An Independent evaluation of the Keeping Families in Mind Service

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Abbreviations and symbol list

AFF	Army Families Federation
BRS	Brief Resilience Scale
CELMT	Campaign to End Loneliness Measurement Tool
CPD	Continuing Professional Development
CSJ	Centre for Social Justice
DWP	Department for Work and Pensions
GP	General Practitioner
KFIM	Keeping Families in Mind Service
MOD	Ministry of Defence
OVA	Office for Veterans Affairs
PTSD	Post-traumatic stress disorder
RAFFF	Royal Air Force Families Federation
WEMWBS	Warwick Edinburgh Mental Wellbeing Scale
YSJU	York St John University

N or n	Number of clients / participants
p	Probability (statistical significance set at $p \leq 0.05$)
s d	Standard deviation
<	Less than
≤	Equal to or less than

1. Executive summary

1.1 Background:

Keeping Families in Mind (KFIM) is funded by the Armed Forces Covenant Fund Trust following a successful application to the Covenant Fund Families in Stress. Patel et al (2017) reported that it was clear from the 'Call to Mind' reports 'that the needs of [military] families are not being adequately recognised or addressed and that this is a gap in current provision across the UK' (p.46). In response to this identified need, the *Keeping Families in Mind* service aimed to work with families in the Sheffield area, offering one-to-one counselling, group anger management, mental health and wellbeing activities and a volunteer skills building programme. They planned to work closely with Armed Forces Welfare Officers, and to offer a bespoke programme of interventions, tailored to build resilience and discourage dependency.

When Sheffield Mind applied for funding to develop and deliver this service they had to plan for an independent evaluation of the service as part of the funding agreement. The evaluation aimed to discover whether or not the service has been beneficial for families of serving and veteran personnel. The evalation was conducted to inform decisions about whether the KFIM service should be continued.

1.2 Aims, objectives and hypotheses

The overall aim was to evaluate whether, or not, the KFIM service has been beneficial for families of serving and veteran personnel. There were five study objectives, three of which had a related hypothesis:

1. To examine if there was a statistically significant change to participants' Warwick Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al 2007) pre-counselling and post-counselling scores (anonymised scores were provided by Sheffield Mind to the project team for analysis). 1st Hypothesis: that the counselling provided by KFIM would result in statistically significant ($p<0.05$) improved scores on Warwick Edinburgh Mental Wellbeing Scale the from the baseline assessment to follow-up test.
2. To examine if there was a statistically significant change to participants' the 6-item Brief Resilience Scale (BRS; Smith et al, 2008) pre-counselling and post-counselling scores

(anonymised scores were provided by Sheffield Mind to the project team for analysis). 2nd Hypothesis: that the counselling provided by KFIM would result in statistically significant ($p<0.05$) improved scores on the Brief Resilience Scale from the baseline assessment to follow-up test.

3. To examine if there was a statistically significant change to participants' 3-item Campaign to End Loneliness Measurement Tool (CTELMT) pre-counselling and post-counselling scores (anonymised scores were provided by Sheffield Mind to the project team for analysis). 3rd Hypothesis: that the counselling provided by KFIM would result in statistically significant ($p<0.05$) improved scores on the Campaign to End Loneliness Measurement Tool from the baseline assessment to follow-up test.

4. To evaluate questionnaire data collected by Sheffield Mind from clients' attending KFIM service (3 closed questions and 3 open questions) following completion of counselling (Sheffield Mind provided the anonymised survey data for analysis).
5. To explore the views of clients, referrers and staff regarding the KFIM service (data was collected by the YSJU research team using semi-structured virtual interviews.

1.3 Method

This service evaluation was a longitudinal, mixed-methods prospective study with three separate data collection phases:

1) The KFIM clients undertook outcome measures (WEMWBS, BRS and CELMT) at a baseline assessment and were then re-assessed at three additional points in time. The measures were given to clients to complete for the first time at their assessment session, and this provided the baseline measures. Follow-up measures were usually undertaken at the beginning of the 1st, 8th and 16th counselling sessions. Pseudonymised scores were analysed by the York St John University (YSJU) research team for changes and statistical significance.

2) An online survey, comprising 3 open questions and 3 rating scales, was given to clients by the KFIM team following counselling, pseudonymised results were analysed by YSJU research team.

3) Semi-structured interviews were undertaken with a sample of clients, staff and referrers by the YSJU research team in the summer of 2021, these were transcribed verbatim and analysed using thematic analysis.

Ethical approval was obtained from the Cross Schools Ethics committee at York St John University. Participants were all over 18 years of age and able to provide informed consent (according to the guidelines for the Mental Capacity Act 2005). Sheffield Mind obtained consent for the pseudonymised outcome measures and survey results to be used for the service evaluation. For the semi-structured interviews, participants were provided with an information sheet about the purpose of the interviews and use of the findings and provided either written, electronic and / or audiotaped consent.

1.4 Results:

1.4.1. Outcome measures

Sample: Not all clients who were referred or self-referred to KFIM went on to receive therapy. Eleven people did not have the initial assessment, and another one dropped out before their first therapy session. Four people were assessed but accessed a different service. Only 23 clients completed a full course of therapy with KFIM. The number of counseling sessions received varied owing to clients' needs and for the analysis clients were divided into three sub-samples: sub-sample A had undertaken the outcomes measures at least twice; sub-sample B had undertaken the outcome measures at least three times; and sub-sample C had undertaken the measures four times.

WEMWBS Sub-sample A: Thirty-three clients had a baseline assessment on the WEMWBS and a follow-up assessment (which had usually been taken at the start of the first therapy session). The means for the 14 WEMWBS questions and the means for the total scores were compared between the baseline and 2nd test. Mean scores increased for 12 of the 14 WEMWBS questions and for the total score. The Related-Samples Wilcoxon Signed Rank Test was undertaken to examine whether changes in scores were statistically significant and statistical significance was set at $p \leq 0.05$. The overall improvement across the sample's total scores from baseline assessment to the first therapy session was found to be statistically significant at $p \leq 0.023$, with six of the 14 individual questions also showing statistically significant improvements (n = 33).

WEMWBS Sub-sample B: Twenty-six clients had undertaken a baseline assessment on the WEMWBS and two follow-up assessments (which has usually been taken at the start of the first therapy session and the beginning of the 8th session). Increases in mean were found from baseline to the 3rd test for scores for all 14 WEMWBS questions, with these improvements being statistically significant for 12 out of 14 questions. The improvement across sub-sample B's total scores from baseline assessment to the first therapy session was found to be statistically significant at p=0.047 and from 2nd to 3rd test was also statistically significant at p = 0.004. There was a mean increase of 9.5 between the baseline total score compared to the 3rd test which was statistically significant at p = 0.000.

WEMWBS Sub-sample C: Eight clients had undertaken the WEMWBS scale on four occasions. There was a positive mean difference between the Baseline and the 4th test scores for all 14 WEMWBS questions and the total score. Improvements from baseline to 4th test were statistically significant at p≤0.05 for nine out of 14 questions and the WEMWBS total score (p=0.017).

Therefore, the 1st Hypothesis that the counselling provided by KFIM would result in statistically significant (p<0.05) improved scores on the Warwick Edinburgh Mental Wellbeing Scale from the baseline assessment to follow-up tests was supported for the analyses for sub-samples A, B and C, indicating clients' mental wellbeing improved following counselling provided by KFIM.

BRS Sub-sample A: Thirty-four clients had a baseline assessment and a follow-up BRS assessment. Increased means were found for all six BRS questions and the average score. A paired samples T-test was undertaken for the BRS average score which was statistically significant (t -2.475, degrees freedom 33, p = 0.019). Related samples Wilcoxon signed rank tests were undertaken for each BRS question and for the average score, with only the average score (p = 0.018) and question 1 (*I tend to bounce back quickly after hard times*; p = 0.015) showed statistically significant increases.

BRS Sub-sample B: For sub-sample B (n = 26) the BRS average mean score for the sample increased from 2.36 at the baseline to 2.65 at the third test (post-test). Following analysis with the Related samples Wilcoxon signed rank test the BRS average score (p=0.018) and only question 1 (p=0.015) were found to be statistically significant.

BRS Sub-sample C: Nine clients undertook the BRS on four occasions. The average mean score increased from 2.52 at the baseline to 3.18 the fourth test. This increased mean indicated an improvement in resilience; however, it was not statistically significant at p<0.135.

Overall, the 2nd hypothesis was only supported for the analysis of BRS scores for sub-sample A and B. So, whilst the mean differences for all six questions and the BRS average score indicated improvements in resilience across all three sub-samples, the results were not statistically significant at the $p \leq 0.05$ levels for analyses of scores clients who undertook four tests. Therefore, the 2nd Hypothesis was partially supported.

CELMT Sub-sample A: Thirty-four clients had a baseline assessment and at least one follow-up assessment on the CELMT. The means for question 1 and 3 reduced between the baseline and 2nd test, whilst the mean for question 2 increased slightly by 0.15. Scores did not show a statistically significant change for all three CELMT questions.

CELMT Sub-sample B: The means for all three questions were found to decrease from the baseline to 3rd test. Scores also decreased from the baseline to 2nd test for question 3. The CELMT baseline and 3rd test data (n = 26) did not show a statistically significant change for all three questions.

CELMT Sub-sample C: For Sub-sample C (n = 9) the means for all three questions decreased from the baseline to 4th tests. Scores also decreased from the 2nd to the 3rd test and between the 3rd and 4th tests. The means from baseline to 2nd test increased for question 2 but remained the same for questions 1 and 3. The CELMT baseline and 4th test data showed a statistically significant negative change for questions 1 and 3.

Therefore, the 3rd Hypothesis that the counselling provided by KFIM would result in statistically significant ($p<0.05$) improved scores on the Campaign to End Loneliness Measurement Tool from the baseline assessment to follow-up test was not supported by the findings from sub-samples A, B or C.

1.4.2. Sheffield Mind's online evaluation survey: Eighteen clients completed the online survey. Most respondents (15/18) rated their therapy as effective to some degree (extremely effective = 8; very effective = 6; and somewhat effective = 1). Twelve of the 18 respondents indicated counselling had enabled them to cope better with the stressors of military life to some degree (strongly agree = 5; agree = 6; somewhat agree = 1), with five rating their response as 'neither agree nor disagree' and only one person disagreeing. Sixteen of the 18 participants (strongly agree = 7; agree = 8; and somewhat agree = 1) indicated that counselling has improved their capability to support others emotionally to some degree. But two respondents rated this statement as 'strongly disagree'. Clients did not mention anything about the KFIM service that was unhelpful. Four themes (Importance of

talking; KFIM was helpful; Sessions could be challenging; and Timing) and two sub-themes (Being listened to; and the therapist being non-judgemental) from analysis of responses to the question *'What did you find most helpful or unhelpful in your therapy?'* Clients spoke about the value of having someone to talk to, of being listened to and having a counsellor who was non-judgemental. Clients provided examples as to how the KFIM had been helpful to them, however, some clients reported finding the counselling sessions challenging as they were reflecting on difficult experiences and emotions The short waiting time and regularity of sessions was found to be helpful. Five themes (confidence, coping, relationships, positive feelings, and self-worth) *'What aspects of your life has it affected most?'* some clients provided examples of how counselling had given them more confidence in other aspects of their lives and how they were coping better in situations. Clients gave examples of relationships that had been affected and described several positive feelings, such as passion and motivation, improving or returning. Clients mentioned changes indicating improved self-worth. Four themes (confidence, making changes, self-care and self-awareness) emerged from analysis of the question *'How has if affected your relationships?'* Confidence appeared as a theme again in response to this question, with additional examples of how counselling had given them more confidence in other aspects of their lives and clients provided some examples of changes they had or were making in their lives following counselling. Clients spoke about how they were taking better care of themselves and gave examples of how they had increased in self-awareness.

1.4.3 Interviews with clients, staff, and referrers: The sample interviewed comprised of 10 clients who had accessed the KFIM service, four staff members and one person who was a referrer to the service. To maintain anonymity people were given a participant code.

1.4.3.1 Clients' perspectives: **Referral:** Of the 10 clients interviewed, most (n = 7) had referred themselves to KFIM. One person had been referred by a friend, another by their General Practitioner (GP) and whilst the last person could not remember exactly how they had been referred, although they thought the referral had either been made through Project Nova or the South Yorkshire Police. People had found out about KFIM through a variety of sources including friends, family, their GP, Twitter, Ripple Pond, a bereavement counsellor, and Help for Heroes. People's reasons for self-referring to KFIM or for being referred to KFIM were varied. Themes included: dealing with threats of violence; livening with a partner with Post Traumatic Stress Disorder; and the loneliness experienced when partners were deployed.

Experience of the KFIM service: Clients were asked what they had hoped to gain from the KFIM service. Some clients mentioned that they did not know what to expect from the KFIM service, but soon realised that it would be helpful and that it was good to get the right support, with others feeling that previously they had had no support. Clients spoke about the value of having someone to talk too and of experiencing a crisis point which had led to them seeking help. Only two of the ten clients interviewed had the opportunity to take part in face-to-face group sessions as the COVID pandemic directly affected service delivery. Most clients interviewed received individual sessions or accessed online support groups and their sessions were conducted by either telephone or video call. The virtual service was seen as a positive by some clients who had found it easier to access the service online and fit therapy around other commitments, such as work. Clients appreciated Staff flexibility regarding scheduling appointments. Several clients mentioned that having someone to listen to them was very beneficial and that having someone who had the knowledge and understanding of the military community was helpful. Having the opportunity to talk about and work through anxieties and changing how people thought about their lives and helping them to look at things differently were mentioned. In response to the question about how they had found their individual or group sessions, all but one person said that they had found the KFIM service helpful, with most adding that they thought the service should continue. The client who appeared not to find the service helpful, said that they had been looking for specific mechanisms and methods to be suggested by the KFIM staff to help with coping strategies. Clients commented positively on the service's flexibility and availability of staff, the timely access to the service, and on not being judged. Clients described the therapists' skills in enabling reflection and insight and gave examples of how therapists had validated their experiences and feelings. Clients gave examples of things they had changed and that had improved in in their lives following therapy. Some clients said that they initially found talking in sessions difficult as just speaking to someone was a new experience for them. Many said that just being listened too and receiving prompts from the KFIM staff made it easier. Several clients mentioned that the sessions could be emotional but added that KFIM staff had professionally and sensitively processed the issues identified. Finding solutions themselves was thought helpful with some identifying that their anxieties were more complex than they had previously thought before accessing the service.

Clients' views of the KFIM service: All clients were unanimous in their recommendation of the KFIM service to anyone who found themselves in a similar position. An ongoing theme running through the interviews was how clients valued having someone to talk too who understood the military lifestyle and who created a supportive and comfortable environment where individuals did not feel alone. Most clients reported that they felt that their needs had been met and that their KFIM sessions had successfully explored their concerns and issues they were experiencing at the time. One person identified some ongoing challenges and the need for support with goal setting and time management. Concerns were expressed that some community services were unaware of the KFIM service and that people who would benefit from the service may be unaware it exists. Concerns were also raised regarding ongoing funding for the service. The need for wider support outside of counselling sessions and 'safeguards' for people with severe mental health problems was raised. Those interviewed clients who had a close connection with the military or were from a military family (as opposed to people who were family members of someone with military background) reported that they felt the KFIM staff had a good understanding of military life and that this understanding had been helpful when discussing issues. Six of the 10 clients interviewed made additional comments, and of these five people wanted to express their thanks and their gratitude to the Keeping Families in Mind service and the staff who provided their counselling. In addition, the accessibility of the service was mentioned positively. The other person asked for more information about why the KFIM service was focussed on military families, commented on the need for wider advertising of the KFIM service and the risk of mental health problems and suicide, particularly amongst men.

The themes emerging from the client interviews have been collated and summarised in the table below and provided with illustrative client quotes.

Summary of themes and sub-themes that emerged from Clients' interviews (n = 10)

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Threats of violence	Client spoke about ex-partner making threats	*"I was getting a lot of anxiety …I couldn't concentrate at work"*	Being able to access bespoke support	Client said that they had found other services accessed not useful	*"…just a bit support really…"*
Partner with PTSD	Client spoke about partner who suffered with PTSD	*"…just like just processing things and like trauma and touched on PTSD and that kind of thing…"*	Being able to access support and process trauma	Client said that the anxiety was affecting their work	*"I just felt like I had to bottle everything up and I couldn't cope with all the pressures of … sorting everything on my own."*
Loneliness being a military spouse	Client spoke about living away from military bases and the support network	*"People ask me are you married to him or do you live on base. I'm neither of those, but I'm still a military spouse. It doesn't take away the fact that I'm still dealing with him being deployed and everything"*	Being able to access support due to wider KFIM military partnership definition	Accessing support was difficult due to partnership status not being recognised	*"I'd struggled quite a bit because I live on my own anyway when he's away."*
Importance of having someone to talk too	Clients spoke about the value of having someone to talk too.	*"I was just hoping to have someone to chat to about the reasons as to why and sort of have someone give me some insight into those feelings"*	Being listened too	Client said that it was beneficial having someone to talk too to gain an insight into their own feelings	*"…have someone give me some insight into those feelings…"*

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Mental Health – PTSD	Coping with a family member who would not access support	*"…it was as if the other person is not important, and it didn't show the importance of the family and didn't show what it's like to live with somebody whose suffering…"*	Mental health and other family members	Client said that they felt living with someone who suffered with a mental health condition can have an impact on them also.	*"…what it's like to live with somebody whose suffering and the sort of the secondary post-traumatic stress… it's a knock-on effect…"*
Coping with emotions and feelings - anxiety	Client experiencing a crisis point	*"I just wanted to regain control of everything that was going off in my head"*	Feelings of anxiety and loss of control	Client expressed feelings of anxiety and loss of control	*"…how I was feeling I just felt out of control…"*
Impact of Pandemic	Attending Group activities were impacted owing to the COVID 19 pandemic	*"…We started off on the phone because obviously it was during the first lock down when we couldn't go…"*	Use of telephone and online platforms	KFIM services continued during the pandemic utilising online delivery	*"I thought it* [online service delivery] *was very useful…"*
Benefits of online access	Access to group activities and appointments was enable through an online service delivery	*"…we then changed to video call which I thought was very useful because I was very anxious at first…"*	Staff flexibility regarding scheduling appointments	Clients have been able to access support at times to work around other commitments	*"…we've had appointments either side of a normal lunch break and it worked great…"*
Understanding of Military family life	Accessing a service that understands military family life	*"…not that many people outside of the military community would understand or tolerate…"*	No sub-theme		

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Experience of crisis	Some clients said that they'd reached a point of crisis	*"I mean, for me, …I was at breaking point"*	No sub-theme		
Timely access to service	Clients commented positively on the service's flexibility and availability of staff	*"And she came to me because obviously with my anxiety, I said to her, I feel too afraid to leave the house."* *"…it was really helpful to be offered it on the telephone…"*	Prompt access to service compared to other services	Short waiting lists	*"For me, actually, like self-referring to getting the therapy wasn't that long at all. I think it was like three weeks …was not that long at all…"*
Non-judgemental service	Clients commented on not being judged	*"…one of my biggest concerns was like the feeling of being judged…"*	Therapists' understanding and acceptance	Clients commented on how therapists accepted their situation	*"So, to actually have somebody listen and, and accept that's that…"*
Therapists' skills	Clients described the therapists' skills in enabling reflection and insight	*"…she was really good at listening …it's not about her telling me what's right and wrong, but making you realise yourself."*	(no sub-theme)		

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Feeling validated	Clients gave examples of how therapists had validated their experiences and feelings	*"…helped me understand …you have every right to feel afraid. And she just helped me know that it was OK to stand there and go, no, it's not silly actually it did affect me…"*	(no sub-theme)		
Improving and making changes through therapy	Clients gave examples of things they had changed and that had improved in in their lives following therapy	*"She kind of gave me a proper life back - I honestly don't think that I'd be where I am now without [name], literally"*	(no sub-theme)		
Recommendation of service to others	All clients would recommend the service to others	*"Yes, definitely. Without a doubt"* *"I found it so helpful more than I expected much more than I actually expected…"* *"…it worked for me…"* *"…you will get someone giving you professional help and advice…"*	(no sub-theme)		

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Not feeling alone	Clients talked about how the KFIM service had provided someone to talk to when they did not have anyone else to speak to about their concerns	*"I've not got anyone else who's in the same situation you know, not anyone…"* *"…it was nice to be able to have somebody just to talk too…"* *"……they made me feel like I wasn't alone…"*	(no sub-theme)		
Meeting clients' needs	Sessions successfully explored clients' needs, concerns, and issues they were experiencing	*"Like I say, I think she opened up those I didn't even realise were there and helped me more than what I was expecting to get…"*	Further client support explored via KFIM or other appropriate service subject to client need	Some clients mentioned KFIM follow up, or signposting or referral to alternative service dependant on client need	*"…I did have a follow up and a couple of calls…"*
Awareness raising of KFIM service to other community service providers	Concerns that some community services were unaware of the KFIM service affecting referrals	*"…there might be other people out that don't know about this service…"*	Engaging with stakeholders to share information about KFIM	Clients suggested other stakeholders and charities could help raise awareness of KFIM	*"…So, if it [KFIM] was just more out there, if more stakeholders could be shouting about it …that'd be great."*
Funding	Concerns raised that funding for the service may disappear	*"I just wish that … you could have … funding for a bit more…"*	(no sub-theme)		

Themes	**Definition of theme**	**Themes: Illustrative quotes**	**Sub-themes**	**Definition of sub-themes**	**Sub-themes illustrative quotes**
KFIM service had helped	Clients felt accessing the service had helped them	*"…they've helped me massively …I don't think I'd be half the person I am now"*	Developing skills to help others	Examples of how clients were using learnt skills and strategies to support family members	*"…the skills that I've learnt to cope with my own anxiety and …my depression I was actually able to …help my sister go through a really hard time…"*
Staff understanding of military culture and lifestyle	Some clients reported that they felt the KFIM staff had a good understanding of military life	*"…you could just tell by certain things that I said or that she did understand and understood really well what I was referring to. things that she did understand..."*	Staff knowledge of wider support for military personnel, veterans, and families	Some clients shared that the therapist has signposted to help and support for their family member who was in the military	***"…****she signposted me with places that I could take home and offer to [name] for help."*
Unique Bespoke Military family focused service	Military family members prioritised	*"It was that something was finally there for me that I could access…"*	No sub-theme		
Expressions of thanks and gratitude	Several clients used this 'have you anything to add' question as an opportunity to thank their therapist and / or the wider KFIM service	*"…just that I was extremely thankful for the service…"* *"Just that I am very grateful that I was able to access the service…"*	No sub-theme		

1.4.3.2: Referrer's perspectives: The response for research feedback from referring organisations was very low and only one person came forward to be interviewed. Therefore, it was not possible to undertake a thematic analysis from a sample of interviews. The feedback received from the one referrer appeared to replicate some of the concerns and issues reported by the client group. The referrer indicated that they had made four referrals to the KFIM service representing a range of people such as parents and veterans and having a referral pathway to KFIM was viewed as a positive resource. Family dynamics and feelings of not being supported were identified as recurring themes in the client group identified by the refer. Of those followed up, the feedback was very positive with family members and veterans reporting that they were finding the KFIM service very useful and helpful. The referrer said that the KFIM service had made a difference and been really useful especially as, in their opinion, Sheffield was '*one of the worst areas'* for waiting times accessing mental health services. The referrer also said that it was often the partners who were trying to offer support who were *'taking the brunt of it'* and not getting the support they needed regarding how to cope, for example with someone with Post-Traumatic Stress Disorder (PTSD). They added that working together as a family would be *'really useful'.* The referrer considered that the KFIM service should '*definitely'* be continued. The referrer suggested that the KFIM service should be extended outside of Sheffield to cover more of Yorkshire, especially where there are a high percentage of veterans and/or military families such as Catterick, as it is a garrison town. The referrer mentioned that without the chance attendance at a meeting where a member of the KFIM staff provided a presentation they would not have been aware of the service. They said that more advertising about the service was essential. Feedback from the KFIM service to the referrer was identified as a communication desire as it would help to know what other services were being accessed providing an oversight of the outcome.

1.4.3.3: KFIM staff's perspectives:

Staff sample: Four staff participated in semi-structured interviews for this evaluation, they included the KFIM manager, therapist, well-being practitioner, community engagement officer. Staff interviewed engaged in a range of activities related to the service including: one-to-one counselling; facilitating support groups; coordination of the KFIM service; taking referrals; arranging

appointments; promoting the service; data management; networking with other organisations; planning; and training.

What KFIM offers: KFIM provides up to 16 sessions of one-to-one counselling, group work and a range of support groups, including: Arts and Craft Group, which has been the "most popular" group; Creative Writing group; Movement and Mood group (which has been the least well attended); a Walking group; a Book club; and a Post-Traumatic Stress Disorder (PTSD) Course.

Impact of the COVID 19 pandemic: Staff reported the period to set up the service, awareness raising, and distribution of service information was impacted significantly by restrictions related to the COVID 19 pandemic. The impact of the pandemic was identified as having both challenges and positive outcomes. The service needed to move online in response to COVID related lockdowns and restrictions. Although staff reported experiencing a significant learning curve around the use of new online platforms, such as Zoom and Microsoft Teams, it was reported that migration over to an online platform did prove to have some benefits, especially around ease of appointment access for clients. This included some clients not having to travel to appointments and having more flexibility around appointment times. KFIM staff plan that online groups will be retained alongside face-to-face groups to maintain the level of support attained.

Raising awareness of the KFIM service: KFIM staff used a range of activities and information sharing practises and events to provide service information for communities, which included: local Radio interviews; handing out leaflets at local supermarkets; Social Media (Facebook, Twitter); advertisement on public transport; downloadable leaflets on the Sheffield Mind website; KFIM staff attendance at community support service meetings; staff engagement with civilian and military charities, and with military units (reservists); staff becoming part of local authorities' Armed Forces Covenant networks; engagement with health and social care professionals; engagement with Department for Work and Pensions (DWP) staff; the provision of Mental health training events; and a KFIM project conference. Staff also engaged with the Citizens Advice Bureau, Project NOVA, Rotherham Federation, and Voluntary Action in Rotherham and Barnsley. KFIM staff have been providing free mental health awareness training as a vehicle to share information about the families support resource. This has generated positive engagement outcomes. Staff reported that initially there was some confusion around what the KFIM service was and who it was for, with many organisations assuming that it was focused on military veterans. This resulted in some early referrals

that were not from the identified families' client group. Staff found that people from military families tend not to perceive themselves as important and consider the serving person as more important. Staff have had conversations with military families to explain that they were important too and how engaging with the KFIM the service may benefit not only them, but also indirectly their partner and/or family. It took a while for KFIM to build a reputation and to be trusted by the military community.

Referral pathways: Staff reported the current referral process was working well with regular referrals being received from various sources. To facilitate easy referral or self-referral to KFIM, several referral routes and pathways are available including by telephone, email, the website, and social media. The inclusion of an addition question on the Sheffield Mind assessment, "Are you part of the armed forces community? Are you serving or are you a veteran or a family member of serving personnel?" has helped to identify more potential KFIM clients. They have requested other organisations to add these questions to their assessments as well, although it is unclear to what extent this has happened.

Benefits of the KFIM service: Staff talked about the positive impact around one-to-one talking therapies and how some clients found it very beneficial. The development of support groups was identified as being impactful by creating a space where supportive friendships and networks could be formed by clients. Staff reported that having several interventions available has been very successful, with some clients utilising both one-to-one therapy and group sessions. Feedback from clients on the KFIM website was used as evidence that KFIM makes a positive difference. A benefit of KFIM was the minimal waiting times to access counselling compared to other mental health services, especially for people at a crisis point. Volunteers who work with the support groups and other activities at Sheffield Mind were seen as a benefit to the service. Staff consider that KFIM has been '*accepted as part of the military scene'* in South Yorkshire.

Concerns if the KFIM funding were to cease: Staff expressed the following concerns if the KFIM was to end: loss of the investment of time spent to set up the KFIM service, sharing awareness of the service and the concerns and challenges military families face; losing the knowledge and expertise gained; how the service had become integrated into community services; risking military families not having access to a bespoke service when in crisis; and providing a voice and representation for families at Armed Forces Covenant council meetings and other planning events.

Plans for the future: Several future developments were identified by KFIM: working with mother and toddler groups; a couple's therapy service; continued information sharing to reduce stigma and barriers to engagement; expansion of support groups to include a wider range of client-centered interests or activities; and the extension of mental health awareness training. Staff consensus was the service should be rolled out across a nationwide footprint to reach out to more military families who they described as *'a forgotten part of society'*.

1.5 Strengths and Limitations of this evaluation

The use of mixed methods and various sources of data, including outcomes measured by three standardized measures, quantitative and qualitative survey data and information from semi-structured interviews with clients, staff and a referrer has enabled triangulation of findings, thus strengthening the rigour of this evaluation (Flick, 2018). The evaluation has been undertaken by a research team outside of Sheffield Mind and the KFIM service, thus reducing the risk of researcher bias and increasing objectivity (Pannucci and Wilkins, 2010). Whilst the desired sample of ten clients were recruited and interviewed, the referrer sample was small than anticipated and only one person who had referred clients to KFIM contributed an interview. A limitation in the quantitative outcome measures data for WEMWBS, BRS and CELMT assessments was the variation in time scales between when the 1st, 2nd, 3rd and 4th measures were undertaken by clients. This variation was influenced by several factors that are not possible to control in service provision (compared to a randomized controlled trial). This identification of differences in time intervals between measures is an important factor to consider (Caruna et al, 2015).

1.6 Conclusions

In conclusion, research findings suggest the KFIM service has been a success and reached military families who may have not had the opportunity to access help if not for the existence of the service. Drawing the results from the WEMWBS and BRS outcome scores, survey results and clients', referrer's, and staff's interviews, it can be concluded that the KFIM service resulted in improved mental wellbeing and resilience for most clients. The impact of the service had been substantial for some people, for example one interviewed client said *"…it saved my life it was a lifeline…"* Feelings of

loneliness did not improve, and loneliness was even found to increase for some clients, however, this finding could be explained by the unprecedented circumstances under which the KFIM service was delivered during the Covid 19 pandemic and research which has indicated loneliness increased amongst the general population owing to lockdowns and restrictions (Mental Health Foundation, 2021; Killgore et al, 2020).

The current referral process appears to be working well, facilitated by easy referral or self-referral to KFIM several via multiple referral routes, including by telephone, email, the website, and social media. Research findings and feedback from clients, referrer, and staff suggests that military families, their location and understanding their needs, continues to present a challenge for many community service providers. This suggests that there continues to be an awareness training need for community service providers. KFIM feedback suggests routine data collection in some community services, and the inclusion of questions identifying members of the armed forces community remains ongoing in development, is sometimes sporadic, and in some cases absent, with concerns that people from military families who may need support, could potentially not be referred to bespoke services and fall through the support net. Having someone to talk too who was trained to understand military life and culture and creating support networks through the groups were positive recurring themes which contributed to breaking down barriers and having a positive effect on help seeking behaviors. Concerns around loneliness and isolation for not only serving families, but also ex-service families, have been addressed by KFIM with the creation of supportive networks and groups enabling clients to create their own support networks and friendships. Referrers describe the benefits of having the KFIM service resource and having the ability to be able to signpost and refer families, how the speed of referral contact was beneficial, and engagement with the KFIM service has made a positive difference. Such positive impact results suggests that the KFIM service should not only continue to be funded, but the model should be replicated over a wider geographical area to close a gap in provision supporting military families. There was consensus amongst staff and the referrer interviewed that the KFIM should be rolled out wider across a nationwide footprint to reach out to more military families who they described as *'a forgotten part of society'*. Adopting the commitments of the Armed Forces Covenant, KFIM is a good example of recognising the sacrifices military families make and the service addresses the needs of military families ensuring they face no disadvantage.

1.6 Recommendations

1. The Keeping Families in Mind (KFIM) service provide by Sheffield Mind provides a valued service that is making a positive impact in the lives of its clients and the service should be continued long-term.
    1. The blend of face-to-face and online service provision providing choices to clients and enabling a range of activity focussed support groups should be continued.
    2. Future developments identified by KFIM staff should be pursued: working with mother and toddler groups; a couple's therapy service; continued information sharing to reduce stigma and barriers to engagement; expansion of support groups to include a wider range of client-centred interests or activities; and the extension of mental health awareness training.
    3. Services who may come into contact people with links to the military community should include screening questions in their assessment to identify people who may be currently serving, veterans or family of serving personnel or veterans.
    4. Mind, with a network of around 125 local Mind services spread across England and Wales (Mind, 2021), is well placed to deliver additional KFIM services across the country, with a priority being locations where there are military garrisons.
    5. Sufficient time needs to be allowed when setting up further KFIM services to the development phase, raising awareness of the service amongst the military community and to potential referral sources.

1. Background

Patel et al (2017) reported that 'there are variances and some important gaps in national and local strategy and planning for meeting the mental and related health and social care needs of veterans and their families' (p.6). In England, the neglect of family needs was one of the gaps in service provision with the needs of parents, especially mothers, particularly over-looked (Patel et al, 2017); 'across the UK, the needs of family members including children are often under-identified or over-looked and the mental health problems of family members (including children and carers) are sometimes associated with living with a veteran who has mental and related health problems' (p. 46). Supporting a veteran with mental health problems can negatively impact on family members' own mental health and wellbeing, leading to the development of common mental health disorders including anxiety, stress, depression, and/or drink problems (Patel, 2017).

The need for staff to understand military culture is a recommendation as part of the NHS Constitution (2015) as some veterans and families may have feelings that community services may not understand military life (Ashcroft, 2014). Research suggests that having an understanding may address barriers to engagement., Meyer et al (2016) asserts that the lack of military cultural competence may contribute to people from the armed forces community not approaching service providers; a view supported by Hall (2011) who adds that unless practitioners and providers of community services 'understand their language, their structure, why they join, their commitment to the mission, and the role of honour and sacrifice in military service', they will not be able to adequately intervene and offer care to military families. To address concerns around framing services to better support the armed forces community, Ross et al (2015) suggested the creation of education programmes for providers and practitioners, a view supported by Coll et al (2010), Demers (2011) and Moore (2019). To address the need for cultural competency the KFIM staff received the 'Military Human: Understanding Military Culture and Transition' CPD training provided by York St John University (Wood, 2018; Albertson, 2019).

In 2018, the four South Yorkshire local authorities (Sheffield, Rotherham, Barnsley, Doncaster) embarked on a series of projects and staff training to better understand the needs of the armed forces community in their region by carrying out a mapping study with accompanying follow up report (Albertson et al, 2018; Albertson et al, 2019). The demands on military families (such as regular

moving, deployments or the challenges supporting a family member who has sustained an injury or Post Traumatic Stress Disorder, PTSD) have been discussed in several publications (Centre for Social Justice, CSJ, 2016; Turgoose and Murphy, 2019; MOD,2021). In addition, previous research has suggested that the transition to civilian life for service leavers and families is intense and complex in nature, requiring a holistic approach (Heaver et al, 2018; Selous et al, 2021) and should be preceded by a period of preparation (Ashcroft, 2014). Further research and guidance suggested a low awareness of support services (FIMT, 2018) and a gap in emotional transition and adjustment preparedness (MOD, 2015). Previously in 2016, participants of the Forces in Mind Trust - St George's House consultation event (2016) cited 'cohesive access points' and 'better integrated services' ideal features associated with transition (FIMT, 2016).

Keeping Families in Mind (KFIM) service was proposed in response to this identified need for services to meet the needs of military families. KFIM was funded by the Armed Forces Covenant Fund Trust following a successful application to the Covenant Fund Families in Stress. When Sheffield Mind applied for funding to develop and deliver this service they had to plan for an independent evaluation of the service as part of the funding agreement. The evaluation aimed to discover whether or not the service has been beneficial for families of serving and veteran personnel. The results will help inform decisions about whether the service should be continued. The *Keeping Families in Mind* service aimed to work with families of military personnel or veterans in Sheffield, offering one-to-one counselling, group anger management, mental health and wellbeing activities and a volunteer skills-building programme. The planned to work closely with Armed Forces Welfare Officers, and to offer a bespoke programme of interventions, tailored to build resilience and discourage dependency. The definition of a veteran in the UK is defined as anyone who has served for at least one day in Her Majesty's Armed Forces (Regular or Reserve) or Merchant Mariners who have seen duty on legally defined military operations (Office for Veterans Affairs, OVA, 2020).

2. Aims, objectives, and hypotheses

2.1 Aim:

To evaluate whether, or not, the KFIM service has been beneficial for families of serving and veteran personnel

2.2 Objectives and related hypotheses:

6. To examine if there is a statistically significant change to participants' Warwick Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al 2007) pre-counselling and post-counselling scores (anonymised scores were provided by Sheffield Mind to the project team for analysis).

   1st Hypothesis: that the counselling provided by KFIM would result in statistically significant ($p<0.05$) improved scores on Warwick Edinburgh Mental Wellbeing Scale the from the baseline assessment to follow-up test.

7. To examine if there is a statistically significant change to participants' the 6-item Brief Resilience Scale (BRS; Smith et al, 2008) pre-counselling and post-counselling scores (anonymised scores were provided by Sheffield Mind to the project team for analysis).

   2nd Hypothesis: that the counselling provided by KFIM would result in statistically significant ($p<0.05$) improved scores on the Brief Resilience Scale from the baseline assessment to follow-up test.

8. To examine if there is a statistically significant change to participants' 3-item Campaign to End Loneliness Measurement Tool (CTELMT) pre-counselling and post-counselling scores (anonymised scores were provided by Sheffield Mind to the project team for analysis).

   3rd Hypothesis: that the counselling provided by KFIM would result in statistically significant ($p<0.05$) improved scores on the Campaign to End Loneliness Measurement Tool from the

baseline assessment to follow-up test.

9. To evaluate questionnaire data collected by Sheffield Mind from clients' attending KFIM service (3 closed questions and 3 open questions) following completion of counselling (Sheffield Mind provided the anonymised survey data for analysis).

10. To explore the views of clients, referrers and staff regarding the KFIM service (data was collected by the YSJU research team using semi-structured virtual interviews.

3. Method

3.1 Design:

This service evaluation was a longitudinal, mixed-methods prospective study where the KFIM clients undertook outcome measures at a baseline assessment and were then re-assessed at three additional points in time, a questionnaire was given to clients by the KFIM team following counselling, and interviews with a sample of clients, staff and referrers were undertaken by the research team in the summer of 2021.

3.2 Participant sample:

The gatekeeper was Rob Horsley at Sheffield Mind (see letter in Appendix 4). For KFIM clients, Sheffield Mind emailed clients to invite them to participate and attached the participant information sheet (see Appendix 6) and consent form (see Appendix 7) to the email. As they had experienced a low response rate to their follow up online survey evaluation, they followed this email up with a telephone call and this provided an opportunity to explain further about the project and to answer any questions. For referrers to the KFIM service and staff who have worked in the KFIM service, Sheffield Mind emailed to invite them to participate and attached the participant information sheet and consent form to the email. There were no incentives for participants for taking part. The overall sample size for the quantitative outcome measures was anticipated by Sheffield Mind to be between 40-45 clients who had accessed the KFIM service. Outcome measures and questionnaires were collected by Sheffield Mind (please see Appendix 5 for the wording on the Consent form and Counselling and Therapy agreement used by Sheffield Mind). Participants were all over 18 years of age and able to provide informed consent (according to the guidelines for the Mental Capacity Act 2005).

3.3. Data collection methods:

Sheffield Mind collected outcomes data using three measures. The Research team analysed the anonymised pre- and post data from these measures for any statistically significant change, looking at whether scores have improved from baseline to post-test. The three outcome measures were: Warwick Edinburgh Mental Wellbeing Scale (WEMWEBS; Tennant et al, 2007); the 6-item Brief

Resilience Scale (BRS; Smith et al, 2008); and the 3-item Campaign to End Loneliness (CELMT; Campaign to End Loneliness, n.d.). The measures were given to clients to complete for the first time at their assessment session, and this provided the baseline measures. Follow-up measures were usually undertaken at the beginning of the 1st, 8th and 16th counselling sessions (see Table 3.1 below). The second time clients undertook the measures was at their first counselling session and staff at KFIM reported there can be a time difference dependent on how quickly a client starts therapy after their assessment; this can vary as both clients and therapists need to find mutually convenient times in their schedules. The rationale for undertaking the measures again at the first counselling session was because within Sheffield Mind's other services there was a waiting time from 2 to 6 months from assessment to when clients began therapy. The 2nd measure was undertaken by Sheffield Mind for two reasons: to see whether the offer of help had a positive impact, regardless of how long people had to wait; and to assess how the length of the wait impacted on people. However, Shefield Mind report the nature of the Keeping Families in Mind (KFIM) service was different and there was the availability to normally start work with clients within two weeks so the time between assessment and 1st counselling session was generally only a couple of weeks. The follow-up assessment for most of the KFIM clients was undertaken on their 8th counselling session (there was a little variation in timing for some clients owing to holidays, illness, and other difficulties the clients may have had). This assessment point could represent the end of counselling for some clients if both the therapist and client felt that eight counselling sessions were enough. For those clients who continued with further therapy, the fourth assessment was undertaken at their last therapy session, this could be after 16 sessions or less, dependent on how many additional sessions the client needed. Staff at KFIM reported there was also some variation as some clients preferred to have a session every other week moving towards the end of therapy to test 'doing it by themselves' but having the fall back of therapy if things became difficult, so the timing between the 3rd and 4th assessment points for those clients having more than 8 sessions of counselling was varied. It must be remembered that this was an evaluation of a real service, rather than an intervention trial, and so it was not possible to keep the assessment points to the same intervals for all clients. This reflects person-centred nature of the KFIM service. For example, if a client attended on the 8th session and was in crisis, it was not appropriate to ask them to undertake the three measures again when they

needed time to talk to their therapist about the situation triggering the crisis. Likewise, not every client needed either eight or 16 therapy sessions, and some had less than eight counselling sessions.

Table 3.1: The time intervals for the assessment of measures (WEMWBS, BRS, CELMT)

Measurement	Time 1 (baseline)	Time 2	Time 3 (Post-test)	Time 4 (Post-test)
Timing	First assessment of the 3 measures was undertaken at the client's assessment session	2nd assessment of the 3 measures was usually undertaken at the start of the client's first counselling therapy session	3rd assessment of the 3 measures was usually undertaken at the start of the 8th counselling session, or at their last session if the person needed less than 8 sessions.	For clients who needed additional counselling beyond 8 sessions, 4th the assessment of the 3 measures was usually undertaken at the 16th counselling session, or at their last session if the person needed less than 16 sessions.

3.3.1 Warwick Edinburgh Mental Wellbeing Scale

Objective 1 was to examine if there was a statistically significant change to participants' Warwick Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al 2007) pre-counselling and post-counselling scores. The SWEMWBS (Tennant et al, 2007) is a 14 item self-assessment which was to be completed by all people referred to the service (score range 1-70). The person was asked to complete the WEMWBS based on their thoughts and feelings (see Appendix 1 for the questions and scoring of this measure). The WEMWBS was developed to provide a measure of 'a wide conception of well-being, including affective-emotional aspects, cognitive-evaluative dimensions and psychological

functioning, in a form which is short enough to be used in population-level surveys' (Tennant et al, 2007, p. 2). The rationale for using the WEMWBS as an outcome measure for this evaluation was:

- It was already being used by Sheffield Mind as an outcome measure of mental wellbeing for clients' accessing their counselling services.
- It has an established evidence base, validity and reliability studies have been undertaken and it has been standardised. It can be used to measure changes over time and is, therefore, appropriate for evaluation of the effect of an intervention project or programme.
- It is a self-assessment that can be used for people age 13 years and above.

3.3.2 Brief Resilience Scale

Objective 2 was to examine if there was a statistically significant change to participants' pre-counselling and post-counselling scores on the 6-item Brief Resilience Scale (BRS; Smith et al, 2008; see Appendix 2 for the questions and scoring). Palmer (2008) proposed a theory of risk and resilience factors in military families, identifying 'frequent relocation, deployment, exposure to combat and PTSD, and post deployment reunion as possible risk factors' (p. 205). Some military families need 'additional support to recover from the stresses associated with military life' (Meadows et al, 2016, p.1) and resilience is an important factor to consider when exploring what enables families to cope (Meadows et al, 2016). The BRS 'was created to assess the ability to bounce back or recover from stress' (Smith et al, 2008, p.?). In a critical review of the psychometric properties of resilience scales, Windle et al (2011) identified the BRS as one of three measures with the best psychometric evidence, reporting evidence of its validity and test-retest reliability. BRS is a short, simple to complete self-assessment.

3.3.3 Campaign to End Loneliness Measurement Tool

Objective 3 was to examine if there was a statistically significant change to participants' 3-item Campaign to End Loneliness Measurement Tool (CTELMT) pre-counselling and post-counselling scores. The measure selected comes from the Campaign to End Loneliness Measurement Tool (CTELMT; please see Appendix 3 for the questions and scoring). The outcome measure was chosen for the evaluation because loneliness can be a significant challenge for military personnel, veterans, and their families (Foundation for Art and Healing, 2021). The Royal British Legion (2018) reported

that loneliness and social isolation are significant issues in the Armed Forces community. In a study of the 'Psychological Effects of Deployment on Military Families', Warner et al (2009) found that 89.8% spouses reported feeling lonely when their partner was deployed. Teo et al (2018), in a study that explored the association between loneliness and depress and suicidal outcomes for military veterans, reported that 'social connectedness is correlated with multiple depression outcomes' (p.42). Therefore, the CTELMT was selected to evaluate whether accessing the KFIM service helped clients to reduce feelings of social isolation and loneliness. The CTELMT is a short, simple to complete self-assessment.

3.3.4 Evaluation survey

Objective 4 was to evaluate questionnaire data collected by Sheffield Mind from clients' attending KFIM service following completion of counselling. The survey comprised 3 closed questions and 3 open questions. An on-line questionnaire, comprising both open text and rating scale questions, has been collected by Sheffield Mind to evaluate participants' views of the service at the end of treatment. This comprises 3 open and 3 closed questions. Anonymised results were provided to the Research team for analysis. The three open text questions were:

- *What did you find most helpful or unhelpful in your therapy?*
- *What aspects of your life has it affected the most?*
- *How has it affected your relationships?*

The three closed questions were rating scales:

- *How effective did you find therapy?* (This was rated on a 7-point scale from extremely effective to extremely ineffective)
- *Do you feel counselling has enabled you to cope better with the stressors of military life?* (This was rated on a 7-point scale from strongly agree to strongly disagree)
- *Do you feel counselling has improved your capability to support others emotionally?* (This was rated on a 7-point scale from strongly agree to strongly disagree).

3.3.5 Semi-structured interviews

Objective 5 was to explore the views of clients, referrers, and staff regarding the KFIM service. Data was collected virtually owing to the current COVID-19 Coronavirus pandemic and so interviews were

collected over via Microsoft Teams or the telephone with the participant remaining within their home or usual work setting. Sheffield Mind requested that telephone interviews were offered as an alternative to Teams, because they moved many of their services to Zoom during the Covid 19 pandemic but had a few clients who either preferred the telephone or did not have access to a computer, tablet, or smart phone. The sample size for the semi-structured interviews was 10 people who had used either the individual or peer support group 'Keeping Families in Mind' service provided by Sheffield Mind. The project team also conducted interviews via Teams or telephone with four staff working for Sheffield Mind and one person who had referred clients to the 'Keeping Families in Mind' service. Interview questions for clients, staff and referrers are provide in Appendix 8.

3.4 Data analysis

All the three outcome measures (WEMWBS, BRS and CELMT) comprised Likert scales and these provide ordinal scores. However, in statistical analysis rating scales are often treated as interval scales (Wu and Leung, 2017) and descriptive analysis was undertaken to produce means and standard deviations for scores for all questions in the three measures, across the baseline, 1st, 2nd, 3rd and 4th tests. Mean differences were then calculated and have been presented in tables to show where means have increased, decreased, or remained the same. Tests of normality were undertaken using Kolmogorov-Smirnov and Shapiro-Wilk tests. Statistical significance of changes was calculated using either the Related Samples Wilcoxon Signed Rank Test or the Paired T test. When data was found to not be normally distributed, statistical significance of changes was calculated using the related samples Wilcoxon signed rank test, this is suitable for either metric (interval or ratio) data that is not multivariate normal, or with ranked/ordinal data. The Wilcoxon signed rank test is a non-parametric alternative to the dependent samples t-test. Statistical significance was set at $p \leq 0.05$. The three survey closed questions were analysed through descriptive analysis and the results presented as graphs. The interviews were recorded, transcribed verbatim and the results examined through thematic analysis (Braun and Clarke, 2006). The three survey open questions were also analysed using thematic analysis. Themes, sub-themes (where these occurred) and illustrative quotes are provided for interview and survey questions.

3.5 Ethics

Ethical approval for this evaluation study was granted by the York St John University Cross Schools Ethics Committee (please see the Ethics approval letter in Appendix 5).

3.5.1 Informed consent

For the anonymised data, provided by Sheffield Mind, please see Appendix 9 for the consent form and Counselling and Therapy agreement used by Sheffield Mind. Samantha Mullholland, the Keeping Families in Mind (KFIM) coordinator, has confirmed that the consent form was discussed with clients before they start intervention and, prior to the Covid19 pandemic, all clients signed a copy of the consent form. However, when the pandemic started and the UK went into lockdown intervention was delivered online using Zoom and some clients were no longer able to print, sign, scan and return a copy of the consent form. Instead, these clients have provided Sheffield Mind with verbal consent during their assessment. The use of anonymised outcomes data (referred to in the Sheffield Mind information and form as 'questionnaires' as they are self-reported, Appendix 9) is also discussed with clients during their first session. Clients either signed or verbally agreed to the Counselling and Therapy agreement (where possible they emailed this to the service) before they started the first intervention session.

For the interviews conducted by researchers from York St John, before the interview process began, a participant information sheet (see appendix 6) was emailed to people who indicate an interest in taking part. When potential participants were emailed the participant information sheet, they were also emailed with a copy of the *YSJU The Military Human: Veterans and Families Support Information Guide*. If they did not have an email account, the Participant information sheet and Guide were posted to them. Consent was sought from participants via the Participant Consent Form (see appendix 7). This was an electronic form and was emailed to the participant. If they did not have an email account, the consent form was posted to them. Owing to the Covid 19 pandemic, the participants were asked to complete the consent form on their computer, tablet, iPad or smartphone if possible. Where available, they were asked to print, sign, scan and email the consent form back to the researcher. However, not all participants had the equipment to do this, in this case they read through the consent form and emailed to say they had read the consent form and agreed to

participate, this email confirmation was stored with the completed consent forms. Audio consent was also gained at the start of the interviews after the nature and purpose of study have been reiterated. This was to ensure that participants fully understood their participation throughout the research process. Their verbal consent at the start of the interview was recorded.

3.5.2 Anonymity and confidentiality

Any personally identifying information (e.g., names, addresses, emails and telephone numbers of the participants) was only recorded on the consent form and names only record on the consent form and a list of participant names and codes. All personally identifiable data was removed from transcripts, data analysis documents, and reports. Participant codes were used for pseudonymisation. Unless the participant requested a summary of the project findings, emails and telephone numbers were deleted as soon the interview recording was collected, uploaded to OneDrive, transcribed, checked and analysed. If Participants wished to receive a summary of findings their personal details were to be deleted at the end of the study once these summaries have been disseminated. The outcome measure scores and the questionnaire data were pseudonymised before Sheffield Mind emailed this to the research team at York St John University.

3.5.3 Data protection and Storage:

Consent forms, interview recordings, interview transcripts, and excel spreadsheets containing outcome measures data and survey data were stored on a project folder on the lead researcher's York St John University OneDrive account. The project folder was accessible only to the research team. If an audio recording of a Teams meeting / telephone consent was made, this was uploaded into the project OneDrive folder. If the participants preferred to be interviewed by telephone, their telephone number was deleted from the researchers' phone as soon as data was collected and the interview audio recording was deleted from the researcher's phone as soon as it was uploaded on to OneDrive.

3.5.4 Risk of Possible Distress

Clients were likely to have accessed the KFIM service owing to mental wellbeing challenges, therefore, therefore researchers considered that there was a risk that reflecting on their experience

of the KFIM service during interview might bring back memories of a challenging time and could lead to distress, such as tearfulness. If a participant showed any signs of distress during an interview, the plan was to offer a break, followed by an opportunity to reconvene or to withdraw from the research. They would also be signposted back to Sheffield Mind for support. When potential participants were emailed the participant information sheet, they were also emailed with this a copy of the *YSJU The Military Human: Veterans and Families Support Information Guide*. If a participant became distressed during an interview researchers planned to remind them of the information within this guide which provides details of organisations that can provide support.

3.5.4 Right to withdraw

The participants were able to withdraw from the evaluation up to two weeks after the data of their interview by emailing or telephoning the research assistant or Project Lead.

4. Results

4.1 Analysis of outcome measures data

4.1.1 Sample:

As explained in section 3.3. and Table 3.1, outcome measures (WEMWBS, BRS and CELMT) were undertaken by clients at up to four time points, usually at the beginning of the 1st, 8th and 16th counselling sessions. Not all clients who were referred or self-referred to KFIM went on to receive therapy. Eleven people did not have the initial assessment, and another one dropped out before their first therapy session. Four people were assessed but accessed a different service. Only 23 clients completed a full course of therapy with KFIM. The number of sessions received varied owing to clients' needs. Table 4.1 below provides a breakdown of the outcome measures data obtained for KFRIM clients for this evaluation. Of the 23 clients who received a full course of therapy, 15 completed the outcome measures on three occasions with another three clients also completing the measures three times providing a sub-sample of 18 clients. Eight clients completed the measures on four occasions. Another seven people completed the outcome measures on two occasions. Therefore, for the data analyses, clients have been divided into three sub-samples, which are described in further detail below in relation to data for each of the three measures.

Table 4.1: Break down of the number of tests obtained across the 3 measures for KFIM clients

Client Outcomes	Number of clients	0 tests	1 test	2 tests	3 tests	4 tests
Full therapy	23	-	-	-	15	8
Client started after outcomes sent for evaluation analysis	2	1	1	-	-	-
Client still in therapy at time of evaluation	3	-	-	2	1	-
Fourth outcome collected after outcomes sent for evaluation analysis	1	-	-	-	1	-
Missing last therapy outcome	1	-	-	1	-	-
Dropped out before assessment	11	11	-	-	-	-
Dropped out after assessment	1	-	1	-	-	-
Dropped out after first therapy session	5	-	1	4	-	-
Dropped out after assessment due to accessing other service	4	-	4	-	-	-
Dropped out after Outcome 3 undertaken but before Outcome 4 done	1	-	-	-	1	-
Totals	**52**	**12**	**7**	**7**	**18**	**8**

4.1.2 Warwick Edinburgh Mental Wellbeing Scale

Objective 1 was to examine if there was a statistically significant change to participants' Warwick Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al 2007) pre-counselling and post-counselling scores. The analysis was based on analyses for three sub-samples comprising clients who had undertaken the WEMWBS at: two time points (sub-sample A, n = 33); at three time points (sub-sample B, n = 26) and at four time points (sub-sample C, n = 8; see Table 4.2 below). This meant that clients who had undertaken WEMBS four times had scores that were included in all the analyses for all three sub-samples, those who had undertaken WEMBS three times had scores that were included in the analyses for sub-samples A and B; and those who had undertaken WEMBS twice had scores that were only included in the analysis for sub-sample A.

Table 4.2: Break down of sample for Warwick Edinburgh Mental Wellbeing Scale

Sample	WEMWBS	
KFIM Client Population	People with a Lamplight number provided by Sheffield Mind in the Excel data base	N = 52
Clients removed from analysis	People with no WEMWBS scores recorded	n = 12
Clients removed from analysis	People with only one baseline WEMWBS score recorded	n = 7
Sub-sample A	2 WEMWBS measures	n = 33
Sub-sample B	3 WEMWBS measures	n = 26
Sub-sample C	4 WEMWBS measures	n = 8

It is important to note that as data came from service delivery, as opposed to a randomised control trial, the length of time between each test was not uniform and varied substantially between participants (please refer to Table 3.1 as a reminder of the timings for the measures). As an example, the number of days between each test and between the first and last tests has been calculated and is shown below (see Table 4.3) for the first five participants for the dates when their WEMWBS were undertaken. As can be seen the length of time from the first to the 2nd measure varied from between 5 to 31 days for these five people, the length of time between the second and third measure varied between 21 and 79 days, for the four people who took only three tests the length of time between their first (baseline) test and their last (3rd) test varied between 52 and 97 days. Whereas, Participant

1, who had undertaken four WEMWBS tests during their time accessing services from KFIM, had 148 days between their first (baseline) and last (4th) tests.

Table 4.3: Length of time between WEMWBS tests for the first five participants in the sample

Participant number	Number of days between 1st and 2nd test	Number of days between 2nd and 3rd test	Number of days between 3rd and 4th test	Number of days between 1st and last test for that client
1	14	70	64	148
2	14	77	No 4th measure	97
3	31	21	No 4th measure	52
4	9	79	No 4th measure	88
5	5	63	No 4th measure	68

Thirty-three clients had a baseline assessment on the WEMWBS and a follow-up assessment (which has usually been taken at the start of the first therapy session). The means for the 14 WEMWBS questions and the means for the total scores were compared between the baseline and 2nd test. Figure 4.1 shows the distribution of baseline (assessment) total scores on the WEMWBS with Figure 4.2 showing the comparison distribution of scores at the 2nd test (n=33). As can be seen in Table 4.4 below, mean scores increased for 12 of the 14 questions and for the total score. The item *'I've been feeling interested in other people'* (Question 4) showed a small decrease in mean. The item *'I've been feeling loved'* (Question 12) had no change in mean. Test of normality (Kolmogorov-Smirnov and Shapiro-Wilk) for the WEMWBS baseline and 2nd test data (n = 33) were significant for all 14 items and the baseline total score, indicating that the data was not normally distributed. Therefore, the Related-Samples Wilcoxon Signed Rank Test was undertaken to examine whether changes in scores were statistically significant, this non-parametric test examines the median of differences between the baseline and 2nd test scores. Statistical significance was set at $p \leq 0.05$. Figure 4.3 shows 19 clients had improved WEMWBS total scores (positive differences), four had scores which remained the same (tied scores) and 10 had decreased WEMWBS total scores (negative differences). The overall improvement across the sample's total scores from baseline assessment to the first therapy session was found to be statistically significant at $p \leq 0.023$, with six of the 14 individual questions also

showing statistically significant improvements. Therefore, the 1st Hypothesis that the counselling provided by KFIM would result in statistically significant ($p<0.05$) improved scores on the Warwick Edinburgh Mental Wellbeing Scale from the baseline assessment to follow-up test was supported for analysis of WEMWBS total scores in this sub-sample of 33 clients who undertook the measure on at least two occasions (at the assessment session and at the start of the first therapy session).

Figure 4.1: Distribution of baseline (assessment) WEMWBS total scores (sub-sample A; n=33)

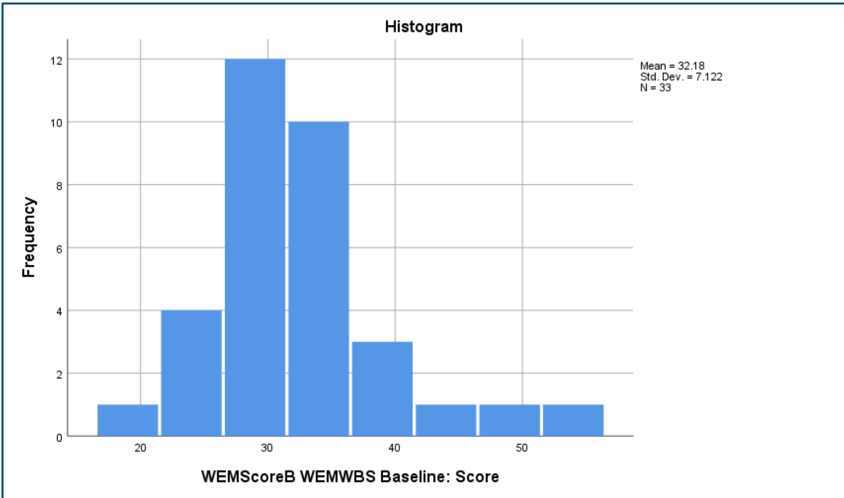


Figure 4.1: Distribution of 2nd test (first session) WEMWBS total scores (sub-sample A; n=33)

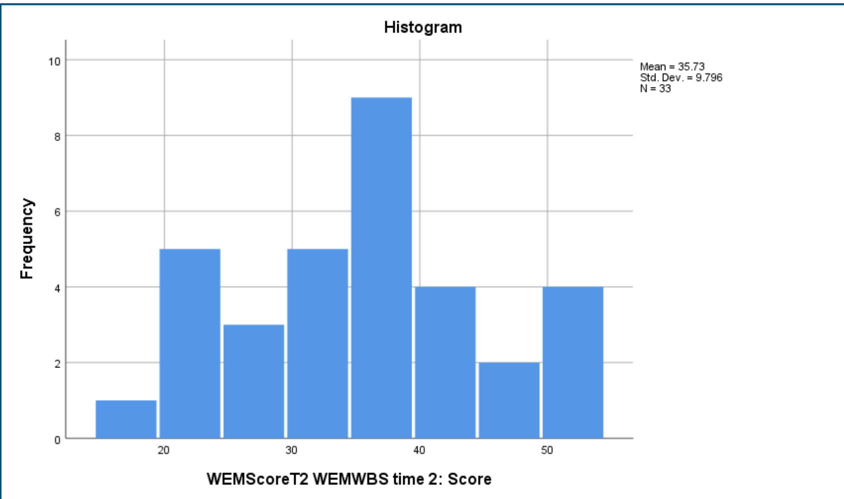


Table 4.4: WEMWBS mean scores for participants with a baseline and 2nd test score (sub-sample A; n = 33)

WEMWS question	Baseline (assessment) Mean (standard deviation)	2nd test (1st therapy session) Mean (standard deviation)	Mean difference
Q1: I've been feeling optimistic about the future	2.09 (0.84)	2.55 (0.94)	+0.46 **(p=0.008)***
Q2: I've been feeling useful	2.36 (0.86)	2.48 (0.91)	+0.12 (p=0.526)
Q3: I've been feeling relaxed	1.94 (0.86)	2.48 (1.0)	+0.66 **(p=0.013)***
Q4: I've been feeling interested in other people	2.82 (0.98)	2.7 (0.95)	-0.12 (p=0.608)
Q5: I've had energy to spare	1.97 (1.13)	2.09 (1.07)	+0.12 (p=0.520)
Q6: I've been dealing with problems well	2.39 (0.83)	2.45 (1.09)	+0.06 (p=0.638)
Q7 : I've been thinking clearly	2.33 (1.02)	2.79 (1.14)	+0.4 **(p=0.045)***
Q8: I've been feeling good about myself	1.91 (0.77	2.3 (0.95)	+0.39 **(p=0.035)***
Q9: I've been feeling close to other people	2.3 (1.05)	2.67 (0.96)	+0.37 **(p=0.032)***
Q10: I've been feeling confident	1.94 (0.2)	2.18 (0.95)	+0.24 (p=0.096)
Q11: I've been able to make up my own mind about things	2.91 (1.1)	3.09 (1.04)	+0.18 (p=0.250)
Q12: I've been feeling loved	3.06 (1.17)	3.06 (1.22)	0 (p=0.926)
Q13: I've been interested in new things	2.03 (1.16)	2.36 (1.03)	+0.33 (p=0.161)

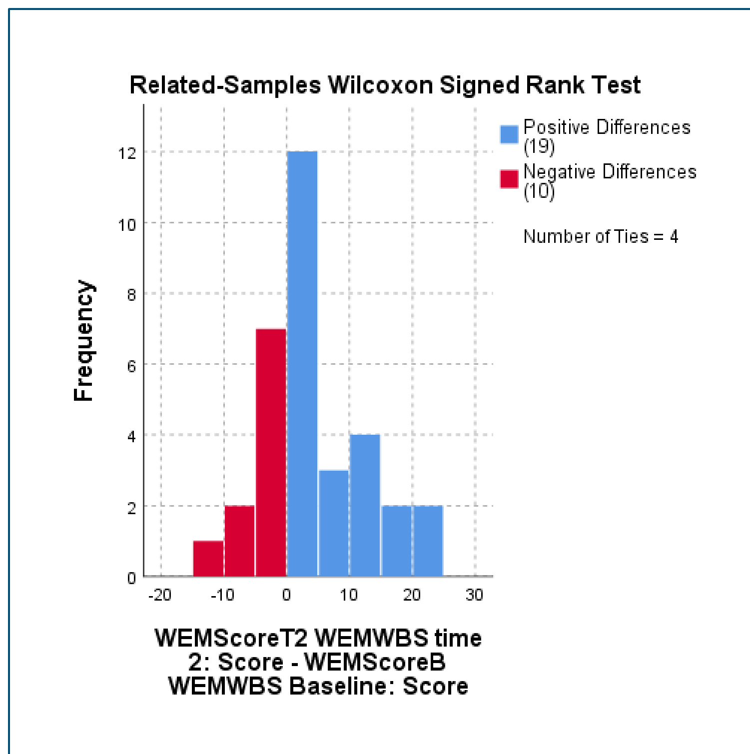
WEMWS question	Baseline (assessment) Mean (standard deviation)	2nd test (1st therapy session) Mean (standard deviation)	Mean difference
Q14: I've been feeling cheerful	2.09 (0.84)	2.55 (0.94)	+0.46 **(p=0.010)***
Total score	32.18 (s.d. 7.12)	35.73 (s.d. 9.8)	+3.55 **(p=0.023*)**

Note: WEMBS questions are rated on a 5-point scale and can range from 1 -5. The maximum possible total score is 70.

Table key

	This shading is used when there was a positive change in mean
	This shading is used when there was no change between means
	This shading is used when there was a negative change in mean
Significance	Statistical significance was calculated using the Related-Samples Wilcoxon Signed Rank Test. Statistical significance was set at p≤0.05. Significant results are highlighted in bold and marked with an asterix *

Figure 4.3: WEMWBS baseline total score compared to 2nd test score (sub-sample A; n = 33)



Twenty-six clients had undertaken a baseline assessment on the WEMWBS and two follow-up assessments (which has usually been taken at the start of the first therapy session and the beginning of the 8th session). The means for the 14 WEMWBS questions and the means for the total scores were compared between the baseline, 2nd test and 3rd tests. Results are shown below in Table 4.5. Test of normality (Kolmogorov-Smirnov and Shapiro-Wilk) for the WEMWBS baseline, 2nd and 3rd test data (n = 26) were significant for all 14 items and the baseline total score, indicating that the data was not normally distributed. Therefore, the Related-Samples Wilcoxon Signed Rank Test was undertaken to examine whether changes in scores were statistically significant, this non-parametric test examines the median of differences between the baseline and follow-up test scores. Statistical significance was set at $p \leq 0.05$. Increases in mean were found from baseline to the 3rd test for all 14 WEMWBS questions, with these improvements being statistically significant for 12 out of 14 questions (see Table 4.5). The other two questions question 11 (I've been able to make up my own mind about things) and question 4 (I've been feeling interested in other people) had small increases in mean scores, but the improvements were not statistically significant. A slight decrease in mean from the baseline to 2nd test was seen for question *4 'I've been feeling interested in other people',* however the mean increased at the 3rd test. The improvement across sub-sample B's total scores from baseline assessment to the first therapy session was found to be statistically significant at $p=0.047$. The improvement in total scores from 2nd to 3rd test was also statistically significant at $p = 0.004$. There was a mean increase of 9.5 between the baseline WEMWBS total score compared to the 3rd test total score, and this improvement was found to be statistically significant at $p = 0.000$. Therefore, the 1st Hypothesis that the counselling provided by KFIM would result in statistically significant ($p<0.05$) improved scores on the Warwick Edinburgh Mental Wellbeing Scale from the baseline assessment to follow-up test was supported for analysis of WEMWBS total scores in sub-sample B with the 26 clients who undertook the measure on at least three occasions.

Table 4.5: WEMWBS mean scores for participants with 3 measures (sub-sample B; n = 26)

WEMWS question	Baseline Mean (standard deviation)	2nd test Mean (standard deviation)	Mean difference 2nd test minus baseline	3rd test Mean (standard deviation)	Mean difference 3rd test minus 2nd test	Mean difference 3rd test minus baseline
Q1: I've been feeling optimistic about the future	2.12 (0.86)	2.54 (1.02)	+0.42	3.04 (1.11)	+0.5	+0.92 **(p=0.000)***
Q2: I've been feeling useful	2.38 (0.85)	2.58 (0.95)	+0.20	3.12 (1.07)	+0.54	+0.74 **(p=0.012)***
Q3: I've been feeling relaxed	2.00 (0.89)	2.42 (0.99)	+0.42	2.92 (1.06)	+0.5	+0.92 **(p=0.003)***
Q4: I've been feeling interested in other people	2.88 (0.95)	2.69 (1.05)	-0.19	3.27 (0.92)	+0.58	+0.39 (p≤0.079)
Q5: I've had energy to spare	2.08 (1.2)	2.19 (1.1)	+0.11	2.77 (0.91)	+0.58	+0.69 **(p=0.016)***
Q6: I've been dealing with problems well	2.42 (0.86)	2.58 (1.14)	+0.16	2.96 (1.22)	+0.38	+0.54 **(p=0.025)***
Q7 : I've been thinking clearly	2.42 (1.07)	2.85 (1.2)	+0.43	3.35 (1.06)	+0.5	+1.43 **(p=0.002)***
Q8: I've been feeling good about myself	1.92 (0.74)	2.35 (0.98)	+0.43	2.81 (1.3)	+0.46	+0.89 **(p=0.003)***

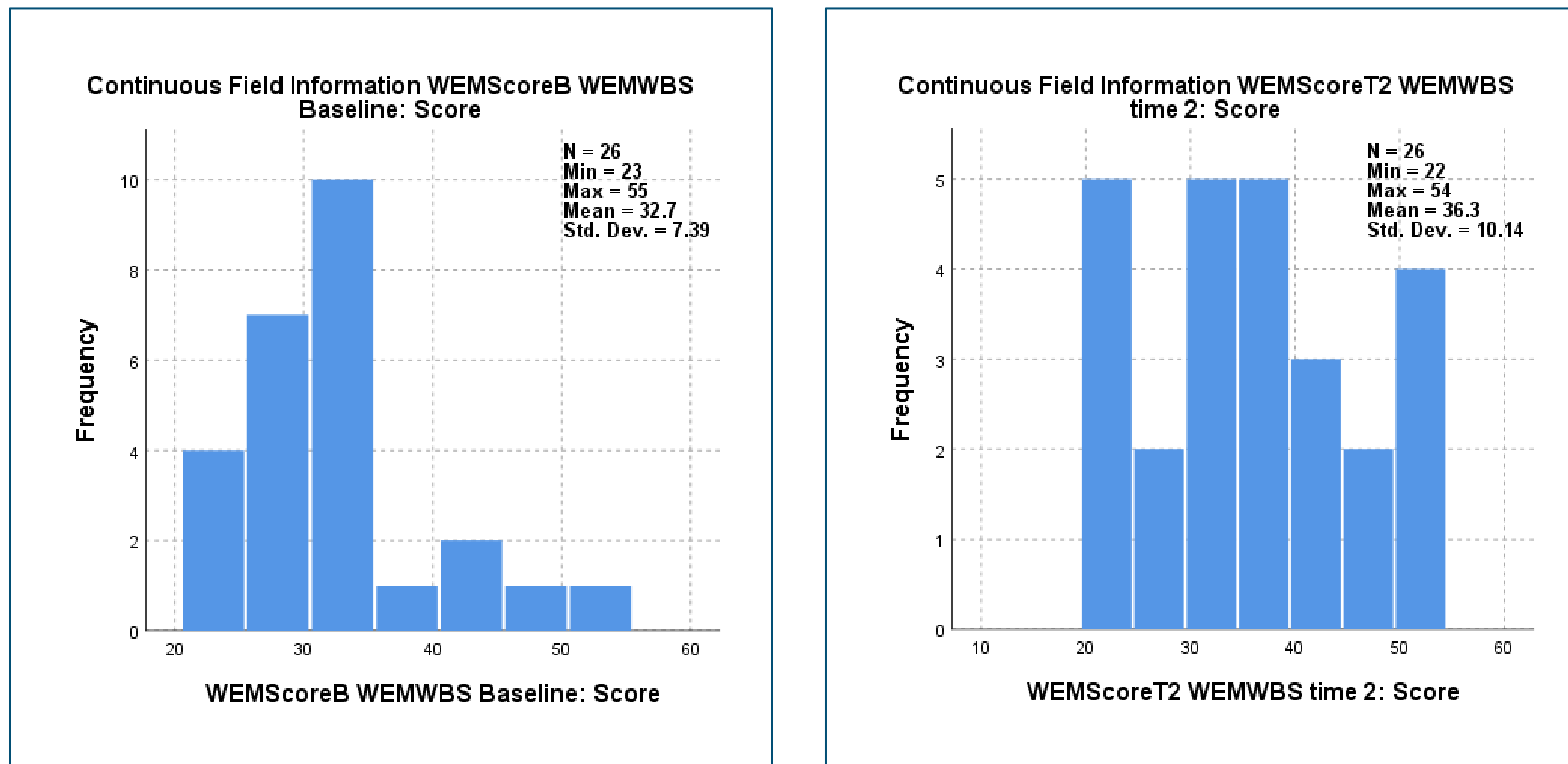
WEMWS question	Baseline Mean (sd)	2nd test Mean (sd)	Mean difference 2nd test - Baseline	3rd test Mean (sd)	Mean difference 3rd test - 2nd test	Mean difference 3rd test - baseline
Q9: I've been feeling close to other people	2.19 (1.1)	2.65 (0.98)	+0.46	3.04 (1.15)	+0.39	+0.85 **(p=0.001)***
Q10: I've been feeling confident	2.04 (1.04)	2.31 (0.94)	+0.27	2.85 (1.26)	+0.54	+0.81 **(p=0.007)***
Q11: I've been able to make up my own mind about things	2.92 (1.2)	3.12 (1.07)	+0.2	3.42 (0.95)	+0.3	+0.5 (p=0.085)
Q12: I've been feeling loved	3.0 (1.02)	3.04 (1.15)	+0.04	3.62 (1.02)	+0.58	+0.62 **(p=0.012)***
Q13: I've been interested in new things	2.12 (1.21)	2.42 (1.10)	+0.3	3.00 (1.01)	+0.58	+0.88 **(p=0.003)***
Q14: I've been feeling cheerful	2.19 (0.85)	2.58 (0.98)	+0.39	3.0 (0.94)	+0.42	+0.81 **(p=0.001)***
Total score	32.73 (7.39)	36.27 (10.14)	+3.6 **(p≤0.047)***	43.23 (11.46)	+6.96 (p=0.004)*	+9.5 **(p=0.000)***

Note: WEMBS questions are rated on a 5-point scale and can range from 1 -5. The maximum possible total score is 70.

Table key

	This shading is used when there was a positive change in mean
	This shading is used when there was no change between means
	This shading is used when there was a negative change in mean
Significance	Statistical significance was calculated using the Related-Samples Wilcoxon Signed Rank Test. Statistical significance was set at p≤0.05. Significant results are highlighted in bold and marked with an asterix *

Figure 4.4: Distribution of Baseline compared to 2nd test WEMWBS total scores (sub-sample B; n=26, clients with 3 measures)



As can be seen in Figure 4.4 above clients' mean total WEMWBS scores improved from the baseline assessment to the 2nd assessment undertaken at the first therapy session. Table 4.5 above, shows that for 12 of the 14 WEMWBS improvement in mean total scores from the baseline assessment to the 3rd assessment (usually undertaken after 8 sessions of counselling) were statistically significant at the $p \leq 0.05$ level.

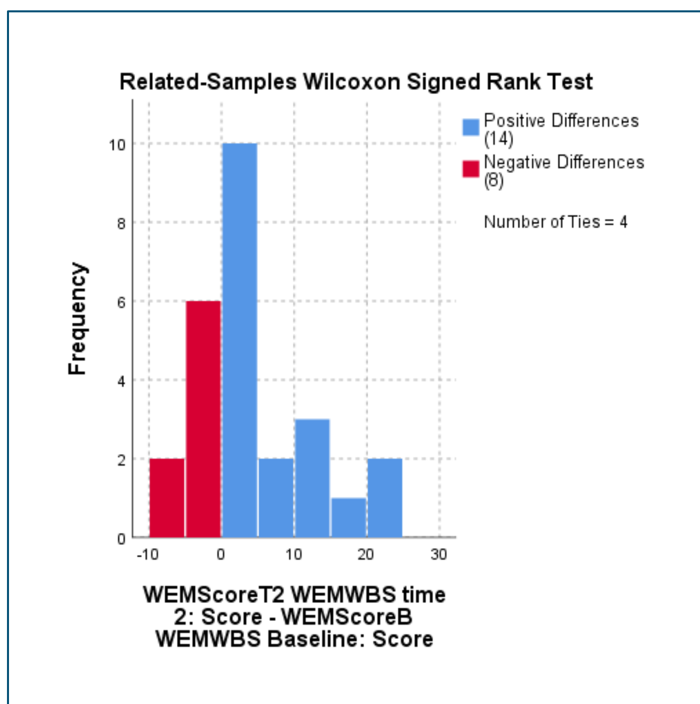


Figure 4.5: showing the positive, negative and tied differences in WEMWBS total scores from baseline to 2nd test (sub-sample B, n = 26)

As can be seen in Figure 4.5 above, 14 clients had improved WEMWBS total scores, 4 clients total score remained the same and 8 clients' total scores decreased from the baseline to the 2nd test. This change in mean scores was statistically significant ($p<0.047$) as can be seen in table 4.5 above.

Eight clients had undertaken a baseline assessment on the WEMWBS and three follow-up assessments (which had usually been taken at the start of the first therapy session, the beginning of the 8th session and the beginning of the 16th session). The means for the 14 WEMWBS questions and the means for the total scores were compared between the baseline, 2nd ,3rd and 4th tests. Results are shown below in Table 4.6. Test of normality (Kolmogorov-Smirnov and Shapiro-Wilk) for the WEMWBS data (n = 8) were significant indicating that the data was not normally distributed. Therefore, the Related-Samples Wilcoxon Signed Rank Test was undertaken to examine whether changes in scores were statistically significant, this non-parametric test examines the median of differences between the baseline and follow-up test scores. Statistical significance was set at $p\leq0.05$.

Table 4.6: WEMWBS mean scores and mean differences between scores for clients with 4 measures (sub-sample C; n = 8)

WEMWS question	Baseline Mean (standard deviation, s.d.)	2nd test Mean (standard deviation, s.d.)	Mean difference between baseline and 2nd test	3rd test Mean (standard deviation, s.d.)	Mean difference Between 2nd and 3rd test	4th test Mean (standard deviation, s.d.)	Mean difference between 3rd and 4th test	Mean difference between Baseline and 4th test
Q1: I've been feeling optimistic about the future	2.25 (0.89)	2.7 (1.16)	+0.45	3.25 (0.71)	+0.55	4 (0.76)	+0.75	+1.175 **(p=0.017)***
Q2: I've been feeling useful	2.5 (0.76)	2.5 (0.93)	0	3.25 (1.04)	+0.75	3.88 (0.64)	+0.63	+1.38 **(p=0.014)***
Q3: I've been feeling relaxed	2.38 (0.92)	2.38 (1.06)	0	3.25 (0.89)	+0.87	3.13 (0.64)	-0.12	+0.75 (p=0.109)
Q4: I've been feeling interested in other people	3 (1.07)	3 (0.76)	0	3.38 (0.74)	+0.38	3.63 (0.52)	+0.25	+0.63 (p=0.160)
Q5: I've had energy to spare	2 (1.41)	2 (1.20)	0	2.88 (0.64)	+0.88	3.38 (1.06)	+0.5	+1.38 (p=0.064)
Q6: I've been dealing with problems well	2.5 (0.53)	2.63 (0.916)	+0.13	3.25 (1.04)	+0.62	4 (1.07)	+0.75	+1.5 **(p=0.026)***
Q7: I've been thinking clearly	2.38 (0.92)	3.0 (0.53)	+0.62	3.25 (1.04)	+0.25	3.63 (1.06)	+0.38	+1.25 **(p=0.031)***
Q8: I've been feeling good about myself	2.13 (0.64)	2.5 (1.07)	+0.37	3.0 (0.93)	+0.5	3.63 (0.92)	+0.63	+1.5 **(p=0.016)***

WEMWS question	Baseline Mean (s.d.)	2nd test Mean (s.d.)	Mean difference between baseline and 2nd test	3rd test Mean (s.d.)	Mean difference Between 2nd and 3rd test	4th test Mean (s.d.)	Mean difference between 3rd and 4th test	Mean difference between Baseline and 4th test
Q9: I've been feeling close to other people	2.13 (0.83)	2.75 (0.89)	+0.62	3.25 (1.04)	+0.5	3.63 (0.74)	+0.38	+1.5 **(p=0.016)***
Q10: I've been feeling confident	2.38 (1.30)	2.63 (0.92)	+0.25	3 (1.31)	+0.37	3.63 (0.518)	+ 0.63	+1.25 (p=0.088)
Q11: I've been able to make up my own mind about things	3.0 (1.41)	2.88 (1.13)	-0.12	3.38 (0.92)	+0.5	4.25 (1.04)	+0.87	+1.25 (p=0.056)
Q12: I've been feeling loved	2.5 (1.07)	3.0 (1.31)	+0.5	3.5 (1.2)	+0.5	3.88 (0.83)	+0.38	+1.38 **(p=0.015)***
Q13: I've been interested in new things	2.13 (1.36)	2.63 (1.07)	+0.5	3.0 (1.07)	+0.37	3.75 (0.71)	+0.75	+1.62 **(p=0.047)***
Q14: I've been feeling cheerful	2.5 (1.07)	3.0 (0.76)	+0.5	3.0 (0.76)	0	3.63 (0.52)	+0.63	+1.13 **(p=0.024)***
Total score	**33.88** (9.09)	**37.5** (10.24)	**+3.62** (p=0.206)	**44.63** (8.85)	**+7.13** (p=0.263)	51.88 (7.72)	**+7.25** (p=0.068)	**+18** **(p=0.017)***

Shading / Key	Description
(light blue shading)	This shading is used when there was a positive change in mean
(green shading)	This shading is used when there was no change between means
(dark blue shading)	This shading is used when there was a negative change in mean
Significance	Statistical significance was calculated using the Related-Samples Wilcoxon Signed Rank Test. Statistical significance was set at p≤0.05. Significant results are highlighted in bold and marked with an asterix *

As can be seen in Table 4.6 above, there was a positive mean difference between the Baseline and 4th test for all 14 WEMWBS questions and the total score for this sub-sample of eight clients. Interestingly, there was an improved mean on nine of the 14 questions and total score from the baseline test (taken at the assessment session) and the 2nd test (taken at the first counselling session). There was an increased mean for 13 of 14 questions and the total score from the 2nd to 3rd test (with the question *'I've been feeling cheerful'* showing no change), and an increased mean for 13 / 14 questions from the 3rd to the 4th test (with the question *'I've been feeling relaxed'* having a small decrease in mean score). Improvements from baseline to 4th test were statistically significant at $p \leq 0.05$ for nine out of 14 questions and the WEMWBS total score ($p=0.017$). Therefore, the 1st Hypothesis that the counselling provided by KFIM would result in statistically significant ($p<0.05$) improved scores on the Warwick Edinburgh Mental Wellbeing Scale from the baseline assessment to follow-up test was supported for analysis of WEMWBS total scores in sub-sample C with the eight clients who undertook the measure on at least four occasions.

Overall, the analysis of data for sub-samples A, B and C found statistically significant improvements in the total WEMWBS scores with statistically significant improvement also found for some of the individual questions. Five of the 14 questions (questions 1, 7, 8, 9 and 14) showed statistically significant improvements across all three sub-sample. Therefore, it is concluded that the 1st Hypothesis that the counselling provided by KFIM would result in statistically significant ($p<0.05$) improved scores on the Warwick Edinburgh Mental Wellbeing Scale from the baseline assessment to follow-up is supported.

4.1.3 Brief Resilience Scale

Objective 2 was to examine if there was a statistically significant change to clients' 6-item Brief Resilience Scale (BRS; Smith et al, 2008) pre-counselling and post-counselling scores. The BRS is scores from 1 = strongly disagree to 5 strongly agree, with higher scores indicating greater resilience. So, an increased mean indicated an improvement in resilience, as measured by the BRS, following counselling services provided by KFIM. The analysis was based on analyses for three sub-samples comprising clients who had undertaken the BRS at: two time points (sub-sample A, n = 34); at three time points (sub-sample B, n = 24) and at four time points (sub-sample C, n = 9; see Table 4.7 below).

This meant that clients who had undertaken the BRS four times had scores that were included in all the analyses for all three sub-samples, those who had undertaken BRS three times had scores that were included in the analyses for sub-samples A and B; and those who had undertaken BRS twice had scores that were only included in the analysis for sub-sample A.

Table 4.7: Break down of sample for Brief Resilience Scale

Sample	**BRS**	
KFIM Client Population	People with a Lamplight number provided by Sheffield Mind in the Excel data base	n = 52
Clients removed from analysis	People with no WEMWBS scores recorded	n = 12
Clients removed from analysis	People with only one baseline WEMWBS score recorded	n = 6
Sub-sample A	2 BRS measures	n = 34
Sub-sample B	3 BRS measures	n = 24
Sub-sample C	4 BRS measures	n = 9

As can be seen in Table 4.8 below, the BRS average mean score for the sample increased from 2.19 at the baseline to 2.44 at the second test (post-test) for sub-sample A. Increased means were found for all six BRS questions and the average score. The BRS average baseline and post-test time 2 scores (n = 34 participants) were analysed for normality and both skewness and Kurtosis were within acceptable ranges for both variables and so a paired samples T-test was undertaken and was found to be statistically significant (t -2.475, degrees freedom 33, p = 0.019). Related samples Wilcoxon signed rank tests were then undertaken for each question and for the average score to examine the differences between the baseline and 2nd test. Whilst all questions were found to have an increase in mean score from baseline to 2nd test this change was too small to be significant at the $p<0.05$ level for five of the six questions. Only question 1 (*I tend to bounce back quickly after hard times*; p = 0.015) and the BRS average score (p = 0.018) were found to be statistically significant. The 2nd Hypothesis that the counselling provided by KFIM would result in statistically significant ($p<0.05$) improved scores on the Brief Resilience Scale from the baseline assessment to follow-up test was supported in sub-sample A (n = 34 clients) based on the average BRS scores.

Table 4.8: BRS mean scores for participants with a baseline and 2nd test score (n = 34)

BRS question	Baseline	2nd test	Mean difference
1. I tend to bounce back quickly after hard times	2.29 (1.24)	2.74 (1.14)	+0.45 **(p=0.015)***
2. I have a hard time making it through stressful events	2.21 (0.98)	2.5 (1.05)	+0.29 (p=0.135)
3. It does not take me long to recover from a stressful event	2.18 (0.8)	2.41 (0.99)	+0.23 (p=0.158)
4. It is hard for me to snap back when something bad happens	2.09 (0.83)	2.26 (0.93)	+0.17 (p=0.284)
5. I usually come through difficult times with little trouble	2.24 (0.92)	2.32 (0.94)	+0.08 (p=0.467)
6. I tend to take a long time to get over set-backs in my life	2.12 (0.95)	2.26 (0.9)	+0.14 (p =0.225)
Average score	2.19 (0.74)	2.44 (0.83)	+0.25 **(p=0.018)***

	This shading indicates a positive change in mean
	This shading indicates change between means
	This shading indicates a negative change in mean
Statistical significance	Statistical significance was calculated using the Related-Samples Wilcoxon Signed Rank Test. Statistical significance was set at p≤0.05. Significant results are highlighted in bold and marked with an asterix *

For sub-sample B (n = 26) the BRS average mean score for the sample increased from 2.36 at the baseline to 2.65 at the third test (post-test). This increased mean indicated an improvement in resilience following counselling services provided by KFIM. The BRS average baseline and post-test time 3 scores (n = 24 participants) were analysed for normality both skewness and Kurtosis were within acceptable ranges for both variables and so a paired samples T-test was undertaken for the BRS average score. However, the increase mean from baseline to 3rd test for the BRS average score was not significant (t -1.119, df 23, p = 0.275), neither were the differences between the average score means for the baseline and 2nd test (t -1.407, df 23, p = 0.173) or the 2nd and 3rd test (t -2.275, df 23, p = 0.33). Increased means were found for all six BRS questions and the average score (see Table

4.9 below). No change in mean was found for questions 2 and 5 between the 2nd and 3rd tests (so between the first counselling session and the 8th counselling session), but the means for these questions did show improvement from the baseline to 3rd tests. Related samples Wilcoxon signed rank tests were then undertaken for each question and for the average score to examine the differences between the baseline and 3rd test. Only the BRS average score (p=0.018) and question 1 (p=0.015) were found to be statistically significant. Therefore, different findings for the BRS average score in terms of statistical significance were found following analysis used the paired T-test compared to the Related samples Wilcoxon signed rank tests. Taking a conservative view and based on the t-test results, the 2nd Hypothesis that the counselling provided by KFIM would result in improved scores on the Brief Resilience Scale was not supported in this sub-sample of 24 clients who undertook the Brief resilience scale on 3 occasions.

Table 4.9: BRS mean scores for participants with 3 measures (Sub-sample B; n = 26)

BRS question	**Baseline**	**2nd test**	**Mean difference between baseline and 2nd test**	**3rd test**	**Mean difference between 2nd and 3rd test**	**Mean difference between baseline and 3rd test**
1. I tend to bounce back quickly after hard times	2.50 (1.29)	2.79 (1.06)	+0.29	3.13 (1.12)	+0.34	+0.63 **(p=0.012)***
2. I have a hard time making it through stressful events	2.29 (1.0)	2.63 (1.17)	+0.34	2.63 (1.17)	0	+0.34 (p=0.252)
3. It does not take me long to recover from a stressful event	2.38 (0.82)	2.5 (1.02)	+0.12	2.58 (1.02)	+0.08	+0.2 (p=0.179)
4. It is hard for me to snap back when something bad happens	2.29 (0.86)	2.33 (0.96)	+0.04	2.71 (0.95)	+0.38	+0.42 (p=0.058)
5. I usually come through difficult times with little trouble	2.42 (0.93)	2.46 (0.93)	+0.04	2.46 (1.1)	0	+0.04 (p=0.851)
6. I tend to take a long time to get over set-backs in my life	2.29 (0.91)	2.42 (0.93)	+0.13	2.46 (1.1)	+0.04	+0.17 (p=0.384)
Average score	2.36 (0.75)	2.52 (0.83)	+0.16 (p=0.221)	2.65 (0.82)	+0.13 (p=0.499)	+0.29 **(p=0.49)***

Table key:	
	This shading indicates a positive change in mean
	This shading indicates change between means
	This shading indicates a negative change in mean
Statistical significance	Statistical significance was calculated using the Related-Samples Wilcoxon Signed Rank Test. Statistical significance was set at p≤0.05. Significant results are highlighted in bold and marked with an asterix *
t	t-test
df	Degrees freedom
p	probability
Statistical significance	Statistical significance was calculated using the Related-Samples Wilcoxon Signed Rank Test. Statistical significance was set at p≤0.05. Significant results are highlighted in bold and marked with an asterix *

The BRS average baseline, time 2, time 3 and time 4 scores (n = 9 participants) were analysed for normality, both skewness and Kurtosis were within acceptable ranges for both the BRS average time 2 and time 3 variables. However, the Skewness for the BRS average time 4 score was -1.185, which at less than -1.0 indicated the distribution was left skewed, and the Kurtosis for the BRS average baseline score was -1.784, which at less than -.1.0 indicated the distribution is platykurtic. Therefore, the Related samples Wilcoxon signed rank tests were then undertaken for each question and for the average score. As can be seen in Table 4.10 below, the average mean score for the sample (n = 9) increased from 2.52 at the baseline to 3.18 the fourth test. This increased mean indicated an improvement in resilience following counselling services provided by KFIM. However, this difference was not statistically significant at $p<0.135$. Given that this result (baseline to 4th test) was not statistically significant, analyses were undertaken for this sub-sample for: baseline to time 2; baseline to time 3; time 2 to time 3; and time 3 to time 4 and all these improvements were found to be statistically significant at the $p \leq 0.05$ level. The means for all six BRS questions increased from baseline to the fourth test. Two items (4. *It is hard for me to snap back when something bad happens* and (5. *I usually come through difficult times with little trouble*) showed a small decrease in mean from the baseline (taken at the assessment session) and the 2nd test (taken at the start of the first counselling session) but the means for question 4 then increased at the 3rd and 4th tests and for question 5 increased at the 4th test. For question 6 (I tend to take a long time to get over set-backs in my life) there was no change in mean between the baseline and 2nd test and a small decrease in mean at the 3rd test, however, the mean score then increased at the 4th test. As the improvement for the BRS average score was not statistically significant for the analysis from baseline to the 4th test, the 2nd Hypothesis that the counselling provided by KFIM would result in statistically significant ($p<0.05$)

improved scores on the Brief Resilience Scale from the baseline assessment to follow-up test was not supported in this sub-sample of 9 clients who undertook the Brief resilience scale on four occasions.

Overall, the 2nd hypothesis was only supported for the analysis of BRS scores for sub-sample A, and not for the analyses for sub-samples B and C. So, whilst the mean differences for all six questions and the BRS average score (displayed in tables 4.8, 4.9 and 4.10) indicated improvements in resilience, as measured by the BRS, the 2nd Hypothesis was not supported.

Table 4.10: BRS mean scores and mean differences between scores for clients with 4 measures (sub-sample C; n = 9)

BRS question	Baseline Mean (standard deviation, s.d.)	2nd test Mean (standard deviation, s.d.)	Mean difference between baseline and 2nd test	3rd test Mean (standard deviation, s.d.)	Mean difference Between 2nd and 3rd test	Mean difference between baseline and 3rd test	4th test Mean (standard deviation, s.d.)	Mean difference between 3rd and 4th test	Mean difference between Baseline and 4th test
1. I tend to bounce back quickly after hard times	2.67 (1.5)	2.89 (1.27)	+0.22	3.11 (1.27)	+0.22	+0.44	3.44 (1.01)	+0.33	+0.77 (p=0.102)
2. I have a hard time making it through stressful events	2.56 (1.13)	2.89 (1.36)	+0.33	2.89 (1.27)	0	+0.33	3.11 (1.05)	+0.22	+0.55 (p=0.236)
3. It does not take me long to recover from a stressful event	2.33 (0.87)	2.56 (1.13)	+0.23	2.67 (0.71)	+0.11	+0.34	3.11 (1.05)	+0.44	+0.78 (p=0.053)
4. It is hard for me to snap back when something bad happens	2.44 (0.88)	2.22 (1.09)	-0.22	2.67 (0.87)	+0.45	+0.23	3.33 (0.87)	+0.66	+0.89 **(p=0.038)***
5. I usually come through difficult times with little trouble	2.56 (1.24)	2.44 (1.13)	-0.12	2.56 (1.01)	+0.12	0	2.78 (1.09)	+0.22	+0.22 (p=0.577)
6. I tend to take a long time to get over set-backs in my life	2.56 (0.88)	2.56 (1.13)	0	2.44 (1.24)	-0.12	-0.12	3.33 (1.22)	+0.89	+0.77 (p=0.161)
Average score	2.52 (0.77)	2.59 (1.02)	+0.07 (p=0.811)	2.72 (0.78)	+0.13 (p=0.779)	+0.2	3.18 (0.92)	+0.46 **(p=0.012)***	+0.66 **(p=0.024)***

[light blue shading]	This shading indicates a positive change in mean
[green shading]	This shading indicates no change between means
[dark blue shading]	This shading indicates a negative change in mean
Statistical significance	Statistical significance was calculated using the Related-Samples Wilcoxon Signed Rank Test. Statistical significance was set at p≤0.05. Significant results are highlighted in bold and marked with an asterix *

4.1.4 Campaign to End Loneliness Measurement Tool

Objective 3 was to examine if there was a statistically significant change to participants' 3-item Campaign to End Loneliness Measurement Tool (CTELMT) pre-counselling and post-counselling scores. Questions were scored on a 5-point scale from 0 to 4 (see Appendix 3). The analysis was based on analyses for three sub-samples comprising clients who had undertaken the CELMT at: two time points (sub-sample A, n = 34); at three time points (sub-sample B, n = 23) and at four time points (sub-sample C, n = 9; see Table 4.11 below). This meant that clients who had undertaken the CELMT four times had scores that were included in all the analyses for all three sub-samples, those who had undertaken CELMT three times had scores that were included in the analyses for sub-samples A and B; and those who had undertaken CELMT twice had scores that were only included in the analysis for sub-sample A.

Table 4.11: Break down of sample for Campaign to End Loneliness Measurement Tool

Sample	CELMT	
KFIM Client Population	People with a Lamplight number provided by Sheffield Mind in the Excel data base	n = 52
Clients removed from analysis	People with no CELMT scores recorded	n = 12
Clients removed from analysis	People with only one baseline CELMT score recorded	n = 6
Sub-sample A	2 CELMT measures	n = 34
Sub-sample B	3 CELMT measures	n = 23
Sub-sample C	4 CELMT measures	n = 9

The means for each of the three CELMT questions were compared between the baseline and 2nd test for sub-sample A (see Table 4.12). The means for question 1 (*I am content with my friendships and relationships*) and 3 (*My relationships are as satisfying as I would want them to be*) reduced between the baseline and 2nd test, whilst the mean for question 2 (*I have enough people I feel comfortable asking for help at any time*) increased by 0.15. The CELMT average baseline, time 2, time 3 and time 4 scores for sub-samples A, B and C were analysed for normality, skewness and Kurtosis. Test of normality (Kolmogorov-Smirnov and Shapiro-Wilk) indicated that the data for the baseline and the

2nd tests for all three questions were not normally distributed. Therefore, the Related-Samples Wilcoxon Signed Rank Test was undertaken to examine whether changes in scores were statistically significant, this non-parametric test examines the median of differences between the baseline and 2nd test scores. Statistical significance was set at $p \leq 0.05$. The CELMT baseline and 2nd test data (n = 34) did not show a statistically significant change for all three questions. Therefore, the 3rd Hypothesis that the counselling provided by KFIM would result in statistically significant ($p<0.05$) improved scores on the Campaign to End Loneliness Measurement Tool from the baseline assessment to follow-up test was not supported by the findings from sub-sample A.

Table 4.12: CELMT mean scores for participants with a baseline and 2nd test score (n = 34)

CELMT question	Baseline	2nd test	Mean difference
1. I am content with my friendships and relationships	2.21 (1.2)	2.12 (1.01)	-0.09 p≤0.618
2. I have enough people I feel comfortable asking for help at any time	1.91 (1.36)	2.06 (1.25)	+0.15 p≤0.586
3. My relationships are as satisfying as I would want them to be	2.62 (1.07)	2.44 (1.08)	-0.18 p≤0.311

Table key:

	This shading indicates a positive change in mean
	This shading indicates change between means
	This shading indicates a negative change in mean
Significance	Statistical significance was calculated using the Related-Samples Wilcoxon Signed Rank Test. Statistical significance was set at p≤0.05.

As can be seen in Figure 4.6 below, for CELMT question 1, 10 clients had improved scores, 12 clients score remained the same and 12 clients' total scores decreased from the baseline to the 2nd test. Figure 4.7 shows the changes in scores for CELMT question 2; 11 clients had improved scores, 13 clients score remained the same and 10 clients' total scores decreased from the baseline to the 2nd test.

Figure 4.6: CEMLT Question 1 baseline total score compared to 2nd test score (sub-sample A; n = 34)

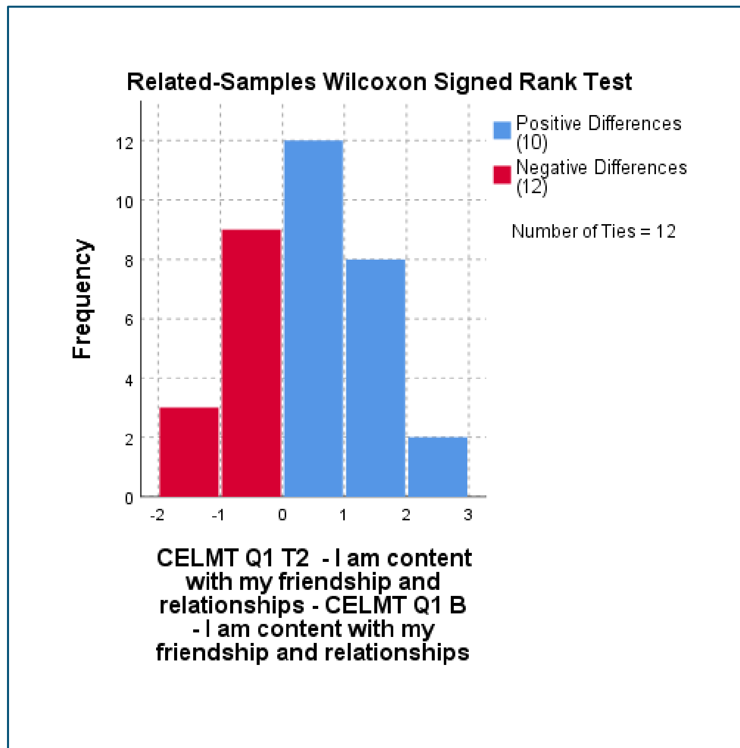


Figure 4.7: CEMLT Question 2 baseline total score compared to 2nd test score (sub-sample A; n = 34)

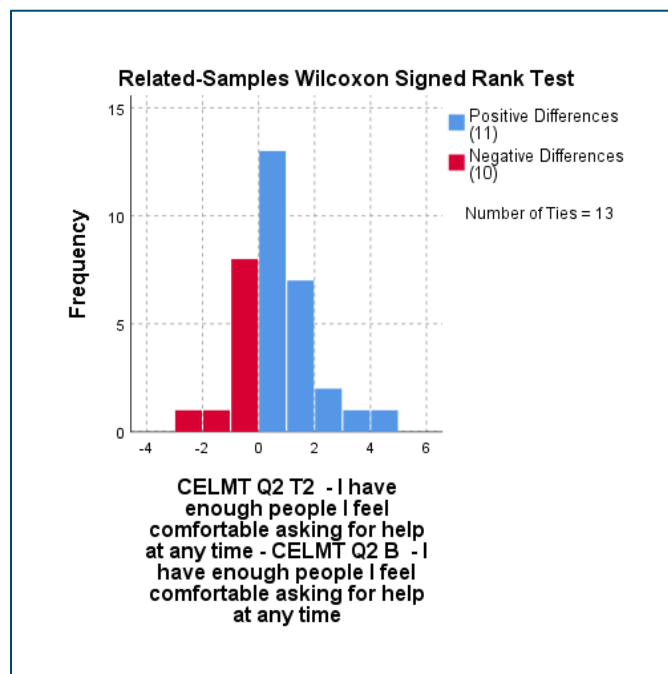
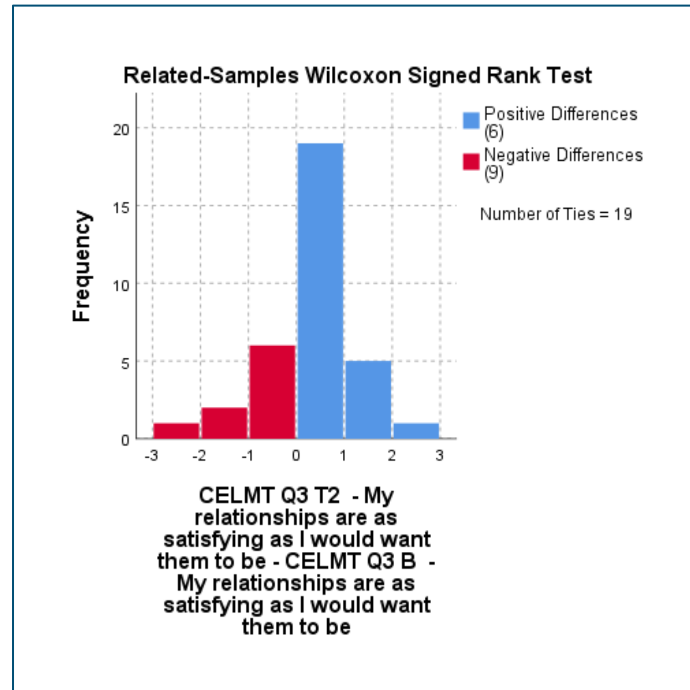


Figure 4.7 shows the changes in scores for CELMT question 3; six clients had improved scores, 19 clients score remained the same and nine clients' total scores decreased from the baseline to the 2nd test.

Figure 4.8: CEMLT Question 3 baseline total score compared to 2nd test score (sub-sample A; n = 34)



For Sub-sample B, the means for each of the three CELMT questions were compared between the baseline, 2nd and 3rd test (see Table 4.13 below). The means for all three questions decreased from the baseline to 3rd test. Scores also decreased from the baseline to 2nd test for question 3. Figure 4.9, 4.10 and 4.11 show how many clients scores increased, stayed the same or degreased for CEMLT questions 1, 2 and 3 respectively. The CELMT baseline and 3rd test data (n = 26) did not show a statistically significant change for all three questions. Therefore, the 3rd Hypothesis that the counselling provided by KFIM would result in statistically significant ($p<0.05$) improved scores on the Campaign to End Loneliness Measurement Tool from the baseline assessment to follow-up test was not supported by the findings from sub-sample B.

Table 4.13: CELMT mean scores for participants with 3 measures (Sub-sample B; n = 26)

CELMT question	Baseline	2nd test	Mean difference between baseline and 2nd test	3rd test	Mean difference between 2nd and 3rd test	Mean difference between baseline and 3rd test
1. I am content with my friendships and relationships	2.04 (1.11)	2.13 (0.92)	+0.09	1.78 (1.09)	-0.35	-0.62 (p=0.299)
2. I have enough people I feel comfortable asking for help at any time	1.65 (1.34)	2.13 (1.29)	+0.48 (p=0.101)	1.43 (1.04)	-0.7	-0.22 (p=0.506)
3. My relationships are as satisfying as I would want them to be	2.52 (1.12)	2.35 (1.11)	-0.02	2.17 (1.07)	-0.18	-0.35 (p=0.101)

(light blue shading)	This shading indicates a positive change in mean
(teal shading)	This shading indicates no change between means
(dark blue shading)	This shading indicates a negative change in mean
Significance	Statistical significance was calculated using the Related-Samples Wilcoxon Signed Rank Test. Statistical significance was set at p≤0.05.

Figure 4.9: CEMLT Question 1 baseline total score compared to 3rd test score (sub-sample B; n = 23)

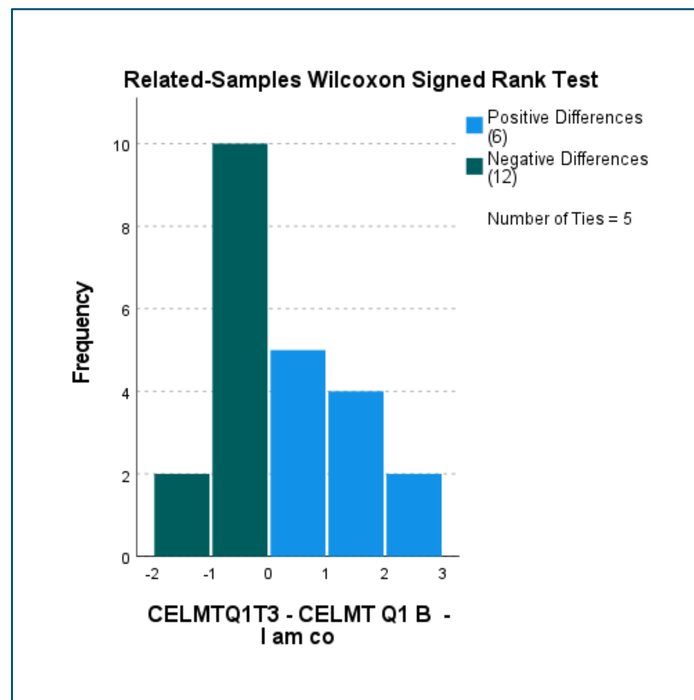


Figure 4.10: CEMLT Question 2 baseline total score compared to 3rd test score (sub-sample B; n = 23)

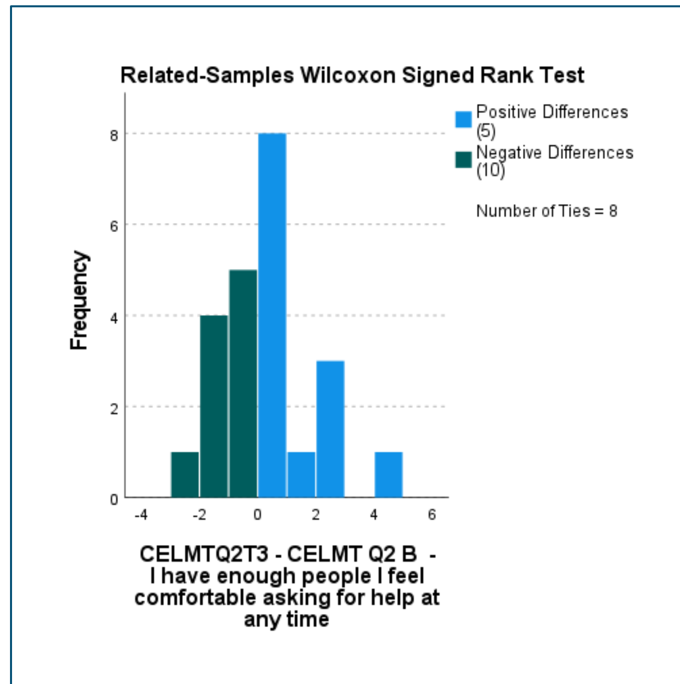


Figure 4.11: CEMLT Question 3 baseline total score compared to 3rd test score (sub-sample B; n = 23)

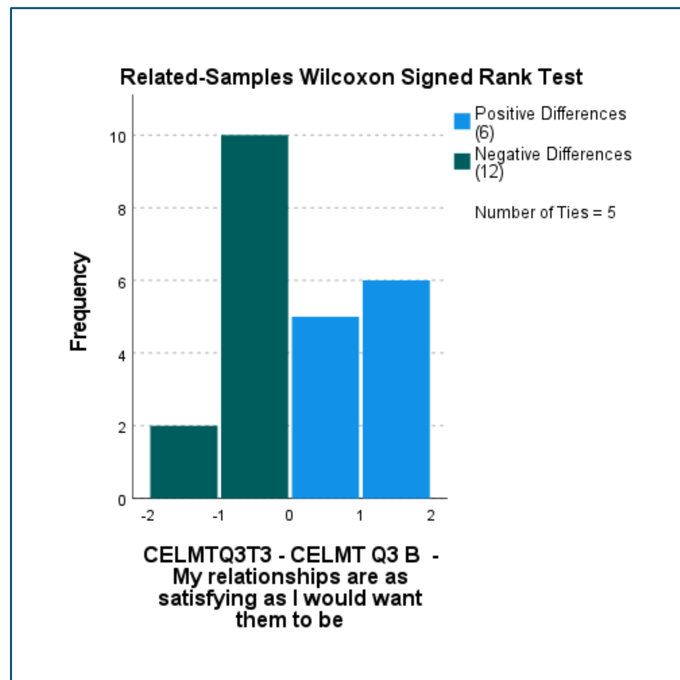


Table 4.14: CELMT mean scores and mean differences between scores for clients with 4 measures (sub-sample C; n = 9)

CELMT question	Baseline Mean (standard deviation, s.d.)	2nd test Mean (standard deviation, s.d.)	Mean difference between baseline and 2nd test	3rd test Mean (standard deviation, s.d.)	Mean difference Between 2nd and 3rd test	Mean difference between baseline and 3rd test	4th test Mean (standard deviation, s.d.)	Mean difference between 3rd and 4th test	Mean difference between Baseline and 4th test
1. I am content with my friendships and relationships	2.22 (1.20)	2.22 (0.97)	0	1.56 (1.13)	-0.66	-0.66	1.33 (1.12)	-0.23	-0.89 **(p=0.023)***
2. I have enough people I feel comfortable asking for help at any time	1.78 (1.64)	2.0 (1.32)	+0.22 (p=0.480)	1.67 (1.22)	-0.33	-0.11	1.11 (1.17)	-0.56	-0.67 (p=0.226)
3. My relationships are as satisfying as I would want them to be	2.44 (1.51)	2.44 (1.51)	0	1.89 (1.05)	-0.55	-0.55	1.67 (1.22)	-0.22	-0.77 **(p=0.038)***

Table key:

[light blue]	This shading indicates a positive change in mean
[turquoise]	This shading indicates no change between means
[dark blue]	This shading indicates a negative change in mean

For Sub-sample C (n = 9), the means for each of the three CELMT questions were compared between the baseline, 2nd, 3rd and 4th test (see Table 4.14 above). The means for all three questions decreased from the baseline to 4th tests. Scores also decreased from the 2nd to the 3rd test and between the 3rd and 4th tests. The means from baseline to 2nd test increased for question 2 (*I have enough people I feel comfortable asking for help at any time*) but remained the same for questions 1 and 3. Figures 4.12, 4.13 and 4.14 show how many clients scores increased, stayed the same or degreased for CEMLT questions 1, 2 and 3 respectively. The CELMT baseline and 4th test data showed a statistically significant negative change for questions 1 and 3. Therefore, the 3rd Hypothesis that the counselling provided by KFIM would result in statistically significant ($p<0.05$) improved scores on the Campaign to End Loneliness Measurement Tool from the baseline assessment to follow-up test was not supported by the findings from sub-sample C.

Figure 4.12: CEMLT Question 1 baseline total score compared to 4th test score (sub-sample C; n = 9)

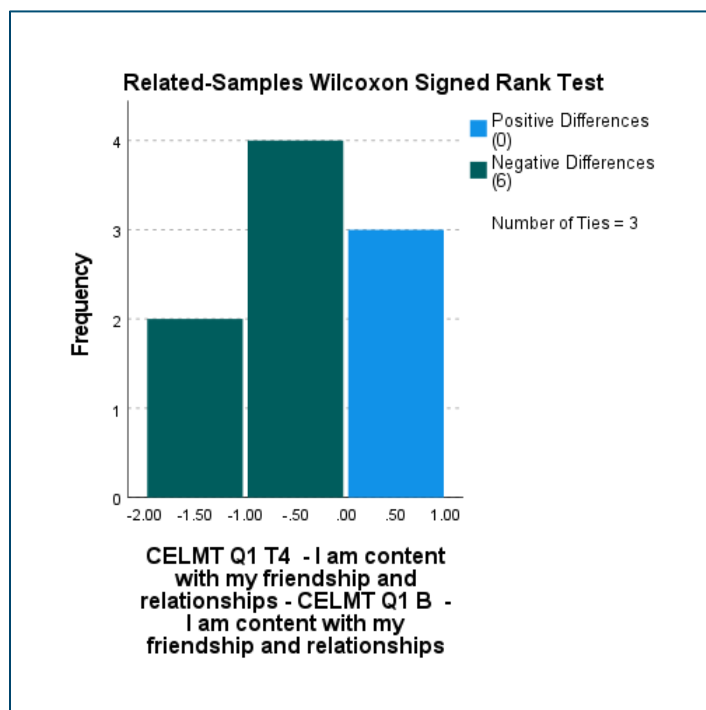


Figure 4.13: CEMLT Question 2 baseline total score compared to 4th test score (sub-sample C; n = 9)

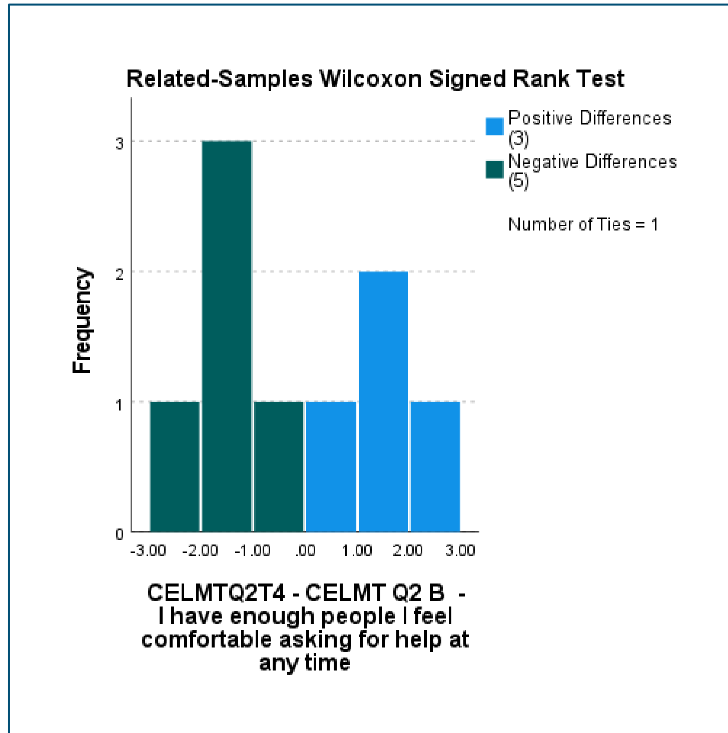
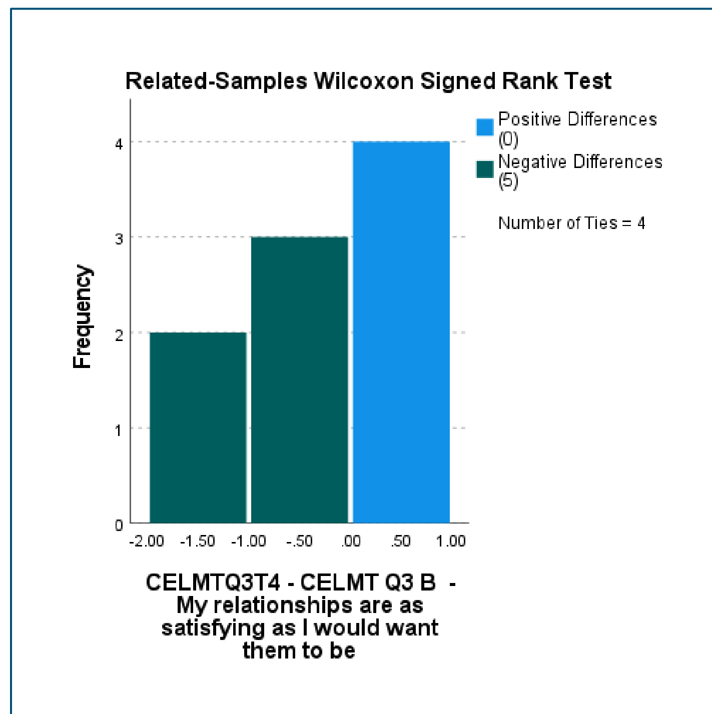


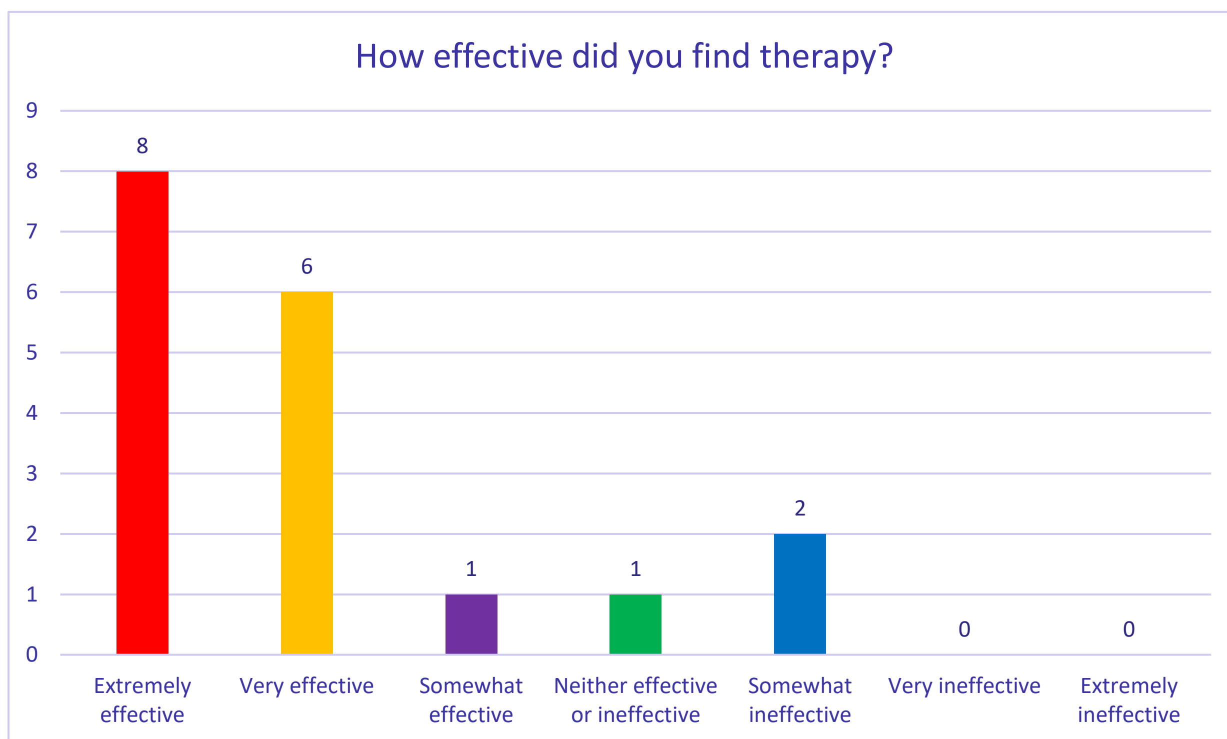
Figure 4.14: CEMLT Question 3 baseline total score compared to 4th test score (sub-sample C; n = 9)



4.2 Evaluation survey

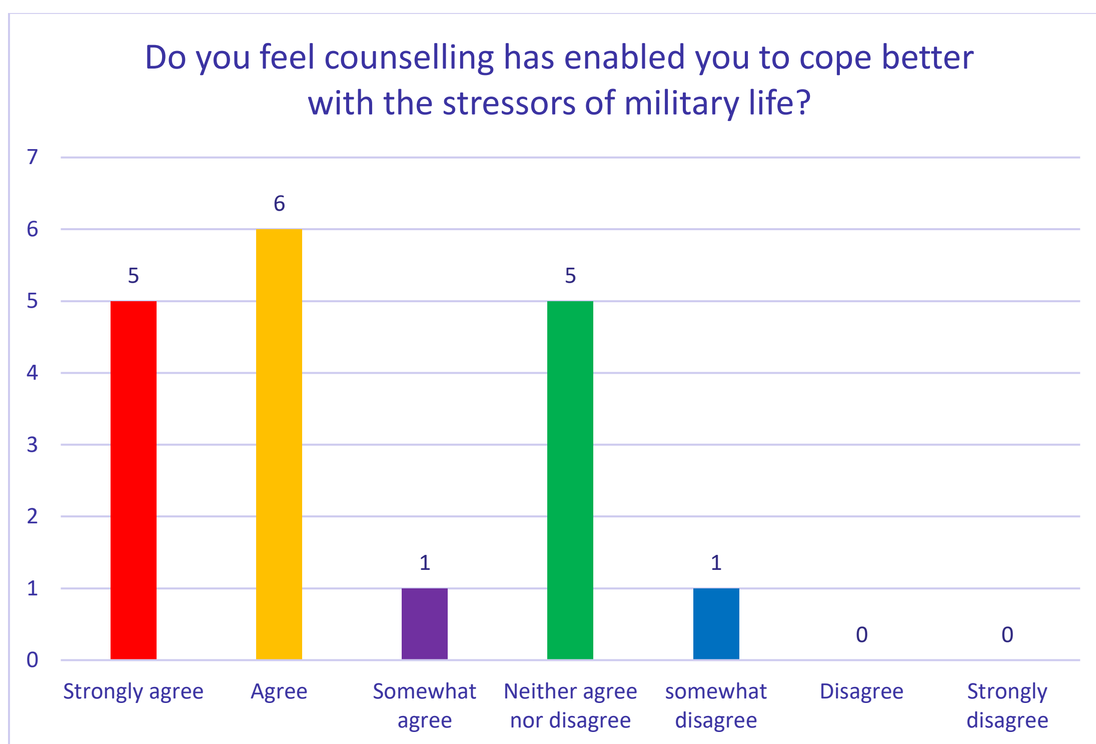
Objective 4 was to evaluate questionnaire data collected by Sheffield Mind from clients' attending KFIM service following completion of counselling. The survey comprised three closed questions and three open questions (see section 3.3.4 for these questions). The majority of respondents (15/18) rated their therapy as effective to some degree (see Figure 4.15 below) with only 2 clients rating their therapy as 'somewhat ineffective' and none rating their therapy as very or extremely ineffective.

Figure 4.15: Clients' ratings of the effectiveness of their therapy (n = 18)



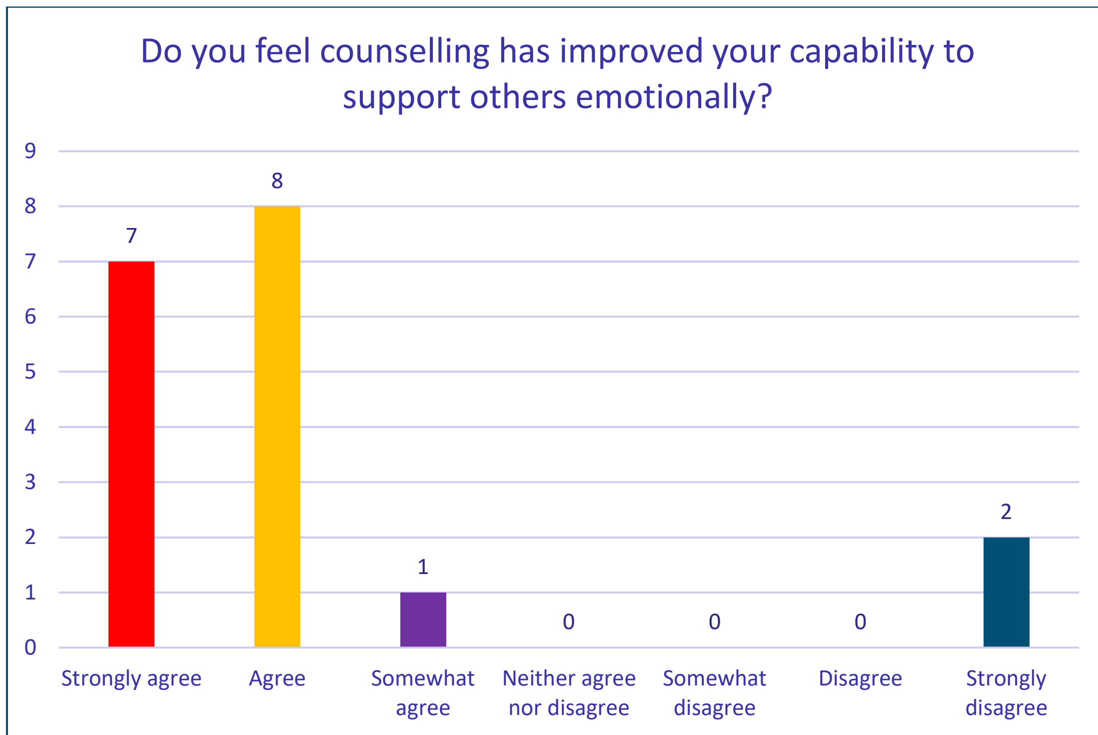
Twelve of the 18 respondents indicated counselling had enabled them to cope better with the stressors of military life to some degree (see Figure 4.16 below). Only one person disagreed but five rated their response as 'neither agree nor disagree'.

Figure 4.16: Clients' ratings on whether counselling had enabled them to cope better with the stressors of military life (n = 18)



Sixteen of the 18 participants indicated that counselling has improved their capability to support others emotionally to some degree. But two respondents rated this statement as 'strongly disagree' (see Figure 4.17 below).

Figure 4.17: Clients' ratings on whether counselling has improved their capability to support others emotionally (n = 18)



The KFIM sessions continued in the unprecedented circumstances of COVID 19 through Zoom or telephone. Clients appreciated that the KFIM staff were able to adapt to maintain support and contact with clients. For example, one person said: *"… It was impacted by COVID-19 initially regarding specifically the fact that was no longer able to meet face to face, however for me on some occasions this was more suitable in terms of the aspect of travelling to the appointments and I am used to phone support as this is my job..."*

Although some clients mentioned the counselling sessions could be hard and emotional at times people perceived the sessions as helpful rather than unhelpful. Clients did not mention anything about the KFIM service that was unhelpful. One person talked about it being *'difficult and very emotional'* but did not report this as being unhelpful. Another person talked about it being '*hard work*' but not in an unhelpful way, for example they said it was '*Hard work but fantastically supportive to my mental health…'* Some clients stated that nothing was unhelpful, for example: '*Nothing has been unhelpful'* and *'Nothing'.*

Table 4.15: Themes from the question: What did you find most helpful or unhelpful in your therapy?

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
2. Importance of talking	Clients spoke about the value of having someone to talk to	*'Talking was helpful in every way'* *'Helpful to talk to someone'* *'I found having someone to talk about how I felt about my anger helpful'*	a. *Being listened to* b. *The therapist being non-judgemental*	Clients mentioned being listened to Clients talked about the person who they were talking to and who was listening to them being non-judgemental	*'…someone to listen to me…'* *'Also having someone who was non-judgemental to talk to'*
3. The KFIM was helpful	Clients provided examples as to how the KFIM had been helpful to them.	*"…It helped me see things clearer and helped me view things in a way I hadn't before…"* *"…helpful to talk to someone… nothing has been unhelpful…"* *"…weekly counselling sessions were very helpful…"*			
4. Sessions could be challenging	Some clients found the counselling sessions challenging as they were reflecting on difficult experiences and emotions	*"…hard work but fantastically supportive to my mental health…"* *"…quite difficult - Found it hard to speak about the past. Stuff happened a long, long time ago … worried that what* [they were] *talking about was wrong…"*			

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Sessions could be challenging (continued)		*"…It has been difficult and very emotional and I still feel like I have a lot to unpick and questions to ask but the support, encouragement and understanding I have received from my* [therapist's name] *has been invaluable. She has challenged me too, when needed, and clearly believes in my ability to cope and deal with my difficult situation moving on…"*	No sub-theme		
5. Timing	The short waiting time and regularity of sessions was found to be helpful.	*"…Weekly counselling sessions were very helpful. At the uni, they could only offer sessions every 3 weeks at best…"* *"…I found the duration of time I had to wait to be seen greatly improved my therapy…"*	No sub-theme		

Four themes (Importance of talking; KFIM was helpful; Sessions could be challenging; and Timing) and two sub-themes (Being listened to; and the therapist being non-judgemental) emerged from analysis of responses to the question *'What did you find most helpful or unhelpful in your therapy?'* (Please see Table 4.15 above). Clients spoke about the value of having someone to talk to, of being listened to and having a counsellor who was non-judgemental. Clients provided examples as to how the KFIM had been helpful to them, however, some clients reported finding the counselling sessions challenging as they were reflecting on difficult experiences and emotions The short waiting time and regularity of sessions was found to be helpful.

Table 4.16: What aspects of your life has it affected the most?

Themes	Definition of theme	Themes: Illustrative quotes
6. Confidence	Clients gained confidence	*"…confidence is better, don't get as depressed as I used to…"* *"…my confidence - It has improved massively…"* *"...I feel more able to cope with difficult situations in the future…"* *"…It has effect[ed] the way in which I cope with situations, I cope better than before and feel stronger…"*
7. Relationships	Clients' relationships with others	*"… my relationship with my children…"* *"…It has had a positive effect on my relationships with others…"* *"… personal relationships with partner & family…"*
8. Optimism and Hope	Clients experienced feelings of optimism and hope	*"… My passion for life is returning I turned up for weeks wanting to die, now I am able to process my thoughts …easier to benefit my mental health more…"* *"…Everything - feels like myself for the longest period… Can finally see a future for herself…"* *"…I feel more motivated to get up in the morning and enjoy my life more. I now appreciate people in my life more too. And I'm trying not to take on stress, for example I have distanced myself from a friendship where they wanted a lot from me. But overall my friendships have improved..."*
9. Self-worth	Clients gained increased self-worth	*"… I have taken more responsibility for myself. I have stood back and allowed others to help themselves…"* *"…and most of all, seeing myself as important…"*

Table 4.17: How has it affected your relationships?

Themes	Definition of theme	Themes: Illustrative quotes
10. Confidence	Clients gained confidence	*"Given me more confidence in my ability to handle relationships"* *"It has given me the confidence to plan for the future (first time in many years)"*
11. Making changes	Clients described changes they had made	*"…I have been able to have a couple of difficult conversations which I had been putting off. Recently I asked for a temporary adjustment to my living arrangements to help me cope with my current difficulties…"* *"… Made them better. Helped me get rid of the people who are negative and bringing me down…"* *"… Partner noticed a small change...".*
12. Self-care	Clients took care of themselves more	*"I no longer put myself out or down to keep everyone else happy…"* *"…I have learnt to tell people it's ok to say I am struggling & need help…"* *"…I don't let them drain me like before I try and look after myself more, my communication is better too…"*
13. Self-awareness	Clients increased in self-awareness	*"…It has made me question how I view my relationships and how I treat others due to my own morals…"* *"…Improved my understanding of mistakes I have been making, hopefully strengthening them for the future…"*

Five themes (confidence, coping, relationships, positive feelings, and self-worth) *'What aspects of your life has it affected most?'* (see Table 4.16 above), some clients provided examples of how counselling had given them more confidence in other aspects of their lives and how they were coping better in situations. Clients gave examples of relationships that had been affected and described several positive feelings, such as passion and motivation, improving or returning. Clients mentioned changes indicating improved self-worth.

Four themes (confidence, making changes, self-care and self-awareness) emerged from analysis of the question *'How has if affected your relationships?'* (Please see Table 4.17 above). Confidence appeared as a theme again in response to this question, with additional examples of how counselling had given them more confidence in other aspects of their lives and clients provided some examples of changes they had or were making in their lives following counselling. Clients spoke about how they were taking better care of themselves and gave examples of how they had increased in self-awareness.

4.3 Interviews with clients, referrer and staff

4.3.1. Sample: Objective 5 was to explore the views of clients, referrers and staff regarding the KFIM service. The sample comprised of 10 clients who had accessed the KFIM service, four staff members and one person who was a referrer to the service. To maintain anonymity people were given a participant code which is used in these results. Codes were allocated in the order in which the interviews were undertaken. Clients were participants P1, P4, P5, P6, P9, P10, P11, P12, P14 and P15. Staff members were participants P3, P7, P8 and P13. The referrer was participant P2.

4.3.2. KFIM Clients' perspectives:

4.3.2.1 Who referred you to the 'Keeping Families in Mind' service?

Most participants (n = 7) had referred themselves to KFIM. One person had been referred by a friend, another by their General Practitioner (GP) and whilst the last person could not remember exactly how they had been referred, although they thought the referral had either been made through Project Nova or the South Yorkshire Police. People had found out about KFIM through a variety of

sources including friends, family, their GP, Twitter, Ripple Pond, a bereavement counsellor, and Help for Heroes. Some clients had heard about KFIM through word of mouth but were not sure exactly who had told them, for example:

- *"And someone just said it. Had you heard about them? And I said no. And she said, I know someone there. And she's absolutely fantastic. And I think it was just because I said I feel like everything's on me, I've got no support and I can't cope with this anymore.* [Name of partner], *obviously with this PTSD* [Post-traumatic stress disorder] *at the time was, you know, he just was absent he wasn't really with me. And if I was stressed, it made everything worse. So, I just felt like I had to bottle everything up and I couldn't cope with all the pressures of … sorting everything on my own. And yeah, they mentioned it and I got in touch and that's how it all started. But I can't think who it was. Cause I'd rung that many people" (P9).*

- *"… I contacted it myself I think, I don't honestly remember I may have been given a leaflet somewhere or seen something somewhere, but I don't know I couldn't remember…" (P5).*

- *"So, my… partner gets he's still in the army and he gets deployed quite a bit. And I think erm his first really long deployment. And I'd like I'd struggled quite a bit because I live on my own anyway when he's away. And I think someone had mentioned to me after that … there's thing's out there your entitled to a bit of therapy whilst he was away" (P11).*

A client stated that she had no idea that the service existed and that it was only by going to her GP that she was made aware of KFIM and a referral made. This evidence demonstrates the importance of GPs as referrers and sign-posters to KFIM and similar services as outlined in the Royal College of GPs' (RCGP) Veteran Friendly GP practice initiative (Patel et al, 2017; NHS England, 2018; NHS, 2021). A few clients mentioned previous counselling or accessing mental health services before receiving support from KFIM, for example:

- *"I think it was originally said to go to Mind Sheffield because the services that I'd been using it was not helping, I had already seen three different counsellors there and it was just not*

working…" (P1).

- *'I think it was erm well I've had two lots of counselling but assumed they'd be both through my work either through erm project Nova to do with my ex-husband…' (P6).*

- *"… so, I've had therapy before anyway. I've had therapy through the NHS … and so I wasn't scared about approaching anyone for mental health reasons" (P11).*

4.3.2.2 Why do you think [referrer role/name] referred you to the 'Families in Mind' service?

People's reasons for self-referring to KFIM or for being referred to Mind were varied. For example, one person had been accessing group bereavement counselling and felt individual counselling after this finished would be helpful. However, they were told by the GP the waiting list was very long and their bereavement counsellor had suggested contacting Mind. Another was dealing with threats of violence and harassment from her ex-husband who had been in the army. The client felt that the stressful situation was impacting her work and emotional state. Concerns around violence have been raised by several authors (Trevillion et al, 2015; CSJ, 2016; Kwan et al, 2018; Selous et al, 2020; JSP 100, 2021). Another was coping with a partner with post-traumatic stress disorder (PTSD) (MacManus et al, 2015), moving home, trying to find schools for their children, trying to find work and had felt overwhelmed with this situation (Lyonette et al, 2018). As stated by Selous et al (2020), *although military families experience the same stressors in family life that all families face*, *they also experience additional stressors such as long deployments*, a factor also identified within the Ministry of Defence's (MOD) Armed Forces Families' Strategy (2016). Importantly, this was evidenced by a KFIM client who was dealing with the stress of being alone whilst her partner was on a long deployment overseas (Royal Air Force Families Federation (RAFFF, 2018; Army Families Federation, AFF, 2018; Gribble & Fear, 2019).

Example reasons for seeking help from KFIM:

- *"… just a bit of support really, just ways to help me deal with it because I was getting a lot of anxiety …I couldn't concentrate at work and or …I'd be getting worried or I couldn't sleep, it*

was just affecting me" (P6).

- *"It was because I was having erm, probably just like just processing things and like trauma and touched on PTSD and that kind of thing" (P10).*

There were several explanations regarding how clients felt other services had not provided the needed or most appropriate support for them, or how some had experienced problems accessing support previously (Selous et al, 2020). Some clients mentioned why they felt the KFIM service was more accessible, for example:

"…I've never found that support through the Army really… I've reached out to charities before and …it … feels like a one size fits all approach to the army, to like military families and stuff, so people always ask me, …are you married to him, or do you live on base? And I'm neither of those, but I'm still a military spouse. It doesn't take away the fact that I'm still dealing with him being deployed and everything. …I've been like turned away at the door really …for not being married to him or not living on base and being part of that community. So, the therapy for me was, was someone finally like going, well actually come in, let's have a chat and let's, let's sort through these things together…" (P11).

Table 4.18: reasons for self-referring to KFIM or for being referred to Mind

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Threats of violence	Client spoke about ex-partner making threats	*"I was getting a lot of anxiety …I couldn't concentrate at work"*	Being able to access bespoke support	Client said that they had found other services accessed not useful	*"…just a bit support really…"*
Partner with PTSD	Client spoke about partner who suffered with PTSD	*"…just like just processing things and like trauma and touched on PTSD and that kind of thing…"*	Being able to access support and process trauma	Client said that the anxiety was affecting their work	*"I just felt like I had to bottle everything up and I couldn't cope with all the pressures of … sorting everything on my own."*

Loneliness being a military spouse	Client spoke about living away from military bases and the support network	*"People ask me are you married to him or do you live on base. I'm neither of those, but I'm still a military spouse. It doesn't take away the fact that I'm still dealing with him being deployed and everything*	Being able to access support due to wider KFIM military partnership definition	accessing support was difficult due to partnership status not being recognised	*"I'd struggled quite a bit because I live on my own anyway when he's away."*

4.3.2.3 What did you hope to gain from the 'Families in Mind' service?

Some clients mentioned that they did not know what to expect from the KFIM service, but soon realised that it would be helpful and that it was good to get the right support, with others feeling that previously they had had no support (MOD, 2011; MOD, 2016; MOD 2020) stating that it was important that families had a voice. The Living in our Shoes report (Selous et al, 2020) reinforces and supports the need for families to have a voice. In addition, it highlights the benefits of families having someone to talk too, along with schools and service providers understanding military life and the demands on military families.

A KFIM client had tried therapy before but felt a bespoke service with an understanding of the military worked better; this need for staff who understand military culture has previously been highlighted by several authors (Samele, 2013; Rafferty et al, 2017; Wood et al, 2017). Several clients mentioned that they were experiencing anxiety and stress, with some saying that it had impacted on their ability to function and having to take time off work. Learning coping mechanisms or techniques and how to resolve or cope with feelings was a priority highlighted by several clients.

Examples of client feedback:

- *"I just wanted to regain control everything that was going off in my head and how I was feeling I just felt out of control…" (P1).*

- *"I don't honestly remember the specifics, my memory is shocking I don't honestly remember the specifics of what I was even talking about at the time I believe it was to do with partly to do with work and partly to do with the fact that I felt really angry and I was just hoping to*

have someone to chat to about the reasons as to why and sort of have someone give me some insight into those feelings…" (P5)

Table 4.19: What did you hope to gain from the 'Keeping Families in Mind' service?

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Importance of having someone to talk too	Clients spoke about the value of having someone to talk too.	*"I was just hoping to have someone to chat to about the reasons as to why and sort of have someone give me some insight into those feelings"*	Being listened too	Client said that it was beneficial having someone to talk too to gain an insight into their own feelings	*"…have someone give me some insight into those feelings…"*
Mental Health – PTSD	Coping with a family member who would not access support	*"…it was as if the other person is not important, and it didn't show the importance of the family and didn't show what it's like to live with somebody whose suffering…"*	Mental health and other family members	Client said that they felt living with someone who suffered with a mental health condition can have an impact on them also.	*"…what it's like to live with somebody whose suffering and the sort of the secondary post-traumatic stress… it's a knock-on effect…"*
Coping with emotions and feelings - anxiety	Client experiencing a crisis point	*"I just wanted to regain control of everything that was going off in my head"*	Feelings of anxiety and loss of control	Client expressed feelings of anxiety and loss of control	*"…how I was feeling I just felt out of control…"*

Further example quotes:

- *"I couldn't concentrate at work and or I'd be getting worried, or I couldn't sleep, it was just affecting me. And then when I had the counselling, it was just ways of helping me deal with that anxiety and just putting things into perspective to just help me to have a better life, if that makes sense. Yeah, totally it worked I can't explain it, but the counselling and the things that*

were said to me sort of helped to put things in perspective and help me get on with my life, basically…" (P6)

- *"There's lots of support for erm ex-forces, personnel, but what they don't take on board as well is a lot of ex-forces personnel, is their partners are ex-forces to. Yeah. And there's like both me and my husband we've both served. And it was as if the other person is not important and it didn't show the importance of the family and didn't show what it's like to live with somebody whose suffering and the sort of the secondary post-traumatic stress, then I don't know the correct terminology, but it's a knock-on effect, isn't it…" (P14)*

4.3.2.4 Did you receive an individual service and / or access the support group?

From the client responses received, it suggests that only two had the opportunity to take part in face-to-face group sessions as the COVID pandemic directly affected the level of person-to-person contact, with the majority receiving individual sessions or accessing online support groups. Therefore, sessions described were conducted by either telephone or video call. One client said that although starting with telephone calls due to feelings of anxiety, she changed to video calls once a therapeutic relationship had been formed and she felt more comfortable with the sessions. Another client stated that after experiencing group sessions for another personal issue, she was looking for more individual sessions which the KFIM service provided. One client felt that the individual approach benefitted them as they tended to put others first and take too much on. But by having individual sessions, they had the opportunity to address their own concerns. Within example comments, partners highlighted how they are required to compromise and make sacrifices to prioritise their partners' military career (Selous et al, 2021).

A positive highlighted by one client was the flexible approach the KFIM project team took working around their own working commitments by arranging for sessions and meetings to be carried out in lunch breaks and break times so as not to encroach on work times. This addressed a barrier to engagement the client felt would have affected them and had this flexibility not being available they would not have been able to undertake the counselling sessions. Example challenges to service access, such as travelling times or having to take time off work, were identified.

Examples of client feedback:

- *"It was the individual services because I work full time… And what was really good is that* [the KFIM staff] *came to me and …met me in my break times and work was flexible as well… you know, worked round appointments. So, we've had appointments either side of a normal lunch break and it worked great…" (P14)*

- *"We started off on the phone because obviously it was during the first lock down when we couldn't go in and then once we had like established a bit more of a relationship, we then changed to video call which I thought was very useful because I was very anxious at first…" (P1)*

Table 4.20: Themes related to accessing the KFIM service

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Impact of Pandemic	Attending Group activities were impacted owing to the COVID 19 pandemic	*"…We started off on the phone because obviously it was during the first lock down when we couldn't go…"*	Use of telephone and online platforms	KFIM services continued during the pandemic utilising online delivery	*"I thought it* [online service delivery] *was very useful…"*
Benefits of online access	Access to group activities and appointments was enable through an online service delivery	*"…we then changed to video call which I thought was very useful because I was very anxious at first…"*	Staff flexibility regarding scheduling appointments	Clients have been able to access support at times to work around other commitments	*"…we've had appointments either side of a normal lunch break and it worked great…"*

4.3.2.5 What was your aim for accessing the service? What did you hope to gain?

Several clients mentioned that having someone to listen to them was very beneficial and that having someone who had the knowledge and understanding of the military community was helpful (Samele, 2013; Rafferty et al, 2017; Wood et al, 2017; MacManus & Wood, 2020), with one saying that having a *'voice'* was important as they were at *'breaking point'* (Donoho et al, 2017; Rafferty et al 2017; Selous, 2020*)*. One client talked about the stress around moving home especially as they were on their own and having to cope due to their partner being deployed. Examples of these unique multiple stressors affecting military families were identified as part of the MOD Tri-Service Families Continuous Attitude Survey (2020). Having the opportunity to talk about and work through anxieties and changing how people thought about their lives and helping them to look at things differently were repeated themes mentioned, with one client saying that whilst engaged with the KFIM service and having personal sessions, it was like having 'light bulb moments'.

Table 4.21: What was your aim for accessing the service? What did you hope to gain?

Themes	Definition of theme	Themes: Illustrative quotes
Understanding of Military family life	Accessing a service that understands military family life	*"…not that many people outside of the military community would understand or tolerate…"*
Importance of having someone to talk too	Clients spoke about the value of having someone to talk too.	*"I knew that in reaching out to Keeping Families in Mind and going through this therapy, I might be able to just get a few things like that off my chest"*
Experience of crisis	Some clients said that they'd reached a point of crisis	*"I mean, for me, …I was at breaking point"*

Examples of client feedback:

- *"…I mean, for me, it was I think I was at breaking point, and it …got me a back to a place of stability and it got me to stop and think about myself for a while…" (P14)*

- *“It was about sort of changing how I thought about things and, you know, patterns that I think weren’t just to do with him going away, just things that I’d always done and looking at things in a different way. And it sounds daft really now, but it did really need to be pointed out to me. You don't realise…” (P15)*

- *“I knew that in reaching out to keeping families in mind and going through this therapy, I might be able to just get a few things like that off my chest that, again, not that many people outside of the military community would understand or tolerate, to be fair…” (P11)*

4.3.2.6 How did you find your [individual / group] sessions with the KFIM staff?

From self-referral to engaging in the first therapy session (at around 3 weeks), the prompt access to the KFIM service was viewed as a positive; particularly, when compared to other services clients reported engaging with, such as waiting times for Improving Access to Psychological Therapies (IAPT) service (NHS England, 2015; NHS Digital, 2021). The flexibility and availability of the KFIM staff was a key factor in accessing the service which for one client meant the difference between being able to access support and not, especially at a time when they said they were *“crippled”* with anxiety (Donoho et al, 2018). Most clients reported that their sessions had been like a *“journey”* reporting a positive experience accessing the KFIM service. Apart from one, clients said that they had found the KFIM service helpful with most adding that that the service should continue. The client who appeared not to find the service helpful, said that they had been looking for specific mechanisms and methods to be suggested by the KFIM staff to help with coping strategies. Some clients said that they initially found talking in sessions difficult as just speaking to someone was a new experience for them. Many said that just being listened too and receiving prompts from the KFIM staff made it easier. Several clients mentioned that the sessions could be emotional but added that KFIM staff had professionally and sensitively processed the issues identified. Finding solutions themselves was thought helpful with some identifying that their anxieties were more complex than they had previously thought before accessing the service.

Examples of client feedback:

- *"It was rollercoaster of a journey, but I felt very supported. One of my biggest concerns was like the feeling of being judged … she created a space where I could be open and I actually told her things that I haven't told anyone ...for like ten years that I had been keeping to myself. It was... it was nice to be able to finally have an environment where I was able to say the things that I'd been needing to say"*
- *"I honestly don't think that I'd be where I am now without [name of KFIM staff member], literally …she just always knew the right thing to ask me or the right thing to say, to make me feel like I wasn't silly, I was normal... She kind of gave me a proper life back" (P9)*
- *"I just found it really helpful. And even though it was really draining, when I finish one of those sessions, I felt like a little bit better. And I just used what I was told to do, whether it be breathing or whether it be just thinking of writing things down I'd do those things. And it just made me feel better and happier…" (P6)*

Table 4.22: How did you find your [individual / group] sessions with the KFIM staff?

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Timely access to service	Clients commented positively on the service's flexibility and availability of staff	*"And she came to me because obviously with my anxiety, I said to her, I feel too afraid to leave the house." "…it was really helpful to be offered it on the telephone…"*	Prompt access to service compared to other services	Short waiting lists	*"For me, actually, like self-referring to getting the therapy wasn't that long at all. I think it was like three weeks …was not that long at all…"*
Non-judgemental service	Clients commented on not being judged	*"…one of my biggest concerns was feeling of being judged…"*	Therapists' understanding and acceptance	Clients commented therapists accepted their situation	*"So, to actually have somebody listen and, and accept that's that…"*

Themes (continued)	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Therapists' skills	Clients described the therapists' skills in enabling reflection and insight	*"…she was really good at listening …it's not about her telling me what's right and wrong, but making you realise yourself."*	(no sub-theme)		
Feeling validated	Clients gave examples of how therapists had validated their experiences and feelings	*"…helped me understand …you have every right to feel afraid. And she just helped me know that it was OK to stand there and go, no, it's not silly actually it did affect me…"*	(no sub-theme)		
Improving and making changes through therapy	Clients gave examples of things they had changed and that had improved in in their lives following therapy	*"She kind of gave me a proper life back - I honestly don't think that I'd be where I am now without [name], literally"*	(no sub-theme)		

4.3.2.7 Would you recommend the 'Families in Mind' service to your family and friends?

All clients were unanimous in their recommendation of the KFIM service to anyone who found themselves in a similar position. Several clients used the word 'definitely' in their replies to the question '*Would you recommend the 'Families in Mind' service to your family and friends?'; for example: "Yes, definitely. Without a doubt" (P6).* An ongoing theme running through all the interviews and this question, was how clients valued having someone to talk too who understood the military lifestyle and who created a supportive and comfortable environment where individuals did not feel

alone (Heaver et al, 2018; FIMT,2021). This was also commented on by a client who felt that even their own support network did not fully understand the military lifestyle. One client, who had not engaged with counselling previously, reported a sense of security around being enabled to explore their own feelings and fears, creating a newfound sense of self confidence. Having flexibility to access the KFIM service was viewed as very useful by several clients as they could work around other commitments, such as employment (Sondergaard et al, 2016). The issue of feeling isolated and not having someone to talk too was highlighted especially, by those whose partners were still serving or due to leave the armed forces (MOD, 2021). This was attributed to feelings of not being part of a wider military community owing to living away from a military base and not being able to access or find out about other support services. These concerns were highlighted within part of the 'Living in our shoes' report with issues around the negative effect of not being able to form friendships (Selous et al, 2020) and not having access to a 'crucial' support network (AFF, 2016) by living in their own home.

Examples of client feedback providing reasons why they would recommend the KFIM service to others:

- *"…the main reason is because they are there to help you … they want to help you …I felt very supported, and they would go out of their way to help me in any possible way …they made me feel like I wasn't alone with how I was feeling and that's one of the main reasons why I would recommend…" (P1)*

- *"I felt very comfortable in that environment, and I could speak about anything …I'd never been able to do that before so it was really, really helpful for me and it's given me a lot of confidence and it's resolved some issues that go back right to childhood …that I have not spoken about to anyone else. So …without being able to that, I am sure I would still be in the same anxious state that I was before I had the counselling and so I found it so helpful, more than I expected, much more than I actually expected…" (P4)*

- *"And you will get someone giving you professional help and advice …you getting somebody that knows what they're doing that's trained in these things, that can help you make your life better…" (P6)*

- *“Just because I think if …someone else can get the help that I got and the support I got, the fact that they put you first this you know, …she came to me that made it totally accessible at a time where I wouldn't have been able to access something because I wouldn't have dared to go anywhere. And just the time and the effort and the way they speak to you, even when I'd have to ring or change an appointment, everyone was so friendly, so helpful. Nothing ever felt like it was you was you know you were being too much trouble to ask for something” (P9)*

- *“…it maintained my wellbeing like you would if you were going to the gym every day to maintain your health and fitness…” (P11)*

- *“I think because it was …really about time to focus on you, to find the individual again…it sort of taught me how to maintain…I think I was existing rather than living…” (P14)*

- *“Well, just that it worked for me. You know, it did work, and it was nice to be able to have somebody just to talk too and it did really help me in that situation …I've not got anyone else who’s in the same situation you know, not anyone. It’s not easy to talk to people about it because they don't understand, and they don't understand you…” (P15)*

One client felt that the KFIM could be better advertised and marketed:

- *“…perhaps because that maybe the marketing could have been done better for the whole service as a whole and maybe there’s connections there that need to be looked at where it’s marketed…”*

Table 4.23: Would you recommend the 'Families in Mind' service to your family and friends?

Themes	Definition of theme	Themes: Illustrative quotes
Recommendation of service to others	All clients would recommend the service to others	*"Yes, definitely. Without a doubt"* *"I found it so helpful more than I expected much more than I actually expected…"* ***"…****it worked for me…"* *"…you will get someone giving you professional help and advice..."*
Not feeling alone	Clients talked about how the KFIM service had provided someone to talk to when they did not have anyone else to speak to about their concerns	*"I've not got anyone else who's in the same situation you know, not anyone…"* *"…it was nice to be able to have somebody just to talk too…"* *"……they made me feel like I wasn't alone…"*

4.3.2.8 Do you have any other needs which have not been met / fully met?

Most clients reported that they felt that their needs had been met and that their KFIM sessions had successfully explored their concerns and issues they were experiencing at the time. However, there were clients who reported finding the sessions challenging. One participant stated that after a session, things might still be on their mind and wondered how to best deal with those feelings. From client feedback concerning these issues, further KFIM support was discussed, or whether other services might be considered should participants feel the KFIM service was not what they felt they required. Most of participants were keen to ensure others who might need the KFIM service had the opportunity to access the service and so some mentioned that they did not want to use sessions that could be offered to others. Client feedback suggested that following attending the KFIM sessions, other life events and challenges have been more successfully navigated. One person identified some ongoing challenges and the need for "*…goal setting and time management…"*

Examples of participant feedback:

- *"… the sessions that I got were the perfect amount it wasn't too overwhelming, and I really liked that it that there was a week between each session …I thought that was really beneficial with the weekly session, I felt that the progression was made a lot easier because it flowed more naturally…" (P1)*

- *"…the counsellor said that there was a chance of extending the sessions if I felt I needed to, I felt that …I was in a much better frame of mind and that her skills would … be more used with someone else, and that some else's needs would be greater than mine, so I didn't need the extra sessions" (P4)*

- *"…the therapy sessions were ... helpful but at the same time it was very difficult to talk about obviously, with what I was going through at the time…" (P12)*

- *"… I don't think so. Like I say, I think she opened up those I didn't even realise were there and helped me more than what I was expecting to get…" (P9)*

- *"I don't think it was anything that I didn't get resolved …I do feel like it's really helped me. I do feel a lot strong[er], it got tested a little bit because he did go again last summer…[for] three months, and I was fine …I suppose it shows it did help me you know cause I'm all right" (P15).*

Table 4.24: Do you have any other needs which have not been met / fully met?

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Meeting clients' needs	Sessions successfully explored clients' needs, concerns, and issues they were experiencing	*"Like I say, I think she opened up those I didn't even realise were there and helped me more than what I was expecting to get…"*	Further client support explored via KFIM or other appropriate service subject to client need	Some clients mentioned KFIM follow up, or signposting or referral to alternative service dependant on client need	*"…I did have a follow up and a couple of calls…"*

4.3.2.9 Is there anything else you would like to tell us about the 'Families in Mind' service?

Lack of awareness of KFIM by other community support services, and the need for advertising and wider information sharing regarding the KFIM service and the group of people it is there to support was raised by several clients. Clients also had concerns that funding for the service may disappear. Most clients felt that accessing the service had been a positive experience and had helped them. For example, one person shared that because of the skills they had learned, through KFIM counselling, they were able to support a close family member. However, one client reported that that although only recently accessing the service, they still did not have a clear understanding what it did. Whilst another person reported that they would like more coping strategies discussed in the sessions and assignments to be done in their own time. For one client, additional support beyond the KFIM weekly sessions would have been beneficial and they raised the need for support outside of sessions:

- *"…you go to these therapy sessions and then you're talking about all of the stuff that's running through your mind and how you feel and then when the sessions over you're then left basically to your own devices…I believe that afterwards there should be some sort of safeguard that makes sure you get home safely or someone's there to meet up with you or there's some sort of transport that makes sure you get to where your supposed to be after the sessions" (P12).*

Echoing some responses to earlier questions, concerns were raised regarding military families that live away from military camps/barracks/stations in their own properties, with one client saying that although they had expected some sort of information from the Army, they had had no information provided regarding family support or spouses'/partners' support networks (Hudson & Ashworth, 2015; Heaver et al, 2018; Selous et al, 2020).

Examples of client feedback:

- *"I am just really grateful that somebody pointed me in that direction …with the efficiency of the service, they were so welcoming and felt so comfortable and …it was just a lovely secure environment and yeah I'd definitely recommend it to others…" (P4)*

- *"[It] can be very difficult to manage if you're a civilian and the person …is sort of still processing as if they are in a war situation when they are in everyday life, …always risk*

assessing, always sitting so they can see the door, so it does impact still definitely …there must be many people who …could benefit from that support." (P5)

- *"…it's really, really good and it …needs to be used more. I think people need to know about [KFIM] more …I just wish that … you could have like funding for a bit more, you know, like …for people to understand how much it does actually help, …people need to take advantage of it and use it" (P6)*

- *"I just thought they were brilliant; they've helped me massively. Like I said to you earlier, I don't think I'd be half the person I am now…" (P9)*

- *"Not everyone will be like me in the sense that they seek these things out…there might be other people out that don't know about this service. So, I guess the only thing I would say is let's get it out there more … [Are] there more stakeholders that could be pushing the message out there that this program exists?" (P11)*

Table 4.25: Is there anything else you would like to tell us about the 'Families in Mind' service?

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Awareness raising of KFIM service to other community service providers	Concerns that some community services were unaware of the KFIM service affecting referrals	*"…there might be other people out that don't know about this service…"*	Engaging with stakeholders to share information about KFIM	Clients suggested other stakeholders and charities could help raise awareness of KFIM	*"…So, if it [KFIM] was just more out there, if more stakeholders could be shouting about it …that'd be great."*
Funding	Concerns raised that funding for the service may disappear	*"I just wish that … you could have … funding for a bit more…"*	(none)		

Themes (continued)	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
KFIM service had helped	Clients felt accessing the service had helped them	*"…they've helped me massively …I don't think I'd be half the person I am now"*	Developing skills to help others	Examples of how clients were using learnt skills and strategies to support family members	*"…the skills that I've learnt to cope with my own anxiety and …my depression I was actually able to …help my sister go through a really hard time…"*

4.3.2.10 Did you feel that the 'Families in Mind' service understood military culture and lifestyle?

The personal background of the clients and whether they had been in the military or were from a military family themselves, appeared to influence the response to the question. For some, they had not served or had a close connection with the military, their experience of the military and associated concerns had manifested or been regarding a family member. A couple of clients said they had not explicitly discussed things to do with military culture and so it was hard to know what level of understanding staff had. However, clients who had a close connection with the military or were from a military family reported that they felt the KFIM staff had a good understanding of military life (FIMT, 2015), and that it had been helpful when discussing issues. One client said that because of the responses from the staff member about the issues they were talking about or what they were referring too, they felt that possibly the staff member was themselves from a military background or family (NHS,2015; Patel et al, 2017; Wood, 2018). Another client said that staff *'had an understanding'* of rank structure and military life, which helped with identifying relationship equality concerns and changing family dynamics. One client found the sessions very helpful especially as the KFIM staff member was able to share support information for their partner (Patel et al, 2017; Rafferty et al, 2017; Selous et al, 2020) also adding that identifying why someone does not ask for help and its origins is helpful to understand (Iverson et al, 2010; Diehle & Greenberg, 2015; Rafferty et al 2017; MOD, 2017).

Examples of client feedback:

- *"I just think it's absolutely incredible that you guys are able to actually be there not only for the people like [name] but their family as well. You've recognised that it doesn't just affect them it effects everyone around them…" (P1)*

- *"…there's just some different cultural differences…" (P5)*

- *"Yeah, because when I'd speak about with his PTSD, …that was [be]cause that was one of the reasons why he'd flair up. So that helped me understand his mental illness because only thing I'd ever known about it was … what he told me or what I'd looked up on internet. So, to have someone sitting in front of me and explaining it to me and saying, this is why it can happen. …It helped me deal with him …to find ways I can help him to help myself…" (P6)*

- ***"…**she signposted me with places that I could take home and offer to **[name]** for help. And obviously, I can't make him get the help. It was down to him to do that. But she was always able to pass on details of what you know, who he can speak to as well…" (P9)*

- *"…it did feel like she had a really good understanding, but not to a point that biased her, which I think is the most important bit really… she was an unbiased opinion on the situation" (P11)*

- *"…Because nothing …about military service was ever mentioned…" (P12)*

- *"…I think they did understand …that there was a complication between me and my husband, … he was always a senior rank to me. And I think that tripped into our relationship as well, rather than it being an equal and it was almost like it was rank structured…" (P14)*

- *"…you could just tell by certain things that I said or that she did understand and understood really well what I was referring to. And it wasn't sort of like direct questions or you know it*

just because of the responses and just because of how I was talking about things that she did understand…" (P15)

Table 4.26: Did you feel that the 'Families in Mind' service understood military culture and lifestyle?

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Staff understanding of military culture and lifestyle	Some clients reported that they felt the KFIM staff had a good understanding of military life	*"…you could just tell by certain things that I said or that she did understand and understood really well what I was referring to. things that she did understand…"*	Staff knowledge of wider support for military personnel, veterans, and families	Some clients shared that the therapist has signposted to help and support for their family member who was in the military	***"…she** signposted me with places that I could take home and offer to [name] for help."*

4.3.2.11 Optional participant comments: Is there anything you would like to add?

Six of the 10 clients interviewed made additional comments, and of these five people wanted to express their thanks and their gratitude to the Keeping Families in Mind service and the staff who provided their counselling. In addition, the accessibility of the service was mentioned positively. The other person asked for more information about why the KFIM service was focussed on military families, commented on the need for wider advertising of the KFIM service and the risk of mental health problems and suicide, particularly amongst men.

Examples of client feedback:

- *"I just want to say thank you… I can't put into words how much it means to me but it you basically saved my life…" (P1)*

- *"Just that I am very grateful that I was able to access the service and I think it is of great value. … I hope you continue to get funded…" (P4)*

- *"I am really grateful and the person who gave me the counselling, it was a God send and it was really good, she was really good … but I would suggest trying to market it more to people or make it more known to people that desperately need it…" (P5)*

- *"…just that I was extremely thankful for the service because do you know what it was? It wasn't even necessarily the service itself. It was that something was finally there for me that I could access, that someone wasn't going, no sorry, you can't or, are you married? It was like you knew what? You're in a relationship with an army person you are going through this, whether or not you're married or whether or not you live on camp. So, yeah, you are welcome. It was that like arm around the shoulder. Come on, come with us..." (P11)*

- *"Just to thank you really. And say thank you very much. And it helped me work through quite a lot of things and I learned a lot about myself. I think I'm far more assertive now in the relationship and in turn that has helped the relationship…" (P14)*

Table 4.27: Themes arising from additional comments

Themes	Definition of theme	Themes: Illustrative quotes
Unique Bespoke Military family focused service	Military family members prioritised	*"It was that something was finally there for me that I could access…"*
Expressions of thanks and gratitude	Several clients used this 'have you anything to add' question as an opportunity to thank their therapist and / or the wider KFIM service	*"…just that I was extremely thankful for the service…"* *"Just that I am very grateful that I was able to access the service…"*

4.3.3 KFIM referrer's perspectives:

4.3.3.1 Sample: The response for research feedback from referring organisations was very low and only one person came forward to be interviewed (this person was given the participant code P2). Therefore, it was not possible to undertake a thematic analysis from a sample of interviews. However, the feedback received is useful and appeared to replicate some of the concerns and issues reported by the client group, which provides some further supporting evidence around clients' identified themes.

4.3.3.2 Have you referred patients to the 'Keeping Families in Mind' service since it started? If yes, how frequently / how many approximately.

The referrer indicated that they had made four referrals to the KFIM service representing a range of people such as parents and veterans.

4.3.3.3 What have been your reasons for referring people to the 'Keeping Families in Mind' service?

From the client group it was reported that one was struggling to support a family member who had served in the military but who at the point of this research interview, was reluctant to seek help for their own concerns. Issues around help seeking behaviour and the barriers to engagement have been extensively explored within several publications (Iverson et al, 2010; Diehle & Greenberg, 2015; Rafferty et al 2017; MOD, 2017). The length of service of veterans varied from basic training to longer service counted in years and included representation of multiple family members having served in the armed forces for some veterans. Family dynamics and feelings of not being supported were identified as recurring themes in the client group identified by the refer. In addition, for one client who was a veteran and had other family members who had served in the armed forces, family dynamics and needing extra support appeared to be of concern.

Examples of referrer's feedback:

- *"…a dependent of a veteran contacted our service, she was struggling with her son who was a veteran…" (P2)*

- *"We did an assessment it was more a family thing…" (P2)*

- *“…he just wanted some extra kind of support as well, around family dynamics…” (P2)*

4.3.3.4 Have you seen any perceived benefits for individuals you have referred?

The refer reported that because their service was an assessment and referral service where client caseloads are not routinely kept, follow up procedures may or may not occur. Of those that were carried out, these were undertaken around a month later to check whether clients had entered the appropriate services identified and their role was complete. At this point in the research data finding process, it is not clear whether a *‘follow up’* is a requirement of the service referred too. However, of those followed up, the feedback was very positive with family members and veterans reporting that they were finding the KFIM service very useful and helpful. Previously recorded data and comments within this report identifying client concerns around isolation and having someone to talk too (AFF, 2016; Heaver et al, 2018; Selous et al, 2021) and the timely way clients were able to access the KFIM service, was replicated in the follow up feedback from the referrer. The referrer said that because one of the veterans’ concerns was not military related, the IAPt service were reported as saying that they would not prioritise access and that the veteran may have to wait for up to two years to access the IAPt service (NHS,2021). To have access to priority healthcare the NHS (2021) guidance states that: ‘*All veterans are entitled to priority access to NHS care (including hospital, primary or community care) for conditions associated with their time within the armed forces (service-related)’.*

Examples of referrer’s feedback:

- *“… his wife was finding it very useful…” (P2)*
- *” I have had some follow up contact with them from him, he was finding it quite helpful because he was feeling quite isolated, glad of basically having somebody to speak to…” (P2)*
- *“… the follow up for the two that I did have was really positive…” (P2)*
- *“…they said they were picked [up] pretty quick as well from me putting the referral…” (P2)*

4.3.3.5 From your perspective, has the 'Keeping Families in Mind' service made a difference? If yes, how?

The referrer said that the KFIM service had made a difference and been really useful especially as, in their opinion, Sheffield was '*one of the worst areas'* for waiting times accessing mental health services. They added that they hoped that the KFIM service would be expanded to cover the wider Yorkshire footprint as after checking they said that other areas did not have such a service currently.

Example of referrer's feedback:

- *"… it has been really useful having the Mind [KFIM] project in Sheffield because it's another option for us to maybe look at…" (P2)*

4.3.3.6 Do you think the service should be continued in future?

The referrer asserted that the KFIM service should '*definitely'* be continued as in their opinion some military charities and some NHS services would not engage with a veteran if they did not present with military attributed trauma. As an example, the referrer talked about how some people join the military as an escape route especially if child abuse was a factor in their decision to join the military (something mentioned in the literature, e.g., see Iverson et al, 2007; Iverson et al, 2008; Fossey,2010). In the referrer's opinion, as this issue is not attributed to military trauma, so if it were not for KFIM and their wider engagement policy, a veteran may not have been able to access support when they needed it.

Having a better understanding of military culture by other professionals and practitioners was highlighted as having an impact of presentation on the wider family group (this understanding is recommended in the literature, e.g., Samele, 2013; Rafferty et al, 2017; Wood et al, 2017; RCGP,2019). Therefore, having a referral pathway to KFIM was viewed as a positive resource. Having a multidisciplinary KFIM service was discussed and seen as positive as this created an understanding of military family dynamics and *'how they work'.* This was viewed as *'really useful'*.

Examples of referrer's feedback:

- *"… yeah, definitely it's an extra resource, its useful definitely…" (P2)*

- *"Keeping Families in Mind is for things around the extra family support so that's very useful for us as a resource because there are not many organisations that would do that…" (P2)*

- *"…if both are suffering because one veteran's presentation is on the family, you know you have only got limited options, maybe Relate counselling, but again maybe the therapist might not have that military understanding about military culture and how that impacts on the family…" (P2)*

4.3.3.7 If the service was to continue what, if any, improvements would you suggest?

The referrer suggested that the KFIM service should be extended outside of Sheffield to cover more of Yorkshire, especially where there are a high percentage of veterans and/or military families such as Catterick, as it is a garrison town. They recognised that although veterans do have access to specific and bespoke services (RCGP, 2019; NHS, 2021), in some cases families have limited support and may be suffering, coping with issues such as PTSD, irritability, angry outbursts or disturbed sleep (as described by Turgoose & Murphy, 2019). The referrer also said that, in their opinion, it was the partners who were trying to offer support who were *'taking the brunt of it'* and not getting the support they needed regarding how to cope with someone with PTSD (this need has been identified, Centre for Social Justice, CSJ, 2016). They added that working together as a family would be *'really useful'.*

Examples of referrer's feedback:

- *" … probably to expand to other areas you know covering more of Yorkshire…" (P2)*

- *"I supposed if Mind was there as well it would be another option [for] where they'd look to put veterans and their families…" (P2)*

- *"…often it's the veteran that will get the treatment for the trauma but it's the family who maybe in a way suffer you know those PTSD symptoms..." (P2)*

4.3.3.8 Is there anything else you would like to mention related to the 'Keeping Families in Mind' service'

The referrer mentioned that without the chance attendance at a meeting where a member of the KFIM staff provided a presentation they would not have been aware of the service. They said that more advertising about the service was essential. As an example, they said that the people who were referred to the service were unaware of it, so promoting it more locally would be beneficial. In their feasibility study, Drabble et al (2019) concluded that the *'Armed Forces Community have some awareness of the wide range of support but were less knowledgeable on how and when to access it,* which echoes the referrer's observations. Feedback from the KFIM service to the referrer was identified as a communication desire as it would help to know what other services were being accessed providing an oversight of the outcome. Having a self-referral online option, replicating other community and charity services provision, was identified as a possible solution to raised awareness of the KFIM service campaigns.

Examples of referrer's feedback:

- *"I suppose the advertising is important, I mean I wouldn't have known about it if [name] hadn't have attended on of our meetings and given a presentation on it, it would have been something that we'd have completely overlooked so definitely the advertising part of it…" (P2)*

- *"…feedback would be good for the referrer…" (P2)*

- *"…the referral process… some online form that might be made, take the pressure off… that we fill in, I am not sure that might be useful I know people self-refer via online referrals…. like the IAPt service, they do an online self-referral service…" (P2)*

4.3.4 KFIM staff perspectives:

4.3.4.1 Sample: Four staff participated in semi-structured interviews for this evaluation (staff members were participants P3, P7, P8 and P13).

4.3.4.2 Please describe your role in the 'Keeping Families in Mind' service.

The staff who participated reported representation from all associated roles required for the KFIM service to operate, including the KFIM manager, therapist, well-being practitioner, community engagement officer). Most staff said that the period to set up the service, awareness raising, and distribution of service information was impacted significantly by the restrictions of the pandemic, so adaptations needed to be explored and implemented, with some roles having to evolve and adapt as the KFIM service adjusted to the new pandemic restrictions and client needs. Some staff reported that while they recognised that the armed forces covenant funding was for three years, it took between a year and eighteen months to successfully *'get the word out'.*

Therefore, comparing pre and post pandemic effectiveness of awareness and engagement is influenced owing to there being an uneven period of time between the pre-pandemic and post-pandemic periods. However, although staff reported experiencing a significant learning curve around the use of new online platforms, such as Zoom and Microsoft Teams, it was reported that migration over to an online platform did prove to have some benefits, especially around ease of appointment access for clients. This included some clients not having to travel to appointments and having more flexibility around appointment times. Various services were introduced including phone, online face-to-face and group activities. Staff reported that having a range of engagement tools was a positive as clients had more choice and that different activities appeared to suit different client groups. So having a variety of exercises and engagement services available has positively benefitted clients. This included creating a '*safe space'* for members to have open discussions and having the opportunity to form friendships and support networks addressing issues and concerns around loneliness and feelings of isolation (issues also identified in the literature, e.g., see RAFFA, 2018; AFF, 2018; Gribble & Fear, 2019). Staff reported that initially there was some confusion around what the KFIM service was and who it was for, with many organisations assuming that it was focused on military veterans. This manifested itself in some early referrals being made to the service that were not from the identified families' client group.

Staff roles included the following activities:

- Therapists delivering one-to-one counselling
- Facilitating support groups

- Coordination of the KFIM service
- Taking referrals
- Arranging appointments
- Promoting the service
- Data management
- Networking with other organisations
- Planning
- Training

Example of Services:

- One to one counselling (up to 16 sessions)
- Supportive Groups
- Group work

Example of activities and groups:

- Arts and Craft Group - the "most popular" group (P3)
- Creative Writing Group
- Movement and Mood - the least well attended group "…didn't get many takers for that…" (P3)
- Walking Group
- Book club
- Post-Traumatic Stress Disorder (PTSD) Course

Raising Awareness:

KFIM staff used a range of activities and information sharing practises and events to provide service information for communities.

Examples of information sharing activities:

- Local Radio interviews
- Local supermarkets
- Social Media (Facebook, Twitter)

- Advertisement on public transport
- Downloadable leaflets on website
- Attendance at community support service meetings
- Engagement with civilian and military charities
- Engagement with military units (reservists)
- Becoming part of local authorities' armed forces covenant networks
- Engagement with health and social care professionals
- Engagement with Department for Work and Pensions (DWP) staff
- Mental health training events
- Project conference

Example of staff comments:

- *"…my role has …been to go out and meet the military community which I think has proved quite difficult …when you do things just by email or by phone conversation you know. I do very much see this role as being a face-to-face role …but we've just had to adapt because of the of the pandemic…" (P3)*
- *"…I think it's fair to say that friendships have been developed from the craft group … it can be lonely, they can be isolated but in coming together they have got that mutual support there, the understanding there of what …people are going through and … there's that willingness to help…" (P3)*
- *"…each group is obviously different …the writing group … allowed people to open up in that safe space and I think there has been both laughter and tears in there … it's that mutual support…" (P3)*
- *"…work's been brilliant and the training … we've had over the …course of nearly a year …it's really made me more familiar with this client group and has allowed me to… have deeper empathy …'cause a lot of …stigmas around …if you're not in the military, you don't understand …but by… trying to get in the client's frame of reference to try and …walk in their shoes…"*

4.3.4.3 How has the referral process worked for this service?

KFIM staff said that the initial setting up phase and raising awareness of KFIM was a challenge as it was a completely new service with some organisations assuming that it was veteran focussed. This was also compounded by the arrival of the pandemic restrictions creating new and unplanned implications. However, as evidenced in the client and referrer feedback, the KFIM team quickly and successfully adjusted and adapted to challenges arising from the pandemic. To adjust to the challenges, numerous referral routes and pathways were employed by the KFIM staff, such as telephone, email, website, and social media. Staff felt that having various contact points, referral pathways and methods of contact provided a more inclusive communication route for clients and referrers, reporting that "…*we even take referrals on social media. If people feel more comfortable that way'.* Because of the bespoke nature of the KFIM client group, staff said that they were able to provide a rapid reaction and engagement response for client's referrals compared to other Sheffield Mind services with longer waiting lists. In addition, providing community services and professionals with a point of contact has led to timely client referral decisions. This was viewed as a significant benefit and a useful addition, as staff said that some professionals do not want to send a referral email to a random mailbox but want to *'speak to somebody on the service'*.

Examples of staff comments:

- *"It took us quite a while to start getting referrals because we had to build up our reputation and an awareness of the service … I would probably say a minimum of a year to even start accessing the right people…" (P8)*

- *"…referral systems work, its quick… we grab hold of the referrals straight away and start talking to the client and finding what's the best support system for them … I think also in …building up my network … it's also been about getting the word out there, promoting the service, …making new contacts and again I thinks it's always good to know the other … contact in another organisation. That way the referral system works … better they're able they feel as though they are able to pick up the phone and say 'look I have got this person can you help them' …it's not just a paper er a paper exercise or an email exercise…" (P3)*

Table 4.28: Themes relating to the referral process

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Setting up of KFIM service and impact of the pandemic	Awareness raising, and distribution of service information was impacted significantly by the restrictions of the pandemic	*"It took us quite a while to start getting referrals because we had to build up our reputation and an awareness of the service"*	Migration of services onto online platforms	Staff roles had to be evolved and adapted to new virtual environment in response to restrictions.	*"…minimum of a year to even start accessing the right people…"*
Identification of military family's client group	Inclusion of identifying question in other community services and referrers processes	*"I think the most important thing is having the question on any referral form of 'are you part of the armed forces community?"*	Armed forces community question acted as a filter	Armed forces community question acted as a filter for directing potential clients to KFIM	*"…and then we would filter off those clients who will contact us…"*
Providing a responsive service	When referrals were received KFIM were able to see clients quickly	*"I think the service has reacted almost immediately to any referral that they have received"*	KFIM was more responsive than other services	Waiting lists for other services	*"…through other routes, other services there is …usually a longer waiting list…"* *"…and so being able to …get going quite quickly really"*

Further examples of staff comments:

- *"…we added the question: "Are you part of the armed forces community?" And then we expanded that to: "Are you serving or are you a veteran or a family member of serving personnel?" …I think the most important thing is having the question on any referral form of "Are you part of the armed forces community" [Sheffield Mind] still get quite a few referrals*

from people just wanting mental health support anyway so having that question on there is huge for us because it picks up so many people that wouldn't have necessarily recognize that they were eligible for the service…" (P8)

- *"…we used to … join the military charities within our area, … like SSAFA and … MCVC …we used to go out with them weekly and then have a stall …being stood next to them increased our …credibility because …the public could see that we were together because we were communicating" (P8)*

4.3.4.4 Would you make any changes to the referral form or referral process?

Staff reported that following a period of awareness raising and engagement with other organisations, the current referral process was working well. However, they also recognised that they had been requesting that other organisations add the question *"Are you serving or are you a veteran or a family member of serving personnel?"* to identify members of their client group who may be eligible for the KFIM service. Staff also recognised so further work on their own client data base systems may require adaptation due to gaps in data collection (Ashcroft, 2017; HOLS,2018; NHS, 2021a). This was reenforced by offering a support pathway for clients identified and earlier engagement options with very short or no waiting lists for the identified military families' client group. Challenges around being aware of other organisations referral systems, their capabilities and data collection processes were reported by some staff as identification of people from the military community may have been *'absent or overlooked'*.

Examples of staff comments:

- *"…I would to make more personal contact within organisations…" (P3)*

- *"People have got their systems in place and we're coming in and asking them if they can… ask [an] additional question … from their referral side of things … it's just trying to …penetrate their systems or …the way they work so …that they are aware of us…" (P7)*

- *"…right now, the referral process has been has worked wonders for us …we've got loads of people through the way that we've been doing it… I think the most important thing is having the question on any referral form of "Are you part of the armed forces community" (P8)*

Table 4.29: Would you make any changes to the referral form or referral process?

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Inclusion of military families' identification in other community services referral and assessment processes	Requesting that other organisations add the question identifying members of their client group into their own client data base systems	*"…asking them if they can… ask [an] additional question…"*	Gaps in data collection	Some organisations or services do not routinely identify members of the armed forces community	*"I think the most important thing is having the question on any referral form of are you part of the armed forces community"*

4.3.4.5 What have been the challenges, if any, of setting up the 'Families in Mind' service?

One of the first challenges reported by staff was identification of who were the armed forces community *'key players'* in the local authorities (FIMT,2017). Who oversaw the welfare of armed forces community, what they were called and how to contact them; this process was reported as taking some time to establish. However, when the local authorities' armed forces lead had been contacted, introductions to other key people were initiated and invitations to attend the Armed Forces Covenant networking meetings proved to be useful and productive.

Staff reported that initially engaging with the military community was a challenge as breaking down barriers and building a level of trust around the KFIM service needed to be established first. Accessing services, stigma, help seeking and building trust are also themes several publications have identified (Iverson et al, 2010; Diehle & Greenberg, 2015; Rafferty et al 2017; MOD, 2017). However, one member of staff reported that once a feeling of mutual respect had been established, they got on *'absolutely great' with* their clients. Another staff member said that the client group they were trying to access was scattered everywhere over the KFIM footprint, therefore, they had to initially establish the best and most effective way to raise awareness about their service. One solution to address this

was that staff approached military reservists' units to offer support and request that the information was shared with families. However, staff had concerns whether the information regarding the KFIM service reached the intended families, adding that there may be a barrier of information sharing between the serving or reservist person and their families. A member of staff did report that they felt as if they were *"treading on people's toes"*, adding that some military people they approached believed that support would be provided by the military itself and appeared not to be *'open'* to exploring a different way to support families. This suggests a barrier to engagement was a factor (Samele, 2013; Rafferty et al, 2017; Wood et al, 2017).

Concerns were also raised following engagement with other military charities as they appeared to be veteran focussed so direct contact was hard to establish with military families. This resulted in a staff conversation acknowledging that the previously attempted route of engagement was not working. Examples of alternative approaches to access military family members resulted in a social media campaign which was reported as being very effective, and awareness raising days at supermarkets. However, there still appears to be challenges related to what other community support services and referrers believe the KFIM service is for and who it supports, with some appearing to still assume that the service is for predominately veterans. This has led some staff to say that they believe military families are still a forgotten and hidden group, although providing stability for the serving person (AFF, 2016; Heaver et al, 2018; Selous et al, 2021).

Staff were aware that stigma to engage with a mental health charity, such as Sheffield Mind, and a service provided by them, may present a challenge and barrier to engagement. Staff reported that this stigma related to mental health appeared to be heightened within the military community (Iverson et al, 2010; Diehle & Greenberg, 2015; Rafferty et al 2017; MOD, 2017). This was attributed to people having concerns about repercussions, especially from serving families (Selous et al, 2021). Staff added that military families appeared not to put a level of importance on themselves, but instead applied this to the serving person. This finding required staff to ensure they had conversations with military families to explain that they were important too and why, and by engaging and accessing the service, it may benefit not only them, but also their serving or veteran family member (MOD, 2017). Overall, the challenges were summarised well by one staff member

who stated: *"…building our reputation, getting people [to] know what we're doing and …enabling people to reach out [are] … the challenges" (P8).*

Examples of staff comments:

- *"You don't know, there's no one particular place that you can go to be like, hey, we're doing this, you know? So, for us that was one of the biggest challenges of okay, how do we raise awareness, how do we know where people are, what can we do?" (P8)*

- *"Accessing the families was one of the hardest challenges… the family don't put the importance on themselves. They put it on the serving personnel…" (P8)*

- *"Another challenge was our reputation, our reputation as a civilian organisation, what do we know? What do we know about military life and all of that?"*

- *"So that was just such a huge thing because families are so kind of hidden and not recognised…people instantly think oh, you support veterans…" (P8)*

- *"Having attended meetings with the Armed Forces Covenant Fund Trust, …I remember sitting in a meeting after six months of having the service and them saying we know it takes ages to set up a service as a civilian organization and just feeling thank God … it's not just me, like it's just a general thing that … is a challenge".*

- *"I don't think all families want support from inside the military for various reasons…" (P13)*

- *"…you've got to … and find people and tell them about you, so promotion was a huge challenge…" (P13)*

Table 4.30: What have been the challenges, if any, of setting up the 'Families in Mind' service?

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Identification of the armed forces community *'key players'* in local authorities	Network building and engaging with armed forces champions and community policy makers	*"Another challenge was our reputation, … as a civilian organisation, what do we know? What do we know about military life…"*	Local authority armed forces champions information	Access to local authority armed forces network meetings	*"…one of the biggest challenges of … how do we raise awareness, how do we know where people are, what can we do?"*
Impact of the COVID 19 pandemic on raising awareness of the service	The pandemic limited the service's promotion awareness raising activities	*"…not being able to be proactive out in the community …in supermarkets, raising awareness, … handing out leaflets…"*	Delivering one-to-one therapy and groups online	All service provision had to be delivered by zoom or telephone	*"…doing counselling remotely is it's difficult because you don't always get that that energy in the room…"*

4.3.4.6 What have been the challenges, if any, of recruiting clients to the service?

Some staff reported that they felt as if they were unable to do their job properly due to the challenges of the pandemic restrictions. These challenges included missing the support of colleagues in the work or office environment which would create delays in obtaining information or advice owing to having to wait for phone or email responses. Staff also talked about having to adapt to working alone from home and adjusting to the challenges around this, such as having to utilise spare bedrooms or other spaces at. One member of staff said that they had been unable meet new colleagues up to the point of interview.

Staff reported that meeting clients and working and supporting them virtually was a challenge, although that it was a new way of working which had brought some added benefits, such as easier access for appointments and removing the barrier of travel for some clients. However, one staff

member reported that it was a disadvantage that the face-to-face element of their work was still missing.

Concerns about General Practitioner (GP) awareness of the KFIM service and who the service was there to support were raised. An example was given as when taking calls from people ringing the main Sheffield Mind switchboard number on advice from their GP, it was only after the Mind staff had intentionally and routinely asked whether the person on the call was from a military family had the caller positively identified themselves as being part of that group. This raised concerns whether, or not, GPs are identifying members of the armed forces community and are aware of the support available to them (RCGP, 2019; NHS Digital, 2020). GP awareness was highlighted as a concern by Drabble et al (2019) who stated that from their findings GPs have 'limited awareness of the range of support available and limited time to manage holistic support via a healthcare pathway'. A positive response to address this initial finding is the RCGP online learning resource (RCGP,2019) and the GP practice Veteran friendly accreditation initiative being rolled out across England with around 1000 GP practices listed at the time of this evaluation.

Examples of staff comments:

- *"…we've being working over zoom… I still feel think that there is a little bit missing in that I have not been able to get out there and meet people, so I think that has been another challenge…" (P3)*

- *"I think another challenge …is …working on your own in the spare bedroom…if you were in the office, you'd shout over to a colleague and say "hey what about this" but then you think … I have got to ring or email them and there's been that bit of a delay, it's … been … missing meeting with people…" (P3)*

- *"I'd answer the phone as Sheffield Mind and somebody would say…"my doctor's told me to ring you because I'm depressed" …it would only be through my conversation with them that I'd find out that they had a husband in the military…" (P13)*

Table 4.31: What have been the challenges recruiting clients to the service?

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Pandemic restrictions	Some staff reported that they felt as if they were unable to do their job as effectively owing to pandemic restrictions	*"I still feel, think that there is a little bit missing…"*	Face to face appointments replaced by online appointments	Staff adjusting to the limitations of working virtually from home	*"I have not been able to get out there and meet people…"*
GPs as a key referral source	GPs were identified as an important potential source for referrals	*"…[how] key the GPs are, and I wonder how on board they are…"*	Accessing GPs to raise awareness of KFIM	The challenge accessing GPs to raise their awareness of KFIM	*"…they're [GPs] not the easiest people to …access and get information, too…"*

4.3.4.7 What do you perceive to be the key successes, if any, of the service so far?

Staff talked about the positive impact around one-to-one talking therapies and how some clients found it very beneficial. This staff perception was supported by the findings from clients' interviews (as reported previously) who said that being able to have someone to talk too and who understood them was positive and echoed in other literature (e.g., Samele, 2013; Rafferty et al, 2017; Wood et al, 2017). Also, the development of support groups was identified as being impactful by creating a space where supportive friendships and networks could be formed by clients. Staff reported that having several interventions available for clients has been very successful as some clients have utilised both one-to-one therapy and group sessions. A second round of funding was identified as instrumental in enhancing the KFIM service as it has allowed the service to expand and also to offer support to relatives of military families.

Staff highlighted how checking with clients how they were at the beginning of a session and again at the end has been useful, as it has provided a measure or marker to see how clients have changed, not only in the short term, but also in the long term. This observation and tracking of clients' wellbeing

has provided evidence to suggest that support groups working hand in hand with the one-to-one therapy are beneficial for clients.

Although KFIM are not a military charity, after building trust with the military families it was evident that there was acknowledgment of this by the client group, but also a recognition that the KFIM team were there to help and support. Positive solutions around this perceived barrier to engagement was achieved by recognising that the military families were the *'experts'* around their concerns and issues. KFIM staff highlighted the importance of showing empathy and a willingness to learn about the unique challenges military families have to endure and the stresses generated from these experiences. Significant levels of trust were built with positive client experiences engaging with the KFIM service being reported. One staff member said that they viewed one element of success as *'being accepted as part of the military scene'* in South Yorkshire. The continued engagement with community support providers was discussed and a recognition that now that the KFIM service has become established, their reach has been extended owing to professionals knowing about the service, what it is, who it is for, and *'spreading the word'* across their professional networks.

The impact of the pandemic was identified as having both challenges and positive outcomes. One example of success was the flexibility of client access to support groups, with staff reporting that prior to pandemic restrictions, a location had to be identified to facilitate a group with reliance on clients being able to travel to that location. However, on commencing the groups online it was evident that clients found it easier to take part in groups with access open to all from across the KFIM footprint, not as previously where a face-to-face support group could only be accessed by the families located near to where it was being delivered. This has led to KFIM staff recognising that moving forward as pandemic restrictions begin to ease, online groups will be retained alongside face-to-face groups to maintain the level of support attained.

To enhance engagement opportunities with organisations such as military reservists' units, the KFIM staff have been providing free mental health awareness training as a vehicle to share information about the families support resource. This has generated positive engagement outcomes. In addition to the provision of training, engagement with other community providers has proved successful, such as the Royal British Legion supporting the KFIM service by providing a *'drop in'* session resulting in previously unknown clients being identified and supported. Other engagement events have led to

other military charities supporting the KFIM service, awareness raising at local supermarkets and football matches taking place with civilian and military teams playing against each other. This suggests success in breaking down perceived military and civilian community barriers, integration of the KFIM service and encouraging community engagement and awareness from both parties.

Following a period of setting up and awareness raising, as previously discussed, one of the most significant successes was reported as staff saying that they believe that they have fully achieved what they aimed to do from the beginning, which was to have regular referrals coming through to the KFIM service from various sources and achieving continued access and support of military families. This has generated a tangible sense of teamwork, professional achievement and personal pride reported by the staff.

Examples of staff comments:

- *"I think for me the success has been in seeing how people have come along on their journey …it's seeing that success and from one position her being in a bad place, to another you know she's quite calm, she's not as stressed, and I think one thing that we do when we start the groups is we ask for a check in word…" (P3)*

- "*We do some really good work with clients and some really good therapeutic work… we used zoom, [for] counselling… and…it might not be as good as [in] person, but it's amazing how both parties soon adapt to that and …just make the most of it, given what given the circumstances were…" (P7)*

- *"…the core of it is that we want to listen to you. We want to work with you and …and we want to help you fundamentally, and I think that comes through with a family member…" (P7)*

- *"…I think the whole service is a success in itself…we've been receiving continuous referrals for the counselling service [and that] itself is a huge success. Now people …directly come to us." (P8)*

- *"…If we wanted to run a support group in [name of town] it was only relevant for people living in [name of town], you couldn't access anybody else, you couldn't offer anything else for any of the other people, but now because we are running the support groups online we can have everybody …in the groups…" (P8)*

- *"…another success was something that we …trialed …the educational training that we offer, [it is] one of the best things to …engage with other organisations is offering them …free training" (P8)* (For example KFIM have offered free mental health awareness training).

- *"… we had a football tournament with local reservists and …one of the army bases sent a team. And so, we're kind of accepted and …at the same time, we are …not a military charity, so it feels like we've got a foot in both camps, or maybe a toe in one camp and our feet in the other…" (P13)*

- *"…it just didn't make any sense when that person still saw themselves as part of a military community, so getting that funding meant that we could see people across the board, you know, reservists, serving veterans, that, I think really added to the success that we're seeing now…" (P13)*

Table 4.32: What do you perceive to be the key successes, if any, in the KFIM service so far?

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Development of online support groups	Online groups were more accessible because people did not need to travel	*"…because we are running the support groups online, we can have everybody in in the groups…" "…we can make [groups] more specifically …activity based rather than just having a general group for each area…"*	*Easier access for clients*	Clients from across the South Yorkshire footprint can join one-to-to therapy and a wider range of support groups with services being online	*"We found that families are more than happy to have, …therapy on [the] telephone or on zoom. … we haven't actually had a lot of people say to us: I want to wait for face to face…"*
Building trust with the military families	Positive solutions to the perceived barrier to engagement achieved by recognising that the military families were the *'experts'* around their concerns and issues	*"…the core of it is that we want to listen to you. We want to work with you and work through stuff and we want to help you fundamentally, and I think that comes through with a family member…"*	Understanding military culture and empathy	KFIM staff showing empathy and a willingness to learn about the unique challenges military families have to endure, and the stresses generated from these experiences.	*"...its seeing that success and from one position her being in a bad place, to another you know she's quite calm, she's not as stressed…"*
Regular referrals	KFIM are now receiving regular referrals for the service	*"…we've been receiving continuous referrals for the counselling service…"*	Training as a way to build partnerships	KFIM offered free training as a way to build partnerships with referrers	*"…engage with other organisations is offering them …free training…"*

4.3.4.8 What has been the reception of services to which you have referred or signposted clients?

Staff reported that following engagement with the Citizens Advice Bureau in Rotherham and sharing KFIM service information, it had generated recognition by CAB staff that there may be a gap in identifying people from the armed forces community, especially families during the initial assessments, so opportunities for signposting to bespoke support services had been missed or overlooked in the past (Ashcroft, 2017). Highlighting the KFIM service and the needs of military families has also taken place with the charity Rotherham Federation a community support service and Voluntary Action in Rotherham and Barnsley, with service provision leaflets being supplied and distributed into the communities they represent. One staff said that due to resources being limited in the community, engagement with other community services raises awareness of the needs of military families and provides a pathway to the KFIM support available. Staff talked about clients being relieved that they had access to a bespoke service and meeting the criteria for support (AFF, 2016; Heaver et al, 2018; Selous et al, 2021). Due to the availability of client capacity, there was also recognition from staff that they needed to inform clients that 16 sessions were available to them and that creating *'space'* for them to explore themselves and their concerns and issues, may not resemble a *'quick fix'* some clients may seek.

When discussing professional referrals staff mention that they had changed the referral process so that they could be contacted directly to avoid potentially clients *'falling through the net'*, as one member of staff described it, and '*filling a gap in support'* for the KFIM client group (Halkiopoulos et al, 2018). An example of success is the interaction and collaboration with the Project NOVA staff who support veterans coming into contact with the criminal justice system. By working together and enquiring about family members the KFIM and Project NOVA staff are able to provide support for the family unit and not just the veteran (Fossey et al, 2017).

Examples of staff comments:

- *"It's raised awareness, it's brought to the front of people's minds, to all different organisations minds. I let them know there is help out there which is always a good thing. So yeah, networking has been the big part of my role as well…" (P3)*

- *“They're [clients] relieved. I think it is so relieved that there is someone there for them because they might have been passed from pillar to post and then they come to us and if they meet our criteria, we can then work with them…” (P7)*

- *“…we had the capacity to give them that space. For us to walk along that journey together and for them to discover, hopefully, discover things that they wouldn't have discovered without our service being there or without us being in their lives…” (P7)*

- *” So, I think in terms of their (Project NOVA) response it's so handy for them to have this service that actually backs up their role as well and kind of takes a bit off of their caseload and plugs that gap in a way…” (P8)*

Table 4.33: What has been the reception of services to which you have referred or signposted clients?

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Engagement with other community support services	Engagement with the Citizens Advice Bureau, Project NOVA, Rotherham Federation and Voluntary Action in Rotherham and Barnsley	*“It’s raised awareness, it’s brought [military families] to the front of people’s minds, to all different organisation’s minds.*	Other organisations changed their referral process	Addressing *‘a gap in support’* and having access to referral pathway for the KFIM client group	*“…in terms of their [Project NOVA] response it's so handy for them to have this service that actually backs up their role as well and …takes a bit off of their caseload and plugs that gap…”*

4.3.4.9 Have you seen any perceived benefits for individual people you have assessed and offered intervention?

Staff reported that providing a holistic approach (MOD,2021) and providing both one-to-one counselling sessions and support groups had been very beneficial for the clients. Staff also said that providing the space and opportunity for clients to focus on themselves and explore their own journeys and emotions attached to those experiences has resulted in clients feeling as if they have a voice, have been able to identify the reasons they feel the way they do, build self-esteem, confidence, and self-worth (Spencer-Harper et al, 2019). This was related to previously mentioned staff observations that several military support services appear to be primarily focussed around supporting serving personnel and veterans. Therefore, by the KFIM service focusing on the family, they feel this has had *'huge'* benefits for military families and their relationships. One example was demonstrated by a military partner who used two initial sessions to talk about military life from her perspective as she did not get to talk about it with her *'civilian'* peers due to feeling that they did not understand. However, after engaging with the KFIM staff and discussing her relationship concerns, both partners are now *'communicating better and enjoying hugely increased relationship satisfaction'* and supporting each other (CJS,2016; Halkiopoulos et al, 2018). Staff said that this has happened on multiple occasions demonstrating that the KFIM service benefits families as a whole.

Examples of staff comments

- *" I don't think there is one organisation where you can refer too that would provide a holistic approach too what that person needs. I think its organisations working in partnership and together and knowing what's out there can help that one family, person whatever it is…" (P3)*

- *"…the first couple of sessions were talking about military life because she didn't get to speak about that with anybody else because her civilian peers didn't understand. So, the first couple of sessions were her saying this is what happens…" (P8)*

- *"That hugely increased their relationship satisfaction because they kind of they were able to move past the difficulties that they had had and communicate better…" (P8)*

Table 4.34: Have you seen any perceived benefits for individual people you have assessed and offered intervention?

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Adopting a Holistic approach focussed on the military family, not primarily veteran focussed	Providing both one-to-one counselling sessions and support groups had been very beneficial for the clients.	*"I don't think there is one organisation where you can refer too that would provide a holistic approach too what that person needs".*	Providing the space and giving military families a voice	Other military support services appear to be primarily focussed on supporting serving personnel and veterans.	*"...the first couple of sessions were talking about military life because she didn't get to speak about that with anybody else because her civilian peers didn't understand"*

4.3.4.10 From your perspective, has the 'Keeping Families in Mind' service made a difference?

Staff reiterated how the KFIM service '*fills the gap*' that they feel many military families fall through when help seeking (Selous et al, 2020). Feedback from clients on the KFIM website was used as an example of evidence KFIM makes a positive difference. One staff member mentioned that by offering a service that families could access might have a wider effect on the families, as having the opportunity to discuss their concerns may improve relationships leaving *'people feeling more content'*, (Halkiopoulos et al, 2018) this was viewed as important. A significant difference highlighted was the minimal waiting times to access the KFIM service compared to other mental health services, especially when people are at a crisis point (Selous et al, 2020). Staff reported concerns that people only access help when in crisis and the impact of long waiting times (e.g., six months) was described as *'horrendous*'. The attendance of KFIM staff at Armed Forces Covenant meetings to raise awareness of military families' needs was seen as a positive difference, as staff had concerns that some council meetings appeared to be just veteran focussed. The benefits of online platforms was recognised as these had improved ease of access to one-to-one sessions and group activities and had widened the reach of the KFIM service across the whole project footprint.

Examples of staff comments:

- *"…and just potentially people feeling better within themselves, which fundamentally for me, that's what's at the core of it. Like people feeling more content more at peace and more in a better place to live their lives and to relate to others. I think that's really important…" (P7)*

- *"You know, as much as a mental health support is increasing, the waiting times are unreal and one of the best things with this service is the waiting times have been minimal. So, it's you refer yourself and you're in a lot of people. Wait till they're in crisis mode to access support and then to be told you have to wait another six months…" (P8)*

- *"…to have somebody sit there and say, but you're not thinking about families…. It raises everybody's awareness, so that they actually have that in the back of their head when they're thinking about things and not just forgetting about the families that are the backbone…" (P8)*

Table 4.35: From your perspective, has the 'Keeping Families in Mind' service made a difference?

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
KFIM has improved clients' wellbeing	By offering a service that families could access, clients' improved wellbeing might have a wider effect on the families, as it may improve relationships	*"Like people feeling more content more at peace and more in a better place to live their lives and to relate to others."*	Having timely access to a bespoke military family service	A benefit is the quick access to service for family members who have reached crisis point	*"…one of the best things with this service is the waiting times have been minimal…"*

4.3.4.11 Do you think the service should be continued in future? Why or why not?

Staff agreed that the KFIM service should continue. Whilst acknowledging that any continuation was related to their own employment status, they asserted that (for the first-time to their knowledge) military families had a bespoke service that they could access where the focus was not on the military service leaver or veteran, but on family members who also make sacrifices supporting service personnel (MOD, 2016; MOD, 2018). The consensus was the service should be rolled out across a nationwide footprint to reach out to more military families who they described as *'a forgotten part of society'*. Staff reported that although the service has been a success and there is still a demand which has continued, there is still more to do working with community organisations and military families, especially around awareness of the client group and help seeking. Concerns were also raised about military families not having access to a bespoke service in the future and falling outside of any existing support that does not have military families as their central focus. This was reported as especially concerning when working with family members whose partners had been diagnosed with Post Traumatic Stress Disorder (PTSD) and where relationships had becoming increasingly difficult. In 2019, Turgoose & Murphy asserted that *'partners of Veterans who have PTSD appear to be at higher risk of experiencing mental health and well-being difficulties themselves',* concluding that partners would benefit from having access to interventions aimed at supporting their needs. This finding aligns with feedback from clients who described having a service where they had a voice was a positive experience.

The KFIM service was described as the *'missing part of the puzzle'*. Staff felt that ending KFIM, would lead to military families being forgotten again, and not having the opportunity for support, to have a voice, and to work through relationship concerns. Staff also expressed the following concerns if the KFIM was to end: loss of the investment of time spent to set up the KFIM service, sharing awareness of the service and the concerns and challenges military families face; losing the knowledge and expertise gained; how the service had become integrated into community services; risking military families not having access to a bespoke service when in crisis; and providing a voice and representation for families at Armed Forces Covenant council meetings and other planning events.

Examples of staff comments:

- *"…we've got experience first-hand of what the family go through, I think they have moved five times in about 6 years.…knowing the impact it has on children…" (P3)*

- *"I think the other thing the other reason for saying yes to continuing the service is … there is still a lot of work to do by breaking down the barriers for families. Families just think that well okay we'll just get on with it, we'll just do it, we'll just get on with it we'll be fine. Yes, I think there's a lot of connections to be made to know that they're not alone..." (P3)*

- *"The family kind of get lost a little bit because potentially the serving personnel can get help, but the families often fall out of, or just outside, that kind of help and it leaves them all out on their own…" (P7)*

- *"… it's always the person serving, and I've only just realised that myself because I served, but I didn't have a family following me around, they've [families] got to put themselves at the bottom of the pile and move around with their partner and put their aspirations on the bottom of the pile again…" (P7)*

- *"I think if anything it shouldn't just be within our area either. I think it needs to be …a national offer…" (P8)*

- *"Well, …obviously I'm going to say yes, but having been there from day one, the work that's gone in to get it established, to get it trusted, to get it integrated it just seems like …why wouldn't you, you know? It would be nonsensical not to continue funding it because it's needed, but it's taken all that time and effort to get to the point where people are using it. And to lose all that would just be, it would be devastating, I think. The other thing is, speaking from somebody who works in the field, and we do lose funding, the need doesn't go away, people just carry on contacting you because with the best will in the world there is always a flyer out there or there's always something on a website that's been updated where somebody thinks, oh, thank God here's the service for me. And then they ring us, and we have to say, no, I'm*

sorry, we haven't got any funding. And the fact that we've now managed to get it right across South Yorkshire would just be such a shame..." (P13)

Table 4.36: Do you think the service should be continued in future? Why or why not?

Themes	Definition of theme	Themes: Illustrative quotes	Sub-themes	Definition of sub-themes	Sub-themes illustrative quotes
Putting the focus on the military family	Military families had a bespoke service that they could access where the focus was on them (not the military personnel or veteran)	*"The family … get lost a little bit because potentially the serving personnel can get help, but the families often fall out of, or just outside, that kind of help and it leaves them all out on their own…"*	Concerns that military families might not have access to a bespoke service in the future.	Ending KFIM, could lead to military families being forgotten and not having the access to service focussed on their needs	*"I think the other thing the other reason for saying yes to continuing the service is I think there is still a lot of work to do by breaking down the barriers for families".*

4.3.4.12 If the service was to continue what, if any, improvements would you suggest?

Staff identified several improvements to the KFIM service that could now be adopted after the work to set up the service (creating a referral network and raising awareness of military families with community service professionals and the wider community via social media, events, information sharing and interviews). A suggested improvement was working more closely with other community organisations and the Army Families Federation (AFF) which would facilitate access to different military units and barracks creating an opportunity to share information and promote the KFIM service.

Improvement plans suggested by KFIM staff:

- Working with mother and toddler groups.
- Offering a couple's therapy service.

- Further addressing stigma and barriers to engagement by continued information sharing.
- Expanding the support groups to include a wider range of interests or activities.
- Extending mental health awareness training.

Staff had discussed a wide range of new ideas that they could trial and evaluate, to learn and share knowledge to better inform professionals as to what military families feel supports and would help them the most. Owing to the pandemic restrictions and the requirement to migrate services over to an online provision, some staff said that although the support groups had been very successful, they would like to further explore and expand online group therapy sessions. It was also mentioned that although a couple's therapy service was not originally planned, it was being developed and viewed as a significant positive step forward.

Example of staff comments:

- *"I'd like to see the service expanded because I think it's unique, maybe if we if we could go wider to reach more people, I think that would be a positive step…" (P3)*

- *"…what we found is when families live on a base, they have that community and then when they move off that base for whatever reason, they're in this big community where they don't know anybody, and nobody understands military life…" (P8)*

- *"…moving forward is to offer different types of therapy to families to become more of an accessible service. You know those who don't necessarily want to talk, could access…" (P8)*

Table 4.37: If the service was to continue what, if any, improvements would you suggest?

Themes	Definition of theme	Themes: Illustrative quotes
Service improvements	Staff had ideas for several service improvements to develop KFIM further	*"I'd like to see the service expanded because I think it's unique, maybe if we if we could go wider to reach more people, I think that would be a positive step"*

4.3.4.13 Did you receive any understanding military culture training? If so, do you think this helped?

Staff reported receiving several training sessions including the ‘Military Human: understanding military culture and transition’ training, provided by York St John University, and Mental Health First Aid training. It was recognised that *‘having an understanding’* of military culture and lifestyle was beneficial when creating the initial bid to fund the KFIM service and subsequently for KFIM staff, especially those who may not have a background that included a personal or military family experience. Several reports and research publications highlight the need for community service practitioners from a wide range of professions to *‘have an understanding’* of military culture and the needs of the armed forces community. This was reflected within the NHS Constitution (2015a) and commented on by Rafferty et al (2017) who called for therapists to learn *‘veteran speak’*. Patel et al, (2013) also suggest that veterans should be able to access services who *‘have an understanding*’ of military culture. Heaver et al (2018) assert that organisations should also understand the needs of families specifically. The need for further training of staff across community support services is also a key finding within the NHS Improving health and wellbeing support for Armed Forces families report August 2021.

Some of the professional practitioners said that the mental health first aid training was useful as the military part, although not focussing on military life, provided useful data and statistics that could be used later. From staff feedback it would appear there were different levels of understanding of the military lifestyle depending on their own lived experiences and backgrounds. Some staff had a personal or military family experience with other staff coming from different backgrounds not associated with the military. Evidence from client and staff feedback suggests that having empathy for military culture and its lifestyle has created a sense of trust from the military families and had a positive effect on breaking down barriers and encouraging engagement. Staff reported that *‘having an understanding’* of the challenges military families face when a member of the family is deployed, and the tensions that may arise from this was helpful, as they could explore where these challenges came from. They also commented on the challenges for serving personnel and their families associated with deployment and the transition coming out of the armed forces. Some staff acknowledged that they were not experts in military transition but added that they had a better

empathy and understanding of what may be concerning a service leaver and their families, and how this may affect a family or a relationship (Selous et al, 2020; MOD, 2015). It was also recognised that hearing about and learning from the lived experiences of the military families engaged with the KFIM service was very beneficial and was an important learning experience for staff.

Example of staff comments:

- *"[Training]…gave us an insight into what it's like when service people deploy and the issues when they come back and the relationship issues, transition into civilian life and just raising awareness of that and trying to develop the knowledge. Having that understanding of the difficulties that they face because …if we are speaking to families then we have that greater understanding of the tensions that might be coming from …the member of the military, and we have more understanding to where that might be coming from …and I would be able to empathize with a greater degree because we've got a little bit more understanding. Obviously, we're not experts, but we've got that from the training that understanding, really…" (P7)*

- *"The training (military culture and transition) was great. I think I did that before I even started the job, so I would I think I was due to start on the week after I had that training, and it was it was a real benefit for me. It gave me a really good starting knowledge because I'm not from a military background I didn't have a huge military background knowledge…" (P8)*

- *"A lot of people did the understanding of the military human [training] which I did whilst I was writing the bid which I thought was fascinating. I really enjoyed it…" (P13)*

Military Human: Understanding Military Culture and Transition CPD training.

Of the KFIM staff who attended the Continuing Professional Development (CPD) training (n=10) those who provided feedback (n=6) strongly agreed that the CPD training course learning could be applied to their work and rated the course as excellent. Examples of staff feedback following training:

- The extent of tutor knowledge which supported the content (the latter was quite thorough) and the appropriate use of videos together with thoughtful discussion.

- Thought provoking in terms of transition impact for families.
- Awareness raising of the culture and ethos of armed services.
- Application of attachment theory.
- The resource packs with links, these will be useful to dip in and out of as needed.
- Videos and personal stories, these make it real and helps understand the different points of view.
- The military core values and CDRILS, as these help to understand the military way of thinking.
- Practical application to my client group, really made sense from a logical point of view.
- Delivered in an engaging way that I paid close attention too.
- Overall excellent, thank you so much for such an excellent presentation both in terms of its contents and knowledge.
- Really enjoyed the course, it was easy to follow (no military jargon) and lots of useful tools and information.
- It was really helpful and I'm so pleased I was able to be part of the course as I have learnt so much.

4.3.4.14 Is there anything else you would like to mention related to the 'Keeping Families in Mind' service?

The KFIM staff were very complimentary of the volunteers who supported the support groups and other activities Sheffield MIND provides. Staff said that the inclusion of volunteers many of which had no prior knowledge of military families, had been beneficial as it had provided a learning opportunity for them. It was stated that although a steep learning curve, all the volunteers had displayed the ability and willingness to not only learn about military families and their lives. Volunteers had adapted to the challenges presented, such as migrating over to online platforms and had *'gelled'* with the groups and *'merged'* into the military community.

It was clear that the KFIM staff have a passion for the service they provide and felt that, after a challenging period setting up a new service, raising awareness, building proactive and successful networks, they were *'closing a gap'* in community services by supporting *'forgotten'* military families. So, the prospect of the service not continuing was seen as *'devastating',* with others adding that it

would be a waste of money not to continue, as if another organisation started to provide a similar service they would have to *'start from scratch'.* One staff stated the KFIM had had a positive *'knock on'* effect for other members of military families. They added that if the client accessing the KFIM service began to feel better about themselves, they may be able to better support partners who may be suffering with a mental health issue such as PTSD, and in turn that family member may feel better themselves.

Examples of staff comments:

- *"…don't want it to stop, I think there's plenty more that can be done, there is a willingness to do that, it's just if the funding's there to be able to be able to do it and as a lot of things it does come down to money, but I could see room for this service expanding and working with a lot more military families…" (P3)*

- *"…in my in my previous employment where there was a family who had lost a son, he was killed in action and basically the family went to pieces….some of the members of the family were too young for Keeping Families in Mind to support, but it was the network that I had built up through the covenant group that allowed me to contact various people and get instant support for them…if families come to us we have a referral process to other organisations that can help them and I think that's invaluable…that is Families in Mind work also…" (P3)*

- *"I think if you have got that passion there it helps a lot more with service providers. It means you will go above and beyond what you're normally asked to do in your job so that's very beneficial…" (P3)*

- *"I've not served in the military or anything like that, so it was kind of a new thing to me. But as I said with the training you'll learn from the families, you learn so much about what it's like to live with someone with PTSD and the challenges, you know I'm always learning. I'm …always learning from them and their experiences and there's so much to learn just from working with this client group…(P7)*

- *“For me, it's just been an absolute pleasure to be on the service and to start from knowing absolutely nothing and to building up a service that I know is really valued within the community, especially within our areas. And …watching it go from just me to having a huge team and having loads of referrals, it's just amazing…” (P8)*

- *“…it doesn't make sense to think that would all go to waste and that's a couple of years down the line. Somebody else would have to start from scratch. … But all the information you get told about military families, and obviously that that's huge even using that term. It's a huge generalisation where every single one of us is an individual and every family is different. But bearing that in mind, everything you get told about military families being very self-sufficient and feeling that perhaps when they have reached out for help, they haven't been understood, … to kind of almost gone through that pain barrier and be where we are now. It just makes sense I think, for a relatively small amount of money to keep funding this service so that our reputation can keep growing and we can keep helping local families…” (P13)*

5. Discussion

5.1 Impact on mental wellbeing

This evaluation indicated that mental wellbeing, as measured using the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS; Tennant et al 2007), significantly improved in clients following counselling provided by KFIM. Measures were given to clients to complete for the first time at their assessment session, and this provided the baseline measures. Follow-up measures were usually undertaken at the beginning of the 1st, 8th and 16th counselling sessions, this meant that three samples were analysed: sample A comprised clients with at least two measures (assessment and 1st counselling session); sample B comprised clients with at least three measures (assessment, 1st counselling session and the 8th or final session); and sample C comprised clients with four measures (assessment, 1st and 8th counselling sessions and the 16th or final session). Statistically significant results were obtained for three samples, sample A had WEMWBS scores recorded on at least two occasions, sample B on at least 3 occasion and sample C on four occasions. The overall improvement across the sample A's (n = 33) total scores from baseline assessment to the first therapy session was found to be statistically significant at $p \leq 0.023$, with six of the 14 WEMWBS questions also showing statistically significant improvements. The 2nd measure at the start of 1st counselling session was undertaken by Sheffield Mind for two reasons: to see whether the offer of help had a positive impact, regardless of how long people had to wait; and to assess how the length of the wait impacted on people. It is interesting to note receiving an assessment and an appointment to attend a counselling session resulted in statistically significant improved mental wellbeing scores. A Sheffield Mind staff member summed this up: "*When people have dealt with things by themselves for so long it can be huge for them to be heard by someone else and have help offered to them, without any other intervention.*" It was also illustrated by this comment from interviewed clients: *"I've not got anyone else who's in the same situation you know, not anyone…", "…it was nice to be able to have somebody just to talk too…" and "……they made me feel like I wasn't alone…"*

For sample B (n= 26), as counselling progressed the improvements in mental wellbeing became even more statically significant. Clients' total scores from baseline assessment to the first therapy session were found to be statistically significant at $p=0.047$, and from 2nd to 3rd test (1st session to 8th or last session) at $p = 0.004$. There was a mean increase of 9.5 points between their baseline WEMWBS total

score compared to their 3rd test which was statistically significant at p = 0.000. For sample C (n=8), there was a positive mean difference between the baseline and the 4th test scores (undertaken at the 16th or final counselling session) for all 14 WEMWBS questions and the total score. Improvements from baseline to 4th test were statistically significant at $p \leq 0.05$ for nine out of 14 questions and the WEMWBS total score (p=0.017). These improved WEMWBS outcome scores were further supported by the online survey and interview findings.

Most clients interviewed (n = 10) reported that they felt that their needs had been met through the counselling provided and that their KFIM sessions had successfully explored the concerns and issues they were experiencing at the time. On the online survey (n=18), 83.3% of clients rated their therapy as effective to some degree (eight = extremely effective; 6 = very effective; 1 = somewhat effective = 1). In the survey response, clients gave examples of relationships that had been affected and described several positive feelings, such as passion and motivation, improving or returning. Clients mentioned changes indicating improved self-worth. Four themes (confidence, making changes, self-care and self-awareness) emerged from analysis of the survey question related to how counselling had affected their relationships.

Drawing the results from the WEMWBS outcome scores, survey results and clients', referrer's and staff's interviews, it can be concluded that the KFIM service resulted in improved mental wellbeing for the majority of clients.

5.2 Impact on resilience

Resilience is an important factor to consider when exploring what enables military families to cope (Meadows et al, 2016) and was considered as an outcome in this service evaluation. Twelve of the 18 respondents to Sheffield Mind's online survey indicated counselling had enabled them to cope better with the stressors of military life to some degree (five strongly agreed, six agreed and one somewhat agreed). In addition, sixteen clients indicated that counselling had improved their capability to support others emotionally to some degree (seven strongly agreed, eight agreed and one somewhat agreed). In response to the online survey question *'What aspects of your life has it affected most?* five themes emerged which included three that could be linked to resilience: confidence; coping; and

self-worth (Feggi et al, 2016). Some clients provided examples of how counselling had given them more confidence in other aspects of their lives and how they were coping better in situations. Clients provided examples of changes they had or were making in their lives following counselling. Clients spoke about how they were taking better care of themselves and gave examples of how they had increased in self-awareness.

Clients' resilience, as measured by the Brief Resilience Scale (BRS, Smith et al, 2008) was found to improve following counselling provided by KFIM. For sample A (n = 34) increased means were found for all six BRS questions and the average score, with the average score (p = 0.018) and question 1 (*I tend to bounce back quickly after hard times*; p = 0.015) showing statistically significant increases. For sample B (n = 26) the BRS average mean score for the sample increased from 2.36 at the baseline to 2.65 at the third test, with the BRS average score (p=0.018) and question 1 (p=0.015) providing statistically significant improvements. For sample C (n = 9) the BRS average mean score increased from 2.52 at the baseline to 3.18 the fourth test; whilst this increased mean indicated an improvement in resilience it was not statistically significant. It is likely that clients who needed more than the initial 8 counselling sessions, and who went on to receive 16 sessions, were likely to be experiencing more severe mental health problems or complex relationship or home situations, and this may be a reason for the lack of a statistically significant improvement in BRS scores in sample C. However, the increased mean for this sample of nine clients did still indicate an encouraging improvement in resilience

Drawing the results from the BRS outcome scores, survey results and clients', referrer's, and staff's interviews, it can be concluded that the KFIM service resulted in improved resilience for most clients.

5.3 Impact on loneliness:

Loneliness: Loneliness was measured as an outcome owing to research indicating that loneliness can be a problem for military families (Royal British Legion, 2018), particularly for spouses during their partner's deployment (Warner et al, 2009). This was also a finding in this evaluation, with the 'Loneliness of being a military spouse' being an emerging theme; for example, one client shared: *"I'd struggled quite a bit because I live on my own anyway when he's away."* However, in this evaluation

loneliness, as measured by the CELMT, did not show statistically significant improvements. In considering this finding, it must be remembered that the KFIM service was partly delivered during the COVID 19 pandemic, and so during lockdowns and the service had to move from face-to-face to virtual counselling via zoom or telephone. The pandemic was a time for greater loneliness for many people; for example, the Mental Health Foundation (2021) conducted a survey of UK adults in November 2020 and found that 24% of adults reported having feelings of loneliness in the previous two weeks. Killgore et al (2020) studied a total of 3,121 adults, during first three months of Covid related restrictions in the United States, their sample completed the UCLA Loneliness Scale-3 (Russell, 1996) and the Patient Health Questionnaire-9 (PHQ-9; Kroenke et al, 2001). The scales were administered cross-sectionally to three independent samples, approximately one month apart, in April, May and June 2020. The researchers (Killgore et al, 2020) reported that 'despite relaxation of lockdowns and shelter-in-place orders over that time, loneliness scores increased significantly, particularly from April to May 2020' (p.1). They also reported that 'loneliness was correlated with depression and suicidal ideation at all [three] time points' (p.1). This increase in loneliness because of the COVID 19 pandemic and related restrictions may explain why the experience of loneliness reported by some clients increased despite receiving services from KFIM.

In conclusion, feelings of loneliness did not improve following counselling, and loneliness was even found to increase for some clients, however, this finding could be explained by the unprecedented circumstances under which the KFIM service was delivered during the Covid 19 pandemic and research which has indicated loneliness increased amongst the general population owing to lockdowns and restrictions (Mental Health Foundation, 2021; Killgore et al, 2020).

5.4 Themes and links to wider literature

Themes emerging from this evaluation clearly link to previous research findings and recommendations from previous reports. Concerns were raised regarding military families having limited support to cope with issues such as PTSD, irritability, angry outbursts, or disturbed sleep (Turgoose & Murphy, 2019); for example, a client interviewed reported threats of violence from a veteran partner (Kwan et al 2018; Selous et al, 2020). Clients also described feeling lonely and overwhelmed having to cope with a partner who suffered with PTSD (Donoho et al, 2017; Rafferty et

al 2017; Selous et al, 2020). Feelings of isolation was a recurring theme from clients, especially those whose partners were still serving in the armed forces, requiring long periods of separation (AFCAS,2020) due to deployments (AFF, 2016; RAFFA, 2018; AFF, 2018; Gribble & Fear, 2019). Clients expressed concerns around isolation and not previously having someone to talk too (AFF, 2016; Heaver et al, 2018; Selous et al, 2021). Clients reported relief at being able to access a service that was focused on the military family and not veterans (Selous et al, 2021). Family dynamics and feelings of not being supported were identified by clients and the referrer interviewed. Concern regarding what the MOD recognised as a partnership status was also raised as this had been an added barrier to one client accessing support previously. The referrer spoke about a client, referred to KFIM, who was struggling to support a family member who had served in the military but who was reluctant to seek help themself (Iverson et al, 2010; Diehle and Greenberg, 2015; Rafferty et al 2017; MOD, 2017). The creation of a supportive and comfortable environment where individuals did not feel alone was highly valued (Heaver et al, 2018; FIMT, 2021). One client who had not engaged with counselling previously, found having a sense of security allowed them to explore their own feelings and fears, creating a newfound sense of self confidence.

Staff were aware that stigma to engage with a mental health charity, such as Mind, may present a challenge and barrier to engagement, with some staff saying that stigma appeared to be heightened within the military community (Iverson et al, 2010; Diehle and Greenberg, 2015; Rafferty et al 2017; MOD, 2017) adding that some clients had concerns about what was described as repercussions, especially from serving family clients (Selous et al, 2021).

Staff reported receiving several training sessions including the ‘Military Human: understanding military culture and transition’ training provided by York St John University and Mental Health First Aid training. It was recognised that *‘having an understanding’* of military culture and lifestyle was beneficial when creating the initial bid to fund the KFIM service and subsequently for KFIM staff, especially those who may not have a background that included a personal or military family experience (NHS, 2015a; Burdett et al, 2012; Patel et al, 2013; Heaver et al, 2018; Mobbs and Bonanno, 2018; Wood et al, 2017). Some of the professional practitioners said that the mental health first aid training was useful as the military part, although not focussing on military life, provided useful data and statistics that could be used later. Staff reported that understanding the challenges

military families face when a member of the family is deployed, and the tensions that may arise from this was helpful as they could explore these with their clients. Also, staff acknowledged that they were not experts in military transition but added that they had a better empathy and understanding of what may be concerning a service leaver and their families, and how this may affect a family or a relationship (Selous et al, 2020; MOD, 2015).

Evidence from client feedback suggests that having empathy for military culture and its lifestyle has created a sense of trust from the military families and had a positive effect on breaking down barriers and encouraging engagement. KFIM Staff's understanding of military culture (Samele, 2013; Rafferty et al, 2017; Wood et al, 2017; RCGP,2019) was highlighted as having a positive impact by clients, the referrer, and staff. Clients reported feeling they now had a voice and a space where they could discuss and explore thoughts and emotions with staff who understood the military lifestyle, rather than using other services with staff who may understand (Samele, 2013; Rafferty et al, 2017; Wood et al, 2017; MOD, 2018). This was also commented on by a client who felt that even their own support network did not fully understand the military lifestyle. There were several explanations about how other services accessed had not provided the needed support, or about problems accessing support previously such as long waiting lists (Selous et al, 2020). This contrasted with the KFIM service which was viewed as a flexible (Sondergaard et al, 2016) bespoke service with military families as its core client group, it was quick to get an appointment and easily accessible.

5.5 Has KFIM met its aims?

All clients recommended the continuation of the KFIM service. Several clients reported that their sessions had been like a journey, reporting a positive experience, that they felt that their needs had been met and that their sessions had successfully explored the concerns and issues they were experiencing at the time. There was only one client who reported that the service had not been what they were looking for at that time. However, concerns around the lack of awareness of the KFIM service on the part of other community support services was reported by interviewed clients, with significant concerns raised that funding for the service may disappear and other families may not have the opportunity to access the KFIM service in future.The referrer said that the KFIM service had made a difference and been '*really useful'*, especially as in their opinion, Sheffield waiting times

accessing mental health services were a factor. The referrer added that the KFIM service should be extended to cover other regions especially where there is a high percentage of veterans and/or military families such as Catterick as it is a garrison town. Mind, with a network of around 125 local Mind services spread across England and Wales (Mind, 2021), is well placed to deliver additional KFIM services across the country, with a priority being locations where there are military garrisons. However, not all towns with garrisons have local Mind services in place, for example, the nearest Mind to Catterick is in Darlington, approximately 14.5 miles away.

KFIM now receive regular referrals to the service. Staff talked about providing a range of holistic approaches (MOD,2021) and the positive impact around one-to-one talking therapies which was highlighted and confirmed clients interviewed who reported that being able to have someone to talk too, and who understood them, was a positive (Samele, 2013; Rafferty et al, 2017; Wood et al, 2017). Staff perceptions of the positive impact of counselling are also supported by the findings from the evaluation of the WEMWBS and BRS outcomes data. The development of support groups was seen as being impactful as they created a space where supportive friendships and networks could be formed by clients. Staff reported that having several interventions available for clients has been very successful as some clients have utilised both one to one and group sessions.

Staff highlighted that while they recognised that the armed forces covenant funding was for three years, it took between a year and eighteen months to successfully *'get the word out'* with one of the first challenges reported being identification of who the armed forces community *key players* in the local authorities were (FIMT,2017), but then adding that when the local authorities Armed Forces lead had been contacted, introductions to other people were initiated, and invitations to attend the Armed Forces Covenant networking meetings proved to be useful and productive. A concern that was raised, was that many other support services assumed that the KFIM service was veteran focussed. This required significant awareness raising campaigns and conversations with service providers to explain the bespoke military families focus of the KFIM service. In addition, staff provided other community services and professionals with a service point of contact which led to timely client referral decisions. Another concern affecting the referral process was that some organisations appear not to identify clients from the armed forces community. This was viewed as leading to a lack of data collection (Ashcroft, 2017; HOLS,2018; NHS, 2021a), and potentially some people not being referred

to the KFIM service. Staff suggested that that inclusion of a question identifying members of the armed forces community in other community service assessments would be beneficial, resulting in appropriate referrals being made and reducing the risk of people not being signposted to other services such as KFIM.

Staff mentioned that military families appeared to be scattered across the KFIM ‘footprint’, therefore, they had to initially establish the best and most effective way to raise awareness about their service. Initially engaging with the military community was a challenge as breaking down barriers and building a level of trust around the KFIM service needed to be established first (Iverson et al, 2010; Diehle & Greenberg, 2015; Rafferty et al 2017; MOD, 2017). One solution was that staff approached military reservists’ units to offer support and request that the information was shared with families. Following engagement with some other military charities, some staff felt that as other charities appeared to be veteran focussed, direct contact was hard to establish with military families. Staff believe military families can be a forgotten and hidden group, although providing stability for the serving person (AFF, 2016; Heaver et al, 2018; Selous et al, 2021).

Staff added that military families appeared not to put a level of importance on themselves, but instead applied this to the serving person. Because of these observations, staff ensured that they had conversations with clients reassuring them that they were important too and by accessing the service it may benefit not only them, but also their partner (MOD, 2017). Although KFIM is not a military charity, after building trust with the military families it was evident that there was acknowledgment of this by the client group, and recognition that the KFIM team were there to help and support successfully breaking down barriers to engagement. One staff member reported that they viewed this success as *‘being accepted as part of the military scene’* in South Yorkshire.

The continued engagement with community support providers was discussed and a recognition that now that the KFIM service has become established, their reach has been extended due to professionals knowing about the service, what it is, who it’s for, and *‘spreading the word’* across their professional networks. Following a period of setting up and awareness raising with a wide range of public and community services, military charities and reservists’ units, one of the most significant successes reported by staff is that they believe that they have fully achieved what they aimed to do from the beginning, which was to have regular referrals coming through to the KFIM service from

various sources and achieving continued access and support for military families. One member of staff described it as *'filling a gap in support'* for military families (Halkiopoulos et al, 2018; Selous et al,2020) with the minimal waiting times to access the KFIM service especially when people are at a crisis point (Selous et al, 2020), as an example.

KFIM staff were very complimentary of the volunteers especially with the support groups and other activities Sheffield MIND provides. Staff said that the inclusion of volunteers many of which had no prior knowledge of military families, had been beneficial as it had provided a learning opportunity for them although a steep learning curve.

Whilst acknowledging that any continuation of the service was related to their own employment status, staff asserted that for the first-time, and to their knowledge, military families had a bespoke service that they could access where the focus was not on the service leaver or the veteran, but on family members who also make sacrifices supporting service personnel (MOD, 2016; MOD, 2018). The consensus from staff and the referrer was that it should be rolled out wider across a nationwide footprint to reach out to military families as *'a forgotten part of society'*. Concerns were also raised about the loss of valuable expertise and knowledge gained by the KFIM staff and military families not having access to a bespoke service in the future and, therefore, falling outside of any existing support that does not have military families as their central focus. This was reported as especially concerning when working with family members whose partners had been diagnosed with Post Traumatic Stress Disorder (PTSD, Turgoose & Murphy, 2019). Staff identified several areas that they felt could improve the KFIM service and that that could be adopted, such as working with parent and toddler groups, a couple's therapy option, expansion of support groups, further anti stigma campaigns and more mental health awareness training.

5.6 Impact of the Covid 19 Pandemic

The effect of pandemic restrictions and how the KFIM staff had adjusted to utilising online platforms was received well by clients with most saying having flexibility around appointment times and having choice around how they accessed the KFIM service was a positive. Most staff said that the period to set up the service, awareness raising, and distribution of service information was impacted

significantly by the restrictions of the pandemic, so adaptations needed to be explored and implemented, with some roles having to evolve and adapt as the KFIM service adjusted to pandemic restrictions and client needs. Some said that they had missed the support of colleagues with one member of staff saying that they had been unable to meet new colleagues up to the point of interview. To adjust to the challenges, numerous referral routes and pathways were employed such as telephone, email, website, and social media. Some staff reported experiencing a significant learning curve around the use of new online service delivery platforms. However, it was reported that migration over to these did prove to have benefits especially around flexibility and ease of appointment access for clients.

5.7 Strengths and Limitations of this evaluation

The use of mixed methods and various sources of data, including outcomes measured by three standardized measures, quantitative and qualitative survey data and information from semi-structured interviews with clients, staff and a referrer has enabled triangulation of findings, thus strengthening the rigour of this evaluation (Flick, 2018). The evaluation has been undertaken by a research team outside of Sheffield Mind and the KFIM service, thus reducing the risk of researcher bias and increasing objectivity (Pannucci and Wilkins, 2010).

Whilst the desired sample of ten clients were recruited and interviewed, the referrer sample was small than anticipated and only one person who had referred clients to KFIM contributed an interview. A limitation in the quantitative outcome measures data for WEMWBS, BRS and CELMT assessments was the variation in time scales between when the 1st, 2nd, 3rd and 4th measures were undertaken by clients. This variation was demonstrated in Table 4.3 and was influenced by several factors that are not possible to control in service provision (compared to a randomized controlled trial). This identification of differences in time intervals between measures is an important factor to consider (Caruna et al, 2015).

5.8 Suggestions for future research

From the client, referrer, and staff feedback there still appears to be a gap in accurate data related to where military families are located, what their needs are, and if it is common practice for public and community services to routinely identify members of the armed forces community. Previous research suggests that gaps in data collection may be an ongoing issue. Following the 2021 Census which included a question asking if someone had served in the armed forces as a regular or a reservist (ONS, 2021), new data may begin to illuminate where they are located. However, the identification of the location military families was not a requirement, therefore, the gap in data may persist and require further research. In addition, further research should explore the transition journey of military families and adjustment to civilian life, with current transition data mainly relating to the Carrer Transition Partnership (CTP) data regarding employment status for UK regular personnel over a six-month and 12-month tracking process (MOD, 2021b). Potential research questions include:

- What happens to veterans after the tracking period has elapsed?
- What happened to other family members during and after this transition period?
- What transition preparation do family members receive?
- Does the relationship status change following transition?
- Where are military families located following transition?

5.9 Implications

Whilst celebrating and fully acknowledging that since the launch of the Armed Forces Act (2011) and Armed Forces Covenant (2011) there has been a public rise in support for the armed forces community, and there have been hugely successful, significant and wide-ranging service improvements across the UK including the launch of bespoke NHS services, local authorities committing to the Armed Forces Covenant and MOD Employer Recognition Scheme, there still appears to be work to do supporting the armed forces community and in particular military families. The Armed Forces Help to buy scheme is a good example of significant change for serving personnel and their families, but since evaluating the KFIM service it appears that a positive solution may have inadvertently created an issue for some families, as some family members feel that there a disconnect from support if not living on base and report feelings of loneliness. As suggested by the KFIM service findings, for military families who are no longer serving, a gap in bespoke support for

them appears to be present with many community services not routinely identifying members of the armed forces community within their assessment processes, resulting in an absence of signposting to military charities or bespoke services. The impact on relationships of service-related injuries and mental health issues (e.g., PTSD) was discussed, with associated issues around stigma contributing to reduced help seeking behaviors and creating barriers to engagement, meaning help was only sought when a crisis point was reached. However, by the provision of a dedicated and bespoke service focusing on military families, this has provided a pathway to support previously unavailable. Having someone to talk too who had been trained to understood military life, the culture, transition experience and creating support networks through the groups were recurring themes which prompted client, referrer and staff concerns about continued funding, as all unanimously not only supported a continuation of the KFIM service but added that to reach more military families the KFIM service should be available outside of the South Yorkshire region.

5.10 Conclusion

In conclusion, research findings suggest the KFIM service has been a success and reached military families who may have not had the opportunity to access help if not for the existence of the service. Drawing the results from the WEMWBS and BRS outcome scores, survey results and clients', referrer's, and staff's interviews, it can be concluded that the KFIM service resulted in improved mental wellbeing and resilience for most clients. Overall, the KFIM had made a significant impact on the mental wellbeing of clients, as demonstrated by the statistically significant improvements found on the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) scores. The impact of the service had been substantial for some people, for example one interviewed client said *"…it saved my life, it was a lifeline…"* Clients' resilience, as measured by the Brief Resilience Scale (BRS, Smith et al, 2008) was also found to improve following counselling provided by KFIM. Feelings of loneliness did not improve, and loneliness was even found to increase for some clients, however, this finding could be explained by the unprecedented circumstances under which the KFIM service was delivered during the Covid 19 pandemic and research which has indicated loneliness increased amongst the general population owing to lockdowns and restrictions (Mental Health Foundation, 2021; Killgore et al, 2020).

The current referral process appears to be working well, facilitated by easy referral or self-referral to KFIM several via multiple referral routes, including by telephone, email, the website, and social media. Research findings and feedback from clients, referrer, and staff suggests that military families, their location and understanding their needs, continues to present a challenge for many community service providers. This suggests that there continues to be an awareness training need for community service providers. KFIM feedback suggests routine data collection in some community services, and the inclusion of questions identifying members of the armed forces community remains ongoing in development, is sometimes sporadic, and in some cases absent, with concerns that people from military families who may need support, could potentially not be referred to bespoke services and fall through the support net. Having someone to talk too who was trained to understand military life and culture and creating support networks through the groups were positive recurring themes which contributed to breaking down barriers and having a positive effect on help seeking behaviors. Concerns around loneliness and isolation for not only serving families, but also ex-service families, have been addressed by KFIM with the creation of supportive networks and groups enabling clients to create their own support networks and friendships. Referrers describe the benefits of having the KFIM service resource and having the ability to be able to signpost and refer families, how the speed of referral contact was beneficial, and engagement with the KFIM service has made a positive difference. Such positive impact results suggests that the KFIM service should not only continue to be funded, but the model should be replicated over a wider geographical area to close a gap in provision supporting military families. There was consensus amongst staff and the referrer interviewed that the KFIM should be rolled out wider across a nationwide footprint to reach out to more military families who they described as *'a forgotten part of society'*. Adopting the commitments of the Armed Forces Covenant, KFIM is a good example of recognising the sacrifices military families make and the service addresses the needs of military families ensuring they face no disadvantage.

6.11 Recommendations

1. The Keeping Families in Mind (KFIM) service provide by Sheffield Mind provides a valued service that is making a positive impact in the lives of its clients and the service should be continued long-term.

2. The blend of face-to-face and online service provision providing choices to clients and enabling a range of activity focussed support groups should be continued.
3. Future developments identified by KFIM staff should be pursued: working with mother and toddler groups; a couple's therapy service; continued information sharing to reduce stigma and barriers to engagement; expansion of support groups to include a wider range of client-centred interests or activities; and the extension of mental health awareness training.
4. Services who may come into contact people with links to the military community should include screening questions in their assessment to identify people who may be currently serving, veterans or family of serving personnel or veterans.
5. Mind, with a network of around 125 local Mind services spread across England and Wales (Mind, 2021), is well placed to deliver additional KFIM services across the country, with a priority being locations where there are military garrisons.
6. Sufficient time needs to be allowed when setting up further KFIM services to the development phase, raising awareness of the service amongst the military community and to potential referral sources.

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Appendix 1: Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)

Client's initials LL

Therapist's initials

Date form given

Stage Completed

A Assessments
F First Therapy Session
D During Therapy
L Last therapy session
TC Telephone Counselling

Stage

Below are some statements about feelings and thoughts.

Please tick (✓) the box that best describes your experience of each over the last 2 weeks.

	STATEMENTS	None of the time	Rarely	Some of the time	Often	All of the time
1	I've been feeling optimistic about the future	1	2	3	4	5
2	I've been feeling useful	1	2	3	4	5
3	I've been feeling relaxed	1	2	3	4	5
4	I've been feeling interested in other people	1	2	3	4	5
5	I've had energy to spare	1	2	3	4	5
6	I've been dealing with problem well	1	2	3	4	5
7	I've been thinking clearly	1	2	3	4	5
8	I've been feeling good about myself	1	2	3	4	5
9	I've been feeling close to other people	1	2	3	4	5
10	I've been feeling confident	1	2	3	4	5
11	I've been able to make up my own mind about things	1	2	3	4	5
12	I've been feeling loved	1	2	3	4	5
13	I've been interested in new things	1	2	3	4	5
14	I've been feeling cheerful	1	2	3	4	5

Warwick- Edinburgh Mental Well- being Scale (WEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2006, all right reserved.

WEMWBS (Warwick-Edinburgh Mental Well-being Scale)
INFORMATION FOR CLIENTS

At Sheffield Mind we use an evaluation system called WEMWBS which helps us deliver and develop the best possible services for our clients. As part of this system all clients are asked to complete a questionnaire at various points in their therapy. You will be asked to complete the questionnaire at your assessment appointment, at your first therapy session, every 8 weeks whilst you are in therapy and at your last therapy session. Your therapist also completes a simple record form relating to your therapy at the beginning and end of therapy.

These questionnaires may contribute towards helping your therapist understand your problems. They also provide valuable monitoring information for the organisation and national research data. The questionnaire is in the form of tick boxes which should be straightforward to fill in, but if you would like help or further explanation, please talk to your therapist.

The information from the questionnaires is treated as strictly confidential. No names are used on any of the questionnaires and the information is input onto the WEMWBS system anonymously. Only WEMWBS researchers and Sheffield Mind will have access to any of the data.

We hope you will agree to complete the questionnaires, but we would like to emphasise that participation is entirely voluntary and declining to complete them will not affect your therapy in any way.

CLIENT CONSENT

I have read the information above and agree to the fair and lawful processing of personal information for the purposes of analysis and research in line with the Data Protection Act 1998.

I understand that the researchers using data collected will not have access to any personal data provided (e.g. name, address, date of birth) which makes the information identifiable to me and that I will not be identified in any way in anything that is written or reported about the research.

Signature…………………………………………………………………….

Name (block capitals)……………………………………………………………………………..

Date…………………………………………….

LL No. ………………………………………..

Appendix 2: Brief Resilience Scale (BRS)

Please respond to each item by marking one box per row

5-point level of agreement scale: Strongly Disagree; Disagree; Neutral; Agree; Strongly Agree.

	STATEMENTS	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	I tend to bounce back quickly after hard times	1	2	3	4	5
2	I have a hard time making it through stressful events	5	4	3	2	1
3	It does not take me long to recover from a stressful event	1	2	3	4	5
4	It is hard for me to snap back when something bad happens	5	4	3	2	1
5	I usually come through difficult times with little trouble	1	2	3	4	5
6	I tend to take a long time to get over set-backs in my life	5	4	3	2	1

Scoring: Add the responses varying from 1-5 for all six items giving a range from 6-30. Divide the total sum by the total number of questions answered.

My score: ______ item average / 6

Smith, B. W., Dalen, J., Wiggins, K., Tooley, E., Christopher, P., & Bernard, J. (2008). The brief resilience scale: assessing the ability to bounce back. International journal of behavioral medicine, 15(3), 194-200.

Appendix 3: Campaign to End Loneliness Measurement Tool (CTELMT).

We would like to ask you a few questions to enable us to measure how helpful our services are.

You can choose to answer all or none of the questions, and choosing not to answer will not affect your access to any of our services in any way.

When answering the questions, you could take account of the following:

- There are no right or wrong answers
- We would like you to be completely honest
- In answering the questions, it is best to think of your life as it generally is now (we all have some good or bad days)

Strongly Disagree / Disagree / Neutral / Agree / Strongly Agree / Don't Know

	STATEMENTS	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
1	I am content with my friendships and relationships	0	1	2	3	4
2	I have enough people I feel comfortable asking for help at any time	0	1	2	3	4
3	My relationships are as satisfying as I would want them to be	0	1	2	3	4

Campaign to End Loneliness. (n.d.) Campaign to End Loneliness Measurement Tool (CTELMT). In: Measuring our impact on loneliness in later life. [internet] Available from: https://www.campaigntoendloneliness.org/wp-content/uploads/Loneliness-Measurement-Guidance1.pdf [accessed 12 July 2021]

Appendix 4. Letter from Gatekeeper

To: Dr Alison Laver-Fawcett
School of Science, Technology and Health
York St John University
Lord Mayor's Walk
York
YO31 7EX

25/03/2021

Dear Alison,

I am writing to confirm that Sheffield Mind will act as a gatekeeper for the funded service evaluation:

An independent evaluation of the 'Keeping Families in Mind' service

The evaluation is being carried out as part of the funding requirement by the Armed Forces Covenant Fund Trust, who have funded the development, delivery, and evaluation of the service.

Our staff will contact people who have accessed the 'Keeping Families in Mind' services, by both email (we will forward an email invitation from you with the information sheet attached) and by telephone, to invite them to take part in an interview for the evaluation. We will also forward an email invitation to the Transition Intervention Liaison Service (TILS) (who have referred people to KFIM) and to staff who have worked in the KFIM service.

We will anonymise the pre- and post-test scores for the 3 agreed outcome measures used by the service and email this to you, by 13th May 2021, in an Excel spreadsheet for analysis.

We will also provide copies of the evaluation form (3 rated questions and 3 open questions) people were asked to complete on discharge from the service KFIM for analysis.

I understand that you will be obtaining ethical approval through the York St John University research ethics process and that the project will not commence until that has been agreed.

We look forward to working with you on this service evaluation,

Yours sincerely,

Rob Horsley
Head of Operations
Sheffield Mind

Appendix 5: Ethics approval letter

Est. 1841 | YORK ST JOHN UNIVERSITY

York St John University,
Lord Mayors Walk,
York,
YO31 7EX

08/06/2021

School of Science, Technology, and Health Research Ethics Committee

Dear Alison,

Title of study: An independent evaluation of the 'Keeping Families in Mind' service
Ethics reference: STHEC0037
Date of submission: 04/06/2021

I am pleased to inform you that the above application for ethical review has been reviewed by the School of Science, Technology, and Health Research Ethics Committee and I can confirm a favourable ethical opinion on the basis of the information provided in the following documents:

Document	Date
Application for ethical approval form	08/06/2021
Appendices 1-7	08/06/2021

Please notify the committee if you intend to make any amendments to the original research as submitted at date of this approval, including changes to recruitment methodology or accompanying documentation. All changes must receive ethical approval prior to commencing your study. You are now free to begin data recruitment and collection for the above approved study.

Yours sincerely,

Dr Sophie Carter
Chair of the School of Science, Technology, and Health Research Ethics Committee

Appendix 6: Participant information sheet for people who have accessed the service

An independent evaluation of the 'Keeping Families in Mind' service

Information Sheet about the Service Evaluation Project

This information sheet contains information about our service evaluation project to answer the type of questions people often have when deciding whether to take part.

Have you used the 'Keeping Families in Mind' (KFIM) service, either individually or through a peer support group, run by Sheffield Mind?

If yes, then we invite you take part in a service evaluation interview about your experience and views of the service.

What is the 'Keeping Families in Mind' service? KFIM is a service for families of serving and veteran personnel. Parents, partners, siblings, grandparents, children and other family members over the age of 18 who live in South Yorkshire can access the service. The staff at KFIM provide free counselling with a qualified therapist in their office, in a community venue or online. They also run peer support groups in Sheffield, Barnsley, Rotherham and Doncaster, where people are able to meet other military families in person or online and participate in a range of activities. For more details see: https://www.sheffieldmind.co.uk/keeping-families-in-mind. Email: therapy@sheffieldmind.co.uk.

Why is this service evaluation being done?

Keeping Families in Mind (KFIM) is funded by the Armed Forces Covenant Fund Trust. When Sheffield Mind applied for funding to develop and deliver this service they had to plan for an independent evaluation of the service as part of the funding agreement. The evaluation aims to discover whether or not the service has been beneficial for families of serving and veteran personnel. The results will help inform decisions about whether the service should be continued.

Who are we?

The Project team: Lynne Gabriel, Alison Laver-Fawcett, Nick Wood and Elly Southwell (Research assistant). We are a group of researchers from York St John University. Professor Lynne Gabriel is Professor of Counselling and Mental Health and is the Director of the Counselling & Mental Health

Clinic at York St John University. Dr Alison Laver-Fawcett is an occupational therapist and an Associate Professor in the School of Science, Technology and Health. Nick Wood is the Armed Forces and Uniformed Services Manager at YSJU, and he delivers training around Military culture and transition. Nick is also a veteran who served in the Royal Navy as an Aircraft Engineer, including active service during the Falklands War.

This project forms part of the expected independent evaluation of the 'Keeping Families in Mind' service evaluation, and it has been approved by the Cross Schools' Ethics committee at York St John University.

Research assistant who will be interviewing people for this study:
Elly Southwell
Email: ellenor.southwell@yorksj.ac.uk

Project Lead
Dr Alison Laver-Fawcett
Associate Professor
Telephone: 01904-876419
Email: a.laverfawcett@yorksj.ac.uk

What will I be asked to do if I take part?

The whole process will take about 30 minutes of your time. You will be asked questions about your experience of, and view about, the 'Keeping Families in Mind' Service, what support was provided to you (e.g. individual sessions or a peer support group), whether or not you found the service helpful, and whether you would recommend the service to other people in a similar situation as your own.

Will the information I provide be anonymous and confidential?
Yes, all information provided will be kept confidential. Any information with your name on (the consent form and a list with your name and the participant code allocated to anonymise your interview) or that could identify you (the recording from your interview) will be stored electronically in a folder on the University's OneDrive account. If you complete a paper consent form then this will be stored in a locked filing cabinet in an office at York St John University, it will be scanned and saved on OneDrive and the paper copy shredded and destroyed using York St John's confidential waste service. Only the researchers will see any information with your name on. At the end of the study the audio recording of your interview, your consent form and the list with your name on will be destroyed.

What will happen to the results of the service evaluation?
The researchers will write up the findings in a report which will go to Sheffield Mind and the Armed Forces Covenant Fund Trust. Your name will not be mentioned in the report. The evaluation may be used by Sheffield Mind and / or the Armed Forces Covenant Fund Trust to make decisions about developing, improving and / or funding this and similar services. The evaluation results may be presented at a conference, and / or written up and published as a journal article. No identifying personal information will be mentioned within any of these documents, presentations or publications and people who took part in the evaluation will remain anonymous.

Do I have to take part?
No, you do not have to take part. Taking part in this service evaluation is entirely your choice. Before or during the interview you can change your mind and stop taking part without giving a reason. You can also withdraw the information you provided in your interview up to two weeks after the date when you do the interview.
If you wish to withdraw from the study you can: tell one of the researchers if they are with you; or contact Dr Alison Laver-Fawcett, (telephone 01904-876419, email: a.laverfawcett@yorksj.ac.uk); or tell a member of staff at Sheffield Mind that you want to withdraw and ask them to contact Alison on your behalf. Withdrawing from the study will not influence your access to services at Sheffield Mind.

Are there any risks involved in taking part in this study?
We will be asking questions about the service you received from 'Keeping Families in Mind' talking about this may surface emotions depending on why you accessed the service. There may be questions you would prefer not to answer. This is fine and we can just move onto the next question. You choose how much you wish to say in response to any question. You will be under no pressure to answer any questions you do not wish to answer. You will be provided with 'The Military Human: Veterans and Families Support Information Guide' this contains information and contact details about a range of services and organisations for veterans and their families. You can choose whether to

receive an emailed copy of this guide or have it posted to you. You may also contact Sheffield Mind for support if you feel upset discussing anything during the interview.

When and where will the research take place?

If you would like to take part in the service evaluation, we will ask you to sign a consent form and we will arrange a mutually convenient date and time for the interview. The interview will be conducted virtually using either Microsoft Teams for a video call or, if you prefer, over the telephone. You can join a Teams meeting from any device (smart phone, tablet, iPad, laptop computer, desk top computer), whether or not you have a Teams account. The researcher will email you information for how to join the Teams meeting. You either click on the meeting link or go to the meeting invite and select 'Join Microsoft Teams Meeting' (using Teams is very like using Zoom, or video calling using FaceTime or WhatsApp).

Who should I speak to if I have further questions about this service evaluation study?

If you wish to ask any questions about this service evaluation project, then please talk to one of the researchers who will be happy to help. You can contact us via post, email or telephone and you will find contact details on the last page of this information sheet.

Project Lead's contact details:

Dr. Alison Laver-Fawcett
School of Science, Technology and Health
York St John University
Lord Mayors Walk,
York, YO31 7EX
Email : a.laverfawcett@yorksj.ac.uk
Telephone: 01904-876419
(If Alison is unavailable please leave a message on the answer phone).

Ethics Approval: This service evaluation study has been reviewed and approved by the York St John University Cross Schools Ethics Committee.
Ethics approval reference: STHEC0037 dated 8.6.2021

Who should I speak to if I have concerns or a complaint about this service evaluation study?

If you have any concerns or a complaint about this project, you can contact Dr Sophie Carter. Sophie is the Chair of the Ethics Panel
E-mail : s.carter@yorksj.ac.uk

Thank you very much for taking time to read this information sheet.

Appendix 7: Consent form

Consent form

Title of study: An independent evaluation of the 'Keeping Families in Mind' service

Please read and complete this form carefully. If you are happy to take part in this study, please put a tick in the box next to each statement sign your name and write the date at end of the form. If you do not understand anything or you would like more information about this project, please ask one of the researchers.

1. I have read the participant information sheet about this study and have had enough time to consider the information and ask questions. ☐
2. I understand that taking part in this service evaluation is voluntary. ☐
3. I understand that I can withdraw from this evaluation within the next 2 weeks without giving a reason. I understand this will not have any impact on my access to future service from Sheffield Mind. ☐
4. I understand that the evaluation involves an interview which will be done virtually on Microsoft Teams or via telephone. If by Teams, the researcher will email me a link to join the Teams meeting. The interview will be about my experience of the 'Keeping Families in Mind' service provided by Sheffield Mind. The interview will take approximately 30 minutes and will be video recorded if conducted by Teams or audio recorded if undertaken by telephone. ☐
5. I understand the interview will be recorded and this recording will be destroyed after the evaluation project is finished. What I say in the interview will be typed up word for word, this is called a 'verbatim transcript'. My name will not be on the transcript so my replies will be anonymous. However, the anonymised Transcript will be kept. However, the anonymised the transcript will be kept until it is destroyed after the report has been completed. ☐
6. I understand that all information about me will be treated in strict confidence and that I will not be named in any written work (for example a report for Sheffield Mind and the organisation who funded the service), research article or presentation arising from this evaluation. ☐

8. I give my consent to take part in this research study and have been given a copy of this consent form for my own information.

Signature: ……………………………………………………………………………………

Print name: ……………………………………………………………………………………

Date: ……………………………………………………………………………………….

9. I would like to be informed of the results of the evaluation and give permission for the research team to do so via email or post. If yes, provide your contact details below.

   (Please circle): Yes No

10. I would like the researchers to post or email me a copy of my typed-up interview transcript

    (Please circle): Yes No

If you answer yes to question 9 and / or 10, please provided either your:

Email address: ____

Your address: ____

____

This study has been approved by the York St John University School of Science, Technology, and Health Research Ethics Committee
Ethics approval reference: STHEC0037 dated 8.6.2021

Names of researchers:

Dr Alison Laver-Fawcett (Project Lead)
Professor Lynne Gabriel
Nick Wood,
Research assistant: Elly Southwell

Appendix 8: Interview questions

Interview questions for clients who had accessed the Keeping Families in Mind service

1. Who referred you to the 'Keeping Families in Mind' service? [check if self-referral is an option and potential referral sources]

2. Why do you think [referrer role/name] referred you to the ''Families in Mind'' service?

3. What did you hope to gain from the 'Families in Mind' service?

4. Did you receive an individual service and / or access the support group?

5. What was your aim for accessing the service? What did you hope to gain? [your need, or problem that you wanted support with when you had your first meeting with staff 'Keeping Families in Mind' service staff member?]

6. How did you find your [individual / group] sessions with the KFIM staff?

7. Would you recommend the 'Families in Mind' service to your family and friends?
   - Why?
   - Why not?

8. Do you have any other needs which have not been met / fully met?

   - If yes, what are these needs?
   - What do you think would help you?

9. Is there anything else you would like to tell us about the 'Families in Mind' service' service?

10. Did you feel that the 'Families in Mind' service had an understanding of military culture and lifestyle?

    If yes how did this affect your experience?
    If no how might this have helped?

Interview questions for referrers into the KFIM service:

- Have you referred patients to the ‘Keeping Families in Mind’ service since it started? If yes, how frequently / how many approximately.
- What have been your reasons for referring people to the ‘Keeping Families in Mind’ service?
- Have you seen any perceived benefits for individuals you have referred?
- From your perspective, has the ‘Keeping Families in Mind’ service made a difference? If yes, how?
- Do you think the service should be continued in future?
- If the service was to continue what, if any, improvements would you suggest?
- Is there anything else you would like to mention related to the ‘Keeping Families in Mind’ service’

Interview questions for KFIM staff:

Keeping Families in Mind (KFIM)

- Please describe your role in the 'Keeping Families in Mind' service.
- How has the referral process worked for this service?
- Would you make any changes to the referral form or referral process? If yes, please explain.
- What have been the challenges, if any, of setting up the 'Families in Mind' service?
- What have been the challenges, if any, of recruiting clients to the service?
- What do you perceive to be the key successes, if any, of the service so far?
- What has been the reception of services to which you have referred or signposted customers?
- Have you seen any perceived benefits for individual people you have assessed and offered intervention?
- From your perspective, has the 'Keeping Families in Mind' service made a difference?
- Do you think the service should be continued in future? Why or why not?
- If the service was to continue what, if any, improvements would you suggest?
- Did you receive any understanding military culture training and if so, how do you think this helped?
- Is there anything else you would like to mention related to the 'Keeping Families in Mind' service'

Appendix 9: Wording on the Consent form and Counselling and Therapy agreement used by Sheffield Mind:

INFORMATION FOR CLIENTS

At Sheffield Mind we use evaluation systems which help us deliver and develop the best possible services for our clients. As part of these systems, clients are asked to complete a questionnaire at various points in their therapy.

These questionnaires may contribute towards helping your therapist understand your problems. They also provide valuable monitoring information for the organisation and national research data.

The information from the questionnaires is treated as strictly confidential. No names are used on any of the questionnaires. Only researchers and Sheffield Mind will have access to any of the data.

We hope you will agree to complete the questionnaires, but we would like to emphasise that participation is entirely voluntary and declining to complete them will not affect your therapy in any way.

If you would like help or further explanation, please talk to your therapist.

CLIENT CONSENT

I have read the information above and agree to the fair and lawful processing of personal information for the purposes of analysis and research in line with Data Protection Legislation. I also understand that I can withdraw this consent at any time in line with General Data Protection Regulations (GDPR).

I understand that the researchers using data collected will not have access to any personal data provided (e.g. name, address, date of birth) which makes the information identifiable to me and that I will not be identified in any way in anything that is written or reported about the research.

Signature…………………………………..………………………………..

Name (block capitals)…………………..…………………………………………………..

Date…………………………………………. LL No. ....

Counselling & Therapy Agreement

Introduction

This agreement is about the relationship between you and Sheffield Mind. It is to make clear what you can expect from us, from our therapists and what we need from you. The counselling & therapy process aims to help you understand and explore your problems. It can offer opportunities for positive change as well as raise difficulties.

Confidentiality

At Mind we regard confidentiality as vital. The discussions between you and your therapist remain confidential but there are occasions where some information needs to be shared within the organisation. Information is only shared with those that need to know and is kept to a minimum. Your therapist needs to involve other people when:

- They are discussing their counselling work with a supervisor. Therapists are either qualified or in recognised training and are required to work to Sheffield Mind's Code of Ethics and Practice. Part of that Code requires all therapists to receive clinical supervision. The purpose of supervision is to support the therapist's and client's work together.
- If you disclose information that leads your therapist to believe that you or someone else is at risk of being harmed then your therapist needs to talk to you about ways of reducing the risk. Your therapist would also need to consult with an experienced colleague or supervisor. It may be necessary to contact another professional, for example, your GP or Social Services. Wherever possible this would be discussed with you first. We would do our best to keep you informed about any action we might take.

Record Keeping and Notes

Your contact details and a record of the information collected at your assessment are kept on computer. We also collect monitoring details such as attendance, for example. The computer system is fully protected and encrypted and only clinical staff and the system administrator have access to any sensitive data. In line with General Data Protection Regulations (GDPR) you can withdraw your consent for us to hold personal data at any time.

Your therapist makes brief notes following each session. These notes include the main points arising from your counselling session, a record of your attendance and a short summary of the work when your counselling is completed. Your contact details are kept separately from your notes. Notes are kept in a way that protects your identity as much as possible. If you would like to see your notes please

ask. You have a legal right to see them. If you do withdraw your permission for us to hold personal information about you this will affect our ability to work with you.

We are required to keep paper records and your counselling notes for 7 years. We are required by law to make records available in rare circumstances if they are subpoenaed by a court in the case of legal action.
Paper records are kept securely in a locked cabinet within the organisation and do not contain anything that would identify you. Sheffield Mind is registered as a controller of sensitive data under the Data Protection Act (Reg. No. Z6993347) and complies with their recommendations for storing sensitive data. Further, Sheffield Mind has a policy that sets out how information is recorded and stored. You can have a copy of this policy if you apply to the Clinical Manager.

Donations and Gifts
Counselling is provided free of charge. However, we are a charity and appreciate any donations to Sheffield Mind if you feel able to contribute. Our suggested donation per session is 0.05% of your annual income. Therapists are not permitted to accept personal gifts apart from items that can be shared out.

Counselling Sessions
Counselling usually takes place once a week at an agreed time, each session lasting 50 minutes. If you arrive late, your counsellor will still be available but the time you spend together will be shorter because the session will end at the normal time. We offer 8 initial sessions, which may be extended following a review with your therapist.

Cancellations and Absences
- If you are unable to attend a session please inform your therapist as soon as possible. You can call 0114 2584489 to cancel a session. Please provide your name and your therapist's name.
- If you cancel sessions frequently, your therapist will discuss the circumstances with you and a decision will be made about whether the sessions continue.
- If you miss a session without contacting us, we will try to contact you to discuss your absence.
- Subsequently, if you miss any further sessions and do not contact us, we will withdraw you from the service.
- The therapist will give you as much notice as possible when they are not available. If your therapist is ill or has to cancel at short notice, somebody from Sheffield Mind will try to contact you. Your therapist will let you know about any holiday breaks.

Evaluation of the service
As part of our funding for the service we have been asked to provide data to York St John's at the end of the service in 2021. In order to do this, we will ask you to fill in questionnaires which are made

anonymous. Questionnaires will be provided at assessment, first session, and week 8 and at the end of your therapy.

We will also contact you 6 weeks after your therapy end date and send you a questionnaires. This is to evaluate whether the service has had a lasting effect.

Communication

On occasion, we will contact you or send you post about events or opportunities that are being provided by Sheffield Mind.

Adoption

Should adoption become the primary reason for seeking counselling, you may need to be reallocated to another therapist or referred to another agency.

Comments and Complaints

Mind has a complaints policy and procedure which can support you to let us know if you are unhappy with something or you may want to comment on the service. Please ask if you would like to see a copy of this.

I have read, discussed and understood the above information and I am willing to work with this agreement. By signing this form you are giving Sheffield Mind permission to hold personal information about you and to use it in accordance with General Data Protection Regulations (GDPR) and this agreement. You can withdraw your consent at any time.

Signed Therapist ……………………………………. Signed Client …………………………………………..

Date……………………………………………………… Print Client Name ……………………………………………….

Using your information

Sheffield Mind is required to demonstrate the effectiveness of the services it provides through internal and external reports. Therapists will, from time to time, write anonymous case studies relating to their client work which may be included in these reports.

I give consent for my information to be used in this way:

Signed ……………………………………. Print name …………………………………………

To reference this document:

Laver-Fawcett, A.J., Wood, N., Southwell, E. (2021). *An independent evaluation of the Keeping Families in Mind (KFIM) service*. York: York St John University.

© Alison Laver-Fawcett, Nick Wood and Ellenor Southwell (2021)