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Full Title: How does a restorative approach work? Supporting military veteran families affected by Post Traumatic Stress Disorder (PTSD)

Short Title: Restorative Approach with Veteran Families

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Abstract

Demands for more participatory, collaborative family support services have grown, however implementing such methods in practice has proved difficult. The use of a restorative approach (RA) within family services shows promise but little research has explored the provision of such services for families affected by parental mental ill-health. To address this gap, this article reports findings from a three-year feasibility study of an innovative restorative family support service developed to support military veterans and families affected by a veteran's service-related mental health problem.

Interviews and focus groups with service professionals (n=4) were conducted on the completion of programme development, and at regular stages during service implementation. Interviews were undertaken individually or in pairs with eight service user families, including six veterans, six partners and two children, and four veterans who chose not to take part in the service.

This article reports professionals' experiences of service delivery and refinements made to support programme implementation, and the veteran and family opinion on service receipt, including the areas they identified that could be improved. It also details the restorative mechanisms which resulted in family changes, with the development of collective empathy being located as a crucial RA mechanism which leads to positive effects.

Introduction

Restorative approaches in Family Services

While the value of family support services is widely recognised, demands for use of more participatory, collaborative services have grown in recent years (Morris et al, 2008; Hughes, 2010; Frost et al, 2009; Featherstone et al, 2014). One route to achieve such practice is use of a restorative approach (Williams & Segrott, 2018; Williams, 2019); an ethos and methodology that stems from repairing and sustaining relationships rather than penalising those involved (Strang & Braithwaite, 2000; Hopkins, 2009).

Although numerous family services in the United Kingdom employ a RA there is limited evidence of use in these settings or knowledge of the processes through which such practice can impact on service efficacy (Saulnier & Sivasubramaniam, 2015). Much knowledge that does exist emerges from exploration of use of restorative justice in criminal settings and the associated emphasis on how this procedure achieves change by generating reintegrative shaming in reaction to community disapproval for the harms caused by the offence (Braithwaite, 1989; Braithwaite, 2000), and procedural justice which is concerned with perceptions of fairness in justice systems used to reach outcomes or decisions (Bennett et al, 2018). Collectively the available literature suggests that these constructs lead to improved levels of satisfaction with operant justice processes and subsequent reduction of recidivism rates (Saulnier & Sivasubramaniam, 2015). Some articles draw attention to the importance of restorative values such as trust, respect openness, non-judgmental attitudes, a willingness to listen, and non-stigmatisation in facilitating reintegrative shaming and procedural justice (Lauwaert & Aertsen, 2015).

When extending this knowledge to use of RA in welfare settings, Braithwaite (2000) linked procedural justice to family group conferences and argued that use of a RA in this context can empower both families and the state by negotiating reciprocal fair exchanges in which social workers can ensure child safety by setting ‘bottom lines’ regarding family behaviours while families retain some control over outcomes via the action plans they generate. However similarly to restorative justice, and as noted by

Lanterman, (2021), little discussion of the mechanisms operating in use of a RA at intra and inter-personal levels in welfare settings can be found.

To contribute to knowledge in this area this article draws on findings from a feasibility study of the Restorative Approach Veteran Family Service (RAVFS), an innovative restorative family support service developed to support military veterans and families affected by a service-related mental health problem. The paper starts by describing the service and how it came about, before detailing the methods, data analysis strategy and ethical approval. It continues with the study findings split into sections on RAVFS service delivery, service receipt, and the restorative mechanisms underpinning family change, before discussing links between this study and the wider research literature.

Study Background

Although significant numbers of military personnel are exposed to traumatic events and stress during service careers the incidence of common mental health illnesses in the UK Armed Forces is low compared to civilians (Hunt et al, 2014; Ministry of Defence, 2020). Unfortunately, this relatively low level of mental health illness does not apply universally. Military veterans (individuals no longer serving in an armed forces' capacity) are more likely to report Post Traumatic Stress Disorder (PTSD) and common mental health illnesses than non-veterans (Palmer et al, 2021), irrespective of whether they were deployed or not while serving (Stevelink et al. 2018).

In Wales, support for veterans with a service-related mental health illness is provided by a therapeutical psychological service: the Veterans' NHS Wales service (VNHSW). In light of knowledge that mental health illnesses can have a negative effect on family wellbeing, relationships and dynamics (Carroll et al. 1985; MacDonald et al., 1999; Calhoun et al. 2002; Evans et al., 2003; Kwan et al., 2017) which in turn can negatively impact patient recovery (Galovski & Lyons, 2004; Lester et al, 2017), VNHSW have long been concerned with the psychological welfare of veteran families but lacked capacity to offer families support. Recently VNHSW were approached by TGP Cymru, a Welsh charity

with experience of delivering child and family services using a restorative framework. TGP Cymru suggested that the two organisations should work together to develop the Restorative Approach Veteran Family Service (RAVFS), a restorative support service for military veteran families whose veteran was living with a service-related mental illness.

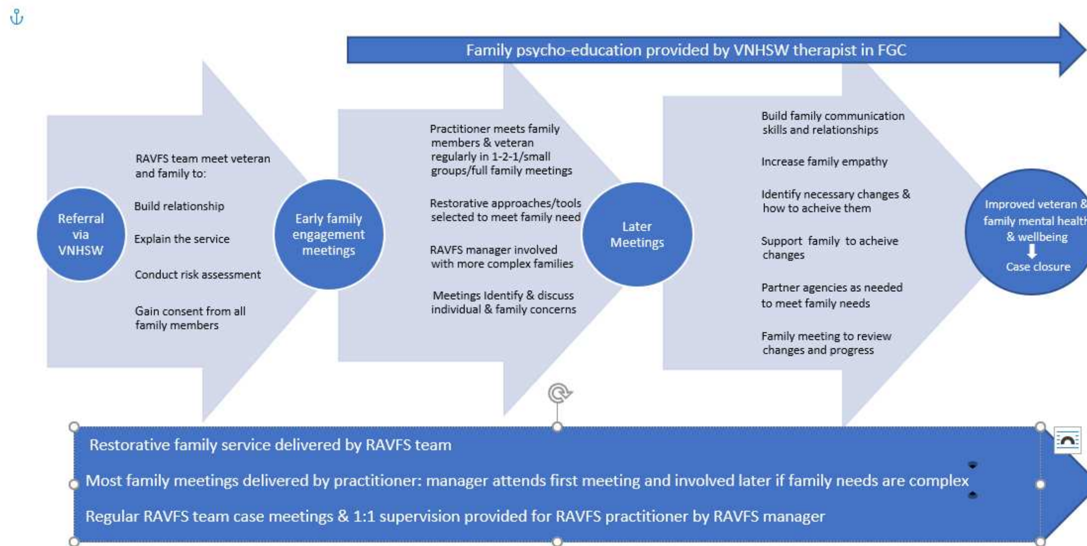

Figure 1: The initial model of RAVFS delivery

Figure 1 illustrates the planned process of the RAVFS service, and Figure 2 sets this within use of wider VHNSW therapy. The process of VNHSW use began when veterans were referred by clinicians, other agencies, or through self-referral. VNHSW then sent out an information pack and gained consent to access military records. An assessment appointment collected a full psychiatric and medical history, self-reported clinical measures of the veteran's psychological state, and information about the family and levels of social support. Veterans with a treatable service-related psychological problem were placed on the VNHSW waiting list. VNHSW therapy typically consisted of 16 one-hour, weekly sessions.

RAVFS service was initiated by a referral after the VNHSW assessment. On receiving the referral, the RAVFS team considered whether their service was appropriate and, if so, the service was offered to the veteran. If the veteran was interested, they were encouraged to consult their family and

collaboratively decide whether to engage. RAVFS typically provided a series of weekly meetings over a period of 6 months. The first meeting was attended by the veteran, the family, the RAVFS practitioner and manager and took place at the family home. At this meeting, the RAVFS team gave additional service detail and gained better understanding of current family problems, with particular interest in the veteran's mental health illness. Subsequent early meetings saw the practitioner talking to family members individually or in small groups to generate mutual trust and give each individual an opportunity to describe the situation from their perspective. The next stage called for larger family group meetings, when safe and possible. Meetings could involve informal discussions, mediation, or full family group conferences, but regardless of format the aim was to facilitate collaborative, inclusive family discussions of presenting problems and concerns, how they came about, and how they were perceived by and affected each family member. The importance of providing the families with information about the illness (Lefley, 2009) was recognised from the onset, and the initial service model included the provision of 'psycho-education' sessions by a VNHSW therapist during full family meetings. Meetings then turned to collaborative consideration of what was needed to resolve the family problems and how this could be achieved. This stage could involve agencies beyond VNHSW and RAVFS if extra support is needed and acceptable to the family.

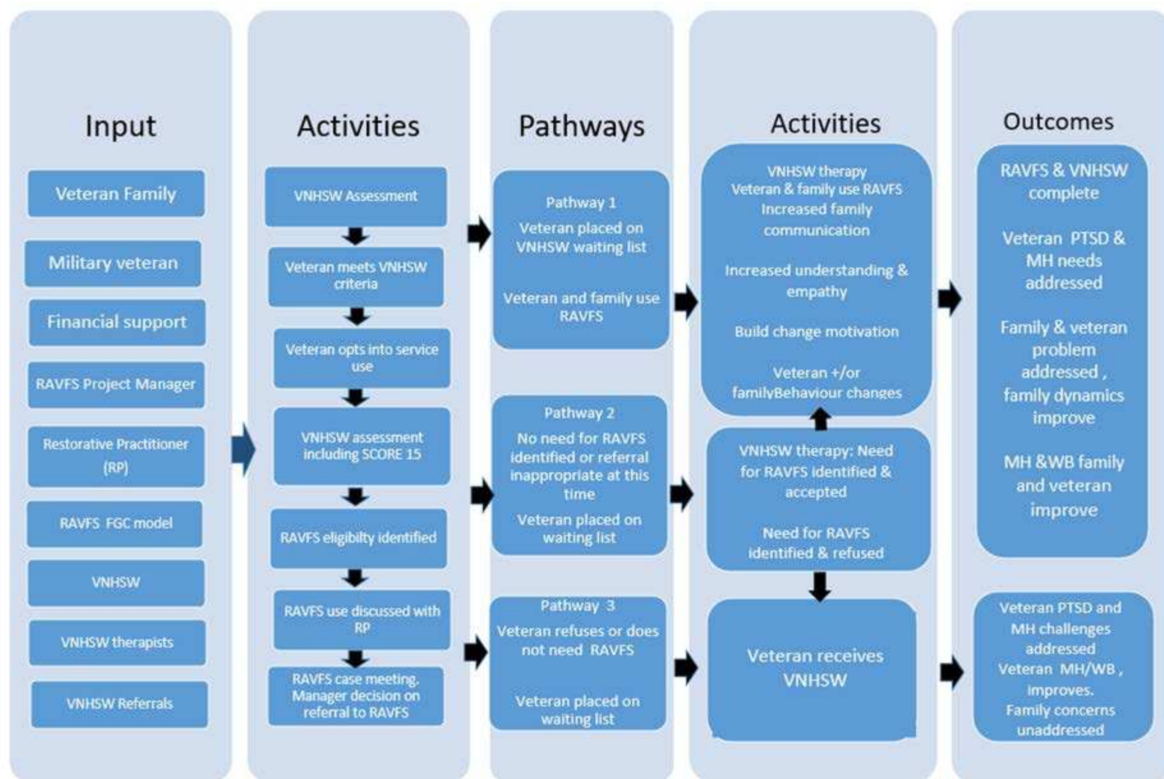

Figure 2: The initial integrated VNHS/RAVFS service

The innovative nature of the RAVFS within an established therapeutical service called for an embedded evaluation during development and early implementation. The aim of the research was to identify and construct the most acceptable and deliverable model of RAVFS. To achieve this, the research had the following objectives: to explain the development of the initial service model; to explore the recruitment and delivery of the service to veterans and families; to identify and assess underlying programme theory. To explore these objectives, the research questions were:

- Could the service be made more acceptable and/or effective by changes in the service model?
- Does use of RAVFS achieve positive changes in veteran and family' wellbeing and mental health?
- If so, what are the mechanisms through which these were achieved?

Methods

A critical realist paradigm (Bhaskar 1978) underpinned the study, allowing the researchers to use data obtained in the empirical realm (Bonell, 2016) to understand the development and delivery of the programme and it's causal mechanisms. Qualitative data was collected via interviews and focus groups at multi different phases/time points in the study (see table 1). The interviews and focus groups with service professionals (n=4) were conducted on completion of the initial programme developmental stage, and at regular stages during subsequent service implementation, with a focus on experiences of delivering and using RAVFS and the perceived impact use had on families and individuals. Early data collection took place in the offices of the professionals or at a university setting, these settings were chosen to make attendance as easy as possible.

Paired or individual interviews were undertaken with eight families altogether. These included 14 individuals who had used RAVFS: six veterans, six partners and two children who took part in 11 interviews post-service use. In addition, four veterans who were offered RAVFS but chose not to take part in the service were interviewed. Family interviews were initially conducted in participants' homes (n =5), allowing veterans, their partners, and children to take part. Later family interviews (n =5) took place via telephone due to the COVID-19 pandemic and consequently only one further complete family unit took part via speaker phone. Initial recruitment for these research encounters was undertaken by the RAVFS practitioner who informed families of the study and passed on the details of those interested to the research team. In all cases, families and veterans were given additional study information immediately before data collection. Consent was obtained in hard copy when possible but recorded before data collection for telephone interviews.

After initial analysis of the qualitative family and veteran data, findings were presented to the RAVFS and VNHSW staff. This allowed reflection on service provision and receipt in a final interview with the RAVFS manager and practitioner and a focus group attended by RAVFS and VNHSW staff (n=4).

Date of Data Collection	Data Source	Participants	Data Collection Procedure	Analysis
March 2018	Paired/Individual Interviews (service specific) followed by combined Focus Groups	TGP and VNHSW staff (n=4)	Face-to-face Interviews led by study team	Thematic Analysis and Logic Model Development
January 2019	Paired Interviews (service specific) followed by combined Focus Groups	TGP and VNHSW staff (n=4)	Face-to-face Paired Interviews led by study team	Thematic Analysis and Refinement of Logic Model
Dec 19	Paired Interviews	TGP staff (n=2)	Face-to-face Interviews/Focus Groups led by study team	Thematic Analysis and Finalisation of Logic Model
Nov 19- Aug 20	Paired and Individual Interviews	RAVFS Family Interviews (n=11), Participants n=14	Face-to-face or telephone Interviews/Focus Groups led by study team	
June–Aug 2020	Individual Interviews	Veterans who had used VNHSW but declined use of RAVFS (n=4)	Face to face or telephone Interviews led by study team	
Sept 2020	Paired Interview with RAVFS staff and combined focus group with VNHSW and RAVFS)	TGP and VNHSW staff (n=4)	Virtual Interviews/Focus Groups led by study team	

Table 1: Summary of data collection for the three-year research project

Data Analysis

Focus group and interview data underwent independent transcription. The resultant documents were stored in password-protected university computers. Framework analysis (Ritchie et al. 2003) in NVivo 12 was used to manage data by dividing it into cases (type of stakeholder), then using codebook thematic analysis (Braun et al. 2018; Braun and Clarke 2019) allowing both a priori deductive coding and inductive coding based on reflective engagement with the dataset (Parkinson et al. 2016; Braun and Clarke 2019). A priori deductive coding drew on the initial models of RAVFS provision (Figures 1 and 2), the process of the RAVFS service, how this reflected the underlying restorative process, and what factors increased or decreased service acceptability. This exercise also centred attention on the impact of the RAVFS on family communication, empathy, goal setting and problem solving; the extent to which the service recognised and addressed veteran and family needs, and the impact of service use on veteran mental health and veteran and family wellbeing.

Ethical Issues

Ethical Approval for the study was obtained from the Research Ethics Committee of the School of Social Sciences, XXXXX University. The sensitive nature of the project raised ethical issues as it was recognised that veterans and families taking part would be talking about difficult family situations as well as their experience of RAVFS, and this could cause distress. To minimise or address this possibility it was agreed that researchers would consult the RAVFS practitioner before contacting the veteran or families to find out whether the professionals felt that the veterans/family were in a suitable psychological state to take part in interviews. Further, veterans and families were given a choice of interview location including the use of a veteran and family support house where further sources of support were available. Leaflets with details of wider sources of support including ChildLine for children and young people were also available.

Findings

The first section draws on professional experiences of service provision to explore the process of delivering RAVFS and changes made during early delivery. The second turns to family service receipt and whether use of the RAVFS promoted changes in the families and veterans who received the service. The last section considers the mechanisms through which such changes were achieved.

RAVFS Service Delivery

Although provision of the RAVFS service progressed largely as planned (see Figures 3 and 4) and with high levels of co-operation between VNHSW and RAVFS professionals, some challenges arose during early service implementation.

First, while the positive attitudes of VNHSW staff proved consistent throughout, it became evident that VNHSW staff needed time to become familiar with the RAVFS, relate the service to veteran needs and gain enough confidence in the service to refer veterans and families. Second, once both the RAVFS and VNHW were fully operational, some further integration to ease referrals and ensure veteran and family safety and wellbeing became necessary. Specifically, the need for RAVFS was often identified at the VNHSW veteran assessment, and while VNHSW therapists had long suspected that veterans tended to minimise the impact of the psychological injury on families, there had been little value in assessing these issues when there was no additional support available, to '*put the spotlight on it, when you, when you can't do anything with it.*' *(VNHSW Therapist).* However, once the RAVFS was in place VNHSW policy changed and added a self-report clinical measure of family wellbeing and relationships (Stratton et al, 2010) to the minimum data set already used by VNHSW therapists. Thirdly, although the need for a close working partnership between VNHSW and RAVFS had always been recognised, holding 'ad-hoc' case meetings to discuss service users became difficult as the RAVFS service provision increased. To overcome this the RAVFS practitioner began to attend weekly VNHSW multi-disciplinary meetings. This change not only provided regular opportunities to discuss veteran and family referrals

and progress, but it also helped the RAVFS become increasingly viewed as a part of VNHSW and keep a strong awareness of the influence of family problems on veteran mental health amongst VNHW staff

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

Turning to the RAVFS delivery process, professionals described early implementation as 'encouraging' as they received positive initial reactions from all veterans and families. Despite this, early delivery allowed the identification of some necessary changes to the practice model that seemed likely to improve acceptability and effectiveness.

One key element was the nature of the interaction between the RAVFS team and veteran families. While use of techniques from the full restorative continuum (Costello et al, 2010) had been anticipated, predominant use of family group conferences was expected. However, on delivery the RAVFS team found informal discussions shaped by restorative values and guided by restorative questions to be more acceptable and more effective in achieving meaningful communication with and between family members.

A further consideration was the timing of the provision of the 'psycho-education' sessions. This element of the service was welcomed by all participant families who were eager to learn more about the veteran's disorder. In addition, some families were interested in the therapy the veteran was receiving but had little or no knowledge of this, as the veteran in their family felt unable to discuss it. When working with families, the RAVFS practitioner also found that talking about mental health illness and therapy was a good opportunity to prepare families for any deterioration in the veteran's mental health at the start of therapy, a recognised risk particularly in trauma focused memory work when treating post-traumatic stress disorder (Ehlers & Clark, 2008). Armed with this knowledge the RAVFS

team made the timing of the delivery of 'psycho-education' flexible, with the service offered when most useful for each veteran family. To facilitate this, the element of psycho-education was thereafter delivered by the RAVFS practitioner rather than a VNHSW therapist.

Service Receipt

When reflecting on receiving the RAVFS service, most veteran and family opinion was positive and supported belief that the process mirrored that set out in Figures 3 and 4. However, these participants were also able to identify further areas likely to benefit from change. The phase of service referral attracted most comment. The referral service is initiated by VNHSW staff, either at the assessment or later during therapy. Veterans and families stressed the importance of the information about the RAVFS provided at this point. For example, one veteran who declined the service had misconstrued the criteria for use and erroneously believed that the non-engagement of some family members disqualified them from use; other families misunderstood the nature of the service believing it to be similar to a referral to social services,

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

There was further opinion on when the RAVFS should be offered. As receiving mental health therapy is demanding and distressing (Ehlers & Clark, 2008), the initial service model allowed veterans to be referred to RAVFS at any point of VNHSW use. In practice this worked well; some veterans delayed use of RAVFS until therapy was established as '*[at] the beginning it would have been too much.*' *(RAVFS Veteran 7);* others with high levels of family conflict at referral used the service while the veteran was on the VNHSW waiting list

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

Different family responses led to a new referral pattern. Some veterans were reluctant to engage in RAVFS before therapy but liked the concept of the service and told their families about it. As these families were eager to learn more about mental health illness, they began service use without the veteran.

Moving to consider service use. Families found the early one-to-one meetings particularly useful as meeting the practitioner on a one-to-one basis gave space to build positive relationships which eased the process of describing family experiences in these and later family meetings,

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

When assessing service acceptability, families and veterans felt the time of day the service was available was important. As the RAVFS became busier, practitioner availability inevitably decreased and this caused difficulties for some,

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

Others made further comment of how lack of a confidential space outside of the family home for individual meetings caused difficulties, as knowing that the family was in another room in the same building made sharing sensitive information hard, sometimes impossible.

Finally, families talked of the decision to end service use. There was strong opinion amongst some families that the RAVFS service should have been provided longer. These families felt that the decision to end service should be made collaboratively rather than having this decision made purely by professionals. This is a difficult area when providing support services, as debate often raises concerns about family dependency (Forrester et al., 2016). In response, RAVFS' staff re-stipulated their commitment to cooperative work with families but identified a need for more transparent conversations that set clearer boundaries around the length of support use at the start of the service. Drawing on the data gained from participant staff, veterans and families, the original models of the RAFVS and integrated RAVFS/VNHSW services were further developed. A revised representation of the embedded RAVFS process can be seen in Figure 3 and that of the integrated service in Figure 4.

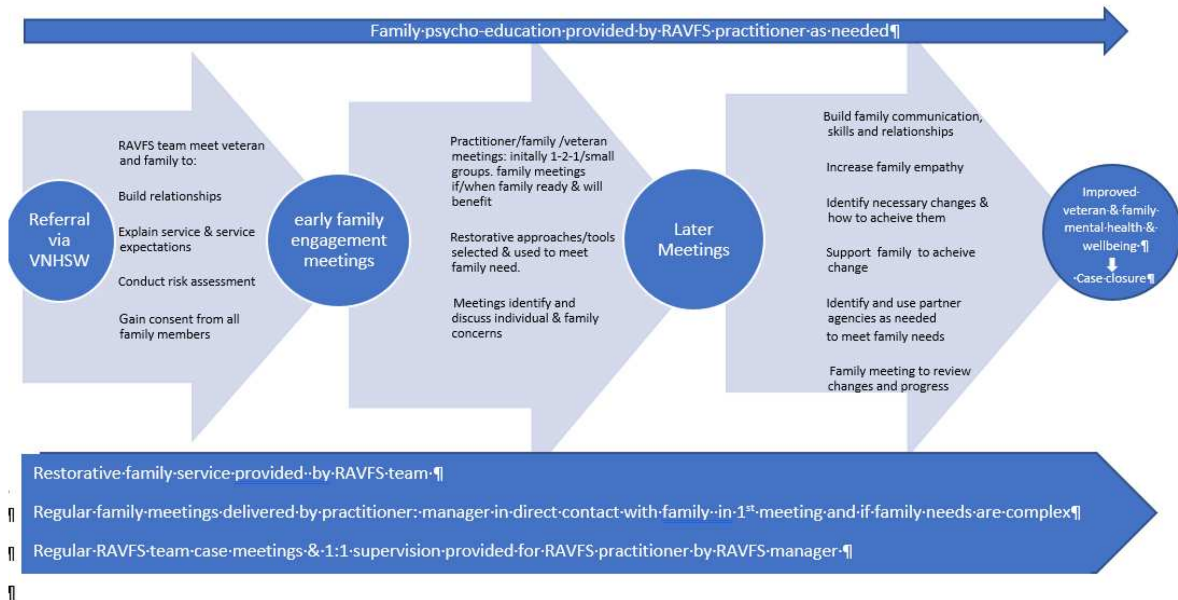

Figure 3: Revised embedded RAVFS process

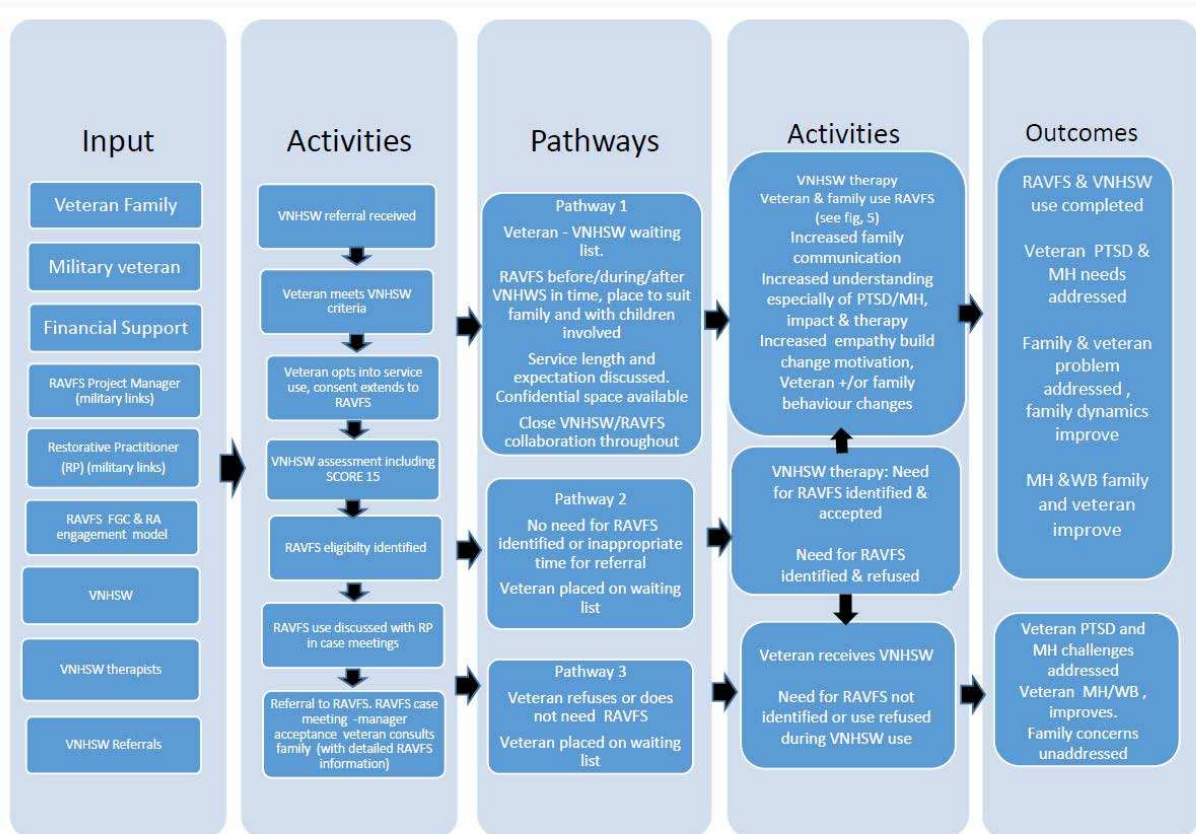

Figure 4: The final integrated model of RAVFS within VNHSW

The next section considers changes in the veterans and families using the RAVFS and how these changes were achieved.

Restorative mechanisms and family change

Drawing on the experiences of professionals and families, good communication and the resultant inter-personal trust built appeared to be key in creating positive working relationships between the RAVFS practitioner and the family. Evidence for this was found in suggestions that the relationships built in early meetings with families by use of restorative values, helped form a secure base for the remaining RAVFS process. RAVFS staff and families agreed that forming positive, trusting relationships facilitated the sharing of the challenges affecting the families and their impact, and thereby gave each family member an opportunity to get to know the practitioner before discussing sensitive family experiences and associated emotions,

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

Others spoke of the importance of the informal and friendly nature of the communication with the RAVFS team.

When describing the RAVFS process and associated changes, veterans and families viewed the mediated nature of the meetings as crucial, as it ensured that each family member had the opportunity to talk and be properly listened to by the rest of the family, an experience uncommon in most families, especially when conflict had previously been high. Nearly all participant families felt that the main benefit of RAVFS had been to provide a forum in which family communication was possible and promoted.

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

This helped families understand the pressures and feelings of each member,

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

Furthermore, the RAVFS staff contended that giving families an opportunity to talk about historical hurts as well as ongoing problematic behaviours was important, as this exercise allowed families to resolve long-standing emotional scars of service-related trauma as well as ongoing or recent ones,

‘*Those scars and everything and all that unsaid stuff was still there underneath and I think some families are definitely hitting level of couples therapy but [for] some it’s not necessarily that in-depth but they need something… A lot of it is just around communication. They just need to learn how to re-communicate with each other.*’ (RAVFS manager)

A restorative meeting begins with participants describing the problem that led to use of the restorative intervention before sharing perceptions of factors underlying the behaviours/events and the emotions and feelings these generated. In relation to veteran behaviours, few families and veterans had prior knowledge of mental illness or the association of behaviours, such as low mood, the veteran preferring to spend time alone, and aggression. Learning of these links changed family understanding of what underlay the behaviours of concern,

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

The psycho-education sessions were central to this, as increased knowledge of mental health symptoms helped families realise that the problem behaviours could most likely be attributed to the underlying mental health disorder. The knowledge also increased family’s understanding of how their own behaviours in reaction could sustain or increase symptom intensity. In addition, RAVFS staff described occasions when sharing such experiences enabled veterans to understand the impact of behaviours, such as withdrawal or aggression on their families. Collectively, the improved levels of understanding led to changes in perceptions of personalities and behaviours across the family unit, which in turn increased mutual empathy and decreased family tension. One family member summarised this well,

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

The increased levels of empathy drove the rest of the restorative processes with families as they increased general motivation to change matters. Families gave examples of how this facilitated family discussions of the changes needed to reduce tension and promote good mental health not only for the veteran but for all family members,

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

With some description of how the practitioner also provided families with tools to address challenges and help families sustain any changes made,

'*I felt anxious ... [practitioner]t would say right now how to cope with being anxious and what tools then you can bring yourself out of being anxious or take you out of a situation and if you're angry, think about something else. Another tool of getting yourself out of that situation.*' (RAVFS Veteran 14)

Overall, nearly all veterans and families found that going through this process had a positive effect on family communication, relationships and emotions,

'*And just ... improved the atmosphere in the house ... the home. … Erm it's more easier ... it's more lighter, we can just have a laugh now and crack jokes and do stuff again sort of thing*'. (Veteran 14)

We had [the children] involved, yeah. …. Yeah, we erm played a game of how we feel and stuff, if like if something happened how would you feel and we all had the chance of writing something down and putting it into like a sequence.' (Partner veteran 6)

Discussion

Study findings are drawn from a feasibility study that explored whether the RAVFS, an innovative restorative support service for veterans with service-related mental health disorders and their

families, could be associated with any positive effect on the mental health and wellbeing of service users. Further interest lay in the process of using a restorative approach in this setting, in the mechanisms within the restorative approach which achieved such changes, and whether changes in the service process and mechanisms may increase the RAVFS acceptability and/or effectivity.

When exploring participant veteran and families' experiences, study findings supported existing knowledge that serious mental health problems such as PTSD can negatively impact on the behaviours of the veteran, subsequent family relationships and thereby the progress of the veteran (Tarrier et al, 1999; Evans et al, 2010; Turgoose & Murphy, 2019). Further findings indicated that supporting the military veterans and families using a restorative approach had positive effect on family relationships by generating increased feelings of trust and improved levels of communication and empathy. Overall, study findings map well onto those associated with a USA intervention that supports in-service veterans and families in times of deployment. As with RAVFS, this intervention found that a strengths-based, practical method of delivery elicited the sharing of individual perspectives and experiences, and thus enhanced understanding, bridging communication, and increasing family cohesion (Lester et al, 2012).

Collectively these studies call for increased attention to be given to military families affected by service-related psychological difficulties, with evidence that such interventions can have positive effect whether military personnel are still serving or not. The similarities of the two interventions call for such support to include a focus on family communication and empathy. Further, the present study highlights the value of facilitated or mediated family meetings as findings suggest that this promotes full family participation and gives voice to involved members with suggestion that, similarly to procedural justice theory (Bennett et al, 2018), this engenders a sense of being heard which tends to raise feelings of collaboration and shared control (Burford and Hudson, 2017), and improve satisfaction with service use and associated family outcomes.

With the positive outcomes identified by the study being improved communication, understanding, and better family relationships, attention turns to how a restorative approach facilitates this. When

considering this, the early stage of the RAVFS process - providing full information about the service and engaging with family individuals - proved important as some families needed to be reassured that a referral to the service was not a criticism of parenting. Others needed to fully understand who qualified for the RAVFS. Later, in the preliminary one to one early meetings, important factors identified were giving time for family individuals to get to know the practitioner, having individual accounts and experiences listened to and heard. These experiences built trust between family members and the practitioner. This trust, together with the in-depth knowledge about family concerns and problems and how these were perceived and experienced by family members, promoted progression to larger facilitated family meetings, where the practitioner could ensure that giving voice to each participant family member in a respectful, non-judgemental environment continued.

Thereafter a crucial mechanism was the collective empathy, understanding and motivation to change built when each group member listened to one another's opinion, thoughts and experiences. While some opinion argues that such emotions and desires are founded on feelings of shame generated by an acknowledgement of the impact of behaviours/events in restorative meetings (Braithwaite, 1999), the focus of a restorative approach on problems rather than blame suggests that the notion of reintegrative shaming could be replaced by one of building levels of shared understanding through discussions and descriptions of events and/or behaviours. Advocates of this approach argue that adopting this principle leads to the more positive feelings of distress and surprise and a desire to remedy matters, rather than generating resentment and anger (Moore, 2004). Theory of the mechanisms through which these emotions are generated can be found in reports of a restorative criminal justice program, which suggest these changes in reactions to events happen through changes in self-schema that guide an individual's perception of situations (Armour & Sliva, 2018). While some evidence of this was found in this study, there was stronger evidence of changes in family perceptions of one another's behaviours - in held schema of other people, rather than oneself. In the context of an intervention that supports families and military veterans negatively affected by service-related

mental health illness, a crucial factor in changing these perceptions was the psycho-education provided. This knowledge triggered changes in understanding of the determinants of behaviours that caused family conflict.

Finally, study findings ask for attention to be given to the process of interagency working when developing collaborative interventions. While the attitudes of each agency were positive throughout and the motivation for developing and implementing the service high, entwining the services to best meet the needs of service users proved lengthy and required high levels of communication, empathy and knowledge of the practice and efficacy of each other's provision. It can be argued that the process of regular communication and meetings when married to a research process that regularly brought professional participants together to reflect on challenges and changes, saw the relationship between the RAVFS and VNHSW shaped by the constructs and processes of a restorative approach.

While study findings strongly suggest that a restorative approach family support service provides an acceptable, effective, strengths and relationship-based intervention for families and veterans affected by service-related parental mental health disorders, study limitations must be recognised. The RAVFS service is new, and while the process and positive effects mirror similar work with military families elsewhere (Lester et al, 2012) a robust evaluation of a larger multi-centre sample is now required, potentially through a randomised controlled trial methodology where families are randomised to a RAVFS or a waitlist condition. With regards to the mechanisms of a restorative approach in this family setting, while findings suggest that the underlying values and process of a restorative approach built shared understanding and empathy which, in turn, triggered changes in perceptions of behaviours, changes that in turn improved family dynamics, our sample is very small. Furthermore, the context of only using veterans and families with links to VNHSW led to contact with participants already committed to improving their psychological state. This, and a recruitment method which saw veterans acting as gatekeepers to RAVFS reinforces the need for a larger evaluation of this service and of similar work with families affected by parental mental health difficulties.

Conclusion

This study affords vital progression in understanding the mechanisms underpinning a RA in family support services, with a particular focus on military families affect by PTSD. The importance of which is in relation to the differences between restorative justice in criminal settings associated with generating reintegrative shaming and procedural justice, and RA in family settings which this study found links to developing collective empathy and communication to increase family cohesion. Whilst this research is of a feasibility study, a further study focused on veteran families demonstrated similar results so future research should focus on testing these pathways to family change.

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