section describes the planned service in a veteran family setting in more detail and ends with a representation of the process in Figure 2.

The initial meeting

In the planned service the first meeting would be attended by the veteran, the family, the RAVFS practitioner and RAVFS manager. The meeting would commonly take place at the family home but could be elsewhere if preferred. During the meeting, the RAVFS team would provide further detail of the RAVFS service, start to build relationships with the veteran and family, gain better understanding of the challenges faced by the family and how these were affecting the veteran and the family unit. The early meetings would also provide opportunity for the RAVFS staff, the veteran and the family to get to know one another. While this is important for any working relationships it would also ease manager involvement in complex group meetings at a later point if necessary. During the introductory meeting, the practitioner and manager will assess any risk associated with working with the family and complete the necessary paperwork concerning consent for service use.

Working with the family

Unless complex family needs called for further RAVFS manager attendance the RAVFS practitioner would work directly with the veteran and family from this point. In the early meetings the practitioner would meet family members in smaller groups (often if a child needs support from an adult family member) or on a one-to-one basis.

Consistent with the restorative ethos and process described, it was anticipated that early meetings would provide further opportunity for trust to be built between the practitioner and family members. The meetings would also allow family members to describe the problem affecting the family from their point of view and the impact it is having in their own words, thus giving the practitioner insight into the situation from multiple perspectives. Overall, this would give a more holistic understanding of the family situation, how it is affecting individual family members, and some idea of how the problem may be addressed.

Initial meetings would also give further insight into the impact of the veteran's mental health on the family. For partners of veterans this may be the first time they have had someone listen to and focus on them. This stage of RAVFS would also seek to ensure that

all family members recognise that the service is there to support each family member individually as well as the family as a unit.

As planned the RAVFS process would then call for the practitioner to bring individuals or smaller groups together for meetings, which could be larger or full family groups according to family needs. As found in the restorative continuum (Costello et al., 2010) these meetings will be able to draw on different restorative elements, (often termed 'tools' by RAVFS,) in response to the family situation. This could result in working with families using informal discussions, mediation, or full family group conferences. When considering this during programme development, regular use of family group conferences was envisaged but with recognition that its use may vary.

'We are feeling it out, we are thinking about how formal it will be and I think this will depend on the family'. (RAVFS practitioner)

During development, as dictated by the restorative process in a family setting, it was expected that family meetings, regardless of format, would revolve around discussion of the main family concern, how that came about, how it was perceived by each family member and the associated effects. The importance of providing the families of individuals living with mental health disorders with information about the illness is recognised (Lefley, 2009) and known to RAVFS. This knowledge led to the agreement that a VNHSW therapist would come to talk about mental health at some point during a family session. During development it was expected that this 'psycho-education' would take place when the family had reached the stage of full family meetings *'this big meeting where the therapist comes in and shares the knowledge'* (RAVFS practitioner). From a restorative perspective, it was hoped this knowledge would change perceptions of the reasons behind behaviours of concern and build empathy. It was also possible that this new level of understanding would lead to changes in family responses to the behaviours and thereby have a positive impact on all family members.

Meetings would also see collaborative consideration of the necessary changes to address family challenges and how these could be achieved in a way acceptable to all.

'Basically, it's an opportunity for everyone to share what they have kind of spoken about or what they would like to share, um, about their wishes, feelings, needs and how they would like to move forward to come up with a plan. So that can be on a bit of a scale so it can be a very formalised plan, or it could be a bit more of a loose plan, because family group meetings come from a social services background where there is a need for it to be very formal, but this kind of depends on our family.' (RAVFS practitioner)

It was also anticipated that this stage could lead to the involvement of further agencies beyond VNHSW if family needs required them and the family felt the extra support was necessary.

As found in use of a restorative framework when delivering family services elsewhere (Williams, 2019), the practitioner expected to draw on a variety of methods to help families articulate their own needs, feelings, and opinions. When younger family members were present it was likely that this would include cards and games.

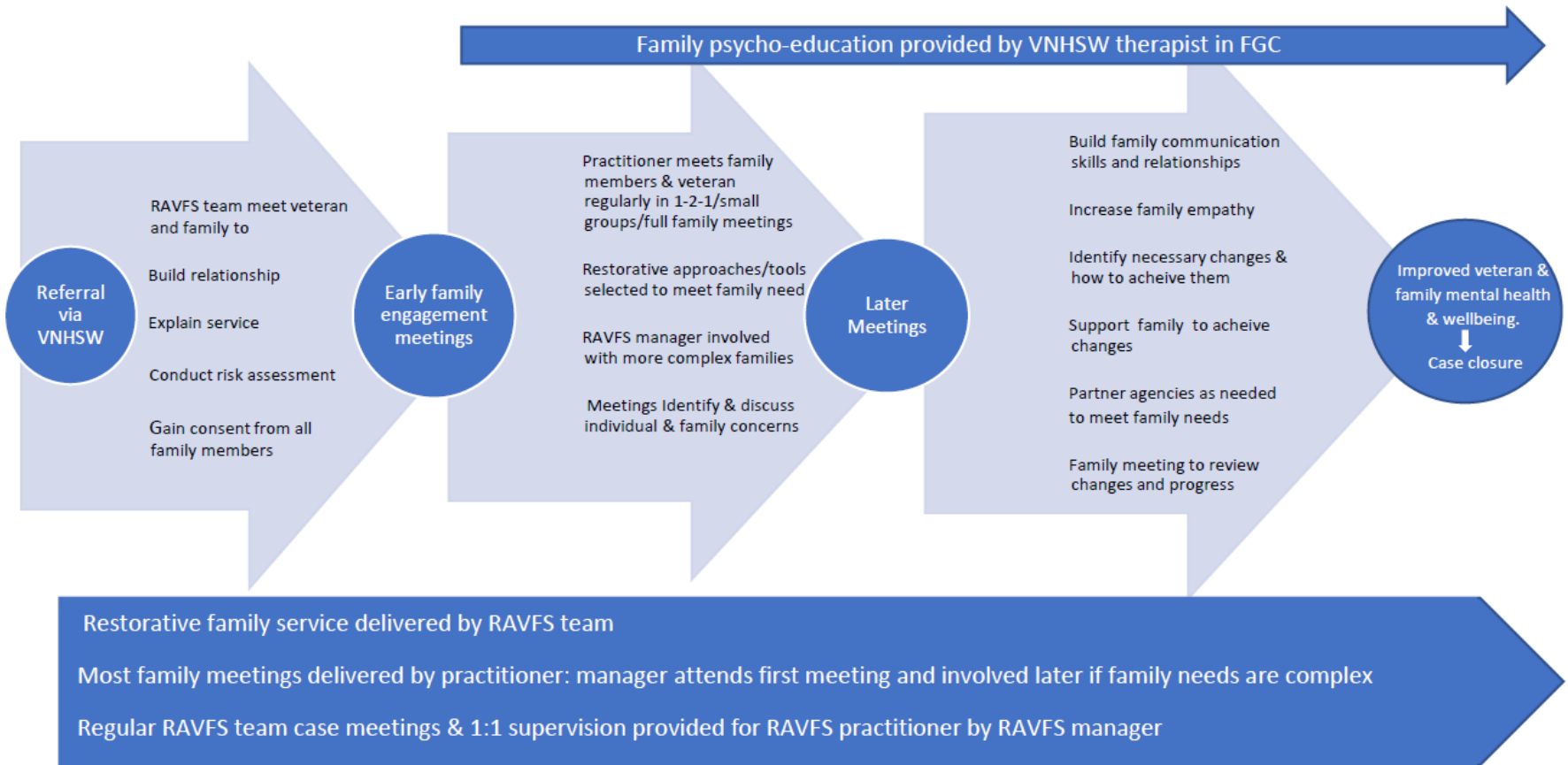
The planned RAVFS process also included regular case meetings between the RAVFS practitioner and manager. During these, the RAVFS team would discuss potential new veteran families as well as the progress of families using the service. The restorative manager would also continually support the RAVFS practitioner through regular supervision sessions.

Service closure

Before service delivery began it was believed that although six months should be an appropriate length of time for service completion, the family-led nature of RAVFS called for service length to vary with family needs. In line with this, it was understood that the decision to end would be considered during case meetings with the service manager and in consultation with the family. Closure was also envisaged if the family and/or veteran disengaged, or the service was no longer required. It was also anticipated that some families may need referral or sign posting to other services.

Figure 3 sets out the planned process and effect of RAVFS before implementation.

Figure 3: The process of RAVFS use



Safeguarding and confidentiality

Ensuring that the practitioner remained safe was recognised as important, and it was appreciated the veteran's mental health problems may increase risk. In response, the established TGP Cymru lone worker policy was extended to RAVFS. Similarly, the TGP Cymru Safeguarding Procedures set to ensure the safeguarding of all service users were extended to include RAVFS, with agreement that, as usual, service users (veterans and families) would be made aware of them. In relation to confidentiality and practice it was acknowledged that VNHSW and RAVFS services needed to regularly review cases in the light of both operational organisational safeguarding policies as these may vary for therapy and the RAVFS service.

5.1.d Integrating VNHSW and RAVFS

With the processes of the two separate services established, it was important for VNHSW and RAVFS managers and staff to plan the integration of the two systems. This required some adaptations in VNHSW procedures to facilitate RAVFS implementation.

During the VNHSW referral, veterans are asked to give consent for medical information to be shared between organisations such as military health and VNHSW. During early discussions it was decided that this consent would be extended to give the RAVFS practitioner access to the referral form.

According to VNHSW therapists, the impact of the veteran's psychological injury on family functioning often became apparent during assessment. Moreover, if veteran partners attended the appointment, it could become evident that it was the family encouraging the veteran to use VNHSW. Once the RAVFS service was operational, VNHSW therapists believed they would give increased attention to family issues. As part of this, the mental health measures routinely taken for the veteran would be supplemented by SCORE 15 which would provide another indication of a need for family support.

As shared decision-making between the two services was perceived as key in implementing RAVFS from the onset, it was agreed that if the VNHSW assessment suggested that the veteran may benefit from using RAVFS, possible referrals would be discussed with the RAVFS practitioner. The decision to offer RAVFS or not would then be made in a case meeting between the RAVFS practitioner and manager. If a decision to proceed was made, the veteran would be given information about RAVFS and encouraged to discuss this with the family. If the collective response was positive, a referral to RAVFS will be made.

While this was one route to RAVFS use planned during development, it was also agreed that a referral to RAVFS could be made anytime during VNHSW involvement: after assessment, during therapy with VNHSW, or at the end of therapy. It was believed these different patterns of use would emerge naturally once RAVFS was implemented. Envisaged scenarios included: family and veteran support needed while on the VNHSW waiting list; a veteran finding VNHSW therapy overwhelming at the start and unable to consider use of an additional service like RAVFS; the veteran may learn more about RAVFS during therapy and realise it may benefit their family; knowledge gained during therapy may make the need for family support evident; and, the veteran may be more receptive of RAVFS when a relationship with the therapist has developed or the veteran has met the RAVFS

practitioner and learnt more about the service. There is no obligation for the veteran to take-up the family service.

How the referral between VNHSW and RAVFS would work in practice proved difficult to determine until the families were identified and referred to the new service. However, with the decision that all possible referrals would be reviewed collaboratively by VNHSW therapists and the RAVFS practitioner, there was thought about where and how this may take place. It was hoped that the RAVFS practitioner could work at the VNHSW office once a week or attend regular VNHSW team meetings. Nevertheless, even with such practices in place it was conceded that these may change over time. For example, the RAVFS family caseload may become high over time and if so, the practitioner may not always have the capacity to be as available in the office for consultations.

During service planning it became obvious that during therapy and/or RAVFS use therapists and the RAVFS practitioner may need to share details about individual veterans or families: the practitioner talked of how, for example, if a veteran with PTSD had suicidal ideation, RAVFS would benefit from discussing the case with the therapist. Conversely the practitioner may, with client permission, feel it would aid therapy if therapists were advised of knowledge gained during RAVFS service.

Figure 4 shows the initial integrated model of RAVFS within VNHSW as perceived before the service began operation.

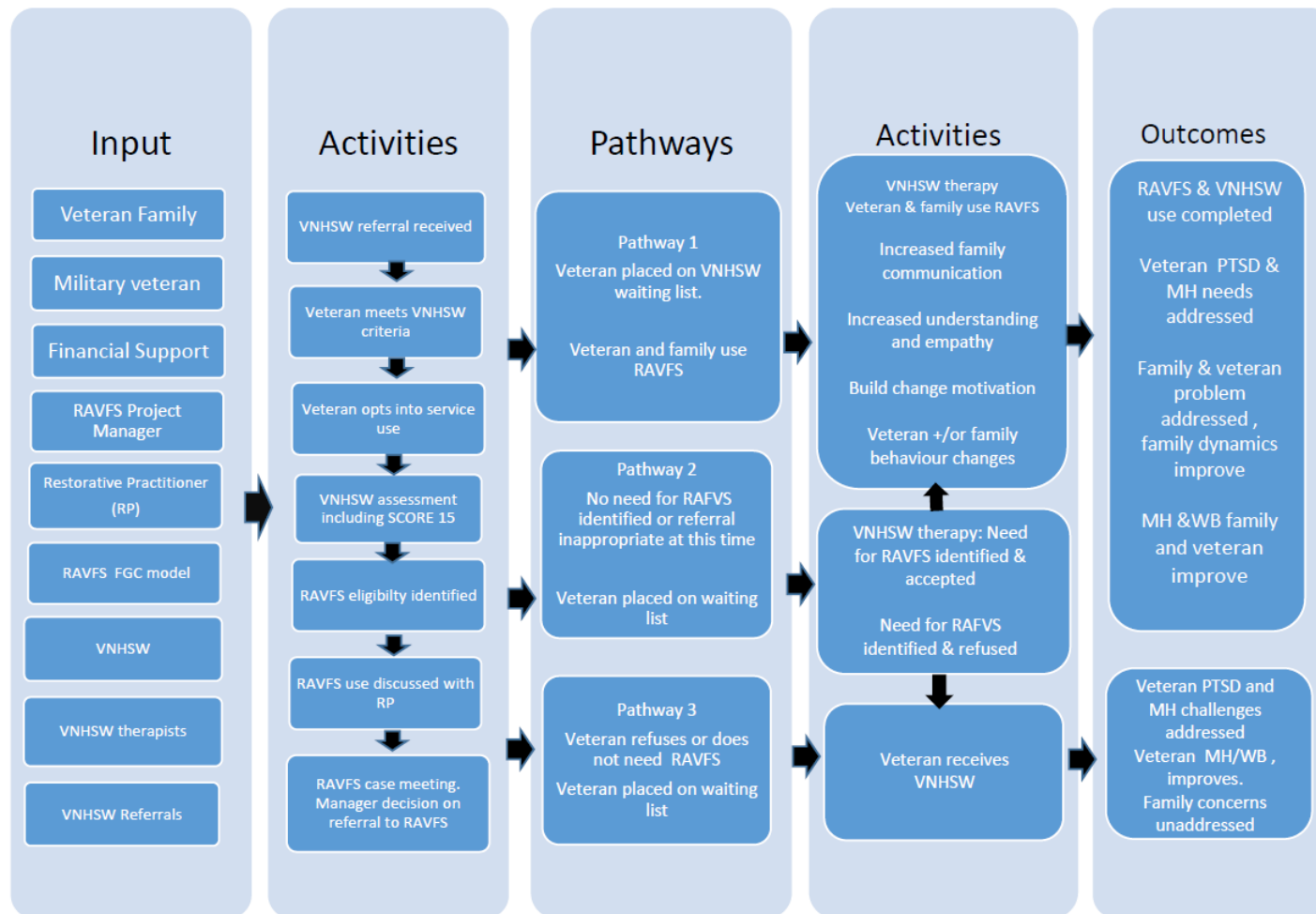


Figure 4: Initial integrated model of RAVFS within VNHSW

The following section is concerned with how the integrated service worked when implemented in practice.

5.2. Phase 2: Integrated RAVFS service implementation

The integrated RAVFS service became operational after three months of development. With the intent of refining the original service model, the research focus changed to exploring the process of service implementation with interest in recruitment to the RAVFS service, how well the initial model worked in practice and whether the restorative process underlying RAVFS worked as intended with veterans and families.

5.2.a Recruitment

It is recognised as important that a new intervention reaches the target population and is adopted for use (Glasgow, 1999). The length of the study and the pattern of service use allowed the exploration of possible barriers and facilitators of service use as perceived and experienced by VNHSW, RAVFS, veterans and families. The following section begins with anticipated and actual facilitators and barriers identified by the professionals, before moving to consider those experienced by veterans and families who had lived with mental health illness. Amongst the participant veterans and families some had used RAVFS, and some had not.

5.2.a.i Recruitment barriers and facilitators

During service development and early implementation VNHSW and RAVFS staff considered barriers to veteran and family recruitment. Those identified can be divided into organisational, family, and individual factors.

At the organisational level, VNHSW criteria for use restricted RAVFS access to veteran families in which the veteran had a Service-related mental health illness. This knowledge was of concern as professionals were aware that many veterans with mental health problems would either not approach VNHSW or if they did so fail meet the criteria for use. Furthermore, while VNHSW believed that many veterans using their service would benefit from referral to RAVFS, it was suspected that the unknown nature of the service could prevent use, especially during the early phase of implementation. There was also concern that veterans and families may prefer to work with staff who were military veterans themselves, and while the RAVFS team all had military connections they had not served themselves. When thinking of the characteristics of all families who could be offered the service there was concern some families would not take part due to fears they would have to share sensitive information such as contact with statutory social services. Finally, a referral to RAVFS is dependent on a veteran accepting the offer and taking information about the RAVFS service to the family to gain their opinion and agreement.

Service delivery made RAVFS and VNHSW aware of the reality of earlier perceived obstacles to service recruitment. As anticipated engaging in VNHSW and RAVFS concurrently proved too much for some veterans to contemplate. Elsewhere previous contact with social services had alienated families from further intervention. In addition some veterans feared the service may increase ongoing family conflict, still more families had become used to family dysfunction and perceived this as normal. However, some veterans and families had welcomed early access to RAVFS as family conflict was high and to some extent had facilitated VNHSW use.

5.2.a.ii RAVFS recruitment barriers and facilitators

During the early phase of RAVFS implementation possible barriers and facilitators to RAVFS recruitment were further considered by veterans and family members with experience of veteran mental illness who used a military charity. Actual barriers were explored with the eight veterans and families who had used the service and four veterans who had declined it.

Most of the perceived barriers to generic mental health service use identified by participant veterans, namely stigma, the military culture, poor previous experiences of service and effect, waiting lists, transport, and financial problems have been previously recognised (Kim et al. 2011; Elbogen et al., 2013; Williamson et al., 2019). In addition, motivation to and confidence in seeking help were mentioned:

'Vets may need a push to go. the first hurdle is going to the GP. That is the first step and then you need a sympathetic doctor who will refer you to the right help.' (Veteran Partner, charity family focus group)

When introduced to the concept of a family support service such as RAVFS, some participants believed that veterans would not involve families to protect them from secondary trauma:

'You've got a weight on your back, it's 100 pounds, and then you pass 50 to your wife. That's fine and all good, but now she's got 50 pounds on her, and you don't really, she might have her own strategies to cope with kids, the family, um do you really want to pass that stress onto her? That's what a lot of them feel like.' (Veteran, charity veteran focus group)

In relation to actual barriers and facilitators encountered, families who had used RAVFS identified a range of factors. Some veterans and parents felt that further detail about RAVFS that explained the nature of the service and the family problems it sought to address before referral would have promoted service acceptance by allaying worries about receiving 'therapy', or suspicion that the referral was a serious criticism of parenting:

'it was sort of like um, implied that it was um, for um, vulnerable um children and, and things like that.' (Partner RAVFS Veteran 8)

As found in other service settings (Rust et al, 2009) the time of day the service was delivered was important. RAVFS availability inevitably decreased when the service became busier, and this caused difficulties for some,

'It became more difficult to see them at 4 o'clock or 5 o'clock which fitted with our work or the parenting, and then so then we were missing weeks and then it was going longer and longer and then it was becoming a massive pressure.' (Partner RAVFS veteran 6)

The lack of a confidential space outside of the family home for individual meetings also caused difficulties,

'They don't have an office and me not being that comfortable about sitting with [practitioner] in one room and the kids and [veteran] being in a different room, I felt that was quite difficult.' (Partner RAVFS veteran 6)

Veterans who had used RAVFS identified few additional barriers in addition to those mentioned earlier. As noted, two had been eager to use RAVFS while still on the VNHSW waiting list as family conflict had been high at that point. The remainder used RAVFS during therapy. One major reason for delay was, as suspected, a fear that using VNHSW and RAVFS immediately and concurrently would be too demanding:

'The beginning it would have been too much. I mean that's only my opinion.' (RAVFS Veteran 7)

For others, the need for RAVFS only became apparent during therapy:

'Then [therapist] mentioned about [practitioner] and the family support, but he said that its support for you as well as [veteran], and because we were struggling to communicate and stuff like that... We were arguing a lot weren't we really?' (Partner RAVFS Veteran 19)

Collectively, veterans and families identified few barriers to RAVFS use. All perceived RAVFS as a positive addition to mental health services for veterans,

'If like their children and their partner can understand it then it makes it a lot easier at home... I know a few people with PTSD and obviously if you understand their triggers it helps them a lot more... Yes, just things, if you understand a bit about it you cannot like provoke it as such.' (Veteran, veteran charity)

This positive reaction to the concept of RAVFS extended to veterans who had refused use. Their reasons for refusal included a partnership breakdown, the belief some family members would refuse the service, and opinion that the PTSD was not impacting sufficiently on the family to warrant use.

5.2.b The integrated RAVFS service implementation

RAVFS implementation began after three months of development. The research team continued to follow this process for the next two and a half years. During this time interest focused on the acceptability and feasibility of the model, and in the changes made to increase and facilitate these. Further interest was in how well the process of RAVFS aligned to restorative theory and the perceived effect of the process on families.

5.2.b.i Changes in VNHSW

While VNHSW staff had always displayed positive attitudes to RAVFS, it took time for them to become familiar with the theory and mechanisms underpinning RAVFS, relate these to the needs of veterans, become confident in the new service, and begin to refer families. Over time, therapists learned more of the process of RAVFS and its positive effects. This,

and the integration of the RAVFS process into use of VNHSW, led to changes in the nature of the VNHSW assessment and associated multi-disciplinary team (MDT) meetings.

As anticipated, with RAVFS available, the veteran's family became of greater focus to the VNHSW team. Previously, therapists had felt that although veterans tended to minimise the impact of their psychological injury on families, there had been limited value in exploring this area as no pertinent service was available:

'You know, why flag up a problem or, or, or put the spotlight on it, when you, when you can't do anything with it.' (Therapist 1)

Initial uncertainty about how the RAVFS practitioner would work with VNHSW, together with difficulties experienced in holding practitioner/therapist meetings to discuss possible referrals, led to the inclusion of the RAVFS practitioner at routine VNHSW weekly (MDT) meetings. On introduction this worked well, and by the end of the year the RAVFS practitioner was perceived as intrinsic to VNHSW service:

'We're probably at that quite nice stage now, where actually [practitioner] feels very embedded into the team, um, and you know, exchange of information just seems much easier, [the practitioner's] at the forefront of our minds and, and likewise.' (Therapist 1)

5.2.b.ii Changes in RAVFS

During RAVFS development it had been anticipated that referral to RAVFS could be made at any point throughout the veteran's involvement with VNHSW. In practice some veterans were motivated to use RAVFS as soon as possible, others delayed or refused use as they felt that use of RAVFS was beyond their capacity while receiving or waiting for VNHSW therapy.

While RAVFS had been aware that some veterans, families, or some family members may not engage in the service, early experiences identified families in which while the veteran was reluctant to engage, the family were likely to benefit from using RAVFS without them. In these instances, the psychoeducation provided proved extremely useful as it helped families learn of the link between problem behaviours and the veteran's mental health.

More generally, the planned psycho-education had a positive effect on the veterans and families worked with. This aspect of service delivery reinforced recognised knowledge of the detrimental effects of PTSD, depression, and anxiety on family relationships (Creech & Misca 2017; Sherman et al., 2016; Brockman et al., 2016; Allan et al., 2010; Sayers et al., 2009, Galovski & Lyons, 2004), and there were few families and veterans with prior knowledge of mental illness or associated behaviours such as low mood or the veteran preferring to spend time alone, rather than with the family *'I don't think there was an understanding of what PTSD or anxiety was, not understanding that... So the partner had internalised everything.'* (RAVFS Practitioner)

Overall, service delivery supported the delivery of psycho-educational sessions containing information about common mental health disorders and how they can affect people's actions and behaviours.

However, early experiences with families also led to changes in the timing, format, and content of the psycho-education element of the service. From the first contact families asked the RAVFS team questions about mental health, illustrating a need for information from the onset of service provision. This finding suggested that the psycho-education sessions would be best provided by RAVFS as and when needed, rather than by VNHSW therapists in formal planned sessions as originally conceived. Early service delivery also identified the need for families to know more about the therapy the veteran was receiving or would receive, especially if veterans felt unable or unwilling to share this information themselves:

'The veteran's going through EMDR therapy and the partner, erm, doesn't really know much of EMDR and would really like to because they would like to prepare themselves and, and the veteran doesn't feel able to share that' (RAVFS practitioner)

Moreover, working with the family before the veteran began using VNHSW gave the practitioner an opportunity to prepare families for possible effects of the veteran's therapy. This was likely to help if there was a deterioration in the veteran's mental health when the therapy started, which can happen when *'Veterans have to confront the situation - This is very, very, hard.'* (Therapist 2). RAVFS and VNHSW staff agreed that helping families understand that this is an expected reaction rather than an indication that the therapy was not working was likely to reduce family anxiety and allow them to better support the veteran.

During development the use of the full range of restorative methods from informal restorative conversations to full Family Group Conferences as set out by Costello et al (2010) had been anticipated, with extensive use of conferencing expected. However, service delivery soon showed that an approach based on restorative engagement: a term that refers to relationship-building and more informal communications with families, was more appropriate for the families worked with so far as these had neither needed nor welcomed a formal intervention. In contrast, the service appeared more acceptable and effective when it focused on forming good relationships and eliciting effective communication with and between family members:

'Nine times out of ten they're like, 'oh just the fact that I was able to talk to you today, and offload...' And not necessarily in a therapeutic way, you know, we're not going deep or anything, they just need to be able to express how they're feeling and have someone reflect that back.' (RAVFS practitioner)

Such statements showing that these were important elements in building the foundation on which the rest of the restorative process could take place.

Regardless of the predominant use of more informal approaches with families using the service during early implementation, RAVFS professionals remained aware that this did not exclude possible use of Family Group Conferences. Rather, experience suggested the need for more formal intervention was less than originally believed, or conversely that using restorative engagement had a positive effect that reduced family tension and removed the need for conferences.

5.2.c The underlying programme theory of the RAVFS Service

Descriptions offered by the eight veteran families who used RAVFS mirrored much of that witnessed in the delivery of other family support services embedded in a Restorative Approach (Williams, 2019). RAVFS use began when the RAVFS team visited the family home to introduce themselves and explain the service. This was followed by individual meetings between the practitioner, the veteran, and family members. For most families this led to later, larger family meetings, although one family did not include the children.

Analysis of the accounts of service provision and receipt by RAVFS staff and the veterans and families who used the service allowed assessment of the extent to which the service followed the underlying process and theory of a restorative approach. It also gave indication of perceived family impact.

5.2.c.i Relationships

Relationships are central to a Restorative Approach (Strang and Braithwaite, 2000; McCluskey et al., 2008; Hopkins, 2009). This was first evident how the relationships built in early meetings with families were viewed as key to the rest of the RAVFS process and impact. RAVFS staff believed that positive relationships built early in service provision facilitated the sharing of the perceived challenges affecting the families and their impact on each person. This in turn generated empathy and trust between veterans, families, and the RAVFS practitioner and created a secure foundation for the remaining RAVFS process,

‘Building relationships, a part of that is building the trust, and so as that builds, the whole dynamics may change.’ (RAVFS manager)

Families reinforced this opinion. Many talked of how the individual meetings were important as they gave each family member an opportunity to get to know the practitioner which eased the often-difficult process of describing and discussing sensitive family experiences and associated emotions,

‘Well, I suppose sometimes you open up a bit more don’t you, to uh, uh other people for myself like, you can explain things better on a one to one as opposed to round the family I found.’ (RAVFS Veteran 20).

Others spoke of the friendly, informal relationship formed quickly with the RAVFS practitioner,

‘[they] made me feel at ease straightaway, I was a bit defensive when they first come in and I was like, is this going to be a thing, and I had my questions, obviously regarding my kids... But I don’t know, s/he just made me feel at ease, I don’t know if it’s just [practitioner] but s/he’s so approachable and that.’ (Partner RAVFS veteran 19)

5.2.c.ii Communication

Communication is essential when trying to build relationships, share experiences and understand people. When describing their work with the RAVFS practitioner, families recounted how they had met with the practitioner to talk about the family situation and its effect on each person in a mediated environment. This, it was felt, had facilitated better communication in which family members had the space to talk and be listened to. Nearly all families who had taken part in felt that the main benefit of RAVFS had been improved family communication,

'I absolutely loved it. The confidence [the practitioner has] given us as a family and as a unit is amazing, like we can all communicate more, ... erm the way [the practitioner] made other people see how I've got to deal with everybody else's stuff and with my own as well so it's made everyone open their eyes a little bit.' (Partner RAVFS Veteran 4)

'I'll be totally honest and say if I didn't have that service with [practitioner] I don't think we'd be as we are now. Because we're communicating a lot more, just as a family like, it's a lot better.' (RAVFS Veteran 19)

RAVFS staff believe the restorative process helped further by helping families talk about hurts inflicted by historical as well as ongoing behaviours,

'Those scars and everything and all that unsaid stuff was still there underneath and I think some families are definitely hitting level of couples therapy but [for] some it's not necessarily that in-depth but they need something... A lot of it is just around communication. They just need to learn how to re-communicate with each other and I think if that isn't done then I think that maybe some of the good work that's done with the veteran may not get entirely fulfilled.' (RAVFS manager)

5.2.c.iii Understanding

The values supporting a Restorative Approach (RJC, 2003) do not attribute blame to individuals, rather they focus attention on the presenting problem and how it affects family members and the family unit. Once communication has been established, mediated conversations can change perceptions of the roots of problematic behaviours (Hopkin et al., 2004). Evidence of this was seen in increased family understanding that the behaviours of concern were associated with the veteran's mental illness and/or therapy,

'We just didn't have a really good understanding of how [veteran's] PTSD um was kind of affecting his mood on some days. And because he's um struggling to sleep at night, he's obviously really tired, and when he comes home from work we've just had to learn as a family that, or me as a wife as well, um that when he's in those kind of moods to just try and understand it is not because of something that we have done. It's just because of what's going on in his mind.' (Partner RAVFS veteran 20)

Further, discussions of how these behaviours affected the family increased understanding of how family reactions could sustain or increase the intensity of said behaviours. In the context of veteran families and as found by Turgoose & Murphy (2019) the education

sessions were central to this change in focus, as families realised that veterans were unable to interact with the family in the ways desired at that point in time but this was due to underlying health problems rather than because they were consciously refusing to engage.

5.2.c.iv The generation of empathy, motivation, and change

As previously argued (Hopkins, 2004; 2009) a reaction to improved family communication and understanding is likely to be increased empathy. A few family members summarised this well,

*'Instead of shouting we'd talk more and listen to the other person and try to understand what was actually going on before we jumped to something'.
(Partner RAVFS Veteran 4)*

This insight was a major factor in reducing family tensions. There were also examples of how the knowledge fuelled family discussions of the changes needed to promote good mental health not only for the veteran but for all family members,

'We just spoke about it as a family, and what you can do as well to help, like coping strategies, like everybody needs. We had to write down what we need for our mental health, what is um helping us individually. Like certain things like um [daughter] said she likes to eat chocolate and likes to have a bath and chill. And then dad said he likes to have a bath and chill when he comes home from work.' (Partner RAVFS Veteran 20)

With further description of how the practitioner had provided support for families to implement the necessary changes when and if needed,

'I felt anxious ... it would say right now how to cope with being anxious and what tools then you can bring yourself out of being anxious or take you out of a situation and if you're angry, think about something else. Another tool of getting yourself out of that situation.' (RAVFS Veteran 14)

And the overall effect on family life,

'Brought us closer together and helped us in dealing with situations. And just ... improved the atmosphere in the house ... the home. ... Erm it's more easier ... it's more lighter, we can just have a laugh now and crack jokes and do stuff again sort of thing'. (Veteran 14)

5.2.c.v Quantitative findings: the feasibility of measuring outcomes

Using SCORE 15 to measure family strengths, communication and difficulties before and after RAVFS use. proved feasible where used. However, SCORE 15 was not acceptable to all service providers. While RAVFS successfully used the measure before and after service provision, VNHSW staff found the measure cumbersome and reported a lack of understanding of what SCORE 15 measured or how it was of use to the research. This led to no measures being collected from veterans and families who did not use RAVFS.

This occurrence contributed to the small sample of SCORE 15 measures gained (n =22) and the associated caution when analysing and interpreting results. Despite analysis indicating that all the changes found proved statistically significant, statistical experts advised that it would be preferable to solely report the changes in means. Table 2 shows that SCORE 15 indicated that use of the RAVFS had a positive impact on family communication and strengths and reduced family difficulties. When considering Table 2 it should be remembered that SCORE 15 has been constructed in a way that makes a reduction of scores indicate a positive change. Further, the small sample size allows the results to be perceived only as a very early indication of possible effect that needs to be followed up with a much larger sample.

Family measure	Mean Pre-RAVFS	Mean Post RAVFS*
Strengths	2.58	1.80
Communication	3.12	2.30
Difficulties	2.80	2.12

*A decrease indicates an improvement in scores

Table 2: Changes in families over RAVFS use

5.2.d Challenges to the RAVFS process

All who took part in the study were positive about the concept of RAVFS and only one negative experience was recounted. While the veteran in this family benefited from VNHSW, the resultant changes and use of RAVFS did not lead to an improvement in family relationships. The partner and veteran had taken part in multiple helpful individual meetings with the RAVFS practitioner. However, wider issues were affecting the ability of family members to fully participate in group work and the difficult decision to end the service was made. Although information about other support services were provided, a participant family member spoke of a feeling of disappointment that the service had not met expectations.

In addition to this there was also strong opinion amongst other participants about service closure. Some families would have liked the RAVFS service to have been provided longer. These families felt they should decide when they no longer needed the service rather than having this decision made purely by professionals.

5.3 Refining the service model

The opinions and experiences of families and veterans were discussed with the RAVFS practitioner and manager and two VNHSW therapists from the initial VNHSW clinic. The purpose of these meetings was to consider family opinion and whether the changes to the RAVFS process they suggested were beneficial and achievable.

The practitioner was unsurprised by the importance given by veterans and families to the psycho-educational sessions. Over time other positive outcomes have been noted as the information had made some veterans conscious of the concerning behaviours they were displaying for the first time:

'The person suffering PTSD sometimes doesn't know and will want to know or recognise what they're doing. Erm, so then when the [family member] tries to approach it, it doesn't compute almost. Erm, so I think sometimes it's maybe a mixture of them going through therapy so they're understanding actually some of what they're doing.' (RAVFS practitioner)

There was further agreement that the mediated meetings integral to RAVFS had a positive effect on family communication, which led to reduced conflict and improved levels of listening. Generally, this change generated greater empathy within families, and this allowed them to move beyond the negative emotions generated by the problem behaviours to consideration of how to change things, whether this be by adjusting the behaviours or changing family reactions to them. There was belief that the change in the perception of the families of the origins of the behaviours, and the veteran realisation of the impact on the family, were mediated by the improved communication generated by the Restorative Approach. This was key to the functioning of the service. The suggested changes to the current model of RAVFS service delivery and criticisms of the service made by families were also fully considered by RAVFS and VNHSW staff.

In response to family opinion that the decision to close RAVFS use should be made by the family, RAVFS staff reflected on psychological factors that operate in relation to service closure. The decision of who decides when to end service often raises concerns about family dependency (Forrester et al., 2014) and RAVFS, like others, recognised that whilst family services must provide support, they have to avoid dependency (Pawson et al., 2005). On reflection, RAVFS staff re-stipulated their commitment to working collaboratively with families and agreed that this should extend to length of service use. To facilitate this, it was recognised that the transparent conversations employed throughout service use must include setting clearer boundaries around service length. In general, the practitioner should be explicit, citing about six months being an average time of service provision, but also making it clear that this time may vary in line with the needs of each family.

When the one account of a disappointing experience of service use was shared with the RAVFS and VNHSW professionals it caused reflection on how to best respond to such challenging situations. RAVFS professionals had withdrawn the service due to the lack of veteran engagement and because family needs proved beyond the remit of RAVFS. RAVFS was developed to support veterans with significant mental health problems that were impacting on their family. Work with this family suggested that the mental health needs of another family member contributed to the problematic family relationship. This instance challenged any widely held notion:

'that actually it's something to do with the veteran and their behaviour and not necessarily somebody else in the [family] unit that's exacerbating that'. (RAVFS manager)

And demonstrated how it must be considered whether any of the family tension or conflict that led to RAVFS use stemmed from the characteristics or needs of other family members.

In some such cases RAVFS may not be able to meet family needs, and so the service should be stopped, and the family signposted to other sources of support, as had happened in this case. In discussion, both VNHSW and RAVFS agreed that conversations with families at the start of RAVFS use should make this possibility clearer.

Further discussion of the work with this family raised the possibility that the fact that the veteran was working with a therapist in another Local Health Board may have been a complicating factor. As delivering RAVFS in this area was relatively new, the practitioner had not yet formed a close relationship with the VNHSW therapist in the more recent setting. This, and the geographical distance between the VNHSW clinic and the practitioner meant the practitioner and therapist did not meet regularly as practiced in the original VNHSW setting. This therefore gave less opportunity to discuss emerging problems and whether RAVFS was appropriate for this family. This case reinforces the need for RAVFS and VNHSW to work closely and collaboratively.

Drawing on the information gained while following the process of implementing the integrated RAVFS/VNHSW model the refined model can be seen in Figure 5. A revised representation of the embedded RAVFS process follows in Figure 6.

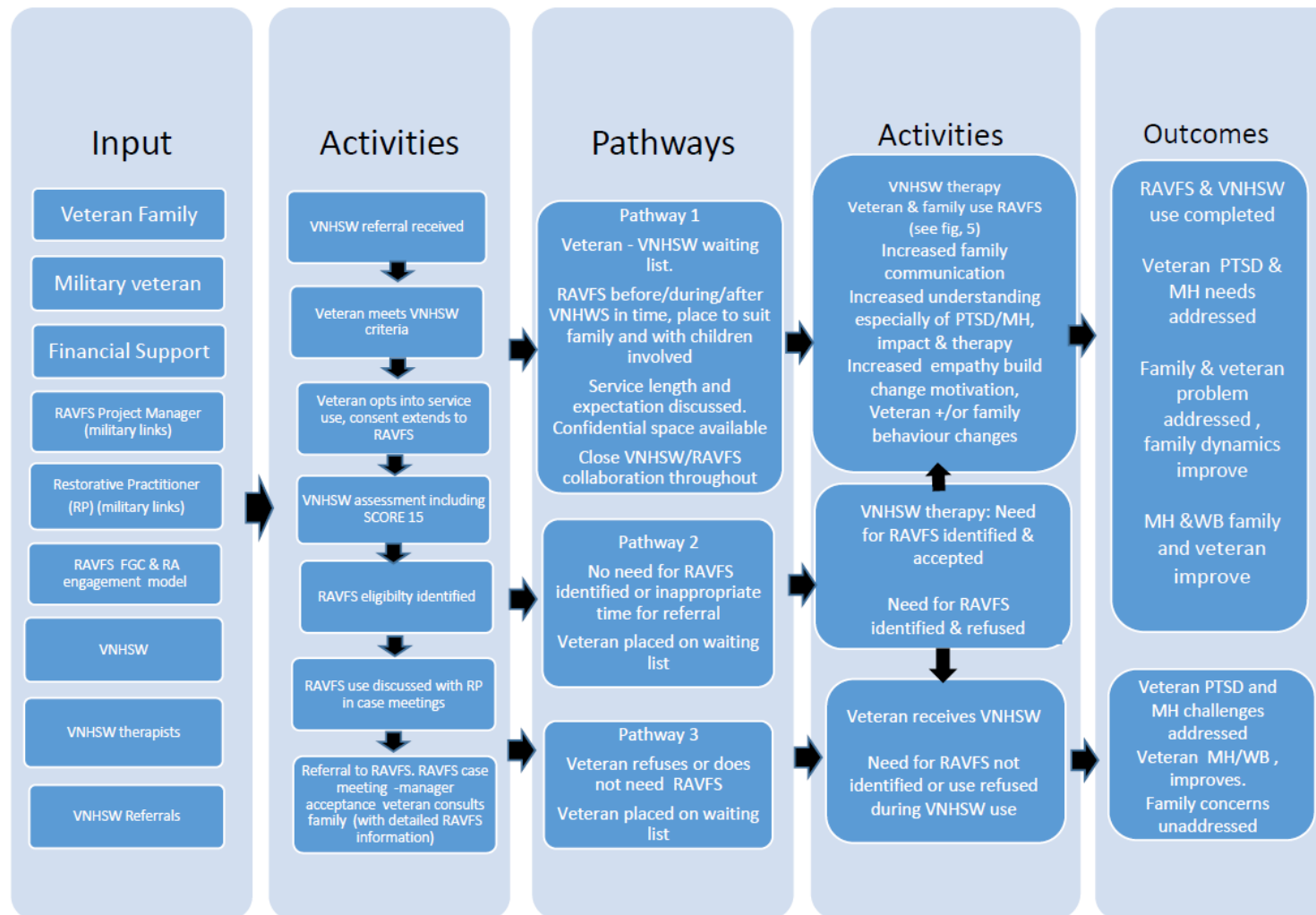


Figure 5: The final integrated model of RAVFS within VNHSW

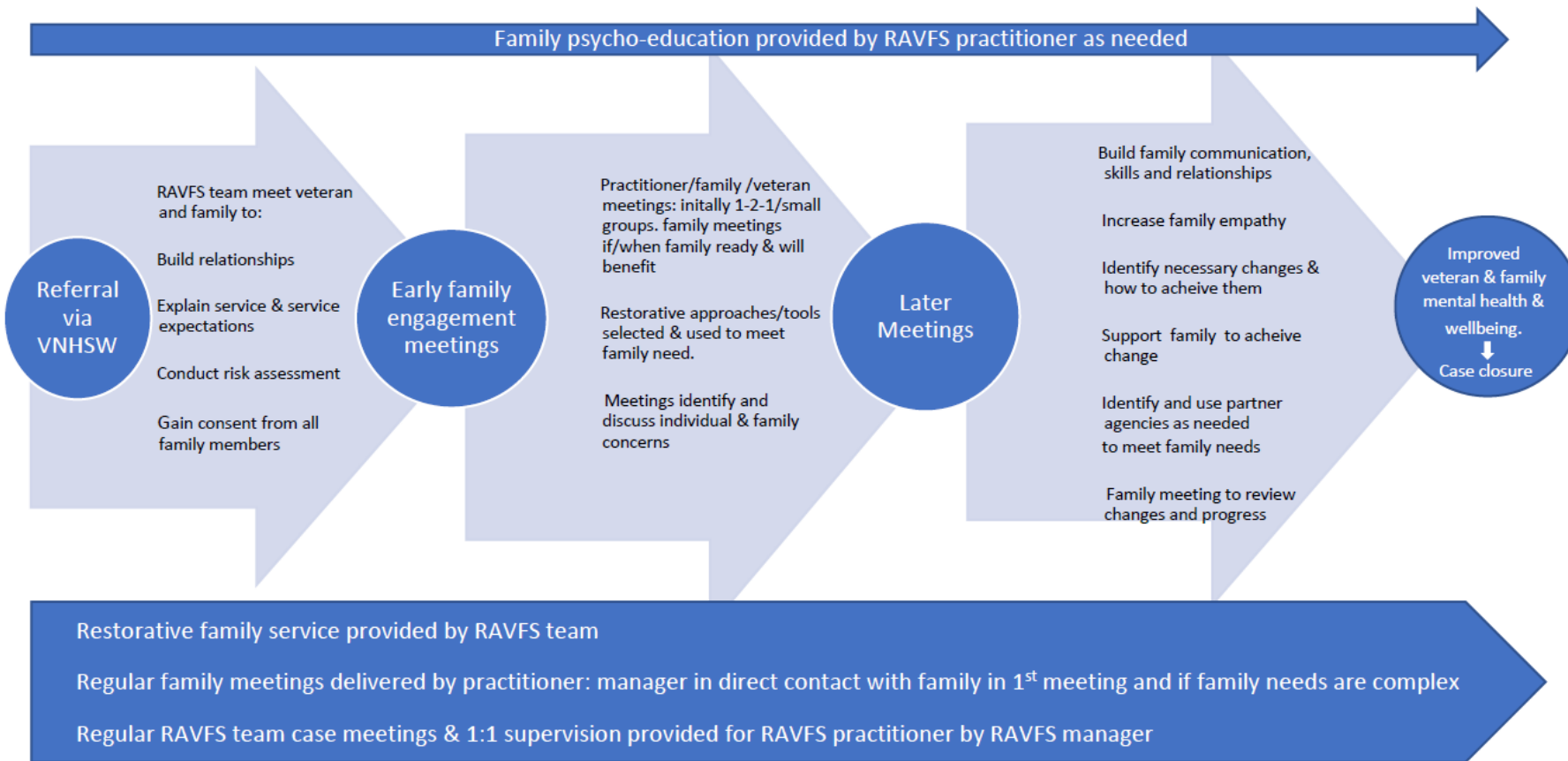


Figure 6: Revised representation of the embedded RAVFS process

5.4 Further development of RAVFS

Families and veterans who took part in the study were asked to consider how RAVFS could be developed in the future.

The majority felt strongly that service access should not be limited to access via VNHSW. Many families need help to better support veterans whose mental health needs did not meet VNHSW criteria. As noted by one participant, this situation leaves them without access to support,

'Respondent 1:[The veteran] listens to Radio Wales, and they came on the other day and there was a, they were chatting, erm, people to ring up about what do they do for ex-veterans and he got through....and I heard the conversation and the lady that was interviewing him she said I can tell you're emotional, even in your voice, you could hear it. She said you could hear the emotion in your voice and he did say, he said people talk about the veterans and everything but they do forget about the families, what the family's got to go through. Respondent 2: And I think because the veteran can't help the family they can only help themselves, I think having something like [RAVFS] coming in, can only be good for them. Cause they, they're thinking that my family's getting support as well as myself. Respondent 1: Yeah, and that's what he said on the radio, he said they forget about the families, they're the ones that's, you know, got to deal with everything.' (Military charity Family focus group)

This opinion voiced by multiple study participants mirrors known difficulties faced by veterans and families after leaving services (Blackburn, 2017; Jolly et al., 1996) and highlights the need for greater and more focused support.

Families and veterans also felt that information about a service such as RAVFS should be accessible and available to all veterans and their families in public spaces and local community settings. There was further support for an extension to RAVFS in the form of a follow-up service. This would provide a route for families to access help to reinforce the knowledge gained and changes achieved while working with the practitioner. It could also be a means of accessing further support for the veteran if improvements made in VNHSW and RAVFS relapsed.

When reporting these views to RAVFS staff, it was encouraging to hear that they had already identified the need for wider support for veterans and their families and a follow-on service for RAVFS families. The RAVFS manager has obtained financial support for a new project, which will provide support for veterans and families. Although the service is still being developed, description of the embedded Restorative Approach service suggests that it will retain the focus on family relationships,

'People getting together in the same room and us doing some sessions to support their relationships. Predominantly from parent or carer to child, erm, but obviously, as you know, any RA sessions we do are all about relationships so it would have benefited anyone. But that's kind of the angle, looking at family

relationships and the dynamics of families, so we were going to do that.'
(RAVFS manager)

Other sources of support in the form of 'bite size' information videos and peer groups are planned.

RAVFS staff are also working to build a network with other agencies capable of providing help with practical and developmental problems affecting veterans and families such as learning support and housing. Not only will this provide much needed support, but it will also allow RAVFS to remain focused on family relationships.

Further reflection by staff on RAVFS provision identified areas where the process of service delivery can be tightened or changed.

In relation to RAVFS criteria, some adult family members had been reluctant to involve the children. RAVFS staff are concerned that if family tension develops or persists during service use, this form of RAVFS delivery can leave the children in the family unsupported. This belief underlies the decision to make the inclusion of family children in RAVFS use a service expectation.

Where family needs have been complex, the RAVFS manager worked with families beyond the first meeting of the RAVFS team and the family to facilitate and aid service provision. When explaining the service, this practice should be discussed and normalised to allow the practitioner to include the manager without suggestion that the family are particularly difficult.

6. Discussion

The primary aim of the study was to construct an acceptable and deliverable model of RAVFS. To achieve this, interest lay in the feasibility of the service model developed initially, barriers and facilitators of family recruitment and in implementing the RAVFS service. In addition, the study sought to discover whether the restorative process embedded in RAVFS worked as intended with veterans and their families, and whether it was feasible to assess outcomes.

The study identified a range of factors affecting veteran and family use of RAVFS. Against knowledge of the reluctance of military personnel and veterans to utilise mental health services (Hom et al., 2017), and the potential trauma of a therapy that asks individuals to relive traumatic experiences repeatedly (Forbes et al., 2019), it became evident that the correct time for referral to an additional service is specific to the situation and the needs of each veteran and their families. Therefore, a decision to refer to RAVFS should be decided on a case-by-case basis. It also became clear that this decision should also be made collaboratively in consultation with the veteran, and through the veteran, with the family. To facilitate family deliberation of whether an offer of RAVFS should be accepted, families believed detailed information about RAVFS would be helpful at this stage. It was suggested that the information provided should also be sufficient to allay any fears that the referral is a criticism of parenting, a recognised barrier to child and family service use (Wilkins & Whittaker, 2018), emphasise the collaborative, democratic values of restorative approaches (RJC, 2003), and set out how the service intends to help families support the veteran better. Further, practical barriers, such as the time and place of service provision prevented some veterans from using RAVFS. This, together with the complex lives of families, calls for meeting times to be very flexible and often out of office and school hours to allow more veterans and families to be able to consider using the service.

In relation to RAVFS implementation, although RAVFS is delivered by an agency experienced in delivering family support services using a Restorative Approach, an early period of adaptation and integration was necessary to facilitate implementation. The relationship formed between RAVFS and VNHSW staff played an important role in this. While staff from both agencies held positive attitudes to both RAVFS and the required service integration from the onset, in practice VNHSW displayed some early hesitation in making referrals to RAVFS, and this contributed to the early slow uptake of RAVFS. As contact between the two agencies grew over the first operational year of RAVFS, it raised mutual understanding of the aims and processes of the separate agencies. This familiarisation increased VNHSW confidence in RAVFS until the service was viewed as an intrinsic part of VNHSW. The changing attitudes also pre-empted the changes that were made in the VNHSW referral and assessment process with the purpose of facilitating RAVFS referrals. As such periods of adjustment are recognised as part of the process of service integration (Majchrzak et al., 2014), and demands that a phase of familiarisation and adjustment should be expected and planned as RAVFS is rolled out to new settings.

Findings also suggested that the nature of the relationship formed between the RAVFS practitioner and VNHSW therapists can affect the process and impact of the family service. While RAVFS worked with three Local Health Boards in total over the time of the study, two only became involved during the second operational year of RAVFS. While the relationships between the RAVFS practitioner and the therapists in the two additional clinics in other

Local Health Boards were good, they can be described as more distant as the practitioner worked with the therapists for less time. It is likely that the opportunity to discuss the family regularly, whether in case meetings or through routine everyday contact as practiced in the original VNHSW clinic, would have allowed more ongoing collaborative consideration of evolving problems, a practice which tends to lead to aid the construction of solutions (Sydow et al., 2016; Zuckerman et al., 1995). While the lack of this relationship was a possible factor in the isolated more negative incident with one family, it illustrated the importance of regular meetings between RAVFS and VNHSW staff. It was also of note that the wider needs of this family were beyond the remit of RAVFS. This draws attention to the need for service boundaries and family expectations to be discussed in detail at the start of service provision and reviewed during delivery.

Practical issues remained important during RAVFS implementation. Although receiving RAVFS at home was generally well accepted and liked, there is a need for additional resources to fund spaces outside of the home in which individual family members can work with RAVFS practitioners safely, confidentially, and in privacy when necessary or preferred.

The study also sought to explore the mechanisms of change rooted within the RAVFS process. The relationship-based ethos of restorative services (Strang & Braithwaite, 2000; McCluskey et al., 2008) remained central as found in the emphasis on forming effective relationships with the families at the start of contact. It was also evident in the alteration of the format of the service process which moved towards informal use of restorative principles and processes rather than routine use of formal Family Group Conferences as initially envisaged. The process of delivering family support services using a Restorative Approach remained similar to that described in detail elsewhere (Williams, 2019): initial individual or small group meetings followed by larger family meetings in which participants are encouraged to share feelings and experiences, consider the changes needed to address family problems and collaboratively decide how these changes can be made. However, while increasing communication is central to a Restorative Approach (Paul & Borto, 2017; Williams et al., 2018) as it promotes the sharing of experiences and associated understanding and empathy, a major factor in the context of the veterans and their families proved to be the educational sessions about mental health disorders, therapy and links to behaviours of concern as noted by Turgoose & Murphy (2019). As found, these gave all participants insight into root causes of problem behaviours and how family responses can escalate and entrench difficulties. Further, study findings indicated that giving veterans and families insight into how many of the problems causing family tensions are symptoms of the veteran's mental health disorder, reduced family tension, and allowed family conversations to start from a position of empathy rather than conflict.

The RAVFS process was generally well received. Both qualitative and quantitative measures showed that use of the service improved family communication and reduced conflict. Despite this, an additional barrier to implementation was found. Some families who have used the service over the time of the study, including some families who did not take part in the study, were reluctant to include children. While involvement in the service is voluntary and no family member should be pressured to take part, inclusion is a central value in Restorative Practice (RJC, 2003). The exclusion of family children limited the perceived impact of RAVFS as it prevented them from sharing their experiences, gaining understanding of what was behind problem behaviours and family conflict, and taking part in discussions of what needs to change and how.

The feasibility of using outcomes measures was also explored by testing use of SCORE 15. While the RAVFS team found the measure acceptable and usable, VNHSW staff described the measure as cumbersome, with further suggestion that they did not understand what factors SCORE 15 measured or how that was of use to the research. SCORE is an established measure of the quality of family life and therapeutic change in family functioning recommended for service evaluation, quality improvement, and to support clinical practice (Stratton et al., 2013). The measures SCORE 15 assesses: family communication, strengths, and difficulties are good indicators of family dynamics and relationships, factors targeted by a Restorative Approach (Williams & Scourfield, forthcoming). Better communication to discuss the purpose and function of SCORE 15 may have seen greater use and larger sample sizes. Conversely discussions with VNHSW staff may have led to the selection of a different measure acceptable to all.

The experience of delivering RAVFS over an extended period of time gave time for reflection on whether the service would benefit from further development. When leaving services, veterans and families are often faced with challenges additional to mental health difficulties. Families spoke of financial and housing problems and while VNHSW has been able to offer such support on occasion, resources have not allowed its provision consistently. Families also voiced a need to connect with other veteran families on a regular basis, suggesting a need for a peer support service or network. For families living with difficulties this could mirror services such as Family by Family: A programme developed in Australia which sees families who have successfully addressed problems mentor and support families currently going through them through community-based peer support (TASCI, 2020). There was further recognition of the need for support for families in which the veteran's mental health disorder did not meet the criteria for VNHSW but needed help. Collectively the information calls for the development of allied but separate programmes of support.

Study Limitations

The limitations of the study must also be acknowledged. Difficulties in obtaining both quantitative and qualitative measures were encountered, and lessons learnt may aid further evaluations. First, the delayed uptake of the RAVFS service led to difficulties recruiting families who had used the service, as by the time families were able to take part the study period was ending. As RAVFS becomes more established and better known this may not pose such a problem, but experiences suggest that the time given to research may have to expand as the study progresses to allow research opportunities to increase, the sample size be larger and more representative of the wider veteran and veteran family population. Quantitatively, for reasons described, the study collected relatively few before and after SCORE 15 measures from families who used the service, and none from veterans who chose not to use RAVFS.

7. Conclusion and Recommendations

RAVFS is an innovative service developed to fill the recognised gap of support for veteran's families when the veteran is living with mental health disorders such as PTSD with comorbid depression and anxiety disorders. RAVFS has been developed to deliver family support services using a Restorative Approach; an ethos and process that seeks to build and maintain relationships by addressing problems affecting communities and/or groups using collaborative, fair, respectful, mediated discussions. The study followed the development and implementation of RAVFS in tandem with VNHSW, a service that provides psychological therapy to military veterans with a diagnosed Service-related mental health injury. The integrated service model developed at the start of the service largely operated well, with effective mechanisms being the close relationship between VNHSW and RAVFS, the adaptation of established VNHSW processes to facilitate RAVFS referrals, and the underlying process of a Restorative Approach that improves family relationships. In the context of military veterans and their families, providing information about mental health disorders, therapies and possible effects was important within this. The feasibility of the RAVFS intervention was improved by a range of changes to the model that revolved around the time, place and content of the intervention. Overall, the positive impact of RAVFS on the functioning and wellbeing of the veterans and families that used it, calls for the following recommendations:

- The positive effect of RAVFS on the relationships between veterans with Service-related mental health illnesses and their families calls for a wider roll-out of the service, possibly to all Local Health Boards in Wales with a VNHSW clinic with a larger associated evaluation of process and effect.
- When developing an integrated veteran/veteran family support service time must be given for the constituent agencies to understand the process and intent of all services involved and to build positive relationships.
- When delivering RAVFS the timing and nature of the service must meet the needs of the veteran and the family.
- Within RAVFS delivery providing information of the link between mental health problems and problematic behaviours that cause family conflict is essential as it has positive effect on family understanding and dynamics.
- While delivering RAVFS in tandem with psychological support for veterans with Service-related mental health illnesses has a positive effect, the mental health problems of many veterans do not qualify them for services such as VNHSW. There is a need for a similar mental health family support service for this cohort of veterans and families.
- Support provided for veterans and families affected by mental health issues must extend to support for practical matters such as housing and finances that can have a detrimental effect on mental health.

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