UK Veterans Family Study

Understanding and mapping the psychosocial wellbeing support needs of veteran family members across the UK: *a multi-methods study*

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Abbreviations & Glossary

AFC	Armed Forces Champions
ARU	Anglia Ruskin University
CBT	Cognitive Behavioural Therapy
CIC	Community Interest Company
COVID-19	Coronavirus Disease 2019
DSC	Directory of Social Change
EMDR	Eye Movement Desensitization and Reprocessing
GP	General Practitioner
ICB	Integrated Care Board
KCMHR	King's Centre for Military Health Research
MOD	Ministry of Defence
NHS	National Health Service
NI	Northern Ireland
PPI	Patient and Public Involvement
PTSD	Post-Traumatic Stress Disorder
UK	United Kingdom of Great Britain and Northern Ireland
UKVFS	UK Veterans Family Study
VFI	Veterans and Families Institute for Military Social Research
WW2	World War II

5-Eyes Alliance Countries - UK, the United States, Canada, Australia and New Zealand

Armed Forces Champions - Individuals who commit to champion the cause of the Armed Forces community within their organisation (e.g., a Local Authority or NHS department)

Adult Children - Adult children (18 years or older) of UK veterans currently resident in any of the four nations who resided in the family home during the period the veteran was in the military and/or during their post-military life for at least six months

Cobseo Member Directory - An online directory of charities and regimental associations hosted by The Confederation of Services Charities (Cobseo)

Family Members - Partners and Adult Children of Veterans in the UK

Partners of UK Veterans - Spouses or intimate partners of UK Veterans currently resident in any of the four nations and: a) in a co-habiting/married relationship with the veteran during their military service or, b) formed a co-habiting/married relationship with a former member of the UK Armed Forces after they had left the military and, c) the relationship is ongoing or has exceeded six months now or in the past

Pseudonymised Data - Identifiable data (such as a participant's name) that has been transformed into an artificial identifier such a number or label

Psychosocial Wellbeing - A broad conceptualisation of wellbeing that recognises individual, psychological, and societal influences

Self-confidence - 1) self-assurance: trust in one's abilities, capacities, and judgment. Because it is typically viewed as a positive attitude, the bolstering of self-confidence is often an intermediate or end goal in psychotherapy; 2) a belief that one is capable of successfully meeting the demands of a task. (APA 2022a)

Self-worth - An individual's evaluation of himself or herself as a valuable, capable human being deserving of respect and consideration. (APA 2022b)

Service Providers - Organisations, and representatives from these organisations, who are providing veteran family-specific services across the UK, either in the charitable or statutory sector

Veterans' Gateway - An organisation designed to provide support, connecting veterans and their family members with relevant support services according to their need and locality. Support organisations listed by the Veterans' Gateway are categorised by the type of support they offer (e.g., employment, housing) and can be searched for online

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Executive Summary

The UK Veterans Family Study (UKVFS) is a cross-institutional, multi-stage, collaborative research project aimed at better understanding the psychosocial health and wellbeing needs of family members of veterans throughout the UK. The first published report of the UKVFS was a systematic review of studies,[1] designed to provide a comprehensive picture of research conducted so far with this demographic amongst 5-Eyes alliance countries. This systematic review found there to be a general lack of research conducted with family members of veterans, with only 24 relevant studies identified. The existing body of research with the family members of veterans was found to be largely situated in the US (with only 2 of the 24 studies identified conducted in the UK), often conducted with families who are actively seeking help and have clinical needs, and typically sought to understand family members using quantitative methods.

In a research landscape that is largely focused on the veteran's needs, seeking and relaying the voices of family members and those who support them is essential, especially when the preferences of the veteran and their family members may not always align. This report, the second produced by the UKVFS, aims to address some of these research gaps. It does so by firstly mapping the landscape of psychosocial wellbeing support provisions for family members of veterans across the UK. The mapping exercise was conducted in three sequential stages – a) searches of multiple databases of military and veteran charities and word-of-mouth referrals, b) searches of the web presence of each organisation, and c) searches of the Charity Commissions for England and Wales, Northern Ireland, and Scotland and Companies House websites to determine size, location and structure of each organisation including the size, location and number of organisations actively providing services to this demographic in each of the four nations. Qualitative interviews with family members and service providers across the UK then offered in-depth perspectives on how family members' psychosocial wellbeing needs are currently being supported. Perceptions of accessibility and availability of existing support services, the degree of structure and formality of support services and how support services were meeting un/under met needs and preferences of family members were also explored.

The main findings from this report are summarised in the infographic below. The third and final report from the UKVFS project intends to build on these findings, and the initial report by Armour et al., 2022, by addressing the psychological health and wellbeing of the family members of veterans from a mixed methods perspective. Combining the findings of qualitative interview data from family members and quantitative data from an online survey identifying trends in psychological health and wellbeing, the final report in the UKVFS series will identify and compare the psychosocial drivers of health and wellbeing in UK Armed Forces veteran families, facilitating comparison between cohort groups (veterans, spouses/partners, and adult children) across all four nations of the UK.

[1]*Armour, C., Spikol, E., McClinchey, E., Gribble, R., Murphy, D., & Fear, N. T. (2022). Identifying the Psychosocial Determinants of Psychological Health and Wellbeing of Families of those who have served in the Armed Forces in the 5-Eyes Alliance. A Systematic Review. https://s31949.pcdn.co/wp-content/uploads/Final-UK_Veteran_Family_Study-Report-1-Systematic-Review.pdf*

KEY FINDINGS

Service Availability

A total of 66 organisations were found to be likely or possibly providing psychosocial wellbeing support to the family members of UK veterans:

- England: 17
- Scotland: 2
- Wales: 6
- Northern Ireland: 3
- Nation-wide service: 38

Interviews were conducted with 11 service provider organisations and with 71 family members (20 England, 15 Scotland, 20 Wales, 16 Northern Ireland)

KEY FINDINGS

Service Delivery

Service providers saw themselves as providing vital services outside of the statutory sector. Rather than competing and similar services, providers described delivering unique services not available elsewhere, parallel services complimenting statutory support, or services that were a stopgap for those on statutory waiting lists.

Services differed in their structure and formality, ranging from professionally led, formal mental health support to coffee mornings.

Family members reported a preference for 'soft', informal and indirect support. Smaller, local providers were seen as providing a more personalised and flexible service.

Peer support was also preferred due to shared expertise and lived experience, without the hierarchical relationships of professional involvement.

Family members were often unaware of available services and provider websites were not always explicit about their location, geographical reach, service eligibility, range/duration of services and methods of delivery.

KEY FINDINGS

Service Needs

Structural support needs: *financial, housing and legal support.*

Clinical and non-clinical psychosocial wellbeing needs: *existing mental health conditions, self-worth, self-confidence and relationships.*

Interdependence between structural and psychosocial needs. Complex, multifactorial needs were perceived by some support providers as becoming more common.

Service-related factors influenced the support needs of veteran family members:

- Multiple relocations drove the need to build new relationships
- Stoicism and stigma affected help-seeking
- Prioritising the needs of the veteran over their own.

Reciprocal social needs of veteran family members were vital to wellbeing:

- Needing to develop new relationships outside the family
- Needing to rebuild relationships within the family unit.

KEY FINDINGS

Barriers to Care

STRUCTURAL BARRIERS:

- physical access issues caused by caring responsibilities and immobility
- in-person restrictions related to Covid-19
- a lack of service provisions that met their needs
- a lack of awareness, visibility, and eligibility of existing services
- unequal geographical provisions of in-person services across the four nations.

PSYCHOLOGICAL BARRIERS:

- Lack of trust in service providers
- Stigma around help-seeking influenced by military cultural attitudes
- Veterans discouraging their family member's help-seeking
- Family members prioritising the veteran's needs over their own.

RECOMMENDATIONS

Many aspects of existing services were described by service providers and family members as being done well, however, from the mapping exercise and interviews, it was clear there were some aspects of existing provisions that could be expanded or improved upon. The following overview of the recommendations outlined some of the suggested areas of need that could be addressed in the future. Consideration will be needed in terms of funding and leadership responsibilities across the devolved nations. More detailed recommendations can be found in Table 6.

Table 1. Overview of recommendations

RECOMMENDATIONS FOR SERVICE PROVIDERS

ACCESSIBILITY

Recommendation 1

Hybrid or digital delivery of services to widen access to family members across the UK who experience barriers due to mobility, distance or concerns for their privacy and safety.

Recommendation 2

Expansion of in-person, informal 'soft support' so highly valued by family members to improve UK coverage and ensure equity of accessibility for all family members across the UK.

Recommendation 3

Increase transparency of services regarding eligibility at the point of initial contact or approach.

RECOMMENDATIONS FOR SERVICE PROVIDERS

FACILITATING SERVICE USE

Recommendation 4

Reframe wellbeing services as informal opportunities to connect, learn new skills, and gain confidence rather than as 'support' to reduce stigma and encourage use.

Recommendation 5

Campaigns highlighting the needs of family members so services and family members are aware family members are deserving of support in their own right.

Recommendation 6

Identification, assessment, and provision of wellbeing services to family members that is independent of the veteran.

Recommendation 7

Raise awareness of the needs of family members and the existence of their services amongst other providers such as veteran friendly NHS Trusts, GP practices and local authorities.

Recommendation 8

Explore means of gauging and building trust amongst current and potential users towards larger providers.

RECOMMENDATIONS FOR POLICYMAKERS

ACCESSIBILITY

Recommendation 9

Increase awareness of the Veterans' Gateway amongst family members at the point of transition as another means of searching for wellbeing support.

Recommendation 10

Optimise search functions for family members and non-statutory psychosocial wellbeing support needs in the Veterans' Gateway.

RECOMMENDATIONS FOR RESEARCH

DEVELOPING EVIDENCE-BASED SERVICES

Recommendation 11

Adaptation or development of evidence-based programmes that speak to the unique, multifactorial needs of the family member.

Recommendation 12

Additional research into the experiences of family members during transition and after the serving member has left the military.

Recommendation 13

Additional research to explore geographical dispersal of the families of veterans and how services may be best adapted or developed to meet need and provide support.

RECOMMENDATIONS FOR ALL

Recommendation 14

When communicating with or about family members, language that values individual family members and their needs should be used over language such as 'and their families' that sees family members as additions to the veteran. Viewing family members primarily as conduits of their veteran family member's recovery should be avoided.

FULL REPORT

1.0 Introduction

1.1 Background

1.1.1 The health and psychosocial wellbeing of families of UK veterans

Life within the Armed Forces can pose several challenges for families, from frequent relocation and separation (Drummet et al., 2003; Gribble & Fear, 2022), to combat-related injuries and illnesses (Hisle-Gorman et al., 2019; Solomon et al., 2022). These challenges can continue when families make the transition from the military to a civilian environment. While most personnel do well, some have difficulties in finding employment and adjusting to civilian life (Bergman et al., 2014; Brewer & Herron, 2022). How families manage these challenges has also been shown to impact their psychosocial wellbeing (Fear et al., 2018; Godier-McBard et al., 2021; Gribble et al., 2019; Reed et al., 2014), particularly if they are living with a veteran with a mental or physical injury related to their time in the military (Beks, 2016; Fossey et al., 2019; Heaver et al., 2018; Solomon et al., 2022).

Psychosocial wellbeing refers to a holistic, all-inclusive understanding of health and its influences (Eiroa-Orosa, 2020; Kumar, 2020), acknowledging that psychosocial wellbeing is affected by individual, psychological and societal elements (Inter-Agency Standing Committee (IASC) Global Cluster Working Group and IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2010). Taking a more holistic view of psychosocial wellbeing is warranted given that mental, physical, and social factors are often interconnected, with one or more elements of psychosocial wellbeing being associated with, or influenced, by others (Oster et al., 2017). Research exploring the psychological health and wellbeing of family members of veterans is limited in comparison to that which has been conducted with serving personnel or veterans and the family members of serving personnel. A recent systematic review of 24 studies (Armour et al., 2022) found research conducted with family members of veterans largely focuses on how veteran PTSD affects family members, often from a US perspective, using quantitative methods. There remain gaps in knowledge regarding what comprises psychosocial wellbeing in family members from a holistic, ecological perspective, especially amongst non-clinical, non-help seeking samples of veteran families. Although a comprehensive account of the dimensions that comprise psychosocial wellbeing in the veteran family demographic is beyond the scope of this report, the third UKVFS report is expected to address these aspects in greater depth.

1.1.2 Seeking support for psychosocial wellbeing issues

Given that little is known about what constitutes psychosocial wellbeing in the family members of veterans, it is unsurprising that support preferences regarding these psychosocial needs remains relatively unexplored. The broader literature has mostly centred around the veteran's own experiences of seeking support during and after leaving the military, particularly around physical and mental health issues (Fulton et al., 2019; Rafferty & Stevelink, 2017; Randles & Finnegan, 2022). In a UK context, research exploring the support needs of the family members of veterans has tended to focus on their needs in relation to an issue of the veteran, such as family members who experience domestic violence by a veteran partner (Williamson & Matolcsi, 2019), those whose veteran partner is wounded, injured or sick (Verey et al., 2017) or has substance misuse issues (Lloyd et al., 2020). Two UK studies have identified barriers to family members of veterans accessing support for themselves - logistical barriers such as transport and finance (Murphy et al., 2017) and stigmatising beliefs about seeking help which were more prevalent amongst family members with mental health difficulties (Murphy et al., 2016). Preferences regarding support delivery styles, whereby group support was not always preferred, and for some, acted as a barrier to seeking or maintaining support amongst those who did not feel they could express themselves in these situations has been found by Murphy et al., 2017. Outside of the UK, research has found that connections with peers or 'fellow experts' with shared experiences were valued amongst Australian spouses of veterans with PTSD, whose non-judgemental connections, centred on their shared experiences, were likened to family-like bonds (Outram et al., 2009); support that was practically orientated and personalised towards themselves as partners was similarly valued. These findings mirror those of the broader international research base on serving personnel's family members who were seeking support for their mental health, with barriers such as logistical issues and difficulties in accessing and scheduling appointments (Eaton et al., 2008; Lewy et al., 2014; Schvey et al., 2022), an inability to find professionals who they could trust and could understand military life (Lewy et al., 2014), negative beliefs about mental health care (Schvey et al., 2022), fear of social and occupational consequences and internalised stigma such as feelings of embarrassment or weakness(Eaton et al., 2008; Schvey et al., 2022). Together these findings suggest that concerns about help-seeking may extend beyond a family's time in the military into Civvy street.

A preference towards more family-focused support services has been found amongst serving personnel and veterans (Armour et al., 2017; Khaylis et al., 2011). However, greater family involvement in the veteran's care may not always benefit their family member to the same degree, with greater involvement in their partner's care associated with greater caregiver burden amongst female partners of veterans with PTSD (Manguno-Mire et al., 2007). Seeking insights on the psychosocial wellbeing support needs and preferences from the family member themselves or indeed the service providers who support them, is therefore essential given that veteran and family preferences may not always align.

1.2 Aims and Objectives

Acknowledging the limited research on help-seeking and support preferences of family members of veterans highlights the need for a holistic understanding of psychosocial wellbeing support amongst this population, especially amongst UK service providers and family members. The overarching aim of this report (the second of three reports produced as part of the UKVFS) is to contribute to the evidence base regarding help-seeking and service use among veteran families in the UK. The specific objectives are to explore and understand:

1. What services are currently available for the family members (spouse/partner, adult child) of UK veterans
2. Which aspects of psychosocial wellbeing among the family members of UK veterans do they address and how are they delivered
3. What are the facilitators and barriers to service use of services for psychosocial wellbeing among the family members (spouse/partner, adult child) of UK veterans

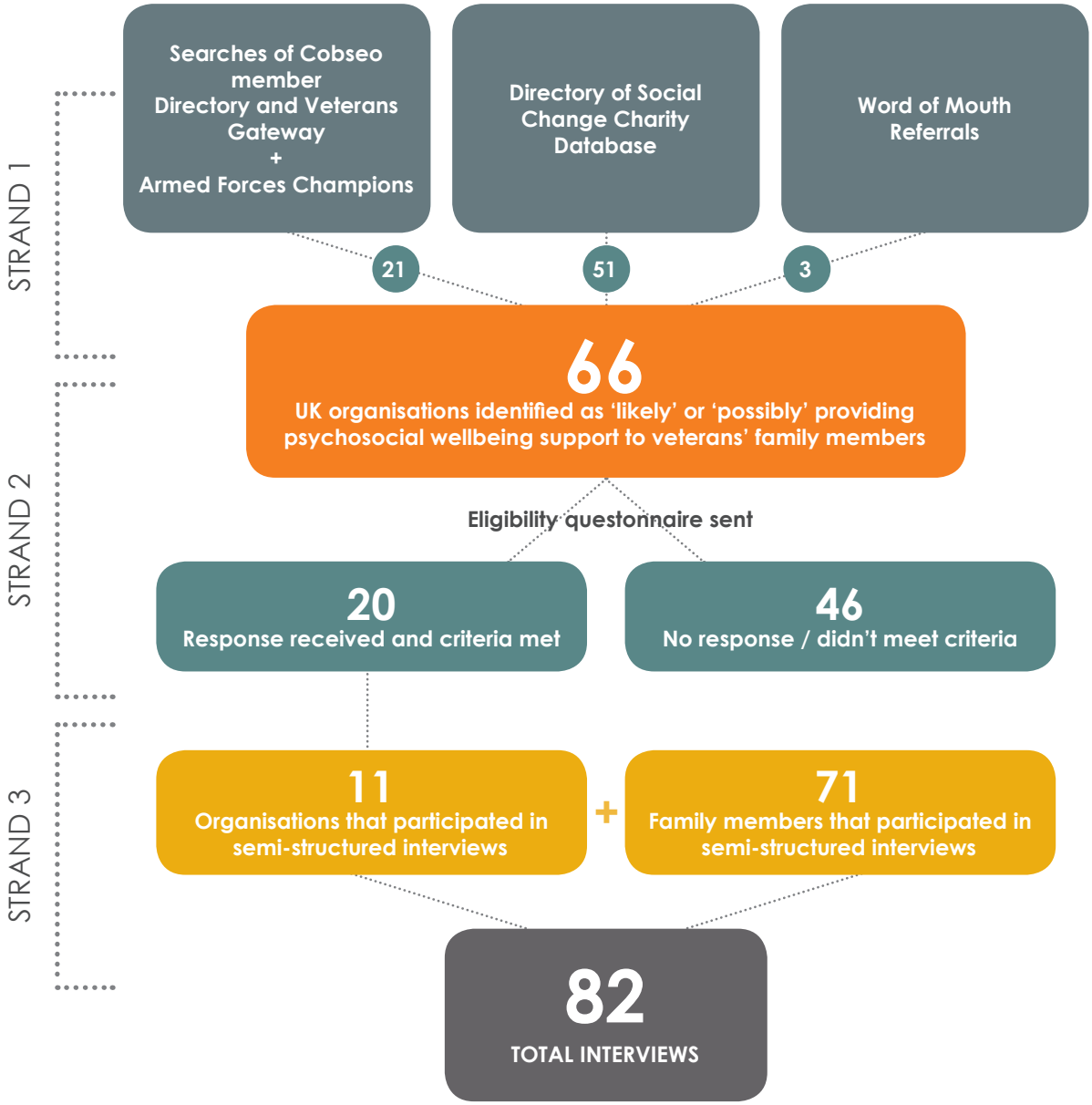
2.0 Methods

2.1 Study Design

To address the above research objectives, a multi-method study design was used, comprised of three distinct strands of research activity (Figure 1):

- Strand 1: a mapping activity of psychosocial wellbeing service provision for family members of veterans
- Strand 2: interviews with representatives from psychosocial wellbeing service provider organisations
- Strand 3: interviews with family members of veterans

Figure 1. Diagram of overall research design



2.2 Strand 1 – Mapping Service Availability

Mapping the availability of psychosocial wellbeing services across the UK was completed by one researcher between March and May 2021. There were three sequential stages – a) searches of multiple databases of military and veteran charities and word-of-mouth referrals, b) searches of the web presence of each organisation, and c) searches of the Charity Commissions for England and Wales, Northern Ireland, and Scotland and Companies House websites to determine size, location and structure of each organisation (see Appendix A for more details).

2.2.1 Database searches and word-of-mouth referrals

A list of 268 charities collated as part of 2021 report: Armed Forces Charities' Support for Families by the Directory of Social Change [DSC] (Cole et al., 2020) was the starting point for the mapping activity. The predetermined keyword limiters of 'families', 'mental health' and 'children' were then applied to the Cobseo Member Directory, and the categories 'families and communities' and 'mental wellbeing' were applied to the list of charities held by the Veterans Gateway.

A list held internally by the Veterans and Families Institute for Military Social Research (VFI) at Anglia Ruskin University of 328 Armed Forces Champions (AFCs) was used to contact each AFC to request information about any psychosocial wellbeing service provisions for the families of veterans within their local authority, including those being provided within the statutory sector. 31 responses were received.

Word-of-mouth referrals by members of the research team and other charitable organisations also contributed to the final list of organisations identified as part of the mapping activity to capture organisations that may not be included in the prior sources.

2.2.2 Web presence searches

Each organisation found on the DSC list, the Cobseo member directory or Veterans Gateway searches or suggested by the AFCs, had its website or social media pages searched to determine if it was 'Likely', 'Possibly' or 'Unlikely' to be providing relevant, psychosocial wellbeing services that were open to the family members of veterans based on the information available online (Table 1). Organisations deemed 'Likely' or 'Possibly' relevant were included in a final list of relevant services.

Table 2. Organisation relevancy criteria (classification & parameters)

'LIKELY' to be providing psychosocial wellbeing support to the family members of veterans	Organisations whose websites explicitly mentioned that their psychosocial wellbeing services were open and accessible to the family members of veterans.
'POSSIBLY' providing psychosocial wellbeing support to the family members of veterans	Services and eligibility for services could not be confidently determined from web presence alone. For example, psychosocial wellbeing services who did not clearly indicate their services were accessible to the family members of veterans, or whose web presence was unclear as to what psychosocial wellbeing services were on offer.
'UNLIKELY' be providing psychosocial wellbeing support to the family members of veterans	Organisations whose web presence indicated that family members of veterans were not eligible to access their services (e.g., whose website indicated their services were for veterans only or family members of serving personnel). Organisations providing purely financial support and grants.

2.2.3 Determining geographical reach and size of each organisation

Each organisation's geographical reach was confirmed via a search of the Charity Commission website[2] for England and Wales, Northern Ireland, or Scotland with which they were registered. Any charities that were not listed as UK-wide on the Charity Commission website had their own webpage cross-referenced in case UK-wide coverage had not been listed. The Companies House website was used to find information on organisations that were registered as Community Interest Companies (CICs) i.e., companies set up with the purpose of achieving social good for community benefit.[3] Organisational income was used as a proxy for size based on the methodology of Cole et. al. (2020) (see Appendix A, Table 7), with each organisation categorised from 'Micro' to 'Large' depending on their income (see Table 2).

2.3 Strand 2 & 3 - Interviews

2.3.1 Interviews with service provider representatives

Organisations identified by the Strand 1 mapping exercise were contacted with four screening questions to determine if the organisation provided mental health psychosocial wellbeing support services for family members intended for their benefit rather than the benefit of the veteran (see Appendix A). Screening also ascertained if support was provided in-house or outsourced to external bodies or agencies. Only those who answered 'yes' to all four questions were invited to take part in the semi-structured interviews. Organisations were then contacted to identify and invite representatives to take part in interviews.

An interview schedule was developed by one research team and refined by members of the larger research team. Interview questions were developed to elicit service provider views on the accessibility and availability of services provided to veteran families, as well as any perceived future needs (see Appendix B) Interviews were conducted between May and August 2021 and transcribed by one researcher. Each organisation was assigned a pseudonymised number (from O1-O11) which was suffixed with the size and location of the organisation (e.g., O11, Small, Wales).

20 of a total of 66 identified organisations responded and confirmed they were providing

Table 3. Service provider demographics

Pseudonymised Participant Code	Geography	Organisation size	Military/civilian focused organisation
O1 Large, UK	UK/Nationwide	Large	Military focused charity
O2 Micro, Wales	Wales	Micro-entity CIC	Military focused CIC
O3 Small, Northern Ireland*	Northern Ireland	Small	Military focused charity
O4 Small, UK	UK/Nationwide	Small	Military focused charity
O5 Large, Scotland	Scotland	Large	Military focused charity
O6 Large, UK	UK/Nationwide	Large	Military focused charity
O7 Small, UK	UK/Nationwide	Small	Military focused charity
O8 Lower Medium, UK	UK/Nationwide	Lower medium	Military focused charity
O9 Upper Medium, UK	UK/Nationwide	Upper medium within a civilian charity	Military family focused scheme
O10 Large, UK	UK/Nationwide	Large	Military focused charity
O11 Small, Wales	Wales	Small	Military focused charity

*NB *two representatives from this organisation participated in a joint interview*

[2]*https://register-of-charities.charitycommission.gov.uk/charity-search; www.charitycommissionni.org.uk/charity-search/?pageNumber=1; www.oscr.org.uk/about-charities/search-the-register/register-search/*
[3]*https://find-and-update.company-information.service.gov.uk/*

relevant support, as determined by a 'yes' answer to all four questions in the screening questionnaire and were contacted for interview. Of these, 12 individuals from 11 organisations consented to take part, with one joint interview (Table 2). All but one of the organisations represented were military focused organisations, with one providing a military family focused scheme within a civilian charity.

2.3.2 Family member interviews

Organisations identified via the mapping exercise (Strand 1) were contacted by the research team via telephone and email to help 'spread the word' about the component exploring help-seeking among family members. This included sharing study flyers and encouraging eligible family members of veterans to take part and contact the research team. Onward sharing of flyers in wider social media and word of mouth referrals captured interest outside of the help-seeking population of veteran families and family interviewees comprised of those who availed of support services as well as those who did not. Eligible family members are described in Table 3:

Spouses/partners

- in co-habiting relationship with someone who served in the UK Armed forces
- currently resident in any of the four nations of the UK
- relationship is ongoing or has exceeded six months

Adult children

- one or both parents were in the UK Armed Forces
- aged 18 years or older
- currently resident in any of the four nations of the UK
- resided in the family home during the period the veteran was in the military and/or during their post-military life for at least six months

**Parents, siblings, and other family members of veterans were not included in this study.*

The interview schedule for family members (Appendix B) was developed by the research team and reviewed and approved by PPI groups comprising one veteran, one spouse/partner and one adult child from each nation. The schedule was designed around the study's broader research objectives of psychosocial determinants of psychosocial wellbeing. This report details participant views and experiences of the accessibility and availability of services provided to veteran families, as well as any perceived future needs.

Interviews were conducted by one researcher between June 2021 and August 2022 who transcribed and anonymised the interviews. Family participants were given a unique ID number to aid the transcription process and to ensure anonymity based on the participant's nation and participant type (e.g., NSIP01 (Northern Ireland Spouse / Intimate Partner 01) and EAC01 (England Adult Child 01). Table 4 provides an overview of the telephone interviews with family members, including a breakdown according to nation and service type. Spouses/partners, of which most were female in heterosexual relationships, are referred to as partners throughout this report. Differences by gender and sexual orientation were explored but were not noted in these analyses.

Table 4. Interviews completed with family members

Nation	Spouses / Partners	Children (18+)	Total
England	10 (Army:7 / RAF:2 / RN:1)	10 (Army:3 / RAF:4 / RN:3)	20
Wales	10 (Army:3 / RAF:2 / RN:5)	10 (Army:4 / RAF:4 / RN:2)	20
Scotland	9 (Army:4 / RAF:2 / RN:3)	6 (Army:4 / RAF:2 / RN:0)	15
Northern Ireland	8 (Army:8 / RAF:0 / RN:0)	8 (Army:7 / RAF:1 / RN:0)	16
			71

**RN includes family members of Royal Navy & Royal Marine veterans*

2.3.3 Combined analyses of interviews with organisational representatives and family members

A hybrid approach to Thematic analysis (Xu & Zammit, 2020) was used by the researchers analysing the data from the interviews. This data was analysed in a way which allowed the final themes, or patterns within the data, to be informed by prior knowledge or theory, in this case, the research objectives and background literature, while also allowing for new categories to emerge from the data that may not have been considered prior. A process of Iterative Collaborative Analysis (Hall et al., 2005) guided the process of inter-institutional collaboration in the development of this report. Collaboration occurred via regular, online meetings between the researchers analysing the data, the wider, the wider cross-institutional team, and the expert advisory group.

2.4 Ethics Approval

All participants in this research gave informed consent before taking part in interviews. Ethics approval was obtained for the three research strands as follows: Strands 1 & 2 - Anglia Ruskin University's School Research Ethics Panel (ESC-SREP-20-215), Strand 3 - Faculty Research Ethics Committee, Queen's University Belfast (EPS 19_284).

3.0 Findings

The findings from the mapping exercise and qualitative interviews are organised according to the following three themes:

3.1 Currently Available Services for Family Members of UK veterans

3.2 Delivery of Psychosocial Support for Family Members of UK Veterans

3.3 Facilitators and Barriers to Service use Among Family Members of UK Veterans

3.1 Currently Available Services for Family Members of UK Veterans

The mapping exercise revealed the geographical spread and size of the organisations who were likely/ possibly providing psychosocial wellbeing support to family members across the four nations. Insights regarding typical structure and funding models, and the collaborative nature of these services with the statutory sector were provided by Armed Forces Champions.

3.1.1 Location and size of organisations

The mapping exercise identified 66 currently available services for the family members of UK veterans. Organisations were typically UK-wide or based in England, with the majority small or medium in size (Figure 2, Table 5).

Figure 2. Map of service availability

Table 5. Organisation size

Organisation size	Income bracket	Number of organisations of this size
Large	£5+ million	10
Upper Medium	£500,000-£5 million	12
Lower Medium	£100,000-£500,000	14
Small	£10,000-£100,000	24
Micro	£0-£10,000	4
Indeterminable	Not listed/unable to access	2

It was not always clear from each organisation's web presence the extent of support provided, who was eligible (e.g., immediate or extended family members of veterans), the precise geographical scope of services (e.g., services that were UK-wide but perhaps only had a physical presence in England), how and when services were being delivered (e.g., online or in-person), or how long services could be accessed for. Therefore, the ability to provide a more comprehensive or detailed map of services throughout the UK was limited.

3.1.2 Structure and funding

As well as location and size, organisational structure and funding models were mapped out. Most organisations (n=63) had charity structures. Two organisations were CICs, and only one was solely operated by the statutory sector/NHS. Responses from Armed Forces Champions highlighted that it was uncommon for psychosocial wellbeing support services for family members to be explicitly set up 'in house' within the statutory sector (e.g., NHS, Local Authority). More typical models of provision centred on support was provided in some way by the statutory sector, yet at a level which was one-step removed. This was usually via funding or joining with existing charitable providers, or by the statutory bodies setting up charities themselves. Examples of these models included:

- A veterans' charity, formed by two local authorities, which applied for and received Armed Forces Covenant Fund Trust funding.
- An Armed Forces Covenant Hub which was initially founded with Armed Forces Covenant funding and has subsequently applied for funding from the Local Authority. It has relationships with the NHS, University, and local military headquarters.
- A veterans community hub which was set up by a Local Authority and a social enterprise. The Local Authority funds at least one post within the hub.
- Funding of posts within existing Local Authority infrastructure – e.g., Armed Forces coordinator roles.
- An Integrated Care Board (ICB) which has provided funding to an existing veterans charity.
- Local authority partnerships with other public, private and charitable organisations. An example being an Armed Forces Covenant partnership of four local authorities who have an information sharing agreement regarding their veteran populations, including local NHS, criminal justice and voluntary sector organisations.

Summary – Mapping Available Services

- 66 organisations were found to be likely or possibly providing psychosocial wellbeing support to the family members of veterans across the UK.
- Service providers websites were not always explicit about their location, their geographical reach, who was eligible to access their services, what services were available (and for how long) and the methods of delivery.
- Most psychosocial wellbeing support was provided within the charitable sector, often facilitated by co-operation, partnerships, and funding from the statutory sector.

3.2 Delivery of Psychosocial Support for the Family Members of UK Veterans

Interviews with service providers and family members described that a range of psychosocial wellbeing services were being provided in the sector, from formal, professionally led interventions such as counselling, to more informal offerings such as coffee mornings. Family members commonly shared a preference for the most informal, least structured styles of support delivery. Service providers saw themselves as providing important services separate to what was available in the statutory sector – 'unmet needs' were described as being addressed through the provision of novel services not available elsewhere, while under-met needs were attended to by services providing interim services to those on waiting lists or who needed additional help alongside statutory support. Service providers explained how their services attended to multiple aspects of psychosocial wellbeing from structural support (e.g., financial and legal support) to individual needs such as self-worth, self-confidence and relationship building – within and outside of the veteran family unit.

3.2.1 Formality vs Informality

3.2.1.1 Spectrum of formality in service provision

Interviews with service providers identified six broad categories of psychosocial wellbeing programmes that were being offered to family members throughout the UK. These categories existed across a spectrum according to the degree of formality, authority, and directness of the intervention (Figure 3). At one end, formalised and direct mental health and/or psychosocial wellbeing interventions from authoritative sources were found. Mental health services that were providing evidence based, professional led support and had received accreditation from the Royal College of Psychiatrist's Quality Network for Veterans Mental Health Services (Royal College of Psychiatrists [RCPsych], 2022) would fall into this most formal category. Semi-formal activities which allowed for support to be delivered by peers with more equal power relations yet retained a degree of input and facilitation from service providers were positioned in the middle

Figure 3. Spectrum of available psychological wellbeing services

SPECTRUM OF FORMALITY

Most formal, most direct, most authorititave

Formal/structured/mental health support

- Counselling services (including bereavement support, relationship and family counselling)
- Human Givens Therapy for PTSD
- Formal advice re: housing, finances and law
- Talking therapy based on Cognitive Behavioural Therapy (CBT) - including high-intensity CBT
- Welfare advice e.g. welfare support and independent living advisors
- Courses including mental health awareness training, supporting someone with PTSD, mental health first aid
- Online mindfulness

Semi-formal direct wellbeing interventions, less authorititave

Emotional and practical support groups

- Peer support groups
- Peer support - advice sharing
- Support groups - bereaved families through suicide (peer to peer)
- Community groups e.g. mental health support, employment
- Wellbeing check-in

Befriending, mentoring and buddying

- Mentoring services and buddying schemes
- Telephone friendship

Least formal, least direct, least authorititave

Outdoor and physical activities

- Walking groups
- Outdoor activity including: Chainsaw courses, community payback and gardening schemes, nature walks, rewilding programmes, beekeeping
- Children's woodland activities and bushcraft
- Children's mud kitchens and tree house building
- Equine therapy
- Fishing
- Physical activity sessions and days including kayaking
- Family fun days

Arts based activities

- Theatre skills
- Sewing and crochet
- Creative writing
- Art/craft
- Photography
- Genealogy
- Calligraphy
- Flower arranging
- Shared interest groups e.g. film club
- Drawing

Food and drink

- Coffee mornings
- Meals on wheels
- 'Packed Lunches' partner and children lunches
- Ukulele

of the formality spectrum. At the least formal end of the spectrum, indirect 'soft' psychosocial wellbeing support programmes were positioned. Psychosocial wellbeing improvements here were sometimes occurring more naturally as a by-product of engagement with social activities rather than because of direct, formalised interventions.

3.2.1.2 Families' support preferences

Families described a range of different support types that they valued as beneficial across the spectrum of formality. Towards the formal end for example, practitioner led psychotherapy, requiring adherence to standardised procedures was found to be successful. Similarly, structured tasks recommended in counselling as effective means of learning more positive ways to cope together as a family unit were welcomed.

> *"I had EMDR which has been life changing for me. Before that I wasn't able to have a normal relationship… [I] could not commit on any emotional level because I didn't have the capacity to. It has helped me so much" (NSIP03).*

However, the limitations of structured support such as counselling were also recognised by families. Although described as valuable in certain circumstances, formal and structured support methods were not always viewed as sufficient in addressing more in-depth family support needs, nor were they favoured by everyone. Some family members found the formal structure associated with counselling unappealing. Indeed, several explained how they struggled to connect with psychosocial wellbeing therapies that required set formats and taking direction from professionals.

> *"Don't get me wrong. I mean, let's not throw the baby out with the bathwater. Counselling can be very beneficial… veteran families need more than that" (SAC04).*

> *"My missus wants me to go to counselling and sit down with a professional and work through my problems. That does not appeal to me in the slightest, that formal treatment where you have to sit and talk about stuff. It's just so awkward and not for me" (NAC03).*

Partners and adult children who were interviewed placed a large amount of importance on support delivery method, indicating a strong preference for supports towards the least formal, less direct, less authoritative end of the spectrum in Figure 3. Family member participants unanimously endorsed what they described as 'soft' or gentle supports with minimal structure as a preferred method of provision, delivered in relaxed settings, often over fun activities with no obligation to participate.

> *"it needs to be soft support, the kind that might involve engaging over activities" (NAC03)*

> *"It was nothing formal like 'Oh let's sit down and you tell me your problems'... I just went in, and she made me a cup of tea and we chatted about the weather and gardening. I met some other people from military families, and everyone was so friendly ... It kind of made me feel more confident in myself and that this place and these people really could do something for me. It did." (WSIP04).*

In addition to informality, family members expressed appreciation in getting to know other service users and spoke about developing supportive peer friendships that emerged organically following their engagement with an organisation due to shared experiences. Related to this was a preference for the support service to be staffed by people with experience of military life due to their lived experiences.

> *"The comradery that I have experienced in my friends here, who have experienced similar things to me. That is invaluable... because in a formal capacity, they often haven't walked the walk of the military family and all the fine nuances that that entails" (EAC04).*

> *"Finding people who have gone through similar experiences to you is like a big cloud being lifted… People who haven't experienced that military way of life can't relate the same way... We have a shared experience and that in itself is very supportive. So, the staff in [name of organisation] all have a military connection" (WAC07).*

Despite the benefits of, and preferences towards, informality and peer support, providers explained how some form of facilitation of these groups by non-peers was important due to the potential for groups to focus on their negative shared experiences, potentially compounding the challenges family members may be experiencing.

> *"They encourage you to talk about your problems and your mental health, which then can ruminate in a room with people and then you're all talking about something negative, and then you will all leave there with that in your head… [we're] trying to flip the coin on that. You come there, you talk to your friends, you have good positive conversations" (O2, Micro, Wales).*

> *"I think support groups are useful where veteran partners can hear about a range of experiences. Any Facebook groups that I have found so far have been places where people just complain…to each other but nothing improves for anyone" (WSIP03).*

3.2.2 Serving unmet needs

Many of the service providers, aware of family member preferences for 'soft' and peer support services, were keen to stress a distinction between their provisions and what was available from traditional/medical/statutory mental health and psychosocial wellbeing services outside of the charitable sector. Distancing their services from medicalised and authoritative labels such as 'therapy' was noted amongst some of the 'softer' service providers, despite recognition amongst the majority that there were positive therapeutic outcomes of their services.

> *"We're not therapists…but it clearly has therapeutic consequences" (O6, Large, UK).*

> *"They are getting support outside of that more formal support like counselling and stuff that they [statutory / medical services] offer. So, in addition to that they are getting that quiet place and that more informal and social support in complement" (WAC05).*

Even amongst those who were providing 'traditional'/formal types of support there was an acknowledgement amongst providers that their psychosocial wellbeing services were not seeking to encroach upon the territory of existing traditional, medical, or statutory services provisions. Instead, psychosocial wellbeing service providers generally saw themselves occupying a separate territory providing for unmet needs that were not being otherwise addressed. Service providers therefore tended to position their psychosocial wellbeing provisions as either:

1. A filler or interim service for those on waiting lists, unable to access other statutory services, or whose needs remained under-met by their current therapies.
2. An alternative service for those who were not satisfied or did not see improvements with other services, or where the alternative services provided a model of psychosocial wellbeing provisions for the military family that was unique and unavailable elsewhere.

3.2.2.1 Filler or interim service

There was an acknowledgement among the service providers that mental health and psychosocial wellbeing services provided by the statutory sector, such as counselling and cognitive behavioural therapy (CBT), were known for having long waiting lists. Wait times were perceived by some service providers as worsening due to COVID-19 backlogs and increased mental health issues in the general population.

> *"So, the idea from the NHS side is there's a 6 to 8 month waiting list now, caused by COVID" (O2, Micro, Wales).*

> *"The waiting list on other services is just sky high, especially at the moment with the increase in mental health difficulties" (O9, Upper Medium, UK).*

One of the advantages of services for family members of veterans reported by service providers was their perceived, comparatively shorter, waiting lists for similar traditional services such as counselling. Having parallel services in the military psychosocial wellbeing space allowed them to provide psychosocial wellbeing support interventions more quickly in the interim to those who were languishing on statutory support service waiting lists as a means of 'bridging the gap' (O8, Lower Medium, UK). Being able to provide a more immediate response was seen as important not only to assist engagement with the services offered, but to avoid worsening the issues which family members had originally sought help for.

> *"They all want to be able to help so… somewhere where they can send them because they've nowhere to go in between their therapies" (O3, Small, Northern Ireland).*

> *"If you are waiting six months for support…in that time things can progressively get worse. So, the quicker the service is, the more likely they are to get help and to stick with it as well because they feel heard" (O9, Upper Medium, UK).*

The importance of early support was also recognised by families. The implications of not having access to interim support were, for some, an exacerbation of symptoms and distress for both family members and veterans.

> *"He had his initial assessment but then unfortunately, they said he would have to wait 6 – 8 months to get treatment. But that first assessment session, it opened up all these boxes that had been closed. And then I was forced to deal with all these boxes without any support, without any guidance of how to help someone who is very confused and sad and depressed and angry. And I was very angry. I felt like there was just no support for him, or for me. I would have liked some support during that waiting period" (WSIP03).*

The type of psychosocial wellbeing support offered by service providers did not necessarily have to be of a similar kind to that which an individual was on a waiting list for it to have a positive impact. Some providers and family members described how the informal support provided or received during the wait for more formal services generated sufficient improvements such that the statutory support they were waiting for was no longer needed.

> *"To find that… for the majority that's enough, and that takes them off the waiting list then. And they can get that support continuously at the hub" (O2, Micro, Wales)*

> *"So, because I have this support now, I don't feel that I need statutory services anymore" (EAC04).*

3.2.2.2 Alternative provisions

Service providers were keen to emphasise their services were not designed as replacements for the statutory support services which "people should always start with" (O5, Large, Scotland), yet dissatisfaction with statutory services, other charities and private providers was reportedly a reason for family members to seek alternatives.

> *"It wasn't that you know that type therapy didn't quite work for them, so they're looking for something else" (O6, Large, UK).*

As well as unmet need, some of the service providers described how they positioned themselves as pioneers in the type of psychosocial wellbeing services they provided, with a unique offering that ordinarily would not be available to the veteran family demographic, especially within the statutory sector. The perceived originality of their psychosocial wellbeing programmes was often grounded in their proximity and accessibility of services, a style/ modality of delivery, a therapy/intervention, or a novel underlying philosophy or approach to the psychosocial wellbeing of family members that was not often found elsewhere.

> *"We include the families and carers and children. That's one of our strengths" (O2, Micro, Wales).*

> *"[Larger organisation], they are needed to signpost beneficiaries [and]…address their needs…we are there to provide this creative platform" (O6, Large, UK).*

Larger charities were sometimes used as a frame of reference by smaller charities as a means of highlighting the uniqueness of their own provisions. One of the benefits of being a smaller psychosocial wellbeing organisation was that provisions could be highly responsive and flexible to current needs, feedback could be acted upon in real time, and services tailored and personalised accordingly.

> *"We've had people who've gone to [larger, national charities]. They're fantastic organisations in themselves. However, they don't work for everybody. I think some people find them very prescriptive. Whereas we… soften it and it's because we're smaller we have the luxury of being able to do [so]" (O4, Small, UK).*

Having access to alternative wellbeing provisions was particularly poignant for participants in Northern Ireland. Enduring issues relating to secrecy and perceived security meant that veteran families felt restricted about the support they could access, in both the statutory as well as voluntary sectors. Veteran organisations in Northern Ireland were seen as protected places by family members, and the only spaces where families could discuss their experiences safely.

> *"We still live in secrecy and can't tell everyone and anyone about our military connection. Even the GP or the dentist. It took me a while to tell my GP about my past" (NAC07).*

> *"Anywhere else, any other community groups that aren't specifically veteran related can't support the way [this organisation] can. Because when someone asks you 'oh what did you do before you retired?' you can't tell them in this part of the world. Living in Northern Ireland means that you have to keep quiet about any army connections. So, in [this organisation] they feel completely and utterly safe to do so" (NAC01).*

The length of time that the 'softer' psychosocial wellbeing services were engaging with family members was also providing an alternative form of support that was seldom being addressed by formal interventions. Short term formal interventions (commonly six sessions) were sometimes perceived as inadequate in addressing the psychosocial wellbeing needs that family members often had. The continuous informal support offered by several organisations with no official end point or conclusion were fulfilling the longer term needs for these family members.

> *"This is this is another problem that I've recognized is there's a lot of support out there but is 6 sessions 10 sessions. It's very small and you know is quick fix, putting a plaster on a wound" (O2, Micro, Wales).*

> *"[Families] need to feel ongoing love and support of a community of likeminded people with similar connections to military life… That supports needs to be available to veteran families on a lifelong basis" (SAC04).*

3.2.2.3 Underpinning models and philosophies

Most providers did not specify that the service they provided was modelled upon explicit guidance, evidence-based research, or theory. Some appeared to be utilising interventions and mechanisms of action mirroring commonly used non-military psychosocial wellbeing programmes, without explicitly labelling them as such. This included 'intergenerational activities' incorporating the children and grandchildren of veterans into mixed generation activities, 'social prescribing' with GP referrals or other professionals referring family members into their programmes, or 'arts' or 'nature/eco' therapies used art-based or outdoor activities for the purpose of improving psychosocial wellbeing.

> *"We are outdoors, getting you know, therapy, nature-on-prescription for want of a better word" (O4, Small, UK).*

Outdoor, social, and art-based activities were cited by several family members as having multiple perceived benefits. Not only did family members enjoy the health benefits of outdoor activities, but they also appreciated the relaxed, supportive, and distracting environments of being in nature alongside others. This was especially common among family members in Wales, where such activities were commonplace and described as the 'Wales' model of service provision.

> *"More support for the Wales model is needed. The model that harnesses nature as the greatest healing power there is" (WAC10).*

> *"I open up better over a shared activity like a walk or a cycle or something. You get to know people with similar issues and if you want to talk about stuff and help each other, you can. It happens more naturally than in counselling and I like it better that way. I need time to get to know people before I open up. And as well as that, nature is a healer, so getting out and about really helps lay the foundation for self-help in groups" (WAC03).*

Service providers and family members alike recognised that the psychosocial wellbeing of family members and the veteran were interconnected. However, approaching veterans' family psychosocial wellbeing in such a way was considered to be a rarity by some service providers and family members, with a tendency of services to provide primarily for the individual veteran separately from their family members and the family units of which they were a part.

> *"We treat the veteran and the family as a singular unit and this is what we're trying to pioneer and encourage other organisations to do" (O2, Micro, Wales).*

> *"When the veteran leaves [the military] there are changes for the whole family. For the individuals, your whole world changes and it can be a massive difficulty to function in the civilian world. So, the service needs to take the whole family in hand and looks after them" (EAC08).*

Nevertheless, a family-unit approach towards services was not always viewed as the most appropriate model for family members. Some organisations and family members recognised that family members may need psychosocial wellbeing services that provided respite for family members away from the veteran or focused on the individual family member, separate to the veteran.

> *"We offer a space for the families where they can get a space away from the veteran. Sometimes the families don't want to share things in front of the veteran because they don't want to hurt him. But they still need an outlet and that's what we offer too" (WAC07).*

> *"My husband got all the support and the spouse, having made many sacrifices, was just kind of like floating around saying 'Well, what about me? What about my needs. My education has suffered. My employment has suffered. My relationships have suffered. What is your responsibility to me now?" (ESIP03).*

3.2.3 Aspects of psychosocial wellbeing addressed

Several aspects of family member psychosocial wellbeing were described as being positively transformed because of engagement with service provisions. These included structural support needs (e.g., financial) and individual psychosocial wellbeing needs such as mental health, self-worth, self-confidence and relationships and the interplay between them.

3.2.3.1 Structural support and wider psychosocial wellbeing

Amongst the service providers, partners and adult children interviewed, there was a recognised connection between the structural aspects of psychosocial wellbeing such as finances, housing, employment and legal issues, and the broader psychosocial wellbeing of veterans and their family members. Support for structural issues was provided in recognition of the benefits it may have on other relational and mental health issues.

> *"The benefits of employment are huge and it's not just about the salary, it's about the social aspects of going to work, you know, engaging with people and the like" (O5, Large, Scotland).*

> *"Everything changes when you aren't working and have to stay at home. You are no longer the sharp-minded person that you once were when you were working… this has knock-on effects on esteem and confidence" (WAC01).*

Financial support, whilst welcome by the families, was often given at crisis points, leaving many feeling ashamed of the situations they had found themselves in. For some, while financial support for essential items was appreciated, it was not until they approached another organisation delivering other aspects of psychosocial wellbeing provision, that the participant felt the most valued support:

> *"They helped us out with £500 to buy a stove... We felt like charity cases and that's not fair, not after the sacrifices he made and the rest of the family as well. It wasn't until I joined [name of organisation] in 2015 we were able to access. counselling and help... they literally saved my life" (NSIP01).*

The interconnected nature of mental health, structural factors, and other aspects of psychosocial wellbeing was also reflected in the some of the complex cases discussed by service providers. These included family members experiencing multiple aspects of disadvantages in several areas such as poor accommodation, debts, poor relationships, and mental health issues. One national service provider believed that such instances were becoming more frequent, with each case taking longer to resolve.

> *"The needs are becoming much more complex. That's something that we're really seeing. Some cases are taking much longer for us to deal with because of the complexity of them and because… people present with one need, but there's five or six other needs that are in addition to that, that they're, you know, maybe they're not flagging" (O10, Large, UK).*

3.2.3.2 Individual, psychosocial wellbeing needs of the family member

Alongside the support for existing mental health conditions that psychosocial wellbeing services were providing, other non-clinical psychosocial needs were described as being positively altered as a consequence of family member engagement with psychosocial wellbeing services.

3.2.3.2.1 Self-worth, identity and self-confidence

Service provider and family members explained how they were attuned to the fact that the building of self-worth and value amongst individual family members was both a need, and a positive outcome achieved through engagement with the psychosocial wellbeing services. A loss of self-worth and individual identity was noted amongst family members of veterans, with and without PTSD. Organisations were described as providing an outlet for family members to reflect on their own situations and gain support.

> *"Your individual sense of person is completely taken away when you marry someone in the military. When your doctor is only interested in what your husband's name and number is... Everything you do, everything you are is all tied up in your husband's identity as a member of the Armed Forces" (WSIP09).*

> *"You're absorbing everything that your partner is throwing out and it's bad for your own mental health and you need a way of dispersing that or it becomes really toxic for you… So, peer support [in this organisation] helps you to not feel so isolated. I mean people with PTSD are so bloody moody and it really does exhaust you so, an outlet and talking really helps" (ESIP10).*

One of the means of building self-worth and meaning amongst individuals in psychosocial wellbeing services was through participatory empowerment, i.e., where family members could engage in activities that were often of value to others. One service provider gave an example of veteran widows who were accessing a veterans' hub and volunteering to help with the activities for the other veterans' children. These interactions were not just considered to alleviate the loneliness and isolation of the older widows but served to provide them a feeling of enjoyment and a sense of purpose. Deriving meaning and worth from peer support and helping other family members with similar circumstances was also noted amongst family members themselves as beneficial to both parties.

> *"You can say well, I built that, or I did that and then the self-esteem and self-worth of knowing that others will follow you and use the space that you provided" (O4, Small, UK).*

> *"These women think they are to blame for their husband's behaviour... That's what I used to do… I've done talks all over the country about living with PTSD … I am doing something useful, by helping other women in the same boat to realise that it's not their fault and helping them develop ways of looking after their own psychosocial wellbeing through all this" (NSIP04).*

Like self-worth, self-confidence it was spoken about as a characteristic that was lacking amongst family members who were seeking support but was being positively cultivated as a consequence of interacting with psychosocial wellbeing services. Service providers discussed providing support, information and skills that deliberately sought to empower recipients to "approach the world" with greater confidence. Assisting individuals and equipping them with the knowledge of how to address issues themselves were empowering acts, improving self-confidence and hence psychosocial wellbeing.

"It kind of made me feel more confident in myself and that this place and these people really could do something for me. It did" (WSIP04).

"And you know what we what we hope…is that… having more knowledge, having more information about your situation would lead to being more confident and more you know, feel more able to… deal with things which we hope would improve wellbeing" (O1, Large, UK).

3.2.3.2.2 Relationship building and cultivating a space outside of the veteran family unit

Another key area of psychosocial wellbeing discussed was relationship building – both within and outside the family unit. A lack of meaningful relationships outside of the family unit was considered to be a common reason for family members accessing psychosocial wellbeing services. This was often attributed, at least partially, to living within the military community. A loss of social network upon leaving the military or a lack of longstanding friendships due to frequent relocations during their time in the military were given as reasons for veteran families' desire for support with relationship building outside of their family unit.

"So, you know you join the army… they've moved different places every couple of years. Different country, different area, and that's the same for the partners as well" (O2, Micro, Wales).

"I mean obviously moving schools is difficult and so I think it becomes difficult to make friends I think because you know you are going to move in a couple of years. So that did sort of impact on me when I was younger. I think long term it really affected me" (SAC01).

A loss of friendships was also noted due to the behaviour of veterans with PTSD. This issue particularly highlighted a lack of understanding from non-military experienced friends:

"It affects my friendships as well because he has had episodes when we have been with other people when he has starting shouting and smashing things off the wall. And my friends are like 'why the hell are you staying with him?' because they don't understand what is going on with him. He a terrified child and I'm his only safe person. So, we tend not to spend time with friends" (ESIP07).

Service providers and family members described how accessing services for families of veterans could address these feelings of isolation and/or lack of self-confidence in family members through the connections formed with other attendees of these services.

"One of the biggest issues [for coming to the service] is friends" (O2, Micro, Wales).

"I'm involved in [name of organisation] in Wales and they just connect you with like-minded people and it builds your confidence" [WAC03].

The desire for family members to recreate the communal support system they experienced during their time as a military family was evident in the interviews with partners and adult children. Organisations that attempted to recreate this communal spirit were therefore highly valued in this regard, especially in Northern Ireland where families described feeling isolated and cut off from interacting socially in the community due to perceived ongoing security issues. Feeling able to relax in a trusted environment with others from military backgrounds was remarked upon as extremely valuable, with some participants explaining how the organisation was their only outlet to socialise.

"The navy community was very supportive… a real communal place and I always felt safe and happy growing up there… I think if more support organisations could recreate that community spirit, that culture of belonging and knowing people care about you, it would be a godsend for veterans' families" (WAC02).

"[I have] somewhere to go a socialise now. And I don't have to be secretive about my past when I am socialising with the other members because we are all in the same boat in terms of our history in the army… most of my friends are there" (NSIP01).

Building new relationships was sometimes achieved subtly amongst users, independent of any interference or structured intervention from the service itself. In these cases, the service merely providing the social context where friendships could happen naturally amongst their users because of participation in the shared social activities put on by the psychosocial wellbeing services. In some instances, providers discussed how they felt the relationships created through people meeting at their service meant that they had served their purpose and the users' need for continued engagement with the services ceased to exist.

> *"While they're watching the kids there chatting to the other veterans' families, and they the sort of making friends without realising it, you know, and that's what [we're] encouraging" (O2, Micro, Wales).*

> *"They catch up for coffee outside and they're now building friendships and networks where they support themselves when they're not with us" (O4, Small, UK).*

3.2.3.2.3 Rebuilding veteran family relationships

Alongside the need to connect with the community and others outside of their family unit, individuals often presented with relationship needs within their own families. Relationship breakdown in veteran families was thought of by one service provider as 'very common in the veterans' community' (O2, Micro, Wales). The rejection by a loved one was identified as a source of distress following a relationship breakdown amongst veterans and their family members. This was sometimes triggered by a veteran in crisis, with resolution often directed by the family member.

> *"It is usually the partner that is trying to, how can I say, redress those and regain some stability within the, you know, within the family unit, bringing Dad back if you like" (O11, Small, Wales).*

> *"I told him then one day when he wouldn't get out of bed that if he carried on like this I was leaving" (ESIP09).*

The psychosocial wellbeing providers who were cognisant of the need to rebuild fraught relationships within veteran families explained how they attempted to address these issues by providing family-unit (rather than individual) focused activities and relational-focused interventions. This often occurred in tandem with providing or signposting to other interventions which could address the related causes and effects of the relationship issues.

> *"Our main approach… I would say would be relational really… building up that relationship with somebody and working on their [own] relationships as well, because that's hugely important for families" (O9, Upper Medium, UK).*

Akin to the mechanism of friendship building noted outside of the family unit, relationship building within families was also described by providers and family members as occurring naturally because of participation in other activities. For example, whilst outdoor activities could be beneficial in their own right for the psychosocial wellbeing needs of families and children, they also provided a relaxed context in which talking and connection could happen more freely, and less obviously.

> *"You know you can't really sit kids in a room or the classroom get them to talk, but in outdoor activities like wild camping and how to light a fire, let's go and explore leaves trees, birds etc. and that sort of thing you can get young people to start to engage and talk about their issues" (O11, Small, Wales).*

> *"You need to help veterans and their families create their own support groups. Likeminded people can help each other much better than putting them in a room with a table and a doctor… But it needs to be soft support, the kind that might involve engaging over activities… Then they start to talk to each other about their common issues and in that informal way become supports for each other" (NAC03).*

Summary – Delivery of Psychosocial Wellbeing Support

- Wellbeing services ranged from the most formal, structured services mirroring those of the statutory sector, to those with the least professional input, such as coffee mornings.
- Whilst recognising the value of practitioner led therapies, there was a strong preference for informal, non-hierarchical, indirect, and outdoor psychosocial wellbeing support over formalised, professional-led interventions amongst family members. Positive outcomes were not always the intended outcomes of such services, instead they were achieved more subtly, as an indirect consequence of engaging with some of the activities and services.
- Peer support provisions and services staffed with those who had shared experiences of military and veteran family life were highly valued by family members. This allowed for expertise to be shared and lived experience recognised, without the hierarchical relationships that may come with professional involvement.
- Service providers saw themselves as providing vital services outside of statutory sector. Rather than offering competing and similar services, providers positioned themselves to deliver unique services not available elsewhere, parallel services complimenting statutory support, or a stopgap for those on statutory waiting lists.
- Multiple aspects of psychosocial wellbeing were being identified as needs among veteran family members and addressed via services. These included structural support (finance, housing, and legal advice), mental health, psychological wellbeing such as self-worth and self-confidence, and relationship building both within and outside the family unit. Military life, in particular multiple historic relocations, was seen as a contributing factor in some family members lacking social connections although aspects of psychosocial wellbeing.

3.3. Facilitators and Barriers to Service Use Among the Family Members of UK Veterans

The following section attends to how psychosocial wellbeing services were accessed by family members from the perspectives of veterans' partner, adult children and the service providers who support them. The multiple pathways into services will first be discussed, followed by the physical and psychological barriers that were found to prevent access amongst the family members of veterans. Lastly, how services are provided amid a wider landscape of consistent demand, societal upheaval caused by COVID-19 restrictions, and anticipated future demographic changes will be considered.

3.3.1 Facilitating pathways into service

There were multiple routes through which family members came to access services. Targeted campaigns, individual self-referrals, referrals from healthcare professionals, referrals from associated organisations, word-of-mouth recommendations from other users and opportunistic referrals (i.e., diverting individuals to services after they had enquired about another matter) were all reported by service providers to facilitate entry into their psychosocial wellbeing services. Trust in the efficacy and the values of the organisation facilitated inter-organisational referrals.

3.3.1.1 Provider-directed efforts to reach and support family members

Organisations of all sizes were using social media to increase the visibility of their services and directly reach individual family members. Strategies such as traditional advertising (e.g., print and media campaigns), were also being used by larger service providers.

> *"We have a good social media presence" (O4, Small, UK).*

> *"We do limited sorts of marketing and advertising" (O1, Large, UK).*

Inter-organisational collaboration via signposting, referrals and partnerships connected family members with the services most relevant to their needs. Referrals were taken from statutory services, including mental health providers, GPs, and social workers. Additionally, referrals came via the community. Members of Parliament and community engagement workers who were positioned within some organisations with the explicit role of connecting with potential service users in the community, were also vital in connecting family members with the support they required. For family members who were harder to reach via the organisations' active recruitment efforts, self-referrals and associated organisations were the remaining routes available to family members requiring support.

> *"The community engagement workers…are really pivotal in getting people to come to us" (O1, Large, UK).*

> *"It's the other families that don't access or the military charities are kind of difficult to get to, so for us, kind of we just have to wait for them to refer themselves to us or get a professional to refer them" (O9, Upper Medium, UK).*

Service providers, in Wales in particular, discussed the importance of growing and maintaining relationships within statutory and other voluntary organisations to maximise social capital for the benefit of veteran families. Supports outside the remit of their own service, were often sourced elsewhere, via developed networks and collaborative working with other organisations. Close working relationships between organisations supported increased knowledge of each other's service remit, leading to reciprocal referrals to the benefit of the family member. Inter-organisational Trust was stressed as an essential component in referrals occurring between service providers.

> *"Veteran NHS Wales… are supportive... We all know each other, and the people are very dedicated… and [we] have great working relationships and that makes it easier to make a phone call and ask for help from another organisation who we think might have something the family can benefit from" (WSIP10, also an organisation representative).*

> *"Is it about working together. But… only… with the ones with the right ethics and the right ethos" (O2, Micro, Wales).*

3.3.1.2 Accidental/opportunistic referrals

Active help-seeking by an individual family member, acting in response to an active campaign or seeking help independently of it, was one of the main routes through which family members accessed services.

> *"I found out about this place on the internet. I had a chat with one of the organisers on the phone and she invited me in to have a look around" (WSIP04).*

However, the identification of family members as a result of them presenting for other services was another valuable method of connecting them with appropriate service provisions. Sometimes an individual help seeker was not always intentionally looking for psychosocial wellbeing service provisions, or a particular service provider, but found these accidentally when using the internet for general information and/or support for the issue they were seeking assistance with.

> *"They Google help or distress or PTSD and find us" (O8, Lower Medium, UK).*

> *"Then we found [name of organisation] which has been a great deal of support to us actually. He actually went there because I was looking for a placement for my uni course and he happened to find it. It is on our doorstep, and we didn't know it existed" (WAC07).*

Other opportunistic referrals were facilitated by service providers who would discover unknown or unmet needs amongst family members actively looking for help for something else – either another issue or support for their veteran family member. The active method of 'scooping up' family members and extending offers of psychosocial wellbeing support to those whose needs were not immediately obvious was therefore another important method in connecting family members with the appropriate psychosocial wellbeing support provisions.

> *"We tend to scoop up everyone else because they come contacting us looking for support for the veteran. So that might be financial support. Or you know benefits support, advocacy, one of our other services" (O1, Large, UK).*

3.3.1.3 Peer referrals

Word-of-mouth referrals were important ways of connecting family members with the relevant psychosocial support services. Individuals not only heard of the existence of services this way but became aware of users who had been positively transformed by these services, hence legitimising their value, acting as a conduit for others into these services. In some instances, family members learned about the service from their veteran partner and were encouraged to attend.

> *"They usually see the wife or partner, mum, starting to come through the door as well wanting to know what's going on because there seems to be a positive input you know at home and then she becomes involved" (O11, Small, Wales).*

> *"When [veteran spouse] joined the charity, he encouraged me to go on a few outings. That's how I came to join too" (NSIP07).*

3.3.2 Barriers preventing access to services

Family members faced multiple barriers in their journey to accessing appropriate psychosocial wellbeing support. These included structural and physical barriers such as service capacity, availability, and travel capabilities, and psychological and behavioural barriers such as trust, stigma, and a lack of awareness of their own needs. The veteran was also identified as a barrier to their family members accessing relevant support, either due to the family members prioritising the veteran's needs above their own, or veterans obstructing the path to help-seeking amongst their family members.

3.3.2.1 Structural and physical barriers

There were general barriers to access which applied to family members as they did to the veteran users of services including transport and accessibility of physical venues (especially for the psychosocial wellbeing services in rural locations) and technological barriers to accessing online psychosocial wellbeing provisions. Although the extent of cross-border availability and hence accessibility of services was difficult to discern from the mapping activity, interview data noted this was proving to be a barrier to accessing services in some regions. In Northern Ireland, there was a perceived lack of psychosocial wellbeing service coverage

compared to the rest of the UK. Having to either contact services in Wales or Scotland, or travel to England to attend in-person psychosocial wellbeing provisions was a common reason for disengagement amongst those in Northern Ireland who sought help.

> *"That's the main complaint we get through here…. and they just don't bother. Somebody said look, give that number a ring. Where's that? Oh, it's somewhere in Scotland, Wales. Don't bother, it doesn't matter, just forget it" (O3, Small, Northern Ireland).*

> *"Northern Ireland is forgotten about and it's just not the same as the rest of the UK. There's not the same help available here" (NSIP08).*

3.3.2.1.1 Service capacity

Whilst there were multiple barriers noted in accessing services, this did not necessarily translate into underutilisation of in-person service provisions. On the contrary, some of the smaller in-person psychosocial wellbeing provisions were experiencing high demand, expanding at a rate which could not immediately be addressed. For these providers, finding enough people who wanted to utilise their services was not an issue as demand continued to exceed supply. This increased demand was seen not just as testament to the success of their programmes, but indicative of the multiple unmet needs that existed within their target demographic, yet whose improvement was only being limited by their capacity to accommodate them.

> *"It's grown very quickly over the last few years… at the moment there's so many joining we've no money" (O3, Small, Northern Ireland).*

> *"Typically, we'd take 16 people in a year. I've taken that so far this month, which is an absolute snowball month for us. This is the busiest month we've ever had, and I've got another seven to register this week" (O4, Small, UK).*

Some service users however, found that organisations were limited in the support they could offer families. Furthermore, if the needs of the veteran were identified as outside of their capacity to assist, the family could be left unsupported.

> *"They decided they couldn't help him because he had complex PTSD … No one ever checked on me or my kids and never asked us if we needed help" (EAC01).*

3.3.2.1.2 The impact of COVID-19 restrictions

COVID-19 related restrictions impacted access to services on multiple fronts. Reduced capacity at in-person psychosocial wellbeing provisions due to 'social distancing' requirements and a cessation of in person activities had implications for the ongoing psychosocial support needs of veteran families.

> *"We could only have 15 people indoors at one stage and 30 outdoors. Now that's gone up to 50 outdoors, but we're still restricted to the numbers in the hub" (O2, Micro, Wales).*

> *"It's a social support, you can, well not now because of covid but you could have just dropped in, had a cup of tea and a biscuit and a chat with people. I enjoyed that and I miss it. Hopefully it will start up again soon" (NSIP06).*

There were also longer-term effects of in-person restrictions on service users who had found that a loss of strength and mobility had occurred because of restrictions on their movements and activities. As a result, service provisions had to be altered to accommodate these changes. Whilst weekday/ daytime provisions may have been more suitable for older service users with impaired mobility, weekday timing of in-person provisions were said to be a barrier for the involvement of children and working family members. Out-of-hours digital psychosocial wellbeing support and weekend in person service provisions were seen as a method of extending their reach amongst the parent demographic, although this was not always within the scope of service provisions that were currently available at each charity.

> *"The mobility is gone… and its changes since covid. They [also] don't like to go out in the evening" (O3, Small, Northern Ireland).*

> *"Know if you're a mum or if you're working, you can't do a nine to five charity [activity]... I've had a couple of people with our women's projects say do you do any of these at a weekend? I think gaps are, where do you go for support at 10:00 o'clock at night?" (O4, Small, UK).*

Online psychosocial wellbeing provisions were described as being used to good effect with parent users at another charity. Online provisions not only mitigated some of the child-care related barriers to access but also acted as a means of widening

access and capacity, allowing for more users within each session than could be achieved in person. However, 'digital poverty' (an inability to act fully with an increasingly digital world) was reported as posing a barrier to some accessing the support they required when services retreated from face-to-face and into the online space.

> *"So, the old model... maybe make sure the kids are alright, jump in the car drive 40 minutes down the road, have a meeting and ride back, it was a big challenge" (O7, Small, UK).*

> *"When you close all the libraries and you close all of the areas where they may have previously been able to go to access the Internet... it separates them off… from accessing services" (O10, Large, UK).*

Some of the larger charities providing more functional types of psychosocial wellbeing support (e.g., financial) had noted there had been a decrease in people accessing support during the COVID-19 pandemic, although the exact reasons for this were not entirely understood. Some potential reasons for this were proposed as a lack of physical presence in the community due to in-person restrictions diminishing their ability to reach new potential service users, and the government support schemes such as furlough and stays on eviction providing temporary respite from issues that the charitable sector would normally address. One service provider who relayed that demand for support had declined between 25-40% during the COVID-19 pandemic believed that similar decreases were being 'replicated across the sector' (O5, Large, Scotland).

Therefore, it was recognised that a decrease in approaches for support was not necessarily indicative of a reduced need – but it was other factors, such as decreased in person outreach or interim government support measures, which were temporarily interrupting usual demand for their services. These changes were in addition to some of

the services which were fundamentally restructured, postponed, or transferred online during this time, affecting access and uptake.

3.3.2.2 Psychological and behavioural barriers to family member access

Trust in the services intentions or efficacy as well as stigma around asking for help were found to be barriers which prevented or delayed family members accessing psychosocial wellbeing support services. Prioritisation of the veterans needs over the family was seen to stand in the way of accessing support; firstly, through the family members minimising their own needs and instead prioritising those of the veteran, and secondly through some services also being perceived to reflect this bias, impacting assumptions around eligibility.

3.3.2.2.1 Trust

Two of the service providers emphasised the importance of trust amongst potential users when deciding to access services. A lack of trust or scepticism towards the intentions of the programme was a barrier for people approaching the service, especially those which were newly established. Establishing a reputation over a number of years was the means through which services were considered legitimate and trustworthy.

> *"I remember the early days we couldn't get people to join coz nobody knew what we were, didn't really trust us" (O3, Small, Northern Ireland).*

> *"There's an acceptance for what we do now and the key to all this…is trust" (O11, Small, Wales).*

Likewise, trust was mentioned as important to family members. Once trust is established, individuals commented on how they felt sufficiently secure to divulge important issues, and additionally, how this was more likely to be achieved in voluntary organisations, compared to their statutory counterparts:

> *"I think it's important not to bottle things up but to talk to people you trust, and trust has to be built up over time and from getting to know people and being sure they can be trusted" (SAC04).*

> *"You know you can tell them anything and it won't go anywhere. I think that's why the statutory organisations aren't as effective in helping us. It's because you have to build up trust and part of why that doesn't happen as easily with professionals is because it's in a formal capacity" (EAC04).*

The issue of trust as a barrier to support was particularly poignant for families in Northern Ireland due to the legacy of the troubles and persisting anti-British sentiment. The issue was also highlighted in some areas in Scotland where negative perceptions towards general Britishness as an identity, within which the military exists.

> *"I can't even really talk about it to many people because there is still this culture of secrecy here. You just have to keep it to yourself because it's not everyone you can trust or want to know you had a connection to the army here" (NSIP01).*

> *"I live near [town in Scotland]… people here class it as an IRA town. There is an IRA shop in town. You can walk in there and buy t shirts with IRA slogans on them. Free Ireland and tricolours and stuff. They do collections in town for IRA funds and always have done… families who have had someone serve in the British army have to keep that part of their identity hidden because the area in which we live in Scotland is a very unfriendly place for veterans. Its full of veterans [and their families] but there is no wellbeing about it" (SSIP09).*

3.3.2.2.2 Stigma

Stigma and shame were considered to be ever present barriers to accessing psychosocial wellbeing services, although these were seen by one service provider as being amenable to change to some extent through the use of positive messaging and communication campaigns. Indeed, the broader cultural and societal shift in recent years which has seen speaking about mental health openly more socially acceptable was attributed by another service provider as being a catalyst for referrals, particularly for younger veterans and their family members.

"I think it's that the world and the UK has opened up more. You know, with all the male mental health adverts and the support… I think it's probably a combination that, you know, younger veterans, are feeling able to ask for help now thank God" (O6, Large, UK).

Paradoxically, some of the psychosocial wellbeing issues that services existed to support were of themselves acting as barriers to reaching out to access that support. For example, being in need and experiencing difficultly or crisis in terms of mental health, housing, or finances could be accompanied by feeling unable to ask for the very help needed to support those issues – a problem considered to be sector-wide by one service provider, and not unique to the family members of veterans.

"When you're at your very lowest, that is the time when you most need to pick up the phone and ask for help... but it's also the time when it's the most difficult for you to pick up the phone up" (O10, Large, UK).

Military culture was considered to compound stigma around help seeking among veterans as well as family members by both providers and partners and adult children. For some family members military values such as pride, self-responsibility and a 'stiff upper lip' instilled in them through their exposure to the military life conflicted with the act of help-seeking.

"Growing up in a military family made me think I have to have a stiff upper lip. I kind of felt instinctively not to burden anyone with my problems, so I tend not to admit I need help or ask for it" (EAC04).

"The military mindset is just get on with it. That mindset rubs off on the family. Stiff upper lip and just get on with it. Asking, or expecting support for yourself isn't on your radar. And as well as that, its not about you. You didn't serve. You didn't see and do terrible things and have terrible things done to you. Thinking about your own needs is ridiculous and selfish. That's what it's like in a military family. That's what you are conditioned to think" (SAC01).

Several family members suggested that military culture prevents or delays until crisis point, help seeking in military personnel and by proxy, veterans, and their families. Perceptions of stigma or 'undeservedness' may delay help seeking until crisis point is reached, with exacerbating effects on families as well as the veterans.

"I tend not to admit I need help or ask for it. Then the issues get so big that it turns into a bigger deal and can quite quickly become unmanageable" (EAC04).

"Often families may only ask for help when it's too late. There's that kind of mindset that perhaps you don't think you should because you weren't the person who served their country. It wasn't your job. It wasn't your career. It wasn't your injury. There's shame around thinking you need or deserve help as a family member of the veteran. But you really do because that person's service really does impact on you so immensely." (ESIP02).

Subsequently, stigma reduction was identified as a priority issue to be targeted by support organisations in order to reach more veteran relatives and something that families advocated for in this research.

"We have a duty to cut through the stigma and reach out to families, not wait until they are in so much need that they are desperate... Offering the support to the people before they even ask for it" (ESIP04).

3.3.2.2.3 Prioritising the veteran and their needs

A tendency for family members to side-line their own needs, whilst prioritising the needs of their veteran family member was noted amongst service providers as a barrier to family members accessing appropriate services. This could be mitigated to some extent by the opportunistic referral strategies that were being deployed by service providers, where family members were being offered support for their own needs when they approached the services for help for their family member. However, despite reassurance that it was OK to access help, and that their receiving help may indirectly help the veteran they were prioritising, the barrier of feeling undeserving of that help sometimes remained.

"Asking or expecting support for yourself isn't on your radar. And as well as that, it's not about you. You didn't serve. You didn't see and do terrible things and have terrible things done to you. Thinking about your own needs is ridiculous and selfish" (SAC01).

"They don't tend to focus on themselves. So, everything in their life is about the veteran in getting support for the veteran or looking after the veteran…they think they shouldn't be accessing help" (O9, Upper Medium, UK).

Some partners felt that they were worsening, or the cause of, the veteran's mental health. In addition, some spouses felt they were adding to the veteran's burden by needing or asking for support themselves. This issue was identified and picked up by organisations, particularly by staff with similar shared experiences.

"I didn't look for it. But that's because I thought it was my fault and for years, I thought I was the problem. I wasn't going to go and talk to anyone and say, 'oh I'm a terrible person look what I've done to my husband'. So, I never looked for help" (NSIP04).

"We don't want to make his suffering worse. I know I was afraid I would make him worse if I started talking about how everything was affecting me. So, I just ignored the impact on me. Told myself I was ok and that I needed to be strong for him" (SSIP08).

Prioritising the veteran and their mental health needs was considered to take a toll on the other family members who may have had their own needs yet felt that these could not be prioritised. Indeed, it often seemed the case for partners that support was offered to the families with the veteran's psychosocial wellbeing in mind, rather than theirs.

"I went on this course... and they explained to me about PTSD and how to help him. The focus was very much helping him though. Not so much how to help myself, which would have been better" (ESIP08).

Prioritising the needs of the veteran over the needs of the family, was not something only family members did to themselves. Some family members thought that organisations, including those held in high regard for valued services they provide, had

a general bias towards the veteran. This was either through subtly prioritisation of veteran needs in the language they used, or through the support they provided being focused on the veteran's recovery rather than their own.

> *"The other things that doesn't help is when you look at all the organisations' websites… they tend to say in their mission statement; 'We support veterans and their families'. I don't think they realise that they are reinforcing that societal message, telling families they are secondary behind the veteran in terms of their needs. Why not just say veteran families. Or have more support organisations that are just for families, not the veteran. Give the families their own space" (NSIP07).*

> *"I did a 12-week course… to help me support him and our relationship as well. Because when he is unwell, it does really annoy me. So, it was to help me not get so stressed out when he is unwell. Just ignore the unwanted behaviour. But there is no support for partners, or children" (WSIP01).*

Further to this, the 'and their families' add-on in descriptions of remit and strategic priorities, categorises family members as extensions of the veteran, and not necessarily as individuals with separate needs.

> *"The partners and the children have their own needs separate from the veteran, for their own wellbeing not his necessarily. Veteran families are people. They are individuals with their own lives to live. Stop grafting their needs onto what's best for the veteran. They are people in their own rights, with their own needs" (NAC01).*

3.3.2.2.4 The veteran as the barrier

A further hurdle faced by partners in accessing support was found to be the veteran themselves. Some family members were worried that discussing their own psychosocial wellbeing needs would cause further anxiety and distress for the veteran and were therefore reluctant to do so. Other partners revealed that the veteran disapproved of them seeking and attending to their own psychosocial wellbeing, indeed, some revealed their veteran relative actively discouraged their help seeking.

> *"We offer a space for the families where they can get a space away from the veteran. Sometimes the families don't want to share things in front of the veteran because they don't want to hurt him. But they still need an outlet and that's what we offer too" (WAC07, also a support worker).*

> *"When I went on the course to help me deal with him, he was absolutely furious with me. He thought I would be talking about him" (WSIP05).*

Veteran opposition to partners' support seeking was an issue that was not raised by the 12 representatives of support organisations in their interviews. However, the following spouse, who is additionally employed as a support worker in an organisation raised the issue while discussing her shared experiences of veteran disapproval of spousal help seeking.

> *"I nearly had to step in between a husband and wife one day. She came to me and said 'Oh I can't stick this anymore. I don't know what I am doing wrong'... her husband saw us across the room, and he was across that room like a shot 'Are you talking about me?'… and he just stood there shouting at her. And I said to her' just walk away'… I had to learn to walk away when that happened with [her partner]... It makes you feel like you are to blame for everything. It makes you feel like you shouldn't have needs of your own and that you aren't as important as him" (NSIP04, also a support worker).*

As a result of these experiences and perceptions, a safe space, solely reserved for family members, away from their veteran relative in which to speak confidently and frankly was identified as an essential facilitator of family engagement in help-seeking:

> *"Families need to be able to go somewhere to talk unhindered by shame and guilt and without the veteran knowing what they are saying" (NSIP07).*

3.3.2.2.5 Lack of awareness of services and their own eligibility

Family members being turned away from psychosocial wellbeing support provisions that focused on the needs of the veteran, to the

exclusion of their family members, was a common problem according to one service provider. This presented a barrier for family members accessing services open to veterans' family members because of an anticipation they would be ineligible. Assuming ineligibility was not only a result of being turned down from veteran-only services in the past. Barriers to access also occurred amongst family members from non-nuclear family arrangements who were also assuming their own ineligibility.

> *"We get a lot of people who have tried to access other services and have been… rejected" (O9, Upper Medium, UK).*

> *"[they would say] I didn't realise I could go to [service] because…my husband was in the military, but we're now divorced. I didn't realize I was still eligible for support, so there's a lot of people not understanding their eligibility" (O10, Large, UK).*

In cases where finding family members due to their dispersed nature was already difficult, and family members were not always aware of their eligibility, a single centralised point of access to services was considered crucial. However, services were considered to be fragmented, and family members were not always familiar with where they could go to seek the support they needed.

> *"Where is a one stop shop for families to go, with a military connection, to find whatever it is they need?" (O4, Small, UK).*

> *"There are so many military charities, but they are all pumping for money and if they could all put their heads together and collaborate and pull their resources" (ESIP05).*

Poor visibility of services was another reason families did not access support. Upon the veteran leaving the military, partners reported losing the social networks they had come to rely upon for sourcing relevant support, with little information offered to families by the military during their transition to civilian life.

> *"Looking back, we didn't realise what was there... So that's another thing about coming out of the forces. All of this help and all of these third sector organisations, but we didn't know about any of it because no one told us. The information is not conveyed to veterans and their families. I think had I known about support I would have liked support when I was pregnant" (SSIP04).*

> *"There might be all sorts of things available, but I don't know what's available… Once you come out of that military environment and you are not socialising with people in the same situation, you don't get that word-of-mouth information of supports that are available" (ESIP02).*

Solutions were presented by family members on how the awareness barrier could be overcome. As most family members did not appear to be aware of a single point of contact to accessing support, there were suggestions this to be developed, featuring the voices of family members like themselves. Improving visibility of support services was considered to be a responsibility of the charitable sector as well as the Armed Forces.

> *"I think all the big charities should have the services that they provide on their websites, clearly visible and easy to find on their website. A whole section about what families can do to help themselves. They need to be more visible and proactively reaching out to veteran families. I also think there needs to be more awareness about PTSD…. The support needs to be more visible. The military needs to do a lot more outreach work" (ESIP10).*

> *"Maybe online, a website or something that's well run and well-advertised. It would be a source of support and information and it would normalise and validate how you are feeling and therefore help you to feel better. It will recreate a supportive community of people who have similar problems" (SAC04).*

Summary – Barriers and Facilitators to Service Access

- Veteran family member awareness of services reflected the difficulties experienced by the research team when attempting to map the landscape of available services across the UK.
- A general lack of awareness regarding services available to the family members of veterans and their eligibility reportedly acted as barrier to accessing services.
- Family members who didn't find the services they needed through active independently searching were often directed to services through peer/word of mouth referrals, referrals by professionals, or were opportunistically directed to services when seeking help for another psychosocial wellbeing need.
- Barriers in accessing services amongst veteran family members were either structural, psychological, awareness, or veteran related.
- Structural barriers included physical access issues caused by caring responsibilities and immobility, in-person restrictions related to COVID-19, and a lack of service provisions that met their needs in their geographical area.
- Psychological barriers included trust (or lack thereof) in service providers, stigma around help seeking underpinned by military cultural attitudes of stoicism, and a tendency of both veteran family members and service providers to prioritise the needs of the veteran over that of the family member(s).
- The veteran themselves could be a barrier to their family members accessing services, either through caring commitments or more deliberate discouragement of their family member(s) in seeking help.

4.0 Discussion

4.1 Service Awareness

Despite efforts in recent years by policymakers to create a centralised point of contact for veterans and their families seeking support (Kulakiewicz et al., 2022), it appears that a lack of awareness of available services remains among help-seeking family members of veterans. This lack of awareness occurs in two ways, a difficulty in finding services and a difficulty in identifying the scope and eligibility of services that were found. Finding appropriate services was inhibited by the perception that there was no 'one-stop-shop' that could be accessed to signpost them to the relevant psychosocial wellbeing support services. A lack of awareness of need was also noted amongst family members who were not actively seeking help but were being opportunistically guided towards services by providers and statutory professionals upon contact with them for help with other matters.

A lack of awareness surrounding eligibility was found amongst family members who were not in a typical nuclear family arrangement. Gribble et al., 2020 previously found non-traditional family members are often neglected in research and in statutory service provisions, although the charitable sector tends to be more inclusive of non-traditional family members accessing their services (Gribble et al., 2018). As a result of eligibility not always being explicitly defined by service providers, non-traditional family members such as ex-partners, family members were found to be excluding themselves on the assumption that they were ineligible. The difficulties experienced by family members in determining the scope of support amongst the support services were similarly experienced by the research team during the mapping exercise, where searches of multiple databases and web presences were not always sufficient in determining what service/s were being provided, who was eligible for these services, the geographical scope of each service, how and when and services were being delivered, and how long services could be accessed for.

4.2 Barriers

In addition to lack of awareness acting as a barrier to access, there were structural and psychological/ behavioural barriers to access found among the family members of veterans. The main barriers identified by family members and service providers were structural and physical, stigma, and the veteran themselves. Structural and physical barriers to access such as distance and transport reflect the findings of Eaton et al., 2008, Lewy et al., 2014, Schvey et al., 2022 and Murphy et al., 2017 who also found these to be barriers amongst military and veterans spouses accessing mental health support.

Stigma acting as a barrier to support amongst the family members of UK veterans reflects the wider literature which acknowledges stigma as a barrier to accessing psychosocial wellbeing support in the civilian population (Gulliver et al., 2010; Henderson et al., 2013) and Service leavers with mental health problems (Rafferty & Stevelink, 2017). Amongst the serving personnel and veteran population, stigma around help-seeking is further compounded by military cultural attitudes such as stoicism and self-reliance that can prevent these individuals accessing the support they need (Randles & Finnegan, 2022). Although it has been argued that military cultural attitudes do not act as a barrier to the same extent as in military personnel due to family members appearing to access services at a higher rate than serving personnel and veterans (Eaton et al., 2008), these findings add to work that shows that restrictive military cultural attitudes are adopted by family members and continue to exist and present a barrier to accessing support (Long, 2022), even in their post-military civilian lives.

A less explored barrier to support was found to be occurring amongst family members, where the veteran themselves was acting as a barrier. Veteran resistance to their family members' help-seeking for their own psychosocial wellbeing needs was echoed in the experiences of researchers' when attempting to recruit partners and adult children to this study.

During an online event, researchers were invited to talk about the study and encourage veterans to promote participation among their partners and adult children. Reluctance amongst veterans to endorse the study was noted, illustrated by comments such as "I don't want my wife talking about me" [NI Veteran], highlighting resistance against their families' input into findings in this study about issues affecting their wellbeing. Veterans acting as a barrier to their family member's help-seeking provides a clear example of non-aligned priorities and preferences between the veteran and their family member (Manguno-Mire et al., 2007), further reinforcing the importance of seeking the voice of family members in all aspects of service provision.

4.3 Prioritising the Needs of the Veteran

The family members of UK veterans were found to be prioritising the psychosocial wellbeing needs of their veteran family member at the expense of their own, something that has been observed in the wider family member and military spouse literature (Armour et al., 2022; Long, 2022; Spencer-Harper & Murphy, 2019). Prioritisation of the veteran amongst family members may occur for two reasons, either as a peacekeeping tactic to maintain harmony in their relationship with their partner with PTSD (Spencer-Harper & Murphy, 2019), or as result of internalised undeservedness, in a military culture which prioritises their partner and a broader societal culture which deprioritises women and carers (Long, 2022). Despite some of the services generating positive outcomes on matters such as self-worth and self-confidence amongst family members, feelings of low self-worth and undeservedness were paradoxically creating hesitancy in approaching services for help with these matters. A challenge remains therefore of addressing undeservedness and self-worth amongst family members if these feelings are also acting as a barrier to seeking help for these issues in the first place.

Family-orientated and whole family unit approaches to psychosocial wellbeing were being adopted successfully by some of the service providers. Within the broader military and veteran support literature, there is acknowledgment of the importance of family unit psychosocial wellbeing due to the connection between mental health and psychosocial wellbeing, within and between the individuals in a family unit (Nichols et al., 2015). However, family unit approaches can sometimes reinforce narratives which see the veteran's recovery as the primary endpoint and the family-based approaches as the means of achieving this (Meis et al., 2022). Through extolling these narratives, service providers can deprioritise the needs of the family members as individuals of equal importance to the veteran, in a manner similar to the family members themselves. This appeared to manifest during some of the interviews, with service providers often diverging into discussions about the needs of the veteran more generally in response to questions about family members.

Service provisions for family members as separate individuals appeared to be rarer than those that provided family unit therapy or services in which veterans were also present. Yet, there is clear scope to provide for individual needs of family members that are vulnerable to being deprioritised by service provisions and the veteran family members themselves. Family systems theory (Kerr & Bowen, 1988) proposes that anxiety within family units is due to an imbalance in closeness and/or distance between family members (Brown, 1999). Exploring veteran prioritisation through the lens of family systems theory and an imbalance of closeness to the veteran and their needs warrants further attention, given that this theory has not been adequately explored in this population. The development of service provisions which include a military culture specific form of family systems theory, which address the individual needs of family members, is worthy of consideration when new services are being designed.

4.4 Emphasising Informal Delivery Styles

Psychosocial wellbeing support services often situated themselves as occupying unique and distinct territory compared to the clinical and statutory mental health services, whilst also recognising that family members often traverse between themselves and the statutory support sector. One aspect of psychosocial wellbeing support that was preferred amongst family members when compared to the statutory sector was the low-pressure, more informal styles of service delivery.

These preferences echo previous research with veterans in Northern Ireland who shared their preference for services which were more family focused, holistic and non-traditional (Armour et al., 2017). Whilst the evidence base for less formal interventions of improving wellbeing such as social prescribing and nature based wellbeing interventions is complex and still developing (Garside et al., 2020) some of the positive outcomes noted amongst family members in this study, such as social connection, self-worth and self-confidence, are similarly being generated by other less direct methods of improving wellbeing such as creative arts interventions amongst individuals with mental illness (Zeilig et al., 2021). Gaps remain in our understanding of how and why these non-clinical, less direct forms of general wellbeing support (particularly in specific populations (Garside et al., 2020) such as veteran families) work, and in what contexts. Developing evidence-based interventions that do not only incorporate veteran family specific issues and preferences, but also draw upon the wider and ever developing research base in non-clinical wellbeing interventions, is a worthwhile endeavour for those who seek to support the future psychosocial wellbeing needs of family members of UK veterans.

4.5 Comparison across the Four Nations

Estimates of the veteran population across the UK indicate that the majority (1.7-2.0 million) live in England and Wales (115-140,000) (Ministry of Defence, 2019; Office for National Statistics (ONS), 2022), 220,000 in Scotland (Ministry of Defence, 2019), and 40-60,000 in Northern Ireland (Northern Ireland Statistics and Research Agency [NISRA], 2019). In the absence of available data about family members of veterans across the UK, it could be assumed that family members are distributed in roughly similar proportions across the four nations. The Strand 1 mapping exercise discovered that the distribution of psychosocial wellbeing services for the family members of veterans had the widest coverage in the nation with the greatest number and proportion of veterans, with 17 providers being England based, and 38 UK wide. Although UK-wide services appeared to be open to residents of the UK, it was not possible to determine if each had a physical presence in each of the four nations. It was also evident from the Strand 2 & 3 interviews that some support services were open to residents from the UK but only had a physical presence in England. Although Northern Ireland has the lowest number and proportion of veterans (and potentially family members) compared to the other nations (Northern Ireland Statistics and Research Agency [NISRA], 2019), there were indications that current provisions, especially for in-person support were not adequate in meeting the needs of family members. This was noted in the interviews with family members in Northern Ireland having to travel to England to access some of the more novel, in-person psychosocial wellbeing support programmes that did not have a presence in Northern Ireland. This was not noted for those in Scotland or Wales. The need for cross border travel to access services was proving to be a structural barrier to access amongst those in Northern Ireland who could not or did not want to make the journey to Scotland or England to access the psychosocial wellbeing support that they were entitled to receive. In Northern Ireland, one of the main factors dissuading families from seeking the support was a perception of persistent post conflict anti-British sentiment, trust, secrecy, and security issues, which would suggest that families in Northern Ireland are at a further disadvantage compared to the rest of the UK.

Whilst a physical presence in each of the four nations may not be as relevant for the online and structural support services that were being provided by some of the UK-wide organisations, the often preferred, informal, in-person and outdoor activities could not be substituted by remote services. One nation that was particularly good at accommodating in-person and outdoor psychosocial wellbeing support was Wales. Although there were only six organisations identified in Wales, participants living there talked about a 'Wales Model' which was underpinned by efficiency of organisation across three factors: 1) organisations that are staffed with peer-experienced individuals who are highly motivated and understand the finer nuances of life in a veteran family; 2) Effective networking between the statutory and voluntary sectors to collaboratively identify and provide quality support needs in a timely manner; and 3) Incorporation of health-supporting activities into psycho-social wellbeing support provision, particularly those which are outdoor based.

Scotland out of all four UK nations was found to have the least amount of psychosocial wellbeing support services available to family members. While only statutory sector organisation providing for veteran family needs was situated in Scotland, this broader approach may be more helpful for veteran families and provide a template for other services. However, it is not clear how and if families are able to access this service given the more challenging and remote geography in Scotland compared to the other nations. An additional nation-specific barrier to help seeking was also present in Scotland, with some veteran families describing living in communities where perceived anti-British feeling impacted upon their levels of trust towards local services, potentially dissuading family members from help seeking even where sparse provision existed.

4.6 Study Limitations

4.6.1 Mapping services strategy

Given noted decreases in the number of Armed Forces charities (Cole et al., 2020), it is possible there may be some discrepancy between what services are actively being provided 'on the ground' and what was captured as part of the search due to web presences not always being available, accurate or up to date. Attempts were made to confirm the relevance of the organisations identified as 'likely' or 'possibility' providing psychosocial wellbeing services by contacting each one by email and phone. Therefore, the final list of 66 organisations should not be considered an absolute or definitive list of what is available in the sector. However, we are confident given the search strategy used that we were able to contact the charities most relevant and useful to veteran family members.

4.6.2 Interviews

Interviews were only able to be conducted with 11 organisations out of the original 66 identified. Only those who answered 'yes' to all four questions were invited to take part in the semi-structured interviews. Findings should be considered with these points in mind, as these organisations may be more aware of the needs of family members of veterans or have more capacity for taking part in research than those that did not respond. Organisations not meeting all four criteria may still provide important services for family members which may improve their wellbeing but are not framed as psychosocial services. A large number of qualitative, one-to-one interviews were conducted with partners and adult children. While their experiences may differ from others in the community, they give an in-depth first exploration of the support needs of family members that can be followed-up in future research.

4.6.2.1 COVID-19

The interview data collected for this study was cross sectional, occurring at one time point in 2021, during which COVID-19 related restrictions were in place. This may have affected who participated in the study. The concerns shared by service providers of the future implications of these restrictions (such as service usage) therefore could not be followed up and it remains to be seen if future post-pandemic research works determine whether these concerns have come to fruition.

4.6.3 Children

As the voices of children were not included in this study, this report may not represent the issues that family members under 18 years of age may face. Further research focusing on the children of veterans across the UK is needed to address this gap.

5.0 Recommendations

5.1 Recommendations

Many aspects of existing services were described by providers and family members as being done well, however, from the mapping exercise and interviews, it was clear there were some aspects of existing provisions that could be expanded or improved upon. The following recommendations (Table 6) detail suggested areas of need that could be addressed in the future:

Table 6. Recommendations based on study findings

RECOMMENDATIONS FOR SERVICE PROVIDERS

ACCESSIBILITY

Recommendation 1

Hybrid or digital delivery of services to widen access to family members across the UK who experience barriers due to mobility, distance or concerns for their privacy and safety. These should run in parallel to in person delivery to give choice but may be particularly beneficial for those in Northern Ireland and more isolated areas in Scotland. Lessons could be learned from the expansion of online NHS services but should consider digital exclusion among certain groups.

Recommendation 2

Expansion of in-person, informal 'soft support' so highly valued by family members to improve UK coverage and ensure equity of accessibility for all family members across the UK. Adding on additional family-based schemes into existing veterans' hubs or the use of trained peer-support advisors could be a cost-effective means of achieving greater coverage while using existing skills and resources. Smaller organisations may combine services to improve outreach and impact without an increased need for large amounts of additional funding. Any support should be independent of authoritative professionals and hierarchical arrangements and monitored to show impact.

Recommendation 3

Increase transparency of services regarding eligibility at the point of initial contact or approach. This should include:

- Who is eligible (clearly explaining who is defined as a member of a veteran family)
- Geographical location and coverage
- A clear remit of services, what support is available and for how long
- How, when and where support is delivered (including online/in person)
- If services for family members are offered separately to, and/or with, their veteran family member

RECOMMENDATIONS FOR SERVICE PROVIDERS

FACILITATING SERVICE USE

Recommendation 4

Reframe wellbeing services as informal opportunities to connect, learn new skills, and gain confidence rather than as 'support' to reduce stigma and encourage use. This may also help avoid overly formalising non-clinical services.

Recommendation 5

Campaigns highlighting the needs of family members so services and family members are aware family members are deserving of support in their own right. Campaigns should raise awareness of services as well as tackle stigma around help-seeking, including military cultural stigma amongst family members. As not all veterans will identify as such, different approaches for some families may be needed.

Recommendation 6

Identification, assessment, and provision of wellbeing services to family members that is independent of the veteran. This may aid in limiting the potential for some veterans to act as a barrier to their family member's help-seeking as well as reducing a continual focus on the needs of veterans over those of their families.

Recommendation 7

Raise awareness of the needs of family members and the existence of their services amongst other providers such as veteran friendly NHS Trusts, GP practices and local authorities. Service providers and policymakers could also raise awareness of formal support services which have received quality assurance through the Contact Guiding Principles developed by the Royal College of Psychiatrist's Quality Network for Veterans Mental Health Services (Royal College of Psychiatrists [RCPsych], 2022).

Recommendation 8

Explore means of gauging and building trust amongst current and potential users towards larger providers. This should include research into how trust affects service use and developing strategies how charities can build trust e.g., improving transparency around funding and impact and building local connections.

RECOMMENDATIONS FOR POLICYMAKERS

ACCESSIBILITY

Recommendation 9

Increase awareness of the Veterans' Gateway amongst family members at the point of transition as another means of searching for wellbeing support. There could be greater emphasis in the JSP 100 Defence Holistic Transition Policy (Ministry of Defence, 2022a) and further consideration by the Supporting Partners Workstream of the UK Armed Forces Families Strategy 2022-32 (Ministry of Defence, 2022b) in how to increase awareness of services outside of formal referral channels such as the Defence Transition Services. Consideration should be given to information about services can be directly shared with family members during resettlement.

Recommendation 10

Optimise search functions for family members and non-statutory psychosocial wellbeing support needs in the Veterans' Gateway. For example, expanding the number and type of categories on the Veterans' Gateway search facility that capture all types of psychosocial wellbeing support. This should be supported as part of the investment as outlined in the Veterans' Strategy Action Plan: 2022-2024 (Office for Veterans' Affairs (OVA), 2021).

RECOMMENDATIONS FOR RESEARCH

DEVELOPING EVIDENCE-BASED SERVICES

Recommendation 11

Adaptation or development of evidence-based programmes that speak to the unique, multifactorial needs of the family member. These could be adapted from international programmes such as Homebase (https://homebase.org, US) or the Veteran Family Programme ((Government of Canada, 2019), Canada) but should be based on a strong understanding of military culture and the unique determinants of psychosocial wellbeing within this population. Creative and novel approaches could also be used such as social prescribing and arts-based wellbeing programmes.

Recommendation 12

Additional research into the experiences of family members during transition and after the serving member has left the military. This could include experiences specific to partners/spouses and to children and young people at various timepoints or over the period of transition. Within this, there should be exploration of differences in experiences between Service branches, socio-demographics (e.g., age, gender, education, LGBT+).

Recommendation 13

Additional research to explore geographical dispersal of the families of veterans and how services may be best adapted or developed to meet need and provide support. This may draw on recent census data as well as the preferences of families and service provider.

RECOMMENDATIONS FOR ALL

Recommendation 14

When communicating with or about family members, language that values individual family members and their needs should be used over language such as 'and their families' that sees family members as additions to the veteran. Viewing family members primarily as conduits of their veteran family member's recovery should be avoided.

6.0 Conclusion

Despite the noted limitations, this research study provides one of the first comprehensive accounts of the psychosocial wellbeing provision landscape for veteran family members across the UK. Moreover, it has contributed to the otherwise sparse research base on the psychosocial wellbeing needs, experiences, and preferences of veteran family members from a UK perspective. The recommendations from this report are intended to be actionable by policymakers, service providers and researchers whilst the evidence base on veteran family wellbeing across the UK continues to build. The next, and final, report of the UKVFS will consolidate and further improve upon our understanding of what comprises psychosocial wellbeing in family members of veterans across the UK.

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Appendices

Appendix A. Strand 1 – Mapping Service Availability

Databases search strategy

Methods for sourcing potentially relevant services

Multiple data sources were used as means of scoping potentially relevant services. These included word of mouth referrals, three existing database searches (DSC, Cobseo Member Directory, Veterans Gateway) as well as Armed Forces Champions, using a list held internally by the Veterans and Families Institute; Anglia Ruskin University, who were asked about any potentially relevant services in their local authority, particularly those in the statutory sector.

DSC List

The Directory of Social Change shared their database of 268 charities that had been collated as part of their 2021 report: Armed Forces Charities' Support for Families. The websites for each of these charities were searched to see if they appeared to be providing direct (e.g., counselling) or indirect (i.e., recreational activities which had the express intention of improving wellbeing) psychosocial support services to the family members of veterans. Those who were providing these to the families or serving personnel only, providing services which had no relation to psychosocial wellbeing, or were providing monetary assistance only were excluded. 25 charities were determined as very likely to be relevant and a further 30 determined as potentially relevant based on their website content, totalling 51.

Armed forces champions

A list held internally by the VFI of 328 Armed Forces Champions (AFCs) was accessed. This list comprised of 239 English and Welsh Councillors, 32 Scottish Councillors, 52 other Scottish contacts (e.g., NHS) and five MOD contacts. An email was sent to each AFC asking for information about psychosocial service provisions for the families of veterans within their local authority, particularly those being provided within the statutory sector. Of the total 328 emails sent, 98 bounce backs were received resulting in 230 contacts being made. 31 responses were received.

Cobseo Member Directory

The list of charities held on the Cobseo Member Directory was accessed, and the predetermined limiters 'families', 'mental health' and 'children' were applied to the database to select for the most relevant charities in the directory. The charities which were tagged under these headings were then cross referenced against the full list of charities on the DSC list. Additional charities found and identified as potentially relevant were included.

The Veterans Gateway

The categories 'families and communities' and 'mental wellbeing' were applied to the list of charities held by the Veterans Gateway in order to search for support services specific to these areas. No new charities (that hadn't already been found through the DSC list, Cobseo website, or Armed Forces Champions) were discovered through exploring these categories.

Consolidation of all potentially relevant charities retrieved via all data sources

In addition to the 51 charities identified via the DSC list, a further 12 charities were identified via the Cobseo Member Directory and suggestions from the AFCs. One more charity was identified as result of being personally known to a member of the research team, resulting in a total of 64 potentially relevant charities and organisations. Two additional charities were identified through some of the charities in their response to us and were also included. Therefore, 66 potentially relevant organisations were identified in total.

Organisational Screening Questionnaire

List of charities contacted for screening

Four-item screening questionnaire sent to organisations identified as providing support to family members of veterans.

Do you provide support to the families of veterans?

Yes □ No □

Is this support considered to be psychological/ mental/health/wellbeing related?

Yes □ No □

Do you provide this service in-house/yourself (rather than outsourcing, signposting or providing funding to external bodies)?

Yes □ No □

Is this support provided explicitly for the benefit of the family member themselves (rather than as indirect support to their veteran family member)?

Yes □ No □

Table 6. Method for determining size of organisations

Income bracket	Size category
£0 to £10,000	Micro
£10,000 to £100,000	Small
£100,000 to £500,000	Lower medium
£500,000 to £5 million	Upper medium
£5 million to £100 million	Large
Over £100 million	Super major

Ref: Cole et. al. 2020

Appendix B. Strand 2 – Interview Schedules

1. Service provider representatives

Organisation's background

- Can you tell us a little about your organisation please?
- How many families do you support annually?
- What sorts of wellbeing needs do you help families with?

Access to services

- How do people find your services?
- Can you describe what sort of help-seeking journeys your users have had before they found you?
- What do you think the barriers to access are?

Service/wellbeing needs and gaps

- In what ways do you think military service impacts on the wellbeing of families?
- What would you say is your most successful intervention/programme?
- Nationally, what are the areas of wellbeing needs that you think are not addressed particularly well?
- Do you see the needs of veteran families changing in the future? If so, how?

Perception of quality/ Evaluation

- Do you evaluate or measure the outcomes for your clients? If so, how?
- What sort of feedback do you typically get about your service/if any?

2. Family members

2.1 Spouse / Intimate partner interview

What was it like for you having a spouse / partner in the military?

Questions	Probes
Tell me about your relationship with your spouse / partner who served.	When s/he was serving, how strongly were you engaged on a daily basis? (e.g., meals, social activities, physical and emotional care) How would you describe the relationship? How do / did you feel about it?
How did your spouse / partner's military service impact the household and family life when you were together?	"Military service" refers to the veteran's trade/ rank/tours of duty/postings/deployments while serving. What were the impacts on housing, finances, social life? How would you describe the household? What did you like / dislike about it?
During your time as a military family, did you access any services to help you with any issues? What supports did you / your family use at this time?	Informal - *Family, friends, neighbours.* Military family services – *Welfare, HIVES, Fam Feds.* Other services - *faith organisations, community services?* Were they helpful? Were there any issues accessing services? What could have been improved? What supports did you not have that you would have liked?

What was life like for you after the military?

Questions	Probes
Tell me about what it was like when your family left the military	Where did you live? How was it? What changed?
What supports were you aware of at that time?	Informal - *Family, friends, neighbours.* Military family services – *Welfare, HIVES, Fam Feds.* Other services - *faith organisations, community services?* Perceptions of public support? Were they helpful? What could be improved? What supports did you not have that you would have liked? Would you have wanted support and from whom?
Looking back, how did being a military partner / spouse impact upon your life as it is now? (positively as well as negatively)?	Impacts on health and wellbeing? On choices your made to date? On opportunities available to you? In relation to housing, employment/education, finance, health, life skills and knowledge, social integration, relationships, social network. What was the greatest impact?

What would you say are your needs, if any? (Current and future)

Questions	Probes
What would you say are your needs now?	E.g., for your health and wellbeing, happiness, housing, employment/education, finance, health, life skills and knowledge, social integration, relationships, social network
What do you think might be your needs in the future?	E.g., for your health and wellbeing, happiness, housing, employment/education, finance, health, life skills and knowledge, social integration, relationships, social network.
What supports or services do you think would be of best help to you?	E.g., Family, friends, neighbours, community organisations, faith organisations, military family services?

Finally: Is there anything else that you haven't mentioned that has impacted your wellbeing that you would like to tell us about?

2.2 Adult child interview

Tell me about what it was like growing up in a military family

Questions	Probes
Tell me about your relationship with the parent/s who served	When s/he was serving, how strongly were you engaged on a daily basis? (e.g., meals, social activities, physical and emotional care) How close would you say you were/ are?
Do you think your parent's military service had any impact on the household and family life when you were growing up?	"Military service" refers to the veteran's trade/ rank/tours of duty/postings/deployments while serving. If so, what impact? Positive, negative, both, none? What were the impacts on housing, finances, social life? How would you describe your household growing up? What did you like / dislike about it?
During your time as a military family, did you access any services to help you with any issues? What supports did you / your family use at this time?	Informal - *Family, friends, neighbours* Military family services – *welfare, HIVES, Fam Feds* Other services - *faith organisations, community, services?* How did you find these services? Were there any issues accessing services? What worked? What could be improved? What supports did you not have that you would have liked?

What was life like for you after the military?

Questions	Probes
Tell me about what it was like when your parent/s left the military	What age were you? Where did you live? What was it like? What changed? What was it like living among civilians (if relevant)?
Were you aware of any supports/services your family used at the time?	Informal - *Family, friends, neighbours,* Military family services – *welfare, HIVES, Fam Feds* Other services - *faith organisations, community services?* How did you find these services? Were there any issues accessing services? What worked? What could be improved? What supports did you not have that you would have liked? Would you have wanted support and from who?
Looking back, how did being in a military family impact upon your life as it is now? (positively as well as negatively)?	Impacts on health and wellbeing? On choices your made to date? On opportunities available to you? In relation to housing, employment/education, finance, health, life skills and knowledge, social integration, relationships, social network Career goals? Communication skills / problems solving / social skills? What was the greatest impact?

What would you say are your needs (if any)? (Current and future)

Questions	Probes
What would you say are your needs now?	E.g., for your health and wellbeing, happiness, housing, employment/education, finance, health, life skills and knowledge, social integration, relationships, social network.
What do you think might be your needs in the future?	E.g., for your health and wellbeing, happiness, housing, employment/education, finance, health, life skills and knowledge, social integration, relationships, social network.
What supports or services do you think would be of best help to you?	E.g., Family, friends, neighbours, community organisations, faith organisations, military family services

Finally: Is there anything else that you haven't mentioned that has impacted your wellbeing that you would like to tell us about?