



## Improving Access Report | 2017

Understanding Why Veterans Are Reluctant To Access  
Help for Alcohol Problems



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## The Northern Hub for Veterans and Military Families Research

The Northern Hub for Veterans and Military Families Research is a collective of academics, service providers and service users with an interest in improving the health and social wellbeing of veterans and their families across the life-span.

The hub has evolved from the interests of Dr Mathew Kiernan Lieutenant Commander RN (Q) retired and Dr Mick Hill. It has established itself through an evolutionary process attracting and welcoming anyone with a genuine interest in its vision. We openly welcome visionary and innovative research that helps improve and understand the complexities that our veterans and their families experience across the whole life-span. A fundamental principle of the hub is collaboration in research for the benefit of others.



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Thank you to all those who participated in this project: service planners, commissioners and providers, service users, and veterans for sharing your experiences.



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#### The Royal British Legion

The Royal British Legion help members of the Royal Navy, British Army, Royal Air Force, Reservists, veterans and their families all year round. They also campaign to improve their lives, organise the Poppy Appeal and remember the fallen.

The Royal British Legion provided funding for this project.

[www.britishlegion.org.uk](http://www.britishlegion.org.uk)



#### Northumberland, Tyne and Wear NHS Foundation Trust

Northumberland, Tyne and Wear NHS Foundation Trust is one of the largest mental health and disability Trusts in England, working across Northumberland, Newcastle, North Tyneside, Gateshead, South Tyneside and Sunderland.

NTW helped with initial participant recruitment.

[www.ntw.nhs.uk](http://www.ntw.nhs.uk)



#### Changing Lives

Changing Lives is a national charity, providing specialist support services for vulnerable people and their families. Changing lives works with veterans who are experiencing homelessness, addiction and a range of other problems, offering specialist support services and employment opportunities.

Changing Lives supported peer participant recruitment.

[www.changing-lives.org.uk](http://www.changing-lives.org.uk)



#### Northern Learning Trust

Northern Learning Trust is a North East of England based charity that works with vulnerable young people and adults. They have dedicated support workers in their Veteran Support Service, working with veterans who are ex-offenders.

Northern Learning Trust aided participant recruitment for this project.

[www.northernlearningtrust.org.uk](http://www.northernlearningtrust.org.uk)



#### AF&V Launchpad

AF&V Launchpad is a charity with houses in Newcastle upon Tyne and Liverpool, providing homeless veterans with accommodation, aiming to get them into employment and permanent housing.

Launchpad helped to facilitate peer participant recruitment for this project.

[www.veteranslaunchpad.org.uk](http://www.veteranslaunchpad.org.uk)

## Abbreviations

<b>A+E</b>	Accident and Emergency
<b>AUDIT</b>	Alcohol Use Disorder Identification Test
<b>BTC</b>	Barriers to Care
<b>CCG</b>	Clinical Commissioning Group
<b>ESL</b>	Early Service Leavers
<b>GP</b>	General Practitioner
<b>GW I</b>	First Gulf War
<b>GW II</b>	Second Gulf War
<b>HSCIC</b>	Health and Social Care Information Centre
<b>NHS</b>	National Health Service
<b>NTW</b>	Northumberland, Tyne and Wear
<b>Op Telic</b>	Operation Telic
<b>PTSD</b>	Post-Traumatic Stress Disorder
<b>RAF</b>	Royal Air Force
<b>RBL</b>	Royal British Legion
<b>TIL</b>	Transition, Intervention and Liaison Veterans Mental Health Services
<b>U.K.</b>	United Kingdom
<b>U.S.</b>	United States
<b>VA</b>	Veterans Affairs (Department of)
<b>VSMS</b>	Veterans Substance Misuse Service
<b>VWALS</b>	Veterans Welfare and Liaison Service



## Executive Summary

This project arose from two frequently stated perceptions of clinical practitioners working within the field of alcohol misuse services:

- *Why is it so difficult to engage ex-servicemen (and women) in treatment programmes,*
- *Once they engage, why is it so difficult to maintain that engagement?*



In an attempt to test the validity of these perceptions, a systematic literature review was undertaken followed by a four-phase research study exploring the relationship between being a UK military veteran (ex-serviceman/woman), the provision of alcohol misuse services and veterans' experiences of engaging with these services.

A review of existing literature revealed a limited amount of previous research that has *specifically* considered problems related to alcohol misuse within the UK veterans' population. Paradoxically, the prevalence of alcohol misuse problems amongst the UK veteran population, by (some) previous estimations, is higher than levels found within the general population. Given that there are an estimated 2.56 million UK military veterans<sup>1</sup>, this represents a potentially important, but as yet, largely unaddressed public health issue.

1

The first phase of the study consisted of semi-structured interviews with the commissioners and managers of services for alcohol misuse. Initially, the intention was also to include relevant policy makers in this field. In the event, it proved difficult to identify (and therefore recruit) appropriate policy makers, and this experience in itself is perhaps indicative that improving alcohol misuse services for UK military veterans is not a current strategic priority. Service commissioners and managers expressed the view that veterans found difficulty in navigating services and there was also a widely-shared perception that this was partly due to 'institutionalisation'. Exploring this assertion became a priority in subsequent phases of the project. In the absence of any strong supporting evidence, it would appear that the 'veteran-as-institutionalised' hypothesis formed one means by which veterans could be stereotyped as (partially) the architects of their own difficulties. Most service commissioners and managers also expressed the view that 'front line' staff dealing with substance and alcohol misuse had little understanding of 'veterans' culture' and

<sup>1</sup> Ministry of Defence (2015) *Annual Population Survey: UK Armed Forces Veterans residing in Great Britain 2015*. Bristol: Ministry of Defence Statistics (Health).

the specific issues facing UK military veterans – although it was not clear on what basis they held this opinion.

2

In Phase Two in-depth semi-structured interviews were undertaken with a sample of veterans who were currently experiencing, or had experienced, problems with alcohol misuse. The focus of this phase was therefore on personal accounts of self-identified problematic alcohol use (or of having this ‘identified’ by others, often family members), finding help for their problems, and their opinions in relation to particular barriers that exist for military veterans. In all cases, meaningful engagement with alcohol misuse services could be considered as being ‘delayed’ to a significant extent. The data suggested a number of reasons for this: Primarily it appeared that many participants had a ‘normalised’ relationship with excessive alcohol consumption both during and after their military service. This militated against self-recognition of alcohol misuse. In turn, delayed acknowledgement of problematic alcohol use often meant that by the point at which help was sought, concomitant problems were of such complexity and proportion that they were difficult to address. If the ‘normalised’ relationship with excessive alcohol use is indeed a feature of UK military ‘veteran culture’, it appeared to be largely unrecognised by healthcare staff participating in the study. Some veteran-participants in this phase of the study also reported that it was difficult to communicate their problems to non-military healthcare staff who did not appreciate the nuances of military life and terminology. To reiterate, many of the veteran-participants presented with a very complex combination of medical, psychological and social problems. Given this complexity, it was unsurprising that participants typically reported that negotiating an (arguably fragmented) health and social care system was both difficult and frustrating.

3

In the third phase of the study, a group of UK military veterans attended a focus group in order to explore aspects of ‘veterans’ culture’. None of these participants had any *apparent* history of current or past alcohol misuse. One collective opinion to emerge was that alcohol misuse was (at least historically) a problem within the UK armed services. However, a strong argument was also advanced that a change in policy, the typical length of postings, and less isolation from family and friends meant that alcohol misuse was now less of a widespread problem. These participants also expressed the opinion that seeking help was contrary to ‘military culture’ and that this disposition tended to remain with UK military veterans after transition to civilian life. Focus group participants expressed consensus in relation to the importance of a well-planned transitional period back to civilian life and the collective perception was that that this, at present, remains under-supported. Interestingly, the group collectively expressed the opinion that accessing healthcare of any sort was complex and speculated that in the case of a veteran with an

alcohol problem it would be difficult to know where to seek help. Finally, focus group participants extolled the virtues of third sector provision, and in particular, provision by military charities. This endorsement appeared to be underpinned by a strong belief in the value of veteran-specific services.

#### 4

The final phase of this research project took the form of a symposium of UK military veterans, service commissioners, managers and providers, and representatives of third sector organisations. 'Round-table' discussions were facilitated by healthcare academics. The singular aim of the forum was to suggest how existing services could be improved within existing budgets. Those military veterans present who had experienced alcohol misuse problems unanimously described the problematic nature of negotiating services, keeping appointments etc. This was often against a backdrop of their alcohol misuse, mental/physical health problems, and social problems being at their most acute and disabling. Furthermore, these participants vividly reported that 'systems' for their care were typically patchy and (at worst) chaotic. Typically, these participants expressed the view that they were undervalued by society-at-large as well as those within its healthcare system. For their part, the third-sector workers described an overwhelming workload in dealing with individuals whose lives were made chaotic by the complexity of their problems. A near-consensus emerged that the central issue was one of coordinating the many services for example mental health, physical health, housing difficulties, relationship problems, homelessness, poverty and unemployment required by *some* military veterans. Treatment pathways were often convoluted and varied greatly across geographical and sector boundaries. One emergent idea that enjoyed much support was for a 'peer-support worker' role – a person who could act as a key case-worker for each individual presenting with alcohol misuse problems, responsible for coordinating their many needs and helping to navigate fragmented and complex health and social care provision.

Overall, the outcome of this research would appear to confirm that UK military veterans are relatively disadvantaged in both sourcing help and staying engaged with services for alcohol misuse when needed. As a result of analysis of phase 4 of the research, the report authors contend that one possible solution worthy of further exploration would be a 'hub-and-spoke' model of care. At the centre of the hub would be a military veteran peer support worker, knowledgeable of local and national services, and experienced in navigating existing pathways of care. Perhaps for operational expediency and effectiveness, this worker might usefully be located within the local Transition, Intervention and Liaison (TIL) Veterans' Mental Health Team. Any 'first-point-of-contact' agency, as a matter of course, would be able to refer any veteran with alcohol misuse problems to the 'hub' worker. The designated peer support worker would then, side by side, be able to help the veteran in need to navigate each 'spoke'

of the (arguably fragmented) health and social care system. Acting as, essentially, the key caseworker would allow the peer support worker to maintain a cogent overview of each clients' needs and progress within each agency, advocate and communicate on their behalf as-and-when necessary, avoid repetition and duplication of provision and offer motivational support in a way that is sensitive to UK military veteran culture. This potential solution perhaps offers one possibility by which UK military veterans experiencing alcohol misuse problems might engage with the full diversity of existing service provision in a considered and individually bespoke way.

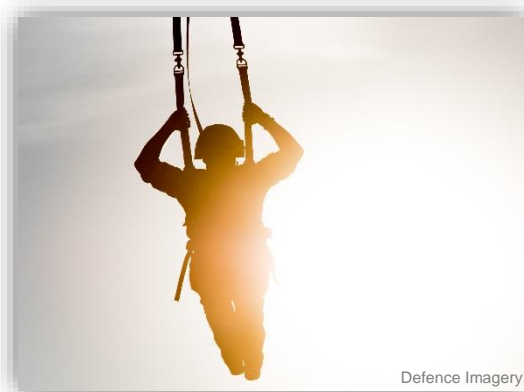


Meet the Veterans Undertaking Ground-Breaking Research Improving the Lives of Fellow Servicemen. *Chronicle Live*, 21 February 2017. By Hannah Graham.

## 1. Introduction

### 1.1 Background

Since the 19<sup>th</sup> century, alcohol has been an integral part of British Military life. For many men, alcohol was seen as an escape from poverty and this was used as part of motivation to join the military, citing availability of free liquor, food, regular wage and escape from poverty as incentives to enlist. Consumption in large quantities was not necessarily discouraged and



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some doctors believed that alcohol gave a degree of protection against various lethal diseases affecting those in the military (Howard, 2000). The relationship with alcohol has continued to develop in the modern day U.K. military, where it is utilised in social bonding and comradeship (Jones and Fear, 2011, Alcohol Concern, 2012).

Traditional military celebrations, such as promotion ceremonies, mess nights, command parties and Hail and Farewell gatherings typically include alcohol. Alcohol also continues to feature in military 'decompression' where combat personnel are given a short period of leave and psychological support following deployment (Hacker Hughes et al., 2008). According to the Motivational Model of alcohol use, individuals may use alcohol to regulate the quality of their emotional experience – to cope and to enhance positive emotional experience (Cooper et al., 1995). Exposure to this social environment in the military can influence and reinforce beliefs about acceptable drinking norms (Ong and Joseph, 2008). Despite the many benefits of alcohol in the social environment, issues arise when alcohol is misused. For service personnel already in a high-stress environment, the social norms that tolerate increased alcohol use for recreation and coping can often influence their behaviour around alcohol long-term (Fernandez et al., 2006, Ong and Joseph, 2008).

Alcohol misuse is generally defined as drinking more than the low risk guidelines, where men and women are advised not to regularly drink more than 14 units a week (Chief Medical Officer, 2016). Misusing alcohol and drinking in excess can have a negative impact on physical and mental health (Fear et al., 2010, Aguirre et al., 2014). The cost of alcohol related harm to the NHS has been estimated at £3.5 billion per year and is expected to increase (HSCIC, 2015). There has been some investment in alcohol services but treatment for alcohol problems is not deemed adequate to match the current demands of the population in the U.K. and is largely failing to address problem drinking (Centre for Social Justice, 2013). The British Army has also expressed concern that excessive drinking can undermine operational effectiveness,

leave soldiers unfit for duty and damage trust and respect within the team (Alcohol Concern, 2012).

Patterns of excessive drinking established during service may be difficult to change upon leaving. Iversen et al. (2009) assessed the prevalence of mental health diagnoses of 821 serving and ex-serving personnel, after identifying alcohol abuse as the most common at 18%, no statistically significant differences were ascertained in prevalence of alcohol misuse between serving and ex-serving personnel. However, there appears to have been limited research undertaken on alcohol consumption in the U.K. ex-service personnel population, despite there being a clear indication that excessive alcohol use is also a risk among veterans (Fossey, 2010). The greatest focus of media coverage and political interest has been on Post Traumatic Stress Disorder in the veteran population, particularly since the recent conflicts in Iraq and Afghanistan (MacManus et al., 2014).

The ex-service population, excluding dependents and any personnel in hidden populations (such as prisons, rehabilitation facilities, temporary accommodation or residential homes) was estimated at 2.56 million in 2015 which is 3.9% of the U.K. population (Ministry of Defence, 2016a). There are many issues with accessing this population, as the self-identity of ex-service personnel varies considerably. They are often referred to as 'veterans', however, the meaning and characteristics of this term depends upon the source and context of its deployment, whether that be by military personnel, public opinion or government policy (Cooper et al., 2016, Burdett et al., 2013, Rice, 2009). The U.K. government define a veteran as someone who has "served for at least a day in HM Armed Forces, whether as a Regular or as a Reservist" (Ministry of Defence, 2011).

Once personnel have left the Armed Forces, the National Health Service (NHS) deals with any requirement for healthcare. In addition to this, there are many U.K. third sector organisations including charities such as the Royal British Legion (RBL), Combat Stress and Help for Heroes that provide further help and support for veterans. Unfortunately, the majority of research on serving and ex-serving personnel and alcohol has been conducted in the U.S. The U.S. culture and healthcare policies are different to that in the U.K., upon leaving the Military, many personnel are supported by the U.S. Department of Veterans Affairs (VA), which takes care of all healthcare needs, and support for veterans. As a result, findings from the U.S. research are arguably not directly comparable to the U.K. military and veteran population.



## 1.2 Systematic Narrative Review of U.K. Literature

In order to identify where there may be gaps in current U.K. literature, a review of U.K. papers on alcohol covering the lifespan of military personnel was conducted. A systematic narrative review strategy was utilised. This review method was most appropriate to the study aims due to the relative paucity of research in this area, rendering it imperative to include evidence from multiple sources, including both quantitative and qualitative data (Popay et al., 2006).

### Systematic Search Method

Databases suitable to the research aim were identified and a systematic search was carried out to identify published evidence relating to the study aim (Table 1).

**Table 1.** Search strategy for first systematic search.

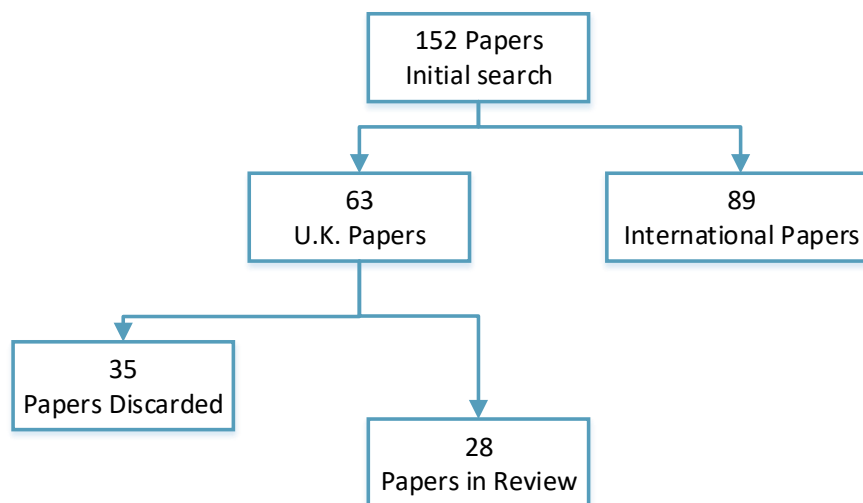
<b>Source</b>	ASSIA Google Scholar Science Direct
<b>Search Field</b>	Title, Abstract, Keywords
<b>Language</b>	English only
<b>Exclusion</b>	Non-English language No full-text available Papers that assessed/evaluated treatment for alcohol problems Papers did not consider U.K. military population
<b>Year of publication</b>	All papers published prior to February 2017

Research papers published prior to February 2017 were considered if they included a military sample in the assessment of alcohol use, including any papers referring to substance misuse. Research carried out in the U.K. was the focus of this review, however, international papers were also considered in the search in order to avoid exclusion of important findings which triangulate with significant U.K. studies. Papers were excluded if they were not written in the English language, there was no full-text available, they assessed or evaluated treatment for alcohol problems, or they did not consider the U.K. military population. Search items were developed using the PICO framework (Russell et al., 2009) (Table 2).

**Table 2.** The PICO framework to develop a search strategy used for the systematic literature search.

<b>P</b> Patient or population	Veteran* OR, 'Ex-Service*' OR, 'Soldier*' 'Military' OR, 'Armed Forces' OR, 'Army' OR, 'Royal Navy' OR, 'RN' OR, 'Royal Air Force' OR, 'RAF' OR, 'Royal Marines'
<b>I</b> Intervention	Various
<b>C</b> Comparison (if applicable)	Not applicable
<b>O</b> Outcome	'Alcohol*' OR, 'alcohol misuse' OR, 'alcohol use' OR, 'alcohol abuse', OR 'alcohol dependent' OR, 'drink*', OR 'Substance misuse' OR, 'substance abuse' OR, 'substance use' OR, 'Mental health'

Relevant truncation and wildcard search strategies were utilised, to ensure that all increased the chance of relevant hits being returned. A total of 152 papers were retrieved from the database search (Figure 1).

**Figure 1.** Papers identified during search process.

After a full-text search, all U.K. papers were isolated, leaving 63 papers. The U.K. literature was then manually assessed for the suitability to include in the review. The Critical Appraisal Skill Programme (CASP) tool (CASP, 2017) was utilised to determine the quality of papers included in this review. Thirty-five papers were rejected as per the exclusion criteria. Reference and citation searches were carried out on all remaining papers; however, no further papers were included. A total of 28 papers were accepted for use in this review.



## Review Findings

### *Paper Characteristics*

Twenty-eight papers were considered for review, all of which were peer-reviewed (see table 3 for paper characteristics). Twenty-six of the papers were quantitative and two were qualitative papers. Nine papers considered alcohol consumption as a primary focus (Aguirre et al., 2014, Browne et al., 2008, Fear et al., 2007, Henderson et al., 2009, Hooper et al., 2008, Iversen et al., 2007b, Kiernan et al., 2016, Rona et al., 2010, Thandi et al., 2015) whereas 12 papers focussed primarily upon mental health (Buckman et al., 2013, French et al., 2004, Harvey et al., 2011, Hatch et al., 2013, Hotopf et al., 2006, Iversen et al., 2005a, Iversen et al., 2009, Iversen et al., 2011, Jones et al., 2006, Jones et al., 2013, Rona et al., 2007, Woodhead et al., 2011). Additionally, two papers examined alcohol use and mental health together (Du Preez et al., 2012, Head et al., 2016). Three papers considered mental and physical health (Fear et al., 2010, Iversen et al., 2007a, Cherry et al., 2001), whereas only one paper looked at behavioural outcomes (MacManus et al., 2012). Finally, one paper considered alcohol, mental health, physical health and behavioural outcomes (Sundin et al., 2014).

Three papers concerned pre-enlistment factors (Iversen et al., 2007a, MacManus et al., 2012, Woodhead et al., 2011), sixteen papers addressed in-service factors (Aguirre et al., 2014, Browne et al., 2008, Du Preez et al., 2012, Fear et al., 2007, Fear et al., 2010, Head et al., 2016, Henderson et al., 2009, Hooper et al., 2008, Hotopf et al., 2006, Iversen et al., 2007b, Iversen et al., 2009, Jones et al., 2006, Rona et al., 2007, Rona et al., 2010, Sundin et al., 2014, Thandi et al., 2015), six papers concerned the post-service period (Woodhead et al., 2011, Iversen et al., 2005a, Hatch et al., 2013, Harvey et al., 2011, Cherry et al., 2001, Buckman et al., 2013) and four studies addressed the issue of accessing healthcare (French et al., 2004, Iversen et al., 2011, Jones et al., 2013, Kiernan et al., 2016).

### *Participant Characteristics*

Participants in 19 papers included military personnel who were in any service (Royal Navy and Royal Marines, Army, Royal Air Force) with any enlistment type (regular or reserve) (Aguirre et al., 2014, Cherry et al., 2001, Du Preez et al., 2012, Fear et al., 2010, French et al., 2004, Harvey et al., 2011, Head et al., 2016, Hooper et al., 2008, Hotopf et al., 2006, Iversen et al., 2005a, Iversen et al., 2007b, Iversen et al., 2009, Iversen et al., 2011, Jones et al., 2006, Jones et al., 2013, MacManus et al., 2012, Rona et al., 2007, Buckman et al., 2013, Woodhead et al., 2011). Six papers included regular personnel only (Browne et al., 2008, Rona et al., 2007, Hatch et al., 2013, Iversen et al., 2007a, Rona et al., 2010, Thandi et al., 2015, Sundin et al., 2014), one considered Royal Naval personnel only (Henderson et al., 2009) and one Army personnel only (Jones et al., 2013).

**Table 3.** Details of papers in review.

<b>Authors</b>	<b>Aim</b>	<b>Participants</b>	<b>Method</b>	<b>Outcome Measure</b>
<b>Aguirre et al. (2014)</b>	To assess the alcohol consumption in the U.K. Armed Forces	325 personnel at routine and discharge medicals	Self-report questionnaires	AUDIT-C
<b>Browne et al. (2008)</b>	To assess occupational factors and deployment experiences associated with heaving drinking in regular U.K. armed Forces personnel deployed to 2003 Iraq war	3578 male, Regular personnel deployed to Iraq (Op TELIC 1)	Cross-sectional postal questionnaires	AUDIT Deployment Experience Questionnaire
<b>Buckman et al. (2013)</b>	To identify characteristics of early service leavers (ESLs) and compare post-discharge mental health of ESLs with other service leavers (non-ESLs)	845 Regular service leavers 80 ESLs. Served and/or deployed during Iraq war (Op TELIC 1)	Self-report questionnaires	Questionnaire on demographics, service information, deployment experience, past and current health and childhood adversity
<b>Cherry et al. (2001)</b>	To assess the health of U.K. Gulf war veterans and to compare their health to that of similar personnel not deployed	11914 serving and ex-serving personnel Served and/or deployed during Gulf war.	Self-report questionnaires	Health questionnaire Deployment experience questionnaire
<b>Du Preez et al. (2012)</b>	To examine the association between unit cohesion and probable PTSD, common mental disorder and alcohol misuse in U.K. Armed Forces personnel deployed to Iraq	4901 male, Regular and Reserve personnel deployed to Iraq on any TELIC operation.	Self-report questionnaires	PCL, GHQ, AUDIT, Questionnaire on military and deployment factors, lifestyle factors and health outcomes
<b>Fear et al. (2007)</b>	To examine patterns of drinking in the U.K. Armed Forces, how they vary according to demographics, and to make comparisons with the general population	8686 Regular personnel (7917 men, 749 women) General population comparison group: Office of National Statistics National Psychiatric Morbidity Survey (March - Sept 2000).	Cross-sectional postal questionnaires	AUDIT
<b>Fear et al. (2010)</b>	To examine the consequences of deployment to Iraq and Afghanistan on the mental health of U.K. Armed Forces from 2003 to 2009, the effect of multiple deployments, and time since return from deployment	9990 personnel (8278 Regular, 1712 Reserve) Served and/or deployed during Iraq war	Self-report questionnaires	GHQ-12, PCL-C, AUDIT Questionnaire on sociodemographics, service history, post service experiences, recent deployment experiences

Authors	Aim	Participants	Method	Outcome Measure
<b>French et al. (2004)</b>	To identify any potential barriers to the effectiveness of a military health screening programme based on the beliefs of British service personnel	73 personnel completed questionnaire and interview. 4496 service personnel completed a validation questionnaire.	Questionnaire, semi-structured interviews	Questionnaire screening for physical and psychological illness Interview schedule to validate screening tool
<b>Harvey et al. (2011)</b>	To examine the post-deployment social functioning of Reservists and to explore the relationship between adverse post-deployment experiences and subsequent mental ill health	4991 personnel (4488 Regular, 503 Reserve) deployed to Iraq or Afghanistan	Questionnaires	GHQ, PCL-C, AUDIT demographics
<b>Hatch et al. (2013)</b>	To examine the differences in levels of social integration and association between social integration and mental health among service leavers and personnel still in service	8264 Regular personnel (6511 serving, 1753 leavers)	Self-report questionnaires	GHQ-12, PCL, Questionnaire on social integration, service history and alcohol misuse
<b>Head et al. (2016)</b>	To determine the prevalence of comorbid probable PTSD and alcohol misuse in a U.K. military cohort study and to determine the level of co-occurrence between these disorders	9984 personnel Served and/or deployed during Iraq and Afghanistan wars	Self-report questionnaires	AUDIT, PCL-C, GHQ-12
<b>Henderson et al. (2009)</b>	To compare alcohol consumption and misuse within the Royal Navy (RN) to that in the civilian population	1333 male RN personnel from operational Naval units	Self-report questionnaires	GHQ, PCL, AUDIT-C
<b>Hooper et al. (2008)</b>	To investigate the association between cigarette and alcohol use and combat exposures	1382 personnel 941 personnel followed up at 3yrs Served and/or deployed personnel	Questionnaire based	Questionnaire on cigarette and alcohol use
<b>Hotopf et al. (2006)</b>	To explore the health of U.K. military personnel who deployed to the 2004 Iraq war	10272 personnel: (8686 Regulars, 1586 Reservists) Served and/or deployed during Iraq war (Op TELIC 1)	Questionnaire based	GHQ-12, PCL-C, AUDIT
<b>Iversen et al. (2005a)</b>	To describe the frequency and associations of common mental disorders and help-seeking behaviours in a representative sample of U.K. veterans at high risk of mental health problems	315 ex-serving personnel (98% Regulars, 2% Reservists) 88% men, 12% women	Cross-sectional telephone survey	GHQ

Authors	Aim	Participants	Method	Outcome Measure
<b>Iversen et al. (2005a)</b>	To describe the frequency and associations of common mental disorders and help-seeking behaviours in a representative sample of U.K. veterans at high risk of mental health problems	315 ex-serving personnel (98% Regulars, 2% Reservists) 88% men, 12% women	Cross-sectional telephone survey	GHQ
<b>Iversen et al. (2007a)</b>	To examine the association between self-reported childhood vulnerability and later health outcomes in a large randomly selected male military cohort	7937 Regular male personnel Served and/or deployed during Iraq war	Questionnaire based	Questionnaires on demographics, service information, deployment experiences, past and current health, childhood adversity.
<b>Iversen et al. (2007b)</b>	To assess factors associated with heavy alcohol consumption in the U.K. Armed Forces	8195 male personnel served in: Gulf, Bosnia, not deployed	Health survey	PTSR, GHQ
<b>Iversen et al. (2009)</b>	To assess the prevalence and risk factors of common mental disorders and PTSD in the U.K. Military during the main fighting period of the Iraq war	821 Regular and Reserve personnel Served and/or deployed during Iraq war (Op TELIC 1)	Questionnaires, telephone survey	GHQ, PCL, PHQ, PC-PTSD
<b>Iversen et al. (2011)</b>	To assess the stigma of mental health problems and other barrier to care in the U.K. Armed Forces	821 Regular and Reserve personnel Served and/or deployed during Iraq war (Op TELIC 1)	Questionnaires, telephone survey	GHQ-12, PHQ, PC-PTSD
<b>Jones et al. (2006)</b>	To assess the prevalence of psychological symptoms during periods of relatively low deployment activity and the factors associated with each psychological health outcome	4500 service personnel (8% females) Served and/or deployed	Survey	GHQ-12, PCL, Questionnaire on alcohol use
<b>Jones et al. (2013)</b>	To explore the role of stigma/barrier to care (BTC) in mental health help-seeking among British Army personnel	484 Army personnel (98.3% Regular, 1.7% Reserves) 95.1% males, 4.9% females Served and/or deployed	Questionnaire based	AUDIT-C, GHQ-12, PC-PTSD, Stigma/BTC scale
<b>Kiernan et al. (2016)</b>	To investigate the perceived barriers to care amongst those planning, commissioning and delivering services for veterans with substance misuse problems	6 planners, commissioners and service providers from public and private sector in North East of England.	Face-to-face semi-structured interviews	Semi-structured interview schedule

Authors	Aim	Participants	Method	Outcome Measure
<b>MacManus et al. (2012)</b>	To examine the association between pre-enlistment anti-social behaviour (ASB) and later behavioural outcomes, in a large randomly selected U.K. military cohort	Regular and Reserve personnel (76.3% still serving) (89.9% males, 10.1% females) Served and/or deployed at start of Iraq war (Op TELIC 1)	Self-report questionnaire	AUDIT, questionnaires on risky driving, attendance at A&E and pre-enlistment anti-social behaviour.
<b>Rona et al. (2007)</b>	To assess changes in psychological symptoms in military women over time, to compare them with men and assess the effect of deployment	5036 participants. (3358 men and 1678 women)	Questionnaire based	GHQ-12, SF-36, PCL-C, PTSD
<b>Rona et al. (2010)</b>	To assess whether alcohol misuse was associated with functional impairment in the U.K. military	8585 Regular personnel	Questionnaire based	AUDIT, PCL-C, GHQ-12, SF-36
<b>Sundin et al. (2014)</b>	To compare the prevalence of PTSD, hazardous alcohol consumption and aggressive behaviour and multiple physical symptoms in US and U.K. personnel deployed to Iraq	1560 US personnel (Adler et al, 2011) 313 U.K. personnel (Fear et al, 2010) All male Deployed to Iraq 2007-2008	Questionnaire based	Combat Experience Scale, PCL, AUDIT-C
<b>Thandi et al. (2015)</b>	To assess alcohol misuse in the U.K. Armed Forces	5239 Regular personnel	Longitudinal Study – self-report questionnaire	AUDIT, GHQ-12, PCL-C, questionnaire on childhood adversity,
<b>Woodhead et al. (2011)</b>	To compare mental health outcomes and treatment seeking among post-national service veterans	257 veterans, 504 age and sex frequency-matched non-veterans.	Cross-sectional survey	AUDIT, TSQ, questionnaires on drug-dependence, self-harm and treatment-seeking behaviour

Note for outcome measures: AUDIT – Alcohol Use Disorder Identification Test, GHQ – General Health Questionnaire, PCL – PTSD Check List, PC-PTSD – Primary Care PTSD scale, PTSD – Post-Traumatic Stress Reaction, SF-36 – Short Form-36, TSQ – Trauma Screening Questionnaire

One paper explored perceptions of problematic drinking within the veteran population through the eyes of health and social care planners, commissioners and service providers (Kiernan et al., 2016).

#### *Outcome Measures*

Ten different standardised outcome measures were used across research papers as well as additional questions including those on demographics, service history, deployment experience, past and current health and social integration.

#### *Themes*

Four themes arose from paper findings: pre-enlistment situational factors, military experience during service, post service alcohol use, and accessing healthcare for alcohol problems.

#### Pre-enlistment Situational Factors

Three papers examined pre-enlistment situational factors associated with poor mental health and alcohol misuse outcomes (Iversen et al., 2007a, Woodhead et al., 2011, MacManus et al., 2012). Findings demonstrate the importance of both childhood adversity and anti-social behaviour as components that increase an individual's vulnerability to later develop alcohol problems (Iversen et al., 2007a, MacManus et al., 2012). Variations in outcomes associated with challenging socio-economic backgrounds was a common underlying theme throughout all three identified papers (Iversen et al., 2007a, Woodhead et al., 2011, MacManus et al., 2012).

Utilising unstandardized questionnaires exploring demographics, military experience and childhood adversity, Iversen et al. (2007a) surveyed 7937 Regular serving male personnel. A range of childhood adversity factors were taken into account including: 'challenging' family relationships, home environment, not being close to family, violence at home, and parental drug/alcohol problems. This study also considered 'externalising behaviours' such as evidence of behavioural disturbance, being expelled/suspended from school, playing truant, and being in trouble with police. Both sets of factors were found to be associated with higher levels of alcohol consumption within the population of regular serving male personnel. Whether or not these personnel had any direct operational experience did not appear to affect the results, and individuals from the lowest socio-economic groups in the country appeared to be the most at risk of problematic in-service alcohol consumption.

Woodhead et al. (2011) provide further support for the influence of childhood adversity upon later alcohol consumption. They conducted a smaller comparative study with 257 military veterans and 504 age and sex matched non-veterans. Male veterans reported more childhood adversity and also had a greater prevalence of severe alcohol misuse (7.6%) than non-

veterans (4.6%). However, this difference was not found to be significant - possibly due to limited statistical power.

Pre-enlistment anti-social behaviour also appeared to contribute to problematic in-service alcohol consumption. MacManus et al. (2012) carried out a study with 10272 serving military personnel to examine potential associations between anti-social behaviour and behavioural outcomes, including alcohol misuse (MacManus et al., 2012). Findings demonstrated that the risks of severe alcohol misuse in military personnel more than doubled for those with a history of pre-enlistment anti-social behaviour and that this association remained evident even after controlling for socio-demographic and military service characteristics. It is noteworthy that no comparison group for the general population was included in the study by MacManus et al.; consequently, it is difficult to surmise as to whether the link between pre-enlistment anti-social behaviour and later alcohol consumption is specific to military populations or socio-economic backgrounds. The prevalence of pre-enlistment anti-social behaviour among military personnel was 34%, with 30.9% of personnel exhibiting severe alcohol misuse and a history of anti-social behaviour.

#### Military Experience During Service

Sixteen of the identified papers examined alcohol use during military service. It is evident that levels of alcohol use have been identified as high, with the majority of papers suggesting that military personnel in the U.K. Armed Forces drink alcohol in excess. Hooper et al. (2008) found that 1382 personnel surveyed reported drinking 14.6 units of alcohol on average per week, this is greater than the suggested 'safe' drinking threshold (NHS, 2015). Additionally, 42.5% of personnel were classified as binge drinkers. When comparing the serving military population to the general population, Fear et al. (2007) identified 67% of male and 49% of female personnel in regular service as hazardous drinkers in comparison to 38% of men and 16% of women in the general population. Problems associated with the consequences of heavy drinking during service have also been considered. For personnel deployed during service, heavy drinking was associated with major problems at home during, and following, deployment (Browne et al., 2008). At the time of discharge, Aguirre et al. (2014) identified that 65% of service personnel engaged in higher risk drinking. Utilising a questionnaire to assess alcohol use during routine and discharge medicals, Aguirre et al. also determined that personnel with more risky drinking habits were more likely to identify as having mental health issues.

Research appears to suggest that of all the services, the British Army have higher levels of drinking than the other branches of the U.K. Armed Forces (Fear et al., 2007). Such variation across the military has been attributed to the different subcultures of drinking that have

developed within individual services. These subcultures are more likely in situations where there is a high level of teamwork resulting in peer pressure and where traditions of the organisation lead to drinking as a means of relaxing and debriefing (Fear et al., 2007, Fillmore, 1990). These latter social conditions appear to prevail within the Infantry divisions in particular. The Royal Navy similarly appears to exhibit relatively high levels of alcohol consumption. To specifically explore this, Henderson et al. (2009) researched 1333 male Royal Navy personnel from operational Naval units. The aim of the research was to determine the extent of alcohol consumption within the Royal Navy and to compare this with an age-matched civilian sample. Henderson et al. (2009) found high levels of hazardous drinking (92%), binge drinking (58%) and problem drinking (15%) within the naval population. Alcohol consumption found in the Royal Navy participants was consistently higher than age-matched civilians, further supporting the idea that those in the military have higher alcohol consumption than the general population. However, the sample may not have been particularly representative of personnel in the Royal Navy in general, as this study only considered those who were on operational ships.



The impact of service characteristics such as active deployment upon subsequent alcohol consumption has also been considered. It is noteworthy that the majority of research on alcohol consumption has concentrated on personnel who served during Gulf War II (GW II) [2003-2008], with and without deployment experience. The most common diagnosis among personnel who served during GW II was alcohol abuse (Iversen et al., 2009). Rona et al. (2007), found alcohol consumption to be greater in those who served during GW II as compared to those who served in Gulf War I (GW I) [1990-91]. It was also found that this difference was accentuated when personnel had also been actively deployed during this time. Although levels of hazardous alcohol consumption remained consistently high across both regular and reserve personnel, Hotopf et al. (2006) asserted that regular personnel were more likely than their reservist counterparts to score highly for hazardous drinking. Once again, differences in alcohol consumption were found to be associated with deployment experience (27% regulars and 18% reservists being actively deployed). Hooper et al. (2008) similarly argued that combat exposure during deployment was significantly associated with increased alcohol consumption. Personnel who feared that they might be killed, and those who experienced hostility from civilians, showed greater increases in alcohol consumption at a



three-year follow up than those who were not deployed. Experiencing hostility from civilians added an average 6.1 units per week to personnel's alcohol consumption on exiting theatre; with each year that passed this reduced by an average of 2.8 units per week. Historically, the armed forces have used alcohol as a coping device as well as a bonding tool (Jones and Fear, 2011), where heavy drinking has been allied with high levels of comradeship and low levels of leadership (Browne et al., 2008) and these factors may account for the trends reported above.

Browne et al. (2008) reported a small, but significant, association between heavy drinking and deployment in Gulf War II. Heavy drinking was also associated with being deployed with a parent unit, medium-to-high theatre unit comradeship and perceived 'poor' unit leadership (Browne et al., 2008). 'Other' factors that appear to be associated with excessive alcohol consumption in the U.K. Armed Forces include: lower rank, being a regular, younger age, male, being single, serving in the Army or Royal Navy, operational deployments (particularly GW II), poor subjective physical and mental health and being a smoker (Fear et al., 2007, Henderson et al., 2009, Jones et al., 2006, Iversen et al., 2007b, Fear et al., 2010). Conversely, perceived interest shown by senior ranks and feeling well informed about what was happening appeared to be associated with lower levels of alcohol misuse (Du Preez et al., 2012). Support and communication during deployment appear to play a role in subsequent alcohol consumption. A distinct difference in alcohol consumption between U.K. and U.S. personnel has been discussed by Sundin et al. (2014), with 52% of U.K. personnel and 17% of U.S. personnel who deployed between 2007 and 2008 in GW II, reporting drinking 10 or more drinks/units on a typical drinking day.

In line with combat exposure, there has been a suggestion that alcohol misuse is often a featured comorbidity with diagnosis of Post-Traumatic Stress Disorder (PTSD) in military personnel. Head et al. (2016) noted 13% of 9984 personnel who served between 2007 and 2009 met the criteria for alcohol misuse. Of those with alcohol misuse, 13.6% also had probable PTSD. Caution should be taken in determining how strong the comorbidity of alcohol



misuse and PTSD is, particularly as this study only found 1.8% of the sample who met the criteria for both. However, two earlier papers denote support for the association between problematic drinking and concurrent PTSD diagnosis. Jones et al. (2006) established that increased alcohol intake was associated with higher scores on probable PTSD scales.

Thandi et al. (2015) also indicated decreases in scores on the Alcohol Use Disorder Identification Test (AUDIT) were associated with remission in psychological distress and probable PTSD. The links between alcohol misuse and PTSD remain under-researched in a U.K. military context. Whilst it is clear that there is evidence of comorbidity, not everyone with alcohol misuse has probable PTSD and vice versa. It may be possible that those with PTSD may 'self-medicate' with alcohol. A Canadian study found 20% of individuals with PTSD used substances such as alcohol in an attempt to relieve their symptoms (Leeies et al., 2010). This study was conducted with a civilian sample and it is plausible to suggest that the prevalence of self-medication with alcohol might increase in a military population given the relationship that U.K. military personnel have with alcohol (as documented above).

### Post Service Alcohol Use

Six studies examined alcohol use post-service and investigated general incidence of veteran alcohol use, incidence of veteran alcohol use compared to other populations, and the influence of military service on continued veteran alcohol use. Incidence of veterans' alcohol use was generally found to be high. Iversen et al. (2005a) examined the incidence of mental health problems among veterans who were considered to be 'vulnerable', and of the mental health issues reported by 315 veterans participating in this telephone survey, 11.8% involved alcohol dependence.

The prevalence of alcohol misuse is reportedly higher for veterans when compared to both the non-military population and serving personnel. For instance, Buckman et al. (2013) found that the prevalence of alcohol misuse was higher among veterans than among the general public regardless of length of service. Hatch et al. (2013) compared the mental health of veterans to people serving in the armed services and found that, after controlling for possible confounding factors, veterans were still more likely to misuse alcohol than serving personnel. These authors also found that the risk of alcohol misuse among veterans was reduced by being in a long-term relationship and by having a social circle consisting of people who were not serving in the military (Hatch et al., 2013).

In addition to the differences between populations, several studies examined the influence of characteristics of military service upon subsequent problematic alcohol use. Cherry et al. (2001) assessed the health of Gulf War I veterans who were actively deployed, compared to those non-deployed personnel. The findings suggest that the alcohol consumption of U.K. GW I veterans was no higher than those of who had not been deployed on active service. Woodhead et al. (2011) considered the possible effects of length of service and found that early services leavers were more likely than other veterans to be heavy drinkers.

### Accessing healthcare for Alcohol Problems

Four studies specifically identified barriers in accessing healthcare for alcohol problems, and all identified (a) stigma related to the use of these services, and (b) the tendency to normalise alcohol use, or at least view patterns of consumption as being 'non-problematic'.

A key insight into the reasons for serving personnel being reluctant to access services, although now quite dated, was examined by a study of randomly selected personnel across the three armed services (French et al., 2004). The data suggested that serving personnel felt as though they could not be entirely truthful when reporting levels of alcohol consumption. Although it should be noted that this is also a well-documented phenomenon amongst civilian populations. Overall, there was a perception that healthcare within the military was of low quality and poorly resourced and a fear that medical consultations would not be kept confidential and that careers might be damaged by seeking help. The perception that the U.K. military's only interest was in meeting physical health needs to ensure combat readiness resulted in a belief that the military had no interest in (for example) problems at home. Finally, a perception appeared to pervade that seeking help was not the 'done thing', and doing so risked incurring stigma. Iversen et al. (2011) concurred with concerns about the quality of healthcare and stigma and asserted that these serve as barriers for ex-service personnel wishing to access mental health services in both the U.S. and the U.K. Their quantitative study collected data from serving personnel, reservists and veterans. The most commonly identified barriers related to stigma, with 73.2% agreeing with the statement '*members of my unit might have less confidence in me*' if they accessed mental health services, 71.3% that '*my unit bosses would treat me differently*', 47.3% that '*it would harm my career*' and 41.0% '*I would be seen as weak by those who are important to me.*' While some of these concerns are specific to serving personnel, veterans were more likely to agree with the statement that '*my bosses would blame me for my problem.*' Access to services was another issue that appeared more significant for veterans than for serving personnel; veterans were more likely to agree with the statements '*I don't know where to get help*' and '*I don't have adequate transport.*'

Jones et al. (2013) note that efforts have been made to reduce the stigma associated with accessing mental health services among the armed services of a number of countries, including the U.K. Their study analysed 484 questionnaire responses completed by garrison-based military personnel. These authors concluded that military personnel do not seek help for concerns about alcohol use as they do not view this as being as significant an issue as other mental health problems. Kiernan et al. (2016), in a study specific to alcohol misuse within the U.K. veteran population, examined barriers to care as perceived by service planners, commissioners and providers. They found that these perceptions echoed the



findings of the above studies in two areas. The first was difficulty in accessing health care on leaving the armed services; one respondent contrasted the difficulty of accessing civilian services with the position in the armed services: *'they used to go to the medical officer every morning and get it sorted out.'* The second similarity with other studies was the view that veterans did not consider heavy alcohol use to be problematic, but rather as a 'normalised' part of service life. Some respondents questioned whether services were culturally appropriate for

people who had been in the armed services, suggesting that lateness, poor organisation and late cancellation of appointments on the part of service providers were the types of factors that could lead veterans to disengage.

#### *Summary of Review Findings*

This systematic narrative literature review provides evidence of alcohol misuse both during and after military service and it is clear that the relationship between military personnel and alcohol use is complex. Several aspects of pre-enlistment situational factors have been linked to subsequent alcohol consumption, particularly high incidences of childhood adversity, a history of anti-social behaviour and low socio-economic backgrounds. Alcohol use both during, and after, military service is high when comparisons are made to the general population. Incidence levels of problematic drinking were further complicated by service length, and characteristics of service. When considering access to healthcare for alcohol problems, there appears to be a relative paucity of studies in this area, and some of the studies reported here only considered alcohol misuse coincidentally as part of a wider consideration of mental health service use. However, triangulation of the findings of a number of researchers strongly suggests that serving and ex-serving personnel tend to view their alcohol misuse as 'unproblematic', often citing this as a reason for not seeking help. Furthermore, veterans were identified as having lower rates of help seeking for alcohol misuse than for other mental health diagnoses.

#### *Limitations and Recommendations for Future Research*

There are various limitations to the research included within this review. Primarily, only a small number of papers looked *specifically* at alcohol use within military and veteran populations. The majority of papers reported here examined alcohol use only as part of a wider

consideration of mental health issues in general. Secondly, it is clear there has been an over-reliance on self-report questionnaires to assess a variety of issues within the Military population. This may be beneficial to ascertain large volumes of data, but it can result in social desirability bias and a tendency by participants to answer questions in a more socially desirable way than may be accurate (Richman et al., 1999). Papers exploring the stigma associated with seeking help for alcohol use (French et al., 2004, Iversen et al., 2011, Jones et al., 2013) should be considered with a similar degree of caution. To attempt to combat this, future research needs to include a focus upon participants' personal experiences to explore more globally why there is a seeming normalisation of excessive alcohol consumption and a reluctance to access and receive treatment for alcohol problems rather than adopting a primary focus upon the severity of their symptoms (Iversen et al., 2011, Burki, 2012, Jones et al., 2013, Venter, 2014). There is a scarcity of qualitative studies in this field and potentially, participation in an (individual) interview setting would be conducive to exploration of participants' understanding of alcohol in serving and ex-serving military personnel. Findings from the studies in this review are also somewhat outdated with most data collected between 2001 and 2009, mainly concentrating on the Gulf War II with some consideration of the impact of service in Afghanistan. Finally, it is apparent that there is a lack of research addressing help-seeking for alcohol problems amongst the U.K. veteran population.

### **1.3 Project Rationale**

U.K. military veterans do not appear to readily engage with alcohol misuse services when needed. A number of recent reports reviewing the mental health of serving and ex-serving personnel have corroborated a gap in this area of research (Burki, 2012, Iversen et al., 2011, Jones et al., 2013, Venter, 2014). Alcohol misuse is a major public health issue and there is a need to gain a more in-depth understanding of the barriers that prevent veterans from accessing and engaging with services to address alcohol misuse. Understanding the underlying reasons for this seeming lack of engagement presents a complex but important area of research. For instance, in order to successfully address these questions, research would need to focus upon veterans' personal meanings ascribed to their alcohol use, veterans' feelings about stigma and personal beliefs about barriers to accessing and receiving treatment (Iversen et al., 2011, Burki, 2012, Jones et al., 2013, Venter, 2014). It has been suggested that veterans often lose trust in mainstream NHS services because of some of their initial experiences with healthcare professionals resulting in them withdrawing from services in the belief that their needs were not understood (Combat Stress, 2011).

Furthermore, in order to comprehensively answer the 'reluctance' question, full consideration of service provision characteristics would also appear apposite and should include (a) service

availability, (b) service organisation, and (c) inter-agency working practices. De Leo et al. (2014) asserted that the availability of effective interventions in primary care for alcohol misuse by veterans remains a significant health need.

Barriers to mental health care have been researched in serving and ex-serving populations, however, research specifically looking at barriers to care for those with alcohol misuse problems has been limited. From research already conducted, it can be inferred that engaging and treating veterans in traditional models of mental health may be difficult for a range of reasons, including the stigma of mental illness and treatment and barriers to care such as navigating complex mental health systems (Macmanus and Wessely, 2013).

This project therefore aimed to explore why veterans appear reluctant to access help for alcohol problems and suggest strategies that will reduce barriers to encourage veterans with difficulties to engage with alcohol services. The project was conducted through a sequential process over four phases, with each phase informing the next. The first three phases aimed to understand why veterans' are seemingly reluctant to access care. The fourth phase, or the feedback phase, aimed to present the findings to planners, commissioners and service providers with input from veterans and service users. Phase Four of the study is the transformational phase and was aimed at evolving and adapting services within the Northumberland Tyne and Wear NHS Trust catchment area in order to provide a more responsive service for veterans. Ideally, this study will provide the basis for an evolved model of care that better supports veterans with substance misuse problems and has the potential to benefit all veterans nationally who are seeking help for substance misuse problems.

*N.B. This project will be specifically looking at alcohol misuse. Referral to substance misuse is as a result of alcohol treatment being a part of substance misuse services.*



## 2. Project Methodology

### 2.1 Aims

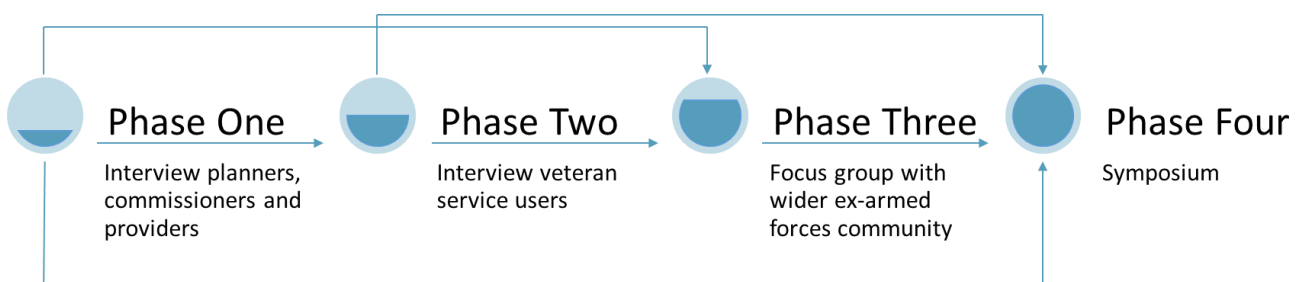
The primary aim of the project was to understand why veterans were reluctant to access help for alcohol problems or engage with alcohol treatment services. The study was conceived as a translational project, with the aim of working with health and social care planners, commissioners and providers to adapt and evolve substance misuse services so that they better fit the need of veterans. At the heart of this project were the service users themselves, who guided the research and were integral in developing the models of care.

A second aim was therefore to collaboratively explore and develop strategies that will reduce barriers and encourage veterans with alcohol problems to engage with alcohol services.

### 2.2 Design

This study used a sequential approach over four phases, with each phase informing the subsequent data collection (see Figure 1). The first three phases aimed to understand why veterans were reluctant to access care. The fourth phase, or the feedback phase, presented the findings to planners, commissioners and service providers with input from veterans and service users. Phase Four of the study was essential in ensuring the findings were presented to the relevant authorities to effect change and impact. The project used semi-structured interviews for Phase One and Phase Two: Phase Three utilised a focus group approach. The first aim of the study was to understand the current service provision followed by a focus on the experiences of veterans that accessed care. Finally, the study examined the wider veterans' community in order to explore and understand the perceived reluctance to access care.

**Figure 1.** Methodological approach.



Phase One aimed to understand the decision making process for substance misuse provision from commissioning to delivery.

Phase Two of the study aimed to understand the complexities veterans experience in accessing alcohol misuse care. An understanding of the UK military veteran culture was particularly important, as due to the social norms associated with alcohol use in the armed

forces, personnel often do not seek help for their drinking, as they typically do not view it as a concern.

Phase Three allowed exploration of the generational differences within the veteran cohort as well as the impact the different experiences of service had on their relationship with alcohol and their views on how those with problems with alcohol should be helped.

Phase Four of the study took the findings of Phase One through to Phase Three and delivered them at a translational event. This event brought veteran service-users together with other research participants so that planners, commissioners and service providers could evolve their current services to ensure that they meet the needs of veterans. A key aspect of this type of event is to examine how current services can be evolved to reduce financial impact and ensure sustainability of change.

### **2.3 Analysis**

The overarching intention of the research was to elicit as much information as possible in order to understand the barriers that apparently discourage veterans from accessing NHS alcohol services. The intention was to use the findings of this study to generate data which could be used to develop a specific veteran's alcohol misuse service model for piloting. This study adopted an applied policy research methodology using Framework Analysis to provide a transparent, trustworthy, transferable dataset, key in Phase One, Phase Two and Phase Three.

To aid in the analysis of textual data NVivo 10 Server software was used. All data were stored on University of Northumbria Newcastle CLC server within the NVivo Server software. NVivo is a qualitative data analysis (QDA) computer software package produced by QSR International. It has been designed for qualitative researchers working with very rich text-based and/or multimedia information, where deep levels of analysis on small or large volumes of data are required. NVivo helps users organise and analyse non-numerical or unstructured data. The software allows users to classify, sort and arrange information; examine relationships in the data; and combine analysis with linking, shaping, searching and modelling. The researcher or analyst can test theories, identify trends and cross-examine information in a multitude of ways using its search engine and query functions. Researchers can make observations in the software and build a body of evidence to support their case or project.

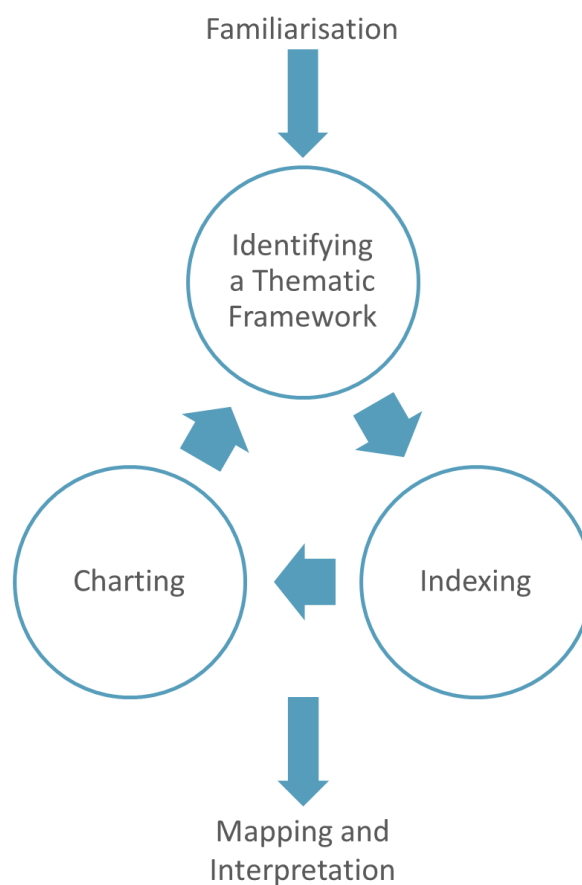
The NVivo project was password protected ensuring that only those within the research team had access to data.



### Framework Analysis (Social Applied Policy Research)

Social applied research concentrates on finding solutions to immediate practical problems (Ritchie and Spencer, 2002), and has a key role to play in providing insight, explanations and theories of social behaviour (Ritchie and Spencer, 2002). Framework Analysis of qualitative data sits at the heart of applied policy research methodology. Framework Analysis has been utilised to help achieve specified aims and outputs as well as to facilitate systematic analysis of data (Ritchie and Spencer, 2002, Ritchie et al., 2013). This method was chosen for its capacity to handle data in a rigorous, transparent and logical process of thematic analysis. The process consists of five phases (see also Figure 2):

**Figure 2.** Framework Analysis in practice.



#### *Familiarisation*

Ritchie and Spencer (Ritchie et al., 2013) identify that when undertaking research where extensive material is available, judgements have to be made as to how data for analysis is to be selected and broken down into a dataset of a manageable size. The initial stage of this method of analysis involves immersion in a pragmatic selection of the data by reading all of the data within the selection (Pope et al., 2000). To achieve this the NVivo software is used

as it is predominately based on the framework approach of thematic analysis. Transcripts are added systematically to begin to catalogue emerging themes. This allows some semblance of order to be brought to the data.

#### *Identifying a Thematic Framework*

The next stage of the process involves taking the familiarised data and identifying the key issues, concepts and themes by which the data can be referenced. This is achieved by returning to the aims and objectives of the study and reflecting on the prior issues as well as the recurring themes in the data (Pope et al., 2000). By the end of this stage the initial data will have been grouped into manageable chunks and a thematic framework established. With the framework established, an index is then added to the data in preparation for passing all data through the indexing process.

#### *Indexing*

'Indexing' refers to the process whereby the thematic framework or index is systematically applied to all the data; it is not a routine exercise as it involves numerous judgments as to the meaning and significance of the data (Ritchie and Spencer, 2002). Qualitative data interpretation is by intention, very subjective. However, by applying a thematic framework or index to all the data the judgements and assumptions of what the data means to the researcher is made transparent for all to see (Ritchie and Spencer, 2002). It is this level of transparent and, potentially, replicable indexing and labelling of all data that adds robustness to this method of data analysis.

#### *Charting and Mapping*

By this stage of the process, the data had been sifted and sorted into its core themes in preparation for summary, interpretation and mapping. Pope et al. (2000) describes the charting stage as re-arranging the data into the appropriate parts of the thematic framework. In reality this was not a distinct process in isolation from any other. As the data was processed the charts appeared to spontaneously grow with the data naturally gravitating into its own charting area. Clear initial chart titles were evident but what was most interesting is that very quickly both sub and supra themes emerged from the initial charts. Summaries are displayed in sets of matrices producing well labelled or indexed data which is sorted in preparation for interpretation. The transparency of the data matrices is a key factor in the rigor and trustworthiness of this method of qualitative data analysis.

#### *Abstraction and Interpretation*

At this stage the researcher draws the main findings from the verbatim material which has been indexed and sorted. These will produce the findings of the study which can be traced back through the index to the verbatim text of a particular respondent or group of respondents.

## **2.4 Ethics & Consent**

This study has full ethical consent from Northumbria University Ethics Committee as well as the NHS. For each phase, participants were given a study information sheet and asked to sign a consent form prior to agreeing to take part in the study.

### 3. Phase One

#### 3.1 Study Aims

The specific aim of this research phase was to investigate the perceived barriers to care amongst those planning, commissioning and delivering services for veterans with substance misuse problems.

#### 3.2 Study Participants

The study population consisted of six respondents - service planners, service commissioners and service providers - who were involved in the provision of substance misuse services and services for veterans in the North East of England. The study included both public and independent sector service providers commissioned to provide substance misuse services.

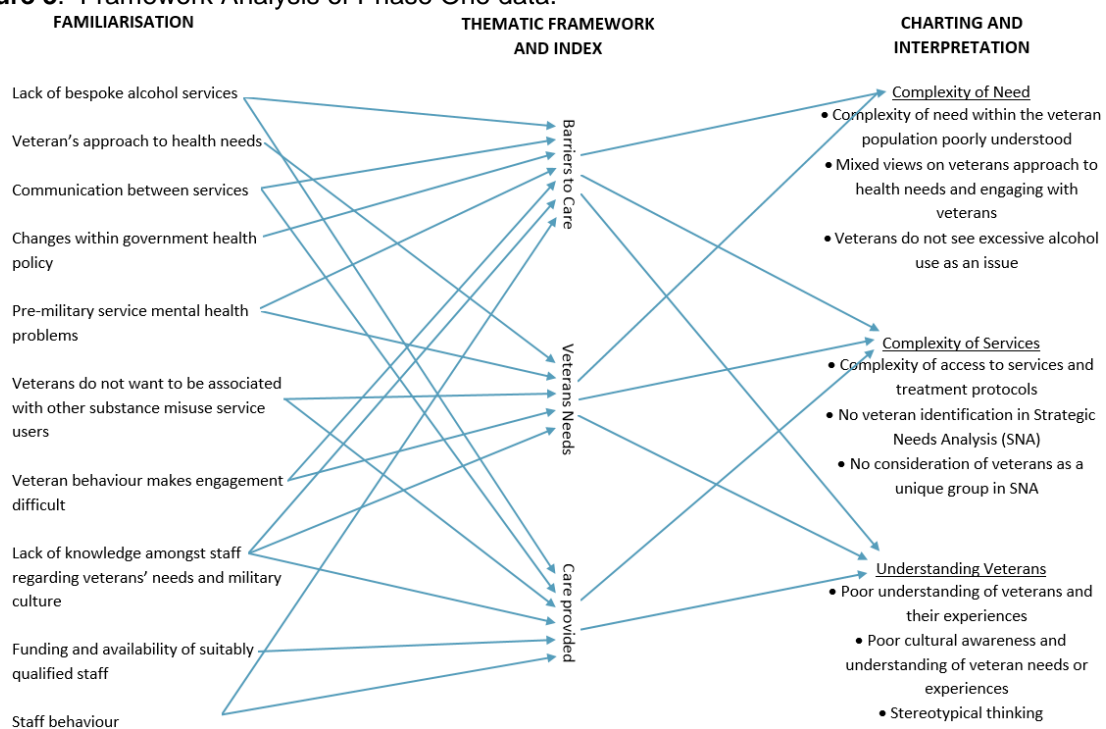
#### 3.3 Data Collection

In-depth semi-structured interviews were conducted to understand the decision making process for substance misuse provision from commissioning to delivery. The specific focus was on the participants' knowledge, beliefs and understanding of the veteran client group (see Appendix A for interview schedule). All of the interviews were recorded, transcribed and then imported into NVivo for Framework Analysis.

#### 3.4 Findings

Following Framework Analysis of the data, researchers identified the following three superordinate themes: Complexity of Needs, Complexity of Services and Understanding Veterans (see Figure 3).

**Figure 3.** Framework Analysis of Phase One data.



### Complexity of Need

The data suggest division over whether veterans are, or should be, identified as a vulnerable group when presenting with substance misuse problems. Planners within the local authority and public sector providers believed that veterans *should* be considered a vulnerable group and have created veteran specific services accordingly. However, public health planners and independent sector providers expressed the opinion that *individual need* should drive care and not *individual status*.

**“.....the treatment agencies work together now to provide one initial screening assessment. So no matter where a person comes and refers to, they're treated in the same way, with the same paperwork, they're asked the same questions. We use a shared diary system and a shared database, so that we can collate all of the new presentations for drug and alcohol referrals ..... it means that there's no wrong door now for people.”**

Respondent 5 Independent Sector Provider

It became apparent that there was a clear division within the data between the public and independent sectors, with the public sector providing veteran-specific services, and the independent sector providing none. What is ambiguous and difficult to determine is whether planners guide or commission any of the service providers to deliver veteran specific services. The data suggest that within the public sector provision the service provided is a local arrangement to meet a specific need, and how that was funded and commissioned remains unclear. What was noteworthy within the public sector provision was that the lead clinician in that service had no input into service commissioning or planning, but provided the most veteran focused service.

What is consistent across the data is the belief that although not all respondents consider veterans a vulnerable group, there is a consensus that they do have complex needs that are a result from military service. The clear observation is that veterans present with a wide range of social, physical and psychological needs caused by or contributing to their substance misuse problems,

**“.....they would be complex. Just really from the experiences that they probably encountered prior to coming in to treatment. And I think from, you know, what I know around veterans that a lot of veterans will have high levels of anxiety or depression or post-traumatic stress disorder, possibly. And, you know, from coming out of a very structured environment when they leave the forces, we know that it can be difficult.”**

Respondent 5 Independent Sector Provider

Public sector respondents felt that one of the key barriers to care was the belief that the veteran does not know how to navigate health systems outside the military.

**“...they don't understand how to access services because they used to go to the medical officer every morning and get it sorted out. And they didn't have to do anything. They didn't have to negotiate services.....in the military you just go and present to your medical officer and... And he says what... Are they fit or not fit ...”**

Respondent 2 Public Sector Provider

This is an interesting and important viewpoint as it implies that forces personnel are conditioned or institutionalised and not only find it difficult to identify their own needs, but also struggle with seeking out help and navigating care pathways. The belief that veterans find it hard to identify their own needs is a clear concern across all respondents, with a general belief that many veterans do not see their excessive alcohol use as an issue, but on the contrary, view excessive alcohol consumption as part of their service life.

**“...they associate their heavy drinking beginning in the army. That it was very much seen as a way of life, and perhaps, kind of, more acceptable..... they've had that culture of heavy drinking....which they associate with being in the army.”**

Respondent 1 Independent Sector Provider

**“....veterans just keep on going and not see themselves as having a problem because that's what they did in the military. So why can't...? Why is it a problem now? You know, but when you look at in the military there were controls and there were gaps in their drinking patterns.”**

Respondent 2 Public Sector Provider

This is a very important observation with regard to understanding why veterans potentially disengage from services. It would appear that veterans that don't believe their excessive drinking is a problem and don't want to be involved in services where they are associated with other substance misuse service users, especially those that use illegal drugs. It would seem that they see themselves as a very different group,

**“...if you've got drug and alcohol services together they might not come because they see who's hanging around outside. And it's a different client group to the group that they are. You know, and these sort of no hopers who haven't done a day's work, and have no respect and no dignity. And they talk like this...”**

Respondent 2 Public Sector Provider

**“.....there's a moral code. An addictive moral code for each substance..... steroid users wouldn't come through the door at the same day as heroin users, because they're not druggies. And that's the perception. And that perception can be taken in to anything, really, can't it?”**

Respondent 6 Independent Sector Provider

### Complexity of Services

The data suggests that recent changes within health and social care delivery have compounded the complexities in navigating service by placing substance misuse services under the auspices of social care rather than within the health sector. Respondents report that there has been a reduction in funding and loss of personnel in substance misuse service planning,

**“We used to actually have a workforce development officer for addictions, only. But we didn't continue that and we...Now that that person is gone, we realise that what we're missing.”**

Respondent 4 Public Sector Planner

It would appear that commissioning cycles and the recent changes have caused a degree of uncertainty and competition between providers, making services even more complex to navigate and competing services reluctant to work together,

**“Every two years you recommission it. And what does that do to the workforce in terms of their stability and what does it do in terms of the general population and knowing what's available. Because it's different provider, different place, ..... in terms of commissioning, it was having a real impact on veterans being able to access the service.....for whatever reasons, providers were going, “Well, we're not going to work with them anymore”.”**

Respondent 1 Independent Sector Provider

**“I think the difficulty comes from the fact that the majority of services, the majority of live services, in any city – [City X] for example – are commissioned services.....the commissioned services can be very protective about their clients, because they need those clients to have a success rate. And they need that success rate to be commissioned again and to pull in more funding and to keep their staff. And that's quite sad. It's the way of the world at the moment.”**

Respondent 6 Independent Sector Provider

This is a significant finding with regard to holistic care provision for veterans. Data suggested identified that veterans typically have difficulties in acknowledging that they have a substance misuse problem, are very poor at seeking help and have difficulties in navigating health and social care services outside of the military. There is a risk that these issues will be compounded if service providers focus on retaining contracts rather than concentrating on implementing a 'shared care' method.

### Understanding Veterans

Although respondents differ on the opinion of whether veterans are a vulnerable group, there is general consensus that they are a client group with unique needs. Respondents from the

public sector were very clear on the need to identify veterans or encourage veterans to let service providers know that they are Armed Forces veterans,

**“I still don’t think people pick out the veterans. They don’t understand what a veteran is, so they don’t know what to pick out. And they’re scared of asking the questions, because they don’t know what to do with the answers.”**

Respondent 2 Public Sector Provider

Respondent 4 not only identifies that services are poor at identifying veterans, but also raises the important conundrum of what staff do when they discover that their client is a veteran. What appears to be clear across the public and independent provision is that frontline staff do not really understand veterans' or the culture of the armed forces that they have come from. The armed forces culture is as alien to care providers as civilian health systems typically are to some veterans. Respondent 2, who was from a veteran specific service, felt that understanding the veteran and armed forces culture was imperative in encouraging veteran engagement in order to maintain contact with services. In particular, they identified that the way staff conduct themselves and approach their work is as important as the care delivered, as veterans find poor punctuality, poor organisation and last minute cancellations of appointments very difficult and potentially a key reason for disengagement from services,

**“We don’t always turn up in time for appointments. You know, appointments get cancelled. You have to be assessed all the time. All those processes, you know. And then they don’t... You know, like we’re saying, you know, shine your shoes, the way you’re dressed and the way you approach them. All those things. The respect—all that. They don’t think we, sort of, respect them in the same way as they feel...All those things can be barriers to them as you come in again. Even if they get into services. So...And then, you know, I mean, I’ve got patients that will come down the night before and check out the building.”**

Respondent 2 Public Sector Provider

Service planners feel that there is a huge amount of work to be undertaken in up-skilling care providers in understanding the armed forces culture and veteran needs as well as having a degree of knowledge of what veteran specific services are available for veterans within the state and third sector,

**“How we address the culture is to make sure we have good information, advice and guidance for people at the very basic level to make sure people understand, one, what services are available in relation to need and not just what services are available. Because I think, if I’m truly honest, I think a lot of frontline professionals don’t know where to refer people to either.....and I think there’s a huge amount of work to do around skilling up the population, both in mental health services and**



.....those more generic universal providers that need to understand more about those conditions and where somebody is at in order to refer appropriately.”

Respondent 4 Public Sector Planner

What was evident within the independent sector was that their services were very needs-focused and until they were contacted by this study they had not really considered how their services met, or whether they needed to meet the needs of veterans,

“Before you came I must admit I was thinking “What can I try and have a look at?” I wasn’t aware of this, but apparently there’s a South Tyneside Armed Forces Forum.....I didn’t realise that there was an armed forces community outreach worker in South Tyneside homes.....I’m not personally really aware of very many... I would have to research it.”

Respondent 6 Independent Sector Provider

### 3.5 Discussion

Complexity of need, complexity of service / care and a lack of understanding of veterans culture were identified as factors that made accessing substance misuse care difficult for veterans. Health and social services can struggle to truly understand the unique needs and experiences of the veteran community.

Veteran’s complex needs were cited as a result of military service, where they present with a wide range of relatively specific social, physical and psychological needs caused by or contributing to their alcohol misuse problem. Previous literature has acknowledged that substance misuse problems are often concurrent to mental and physical health problems and homelessness (e.g. Head et al., 2016, Jones et al., 2014). However, the application of this insight in a healthcare setting has not been previously explored to any notable extent.

Participants argued that a key barrier to care was the belief that veteran’s do not know how to navigate health systems outside the military, suggesting personnel are institutionalised. The ‘veteran as institutionalised’ hypothesis pre-supposes that military veterans fail to engage with services as a consequence of being institutionalised, thus having reduced agency and wherewithal by which to negotiate complex health care systems. Goffman (1961) first delineated the disabling nature of institutional practices within the ‘total’ institution: regulated block treatment, regimentation, and depersonalisation, strictly enforced hierarchical difference and loss of individual identity in favour of the collective. Indeed, it is not difficult to reconcile many, if not all, of these features with military service. The consequences of life confined within such social contexts are, typically, a diminution of agency to the extent that individuals, once ‘de-carcerated’ rather than ‘deinstitutionalised’, can no longer effectively negotiate the contingencies of life. There are, however, other (contradictory) possibilities at play within the ‘veteran as institutionalised’ claim.

A subtle (yet more pernicious) possibility is that the ‘veteran-as institutionalised’ hypothesis provides a convenient shorthand mechanism by which to blame ex-service personnel for their own inability to access effective services (Crawford, 1978). Our data recurrently points to the complexity of mixed economy service provision for military veterans. It is entirely possible that ex-service personnel find services difficult to negotiate precisely because they are. Furthermore, the ‘veteran-as-institutionalised’ construct may comprise a form of self-fulfilling prophecy: the health care professional expects poor engagement and compliance, selectively attends to any evidence of such, and thus confirms their original stereotype. Any actions that ex-servicemen (or women) might subsequently take are subject to exclusive interpretation through an a priori lens of assumption—that they really are ‘institutionalised’. In totality, this mind-set has the potential to effectively divert attention from the poor resourcing and organisation of services themselves.

There was a consensus that frontline healthcare staff do not have an understanding of veterans or of the culture of the armed forces. This lack of understanding was acknowledged as another barrier to care and a reason for veterans’ disengagement from services. Healthcare professionals, and indeed the population at large, might be accused of a lacking adequate knowledge and insights into veterans’ health needs. One possibility is that the roots of such lack of awareness arise from widespread misconception of the demands and experiences of contemporary military service. Castles et al. (2013) coined the term ‘new wars’ in order to characterise recent asymmetrical conflict situations. When the U.K. Government deploys Armed Forces, they inevitably put military personnel in ‘harm’s way’. In terms of new wars, the nature of such ‘harms’ include bearing witness to a variety of attendant atrocities e.g. child soldiers, civilian population expulsion, exemplary violence, torture, and sexual assault. We would contend that the potential for psychological sequelae for military personnel is clear and present. Whilst much has been (rightly) claimed concerning ‘signature’ physical



injuries associated with recent conflicts, it is at least possible that ‘signature’ psychological consequences also exist. What our data reveals is that those commissioning (or in charge of delivering) services rarely raised these matters as topically relevant during the course of the interviews. Even those nominally identified as ‘veterans champions’ on occasions exhibited, in our view, a naivety in relation to the contemporary military experience. This raises the possibility of a substantial gap between the discursive rhetoric of the ‘champion’ role and the realities of service provision.

Military culture is comprised of values, traditions, norms and perceptions that govern how members of the armed forces think, communicate and interact with one another and with civilians. The way in which healthcare professionals present themselves to veterans can be just as important as the care that they provide. For example, poor punctuality, poor organisation and last minute cancellations of appointments, factors identified in Phase One, can put veterans off accessing care. It is unclear as to whether any U.K. literature has also found this, however, a study on the Dutch military ascertained that military personnel were self-confident, punctual and did not like to show their vulnerability or dependence on others (Scheltinga et al., 2005). In order to engage and develop therapeutic relationships with this client group, it is essential for healthcare professionals to understand the 'military mind set' (Coll et al., 2011). Unfortunately, it was clear from the data that healthcare professional, particularly from the independent sector had not considered as to what extent their services met the needs of veterans prior to this study. Furthermore, Algire and Martyn (2013) argue that in order to provide clinically appropriate care for veterans, healthcare providers need to understand the characteristics of today's veteran population and have an awareness of the cultural sensitivities associated with having been a member of the Armed Forces.

### Limitations

It is acknowledged that this was a small scale qualitative study of health service planners, commissioners and providers in the North East of England. Although the sample, in this instance, was purposively selected, the location of all respondents within a single region may give rise to limitations similar to those that are characteristic of snowball sampling techniques, namely an inherent selection bias towards the inclusion of respondents from within the same professional networks and having pre-existing inter-relationships (Atkinson and Flint, 2001).

### Conclusions

Looking at planners, commissioners and service providers' views on why veterans are (seemingly) reluctant to access help for alcohol problems laid the groundwork for this project. Understanding how veterans are viewed and how services are ran from a planning and commissioning perspective aided the understanding of veterans' personal experiences and opinions regarding accessing and engaging in healthcare services for alcohol problems. These findings from Phase One informed Phase Two of the study, helping to identify areas of greatest interest for the semi-structured interviews with service users. It was important to gauge whether or not the experiences planners, commissioners and service providers have of veterans accessing healthcare for alcohol problems corroborated with the actual experience of the veterans.

*N.B. The research undertaken during Phase One of the study has provided the basis for a published peer reviewed paper (Kiernan et al., 2016).*

## **4. Phase Two**

### **4.1 Aims**

The overarching aim of this phase of the study was to understand why U.K. veterans may be different to other substance misuse service users by (1) exploring veterans' relationship with alcohol; (2) exploring why veterans are reluctant to access help for alcohol problems; and (3) understand the complexities veterans may experience when accessing and receiving treatment.

### **4.2 Participants**

In partnership with Northumberland, Tyne and Wear NHS Foundation Trust (NTW), Changing Lives, Northern Learning Trust and Armed Forces and Veterans (Launchpad), 22 ex-forces personnel who were accessing/engaging in alcohol and substance misuse services (or had a history of alcohol/substance misuse) were recruited and interviewed. There were no restrictions on participants' level of engagement with substance misuse services. However, assessments were made as to their suitability to participate in the study due to the sensitive nature of the questions.

#### Recruitment

To ensure a maximum variance sample, the sampling strategy incrementally developed over the participant recruitment period. Initial recruitment from Northumberland, Tyne and Wear NHS Foundation Trust (NTW) resulted in five participants who were accessing local NHS alcohol services. Recruitment of those early on in their treatment meant that many participants preferred telephone interviews over face-to-face, resulting in a two poor quality recordings. As a result, the sampling strategy changed, 12 participants were then recruited through Changing Lives, a third sector charity primarily dealing with homelessness and substance misuse. Participants were often further through their treatment programs and were able to reflect on their experiences in face-to-face interviews with researchers.

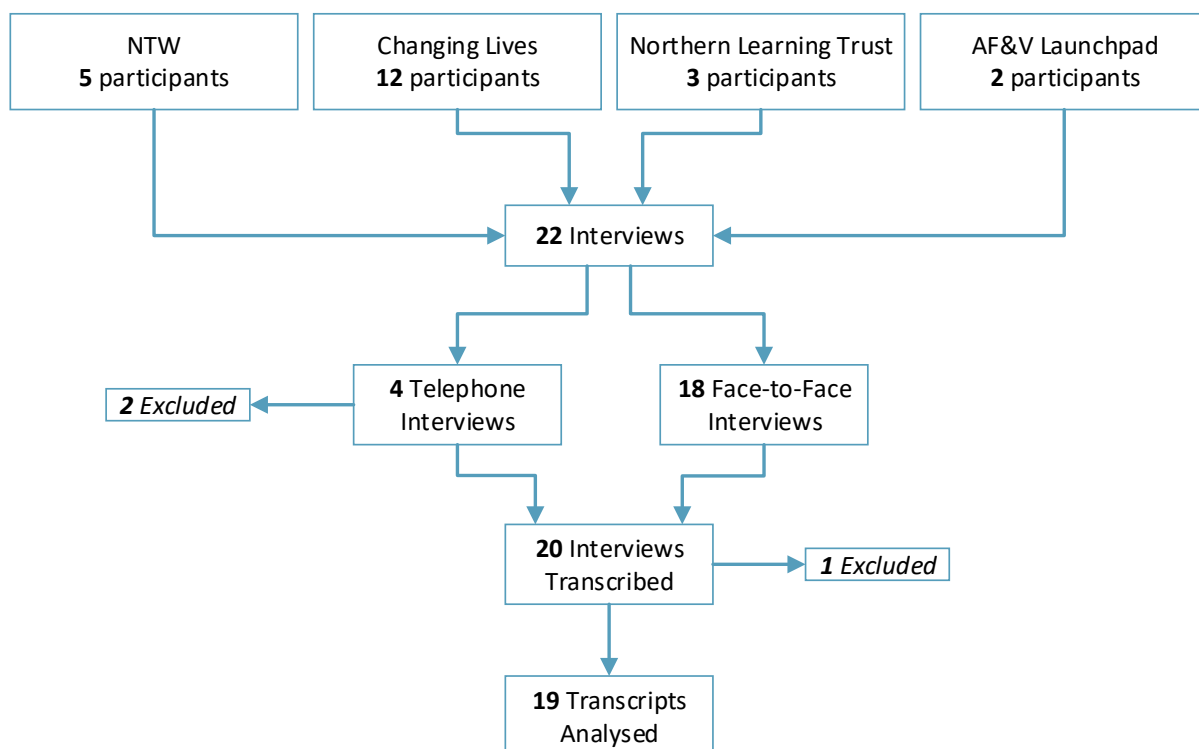
Problems arose in finding younger veterans (i.e. under the age of 40), and as a result, researchers recruited three participants through Northern Learning Trust, another third sector charity primarily dealing with individuals who have been through the Criminal Justice System. These participants were marginally younger in age. Finally a further partnership with Armed Forces and Veterans Launchpad, a veteran's homeless charity was made. Two participants were recruited, and again, were marginally younger than the initial recruited participants.

### **4.3 Data Collection**

In-depth semi-structured interviews were conducted to assess why veterans are reluctant to access help for alcohol problems (see Appendix B for interview schedule). This included both

telephone and face-to-face interviews. For participants who were not comfortable/able to attend a face-to-face interview, telephone interviews were arranged to ensure their stories were captured. However, two telephone interviews were excluded due to the poor quality of recordings obtained. Consequently, twenty interviews were transcribed with a further interview being excluded from analysis due to poor quality of data (see Figure 4 for recruitment). Transcripts were imported into NVivo for Framework Analysis. Data collection was completed during February 2017.

**Figure 4.** Participant recruitment.



## 4.4 Findings

### Demographic Characteristics of Participants

Participant characteristics were identified for the service users whose transcripts were included in the analysis (see Table 1). Participants served in the U.K. Armed Forces between 1967 and 2015 and predominantly had served in the Army. Almost all identified as having severe alcohol misuse.

The sample included those who had been on operational deployments during their time in the military as well as those who had not. Participants with a long military service ( $\geq 15$  years) and/or served post 2000 had typically been operationally deployed on multiple occasions.

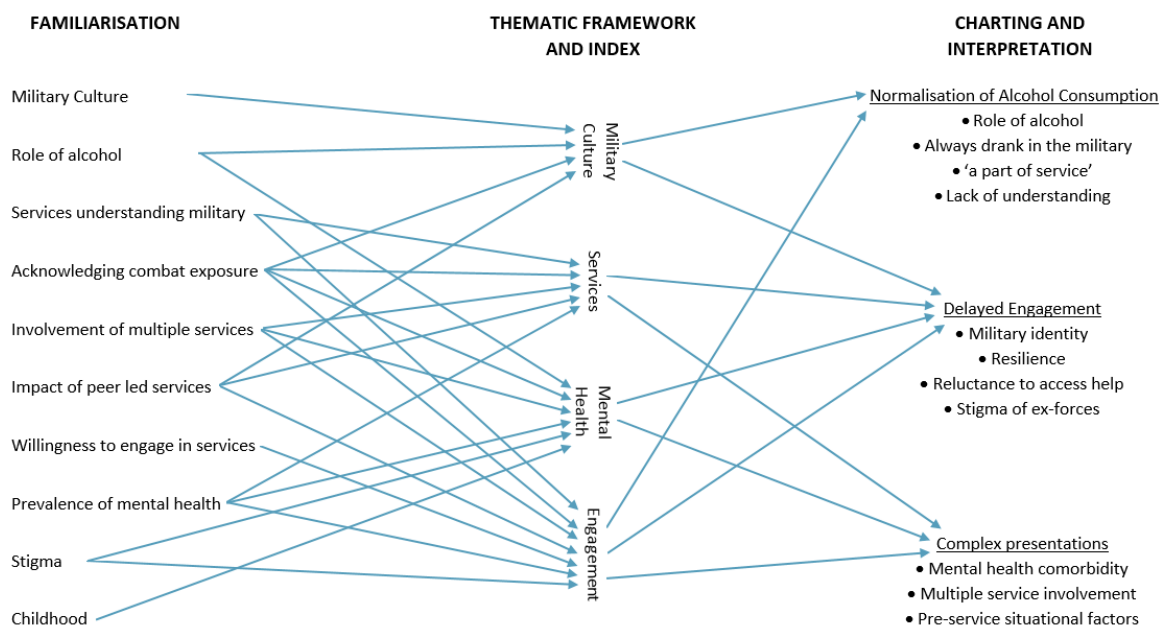
Eight participants had no operational deployments (including one with 24 years' service). Of the 19 participants who were included in the analysis, 18 participants had a history of alcohol misuse and five mentioned drug misuse. All the respondents had multiple failed engagements with health and social care services over a period of time, and the mean length of time for them engaging with a service that was successful in providing effective treatment was 17.37 years from the end of military service.

**Table 1.** Participant characteristics (N=19).

<i>Age at interview (years)</i>	
Mean (SD)	45.05 (7.230)
Range	35-64
<i>Gender</i>	
Male	18
Female	1
<i>Service</i>	
Royal Navy	2
Royal Marines	1
Army	14
Royal Air Force	0
Reserve Forces	2
<i>Age on Enlistment (years)</i>	
Mean (SD)	17.58 (2.364)
Range	15-22
<i>Length of Service (years)</i>	
Mean (SD)	9.30 (7.113)
Range	5 months – 24
Early Leavers ( $\leq 4$ years)	6
<i>Operational Deployments</i>	
Deployed	11
No deployments	8
<i>Years post service to engage in help (years)</i>	
Mean (SD)	17.37 (8.726)
Range	1-30

After applying the Framework Analysis method, 10 themes were identified within the data, which were further conceptualised into 3 superordinate themes: Normalisation of Alcohol Consumption, Delayed Meaningful Engagement and Complex Presentations (see figure 5).

**Figure 5.** Framework Analysis of Phase Two data.



Normalisation of Alcohol Consumption

Alcohol was identified as playing a big part of the military culture that the participants experienced; it was often used as a bonding tool to build trust and camaraderie and featured heavily in the socialisation of personnel. The participants explained how bonding was essential in developing trust between personnel and as a result drinking was encouraged and not often viewed as an ‘issue’.

**“it gets you together and it’s social..... it’s another way of getting us to bond together and to get to trust of each other.”**

Participant 05

**“For alcohol. A lot of the squaddies think it’s normal. Actually I thought it was normal the way I was drinking for a long time. It was normal for the army.”**

Participant 02

Alcohol use in the military was very much accepted and normalised and the behaviour associated with the use of alcohol for socialisation and coping during service often continued after leaving the military. Most participants did not acknowledge that these drinking patterns developed in the military exemplified binge drinking or alcohol misuse. In many cases, even after treatment, service users still did not see their drinking habits in the military as problematic, just a part of their service.

Participants often drew comparisons with civilian counterparts, noting that it was typical behaviour at that age. There appeared to be a difficulty in understanding/accepting that they had an issue with alcohol – or at least a historic problem – due to the normalisation of alcohol consumption within the military. It is this cultural acceptance and normalisation of excessive

alcohol consumption which suggests that the participants' relationship with excessive alcohol intake has been normalised, and contributes significantly to their inability to identify that their alcohol consumption is problematic. Consequently, this may be a contributing reason for difficulties in service engagement as the participants in this study reported their belief that there was nothing abnormal about the amount of alcohol they consumed, or the regularity in which they consumed it.

**“It’s all work hard, play hard. It’s all around that. You hear it all the time and it’s... its norm to you because it’s pumped into you. And it’s not just like oh well we might go down the bar, it was like everybody will be in the bar and you just stay there.”**

Participant 10

What was most significant was that when considering the episode of care which was successful in treating their alcohol use, their primary presentation was not for alcohol problems, but other psychological, social and physical reasons.

#### Delayed Meaningful Engagement with Alcohol Services

The data suggested a number of reasons for delayed engagement with alcohol services. Primarily, it is suggested that the participant's normalised relationship with alcohol prevented the individual from identifying that alcohol was causing the difficulties. Subsequently, they would rarely or never report or discuss their drinking patterns with health or social care services.

Health and social care service providers' lack of understanding of military culture was cited as a key reason for not engaging with care for their alcohol problems, with many of the participants citing their military service as a contributing factor to their alcohol misuse.

**“But that was again I was talking to somebody who had no idea what it was like being in the military so there was no way I was going to talk to them.”**

Participant 02

This lack of understanding was emphasised when the participants reported that when being assessed and discussing their military service, they found themselves having to explain terminology. Health and social care workers not understanding 'military' terminology was a relatively common reason for service users disengaging with services. More importantly, participants seemed to engage well with care workers who were peers, or had a good understanding of their background. One participant in particular, who was receiving care from a third sector provider noted:

**“He was great because he talked... we talked the same language.”**

Participant 19



A lack of understanding of terminology was a barrier to engagement in services as service providers **“just don’t get it”**.

As with many health problems, service users have to be willing to engage in services in order for treatment to be beneficial. The data suggests that accepting that their alcohol consumption was a problem potentially challenged their ‘military identity’. Participants often referred to being trained to be resilient, where needing help was seen as a sign of weakness.

**“It is about being trained not to be weak. You are trained not to go sick.”**

Participant 10

Upon leaving the military, participants continued to ascribe to this identity, suggesting that they remained reluctant to access help for fear of being seen as weak. There was a suggestion in the data that this stigma was not just anticipated, some participants reported prejudice from family members, members of the community and people they knew from military service. The content of this stigma appeared to be concentrated around being ex-forces.

**“Stereotyped the veterans? - Yeah (umm) I see ‘You’ve shot...’ I’ve been shot at, but I’ve never shot at anybody, which I have been shot at in [PLACE].”**

Participant 14

Despite accessing help being seen as a sign of weakness in the Military, if help was needed participants were able to engage with individuals who had shared experience (i.e. military experience).

**“The military would provide all these services...”**

Participant 12

**“The army was supportive then... my unit itself was supportive. Yeah. Because they were... as soon as I got diagnosed”**

Participant 18

Additionally, participants had the support of their colleagues, participant 18 noted support from the Army and their unit after diagnosis. However, without the same support networks and structures participants had within the military, many personnel struggled with the adjustment.

**“After the military because you haven’t got a support network. You’re on your own. You’ve got no structure, you’ve got no support network, you haven’t got people that have been through everything the same as you have.”**

Participant 02

When participants accessed services, they did not always feel they received the care they needed, consequently disengaging. This prior experience with health and social care services impacted on participants' willingness to engage in services in the future.

**“The GPs waste of space. I mean you go in a lot of surgeries now they just basically file you on a piece of paper...’ like may need sleeping tablets ‘because we won’t provide them, blah, blah, blah’. Alright I’ll just hit the bottle. That’s my sleeping tablet.”**

Participant 12

Meaningful engagement in alcohol services were attributed to acceptance of needing help and accessing peer supported services where the service provider understood the participants personal experiences (see ‘Complex Presentations’ below). Almost all participants were referred for alcohol treatment through other services for other problems such as social housing, unemployment and mental health, thus further delaying access to alcohol services and subsequent engagement.

### Complex Presentations

The data suggests that as a consequence of the participants' normalised relationship with alcohol, which contributes to a delayed presentation, the participants invariably presented with complex, multiple morbidity and not just an alcohol problem in isolation.

**“When I got out (umm) when I got out of the military (umm) obviously I had to get my own GP and I was still suffering from (umm) anxiety, depression, paranoia, this, that and the other.”**

Participant 03

Many participants were experiencing other mental illness, physical illness, social housing problems and unemployment. Often it was not until crisis point that the participants engaged with meaningful services which addressed their problems. As previously reported, what was most significant was that help was rarely achieved through the veteran actively seeking help for their alcohol problem. It was quite often through other services, such as mental health, homelessness etc. that the participants gained access to treatment for their alcohol problems.

The data suggests that participants' typically presented as more challenging to service providers, often resulting in the engagement of multiple services. For some, the involvement of multiple services was beneficial, but the majority referred to confusion for both themselves and the service providers. Involvement of service charities was largely seen as the most beneficial, and were cited as the organisations providing the greatest support. There was a suggestion that service charities provided the most consistent support and helped in the communication with multiple services across sectors, ensuring participants received the right care.

**“No there isn’t and it never did seem connected. It was a lot more connected this time. (umm) But I think that was primarily down to [CHARITY] pushing rather than the NHS side of it.”**

Participant 02

There was a suggestion of a heavy reliance on service charities to provide support and care where, arguably, front-line services should have been providing it.

The data suggested that participants who had meaningful engagement were often accessing peer-led services. Peer-led services were those where the provider was linked to or had experience of the military. For some, it was suggested that more involvement from ex-service personnel (or peer-led services) in service provider roles would be highly beneficial, making the services more accessible and easier for the veteran to engage with. The knowledge that services employ someone with knowledge and insight into military life appeared to increase rapport with the service user and helped ‘breakdown barriers’, and the use of peers also ensured sensitivity to military culture and terminology. When this was not the case, the participants reported being reluctant to explain or report their service experiences and often decided they couldn’t be helped, as the provider ‘did not understand’. It is possible that just having someone who has been through similar experiences providing care could be beneficial, as a veteran who has previously had an alcohol issue may relate better to the experiences of a veteran currently experiencing difficulties:

**“I can’t open up the same to a civilian.... my support worker is a veteran. And this [CHARITY] is run by veterans..... for me I can relate to them and they can relate to me. And you have an instant bond and there’s a trust because you’ve all been through the same thing. Not necessarily the same trauma, but because you’ve been soldiers or you’ve been whatever... whatever service you’ve been in. So you have this... have this common bond so it’s easier to open up and trust and listen than it is with a civilian. Which is something maybe the civilians don’t understand.”**

Participant 05

In addition to citing military service as underlying their alcohol consumption, many participants also noted exposure to alcohol from a young age. Parents with established alcohol problems were fairly common amongst this sample. (It is important to note that this was not the case for all participants).

**“I started drinking very young, very young... I was arrested for drunk and disorderly at thirteen. So I grew up around alcohol and my parents were alcoholics ... alcohol was very prevalent in my life from an early age”**

Participant 06

**“It was always around the house and stuff with my parents and stuff like that, they always drank predominantly on a weekend. I knew my mother drank as well slyly during the day, you know there used to be a joke about it within the family group. So I’d always had alcohol around,”**

Participant 11

**“I would say about... maybe seven year old. I would say a seven year old really, yeah, my mum was a drinker, she was an alcoholic”**

Participant 13

This exposure to alcohol appeared to contribute to the normalisation of alcohol, making it more difficult to acknowledge their own excessive alcohol consumption and subsequently accept help. Joining the military was viewed as an opportunity and in some cases (again not all) an escape route.

**“Well I joined the infantry when I like was leaving school because like at the time there was no job prospects in [area they lived]”**

**“I joined the army, new beginning, new everything”**

Participant 12

There was a suggestion in the data that pre-enlistment factors such as alcohol exposure at a young age and using the military to escape environments, made it more difficult to engage the participants in meaningful treatment due to the complexity of their normalisation of alcohol consumption. Despite using the military as a means to escape, on discharge participants frequently returned to the same locations, often where earlier problems still existed (e.g. unemployment). These situations appeared to exacerbate the prevalence of complex presentations upon meaningful engagement.

#### **4.5 Discussion**

Phase Two has identified three main findings that, in turn, presents a conceptual understanding of why veterans with alcohol problems are potentially different to substance misuse service users from the wider population. A normalised relationship with alcohol, which stems from the culture of military service, appears to delay meaningful engagement with alcohol/substance misuse services. The lack of insight to the role alcohol plays in their lives, and the delay in engagement, results in multiple morbidity and complex presentation. The data suggests that the participants’ alcohol misuse has an impact on all aspects of their life and their families’ lives (including physical, psychological, social and financial aspects). As a result, when a veteran does access health provisions for alcohol problems, they have a complex presentation which spans both health and social care.

From the data, it is clear that the participants’ relationship with excessive alcohol consumption is normalised, to the extent of possibly forming part of their identity. In the military, alcohol

has been used as a social bonding tool and encouraged as a way of coping (Jones and Fear, 2011). It is therefore argued that the military culture experienced by this study's participants conditioned them to be resilient, avoid help seeking behaviour, view injury and illness as a weakness and encouraged alcohol use as a coping mechanism. When we reflect upon these beliefs, it is easy to see why the participants from this study not only viewed their alcohol consumption as acceptable and 'normal', but were also, potentially, very proud of the extent to which they could drink. The pride around the capacity to drink appeared to be formed on the belief that as long as they were fit for exercise and work the next morning, their drinking was clearly not an issue. A term used by many of the participants was 'we worked hard, and we played hard'. The effect that this appeared to have was, that any suggestion that their alcohol consumption was hazardous, harmful or problematic challenged their perception of their own identity. More importantly, accepting that their alcohol consumption was an issue which they needed to address, was potentially a sign of weakness in their own eyes and went against everything that they believed. Most notable from the data was that when all the participants eventually accessed definitive care that actually addressed their problems, their primary presentation to access care was not for alcohol use. In most cases it was for mental health issues and/or social problems such as homelessness.

Similar results were obtained by Jones et al. (2013) where only a quarter of military personnel who were deemed harmful drinkers actually sought help. It was surmised that participants did not see their alcohol consumption as concerning. This normalisation of alcohol consumption is problematic for accessing help. From a therapeutic standpoint, in the Cycle of Change (Prochaska and DiClemente, 1986), veteran participants often appeared to be at the pre-contemplation stage. At this stage, veterans tended to be unaware that a problem exists, meaning there is no intention to change their behaviour or to access help for their alcohol misuse. This stage may be exacerbated by the normalisation of alcohol in the military. Veterans were unable to progress through the cycle to engage in help until there is an acceptance of an alcohol problem. Unfortunately, it is suggested that in comparison to those further along in the cycle, they will process less information about alcohol, spend less time evaluating their drinking and experience fewer emotional reactions to the negative aspects of drinking (i.e. family problems, physical health, mental health, social issues etc.), further delaying any engagement in substance misuse services. An initial acknowledgment of an alcohol problem is



necessary and as this delay in engagement progresses, other aspects of the veteran's life become affected, for example finance, unemployment, homelessness and isolation.

A delay in meaningful engagement with substance misuse services was common among the service users interviewed. Meaningful engagement in healthcare services was on average 17.37 years post military service. A belief that civilian healthcare professionals did not understand veterans or have the ability to help was prominent. Participants noted a lack of understanding of military culture and the role alcohol plays in military service, they found themselves having to explain terminology. In many cases this lack of understanding of terminology was associated with the service providers' inability to help, increasing the participants' reluctance to engage in services meaningfully. There was a break of trust and respect with alcohol misuse services, becoming an unsuitable environment for the participants to come to terms with their alcohol problem. Previous bad experiences with alcohol misuse services meant participants were more reluctant engage in the future. Combat Stress (2011) also suggested that veterans often lose trust in mainstream NHS services because of initial experiences with healthcare professionals, resulting in them withdrawing from services in the belief that their needs were not understood.

Participants have to be willing to engage in alcohol misuse services and this willingness was thought to increase when interacting with service providers who were peers and/or had a good understanding of what it meant to be a part of the military. However, accepting an alcohol problem challenged participants' military identity as it was seen as a sign of weakness. For some participants, it was not just anticipated stigma that caused a delay - some reported enacted prejudice around being ex-forces - with one participant recalling being asked if he had ever shot anyone. Previous research on serving personnel also found a fear of anticipated stigma as a barrier to care (French et al., 2004, Iversen et al., 2011). Iversen et al. (2011), when studying mental health stigma in the British Armed Forces, noted the perceived stigma which serving personnel believed, with 73% believing that "*my bosses would treat me differently*" and 46.5% concerned "*I would be seen as weak by those who are important to me*". Data from this study has identified these same beliefs in the participants and suggests that stigma is a contributing factor to a delay in meaningful engagement in substance misuse services.

A delay in engagement impacted on many other aspects of the participants' lives and not acknowledging an alcohol problem meant that the route to alcohol misuse services was varied for across the study participants. There is a consensus that veterans presented with a wide range of social, physical and sociological needs caused by or contributing to their alcohol problems (Kiernan et al., 2016, Fear et al., 2010, Aguirre et al., 2014). Almost all participants

in this study were experiencing mental health problems, physical illness, social housing problems and unemployment. Most of the participants were accessing third sector charities, primarily dealing with homelessness, unemployment and ex-offenders. Typically, it was not until they accessed these organisations that their alcohol problems were identified and addressed.

Unfortunately, the complex presentations do not appear to be matched by the U.K.'s current organisation or level of healthcare provision. Substance misuse services now sit within public health and social care, with a budget (which is not ring-fenced) being managed by local government. In reality, the data from this study would suggest that substance misuse care runs in parallel and separate to any other health provision, making integrated health and social care for this group of service users very difficult. In the U.K., substance misuse services, appear to prioritise people using illicit drugs, specifically those using crack cocaine and/or heroin, and are not currently set up for alcohol misuse, certainly not to the extent seen in veterans (Roberts and Bell, 2013). As a result, there appears to be a greater reliance on the third sector for providing support and services for veterans with alcohol misuse. Findings in the current study suggest that charity involvement is welcome, particularly when these are affiliated with military organisations, to bridge the gap in support for alcohol problems in primary and secondary care. However, this often means multiple agencies are involved, creating confusion and lack of continuity when veterans do engage in services. Further, this also appears to then encourage the creation of more expensive parallel services, which often rely on short term funding and are hard to sustain. These services are in addition to the statutory health and social care provision and are generally run at a local level. The multitude of seemingly uncoordinated service provision appears to add to the confusion that the participants experienced when accessing care.

### Limitations

An early limitation was identified in participant recruitment, in that within commissioned statutory provision and the NHS we were only finding older veterans. To achieve the maximum variance sample target for this study the sampling strategy was changed and the remaining participants were recruited through partnerships with third sector charities. It is noteworthy that all respondents interviewed in this phase of the study were ex-servicemen. UK women military veterans have recently become more vocal in asserting that women veterans should be acknowledged alongside their male counterparts (Dodds, 2016). Whilst it is claimed that men appear to have greater levels of alcohol consumption than women (Rona et al. 2007), the absence of female military veterans from this study and other research in this area remains a significant limitation.

### Conclusions

The findings of Phase Two clearly identify that veterans with substance misuse problems (alcohol) do have unique difficulties that set them apart from other substance misuse service users within the general population. They have a normalised relationship with alcohol which contributes to a delayed engagement with care. The delayed engagement in accessing care leads to complex presentations where all aspects of the veteran's lives (physical, psychological and social) are impacted. The main barriers to care appear to be a lack of understanding of this unique group of service users, and the confused, duplicated plethora of services available. Complex care pathways and the lack of integrated health and social care would appear to contribute to veterans disengaging with care. What is very notable is that greater success in engaging veterans with substance misuse services was achieved when the service providers had veteran peer support workers as part of their service provision.



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## 5. Phase Three

### 5.1 Aims

To further understand the findings from Phase One and Phase Two, Phase Three aimed to: (1) explore why U.K. veterans may view themselves as different to substance misuse service users within the general population; (2) understand why veterans would be reluctant to access help for alcohol problems; (3) understand how attitudes to alcohol may have changed over generations; and (4) potentially explore how those with alcohol problems should be helped.

### 5.2 Participants

Nine ex-forces personnel from the wider veteran community volunteered to participate in a focus group. Only veterans who were not current substance misuse service users or did not have a history of alcohol/substance misuse were recruited to participate. The inclusion criteria were very broad and included a wide-range of experience and rank across the U.K. Armed Forces (Royal Navy, Army and Royal Air Force).

### 5.3 Data Collection

A semi-structured focus group was conducted to meet the aims of this phase (see Appendix C for schedule). The focus group was held at the premises of a Third Sector organisation during February 2017. The session was audio-recorded, transcribed and imported into NVivo for Framework Analysis.

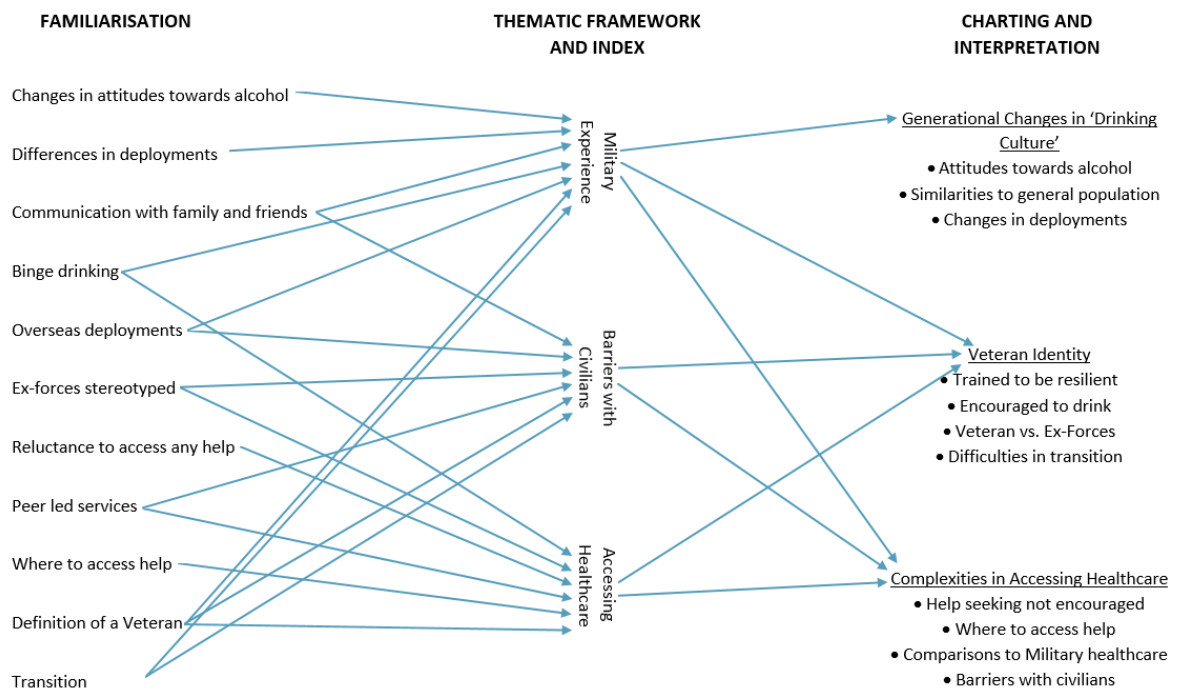
### 5.4 Findings

#### Characteristics of Participants

All participants had served in the U.K. Armed forces for between 8 and 42 years (mean = 26.11, SD = 11.900). All services in the U.K. Armed Forces were represented, where 1 participant served in the Royal Navy, 5 participants served in the Army, 2 served in the Royal Air Force and 1 participant was a reservist. All participants were male with ranks on discharge ranging from Private to Lieutenant Colonel. Participants with a non-commissioned rank on discharge will be referred to as 'Other Rank' and those with a commissioned rank as 'Officer'.

Framework Analysis was conducted on the data from the focus group, 11 themes were identified and further developed into three superordinate themes: Generational Changes in 'Drinking Culture', Veteran Identity and Complexities in Accessing Healthcare (see Figure 6).

**Figure 6.** Framework Analysis of Phase Three data.



**Generational Changes in ‘Drinking Culture’**

Excessive alcohol consumption in military personnel was suggested to be a problem of the past. Participants indicated that those who served in the 1970s to early 2000s had greater problems with alcohol due to longer postings, isolation from family and friends and a normalisation of alcohol consumption. In this earlier period, data showed lengthy postings, far away from home often meaning personnel did not see their families and civilian friends for long periods of time. As a result, military personnel spent most of their time together, often confined to barracks with multiple personnel in one room. Socialisation around alcohol was encouraged and due to isolation from family, one participant noted:

**“If you’ve got nothing to look forward to, the easy way is just to drown your sorrows”**

Former Army Officer

For participants, long, overseas postings were much more common than they are observed to be now. Postings to Germany and Cyprus were the most discussed in the focus group. In these overseas locations, alcohol was not only cheap, but the focus for many personnel;

**“Paid today, hated it so much tried to get rid of it all! Had to drink as much as the others did. Fine, but yeah that was it and the postings.... It was so cheap, you know it was rude not to”**

Former Army Other Rank

Postings are now perceived to be shorter, and often closer to home, meaning weekends are spent at home with civilian families. It was suggested that the current generation of service

personnel will not drink through the week in order to save money, meaning when they return home on the weekend they can go out with their civilian friends. A potential increase in binge-drinking was discussed. However, it was determined that this type of alcohol consumption was not restricted to military populations and in fact may reflect the social demographic from which service personnel may be drawn from.

**“You’ve now got units based in areas where soldiers can get home at the weekend. You know it’s only a train journey away. It’s not a two, three hundred, four hundred miles away. So they’ve got lots of friends now where they go home to every weekend.... in the eighties and nineties you did everything together because you were always together”**

Former Army Officer

**“The actual patterns of drinking that we’re seeing in the military is more or less reflecting what we’re seeing outside of the military”**

Former Army Officer

A clear consensus across the veteran cohort, regardless of rank, was that alcohol played a major role in the lives of military personnel serving in the 1970s to early 2000s. A perceived change in attitudes to alcohol for those currently serving in the U.K. armed forces was clear, with suggestions that the military are now working towards a zero-tolerance alcohol policy and are actively advocating alcohol awareness.

**“Trying to get that zero tolerance. And when we read the policy in regards to alcohol, we’re going down the same route”**

Former Army Officer

### Veteran Identity

The participants felt very strongly that help seeking was not encouraged in the military, and that any form of illness or injury was perceived as weakness or malingering. Participants reported being looked down on by peers if they were ill and would be seen as a malingerer. This belief around help seeking appears to have remained with most of the participants, even after leaving the services:

**“If you went sick in the army and it was for a minor thing you were classed as a malingerer and that just went through the whole of the British Army, you could turn up ‘My legs fell off’ ‘You’re going sick because your legs fell off?’ So when you transition out of the army, if you’ve got a... say problems with an alcohol problem, you won’t go anywhere near a medical centre because they’d just turn around and it’s engrained in that... you just... perceptions changing now, but certainly for me if I was going to go... I wouldn’t go and see a doctor, I’d just head off to get painkillers”**

Former Army Other Rank

**“If you’re self-sufficient you don’t ask for help because you’ve got to be self-sufficient, you don’t want to be a burden”**

Former Naval Officer

The participants reported that personnel are trained to be resilient and transcripts identified that talking about issues, whether that be physical or mental goes against this training.

There was a suggestion that an encouragement to drink in the military was not just as a result of peer pressure. For some, drinking alcohol was almost a part of their training, alcohol became a part of being in the military. Across ranks, veterans acknowledged this:

**“I was seventeen and my first station I went to when I was trained; the first thing they did was went out and got me drunk. That was the first thing they did and it carried on from there”**

Former RAF Other Rank

**“You know you just... peer pressure is there, you know that one person turns round to another who turns round to another... yeah and suddenly you know you’re knocking on each other’s doors saying ‘Right ten minutes, come on we’re going!’ you know and you’re off”**

Former Army Officer

**“The sergeants and officers messes, you go to... once a month you’re expected to turn up and you have gin and tonic to start off with, then you go and have white wine and you have red wine, then you have port and you have liquors and then the drinking starts afterwards. You know when you go to the bar. So that does not encourage matters at all, it’s just binge drinking on a regular basis. So I think from that point of view, the forces almost encourage binge drinking among it’s certainly its senior member”**

Former Army Other Rank

Participants discussed their difficult transition period, and the impact that this had on the development of their post-service life. It was clear that for these participants that their relationship with alcohol did not change when they entered civilian life. Excessive consumption at social gatherings was still thought of as normal, and there was very little evidence of what would be perceived as an alcohol problem, or an ability to recognise if someone was drinking too much. As identified in Phase Two, there appeared to be the suggestion of a normalised relationship with alcohol across the military. As a result, having the identity of a hard drinker, who could drink large amounts, was seen as a positive identity amongst peers. It was suggested that this relationship with alcohol, and being identified as a hard drinker, often remained upon discharge, as personnel developed a veteran identity which incorporates their former service identity. At the centre of this identity appears to be the comradeship and the

social life that they have always enjoyed. Therefore, most veteran organisations gather around social events, where (usually) large quantities of alcohol are consumed. Participants acknowledged that this transition period to civilian life can be challenging and for many, very difficult. Using alcohol to cope during this period may not be uncommon. But, it is the normalisation of this behaviour that can be problematic as this may exacerbate the time in which it takes for the veteran to determine they are drinking excessively.

**“I found it quite difficult when I came out... because I volunteered to come out so it was my own fault and I must admit for the six months I wondered what the hell I’d done”**

Former RAF Officer

**“Yes some find it a lot easier to transit from army life or forces life to civilian life, some of us don’t. I found it a bit of a struggle”**

Former Army Other Rank

**“if you have a hard time one way of getting rid of it is to go and have a few beers. It’s the same probably with these veterans, they’ve fallen on hard times, what do they have? They can drown their sorrows... one shouldn’t underestimate what the transition is like though. Everybody here has left and been moderately successful or very successful. But the fact is it’s an extremely difficult time”**

Former Army Officer

In further exploring why veterans may be reluctant to access help, there was a consensus that they did not identify with the term ‘veteran’ and did not want to be called this. Consequently, participants discussed how they would define a veteran, associating it with longevity of service and a particular conflict. Ex-forces/ex-services/service leaver were noted as preferred terms to describe their own identity.

**“I don’t think I should be called veteran. You know I’d rather be ex-servicemen. That’s what I’d like to be”**

Former Army Officer

**“I certainly used to look at the old and bald as the veterans! The guys what go walking down the cenotaph for... and that’s what I saw as a veteran. I wouldn’t have classed myself”**

Former RAF Other Rank

**“If people don’t see themselves as veterans then they don’t engage because it’s the terms used”**

Former Navy Officer

There was a consensus that if professionals used the term veteran, they would be even more reluctant to access help. Many participants noted that they would not disclose their status if

they were asked if they were a veteran in a healthcare setting. At the same time veterans appear to struggle in the adjustment to being a civilian. This can be a barrier to them accessing healthcare as the military characteristics such as self-reliance, seeing illness as a weakness and resilience remain.

**“If they continue, even ten, fifteen years beyond their service, to continue not to see themselves as civilians it is a huge barrier to them advancing and moving on and moving from one place to perhaps a better place. It’s... and I think we see it reasonably commonly amongst our veterans”**

Former RAF Other Rank

The importance of identifying what is classed as a service leaver was also identified, as some thought that one-day service did not constitute enough experience of being in the military. However, it was acknowledged that there is a responsibility to look after these individuals as early service leavers can be the most vulnerable.

**“If you were in Civvy Street and you were in a company you know training to be a mechanic and after three days you left. You wouldn’t be called a mechanic, would you?... So why should you be called a soldier?”**

Former Army Officer

**“People who join you know on January the 1st and you know after a year’s training yeah don’t make it out of training, yeah. They haven’t... for me they haven’t experienced what operational life is all about”**

Former Army Officer

### Complexities in Accessing Healthcare

A reluctance to access help was not restricted to just alcohol problems and participants agreed that they would be reluctant to access help for any problems. Nevertheless, when the time arose where participants needed to access help, there was agreement that no one was clear on where to go for this, especially for an alcohol problem. Furthermore one participant, a former RAF officer who worked as a practice manager in the NHS after leaving the military, did not know where to go if they had a problem with alcohol:

**“Where to go for help apart from my GP.... if I went to my GP am I going to the right place? I don’t really know and I worked for the NHS”**

Former RAF Officer

When veterans do access/engage with healthcare, it appears they make constant comparisons to military healthcare. If there was a requirement for healthcare in the military, it was noted as quick and effective. Once they have left the military, the way in which they access care and the type of care they receive changes dramatically;

“The biggest issue is actually accessing your GP, you know actually getting an appointment. Yeah you know whereas in the military, yeah, as everyone said, yeah you go sick at seven o’clock in the morning, yeah you go there and you get your appointment and see your MO, yeah you come out with a diagnosis or whatever. Yeah. I have to ring my GP and I’ll be lucky if I get an appointment to see a GP within two to three weeks”

Former RAF Other Rank

“The bottom line is that the quality of service you get in the National Health Service is poor in relation to what you got when you were in the military..... the fact is that you are looked after for your health in the military whereas it’s questionable whether you are as a civilian”

Former Army Officer

It was suggested that the NHS “**treat you like just another number**” and like everyone else and do not provides a bespoke service or give individual attention. This is a vast change from the care they are used to in the military and using the NHS for the first time may result in a bad experience.

Treatment provided by third sector charities associated with the armed forces appeared to be welcomed by many veterans accessing healthcare. Meaningful engagement in such services was suggested to work because the veterans feel valued, time is more flexible, they can build relationships with staff and the focus is on their recovery. Initially, there was a suggestion that veterans may only engage in services where there are other veterans providing them, however, a former Army officer who currently works in the third sector noted:

“None of our psych and wellbeing team have had a military background at all, but is it the fact that they are sitting within an established model like [CHARITY FACILITY]? Perhaps under a trusted brand like [FORCES CHARITY] is actually... is the difference, not whether you have served or not, whether you are dealing with veterans”

Former Army Officer

It was evident that, whether the treatment provider has a military background or experience may not matter. When accessing healthcare, participants’ willingness to engage appears to be affected by the civilian status of the provider. A civilian working in an organisation that is affiliated with the military appears to have the same effect as a worker who has a military background. A reluctance to engage increases when the civilian is a part of a civilian organisation with no connections to or awareness of the military. Therefore, a provider with a purpose to support ex-military, a statutory service that has ex-military personnel, or a provider

that is familiar with the needs of veterans is potentially sufficient to get initial engagement (e.g. service related charities).

Barriers between civilians and the participants were clear and may help explain a reluctance to engage in civilian healthcare. Among participants, there was a consensus that **'Civvies don't understand us'**, often making it difficult to transition to civilian life and access help if needed. There was a belief that this stigma worked both ways and a stigma attached to being ex-forces was identified. One participant's experience of this was not being promoted in his civilian job because he was ex-forces.

**"For some reason I wasn't getting the promotion I was seeking and I was told a few years later that it was because from a governors' conference, an ex-governor told me this in confidence that because I was ex-forces they couldn't bend me and shape me into their business model, what they wanted me to do. I was too set in my ways, I wasn't... I was just very proactive, give 100% and I think a lot of the managers were threatened by that"**

Former Army Other Rank

## **5.5 Discussion**

Phase Three identified three main findings that present a theoretical understanding of why veterans may be different to the general population when accessing healthcare for alcohol problems. Upon leaving the military, there appears to be a development of a veteran identity, very similar to the identity developed whilst serving. Resilience and normalisation of alcohol remain a part of this identity, consequently, when a veteran experiences a difficult time, such as during transition, it was suggested that they may use alcohol as a way to cope. The veteran identity appeared to be a major barrier and created great complexity in accessing healthcare. It was suggested that the reluctance to access help was not just for issues with alcohol; this was a more generic problem in engaging in healthcare. Getting veterans to meaningfully engage in services is challenging, where comparisons to care received in the military are often made. Participants would also be unwilling to disclose their status/service history if the term veteran was used. There are potentially barriers between civilians and military personnel and this can impact of a veteran's likelihood of meaningful engagement. In healthcare, it appears this barrier can be mediated by a connection with the military, such as ex-military personnel on the staff, a veteran bespoke service or even the staff having a good understanding of veterans' needs. It is important to note that participants proposed a generational change, where currently serving personnel are not exposed to alcohol in the same way and are now more like their civilian counterparts. It is the older generations, those who served 1970s-2000s that encounter problems in accessing and engaging in service for alcohol problems.



Like Phase Two, the participants in Phase Three also suggested that excessive alcohol consumption was normal, because alcohol was used as a social bonding tool and a way to cope (see also: Jones and Fear, 2011). Consequently, veterans often do not recognise they have an alcohol problem seeing it as a part of their military service. Participants were also trained to be resilient, where asking for help was seen as a sign of weakness. On discharge and during the adjustment to civilian life, their identity transitioned incorporating a new veteran identity, where a lot of the service identity characteristics remained. According to the principle of self-efficacy, individuals will strive to maintain an identity structure that is dominated by competence and control, failing to do this results in feelings of futility and helplessness (Breakwell, 1993). The development of a veteran identity as a cause for a reluctance to seek help is not a new finding. Litz (2007) found service leavers have reportedly voiced concerns over appearing weak or sick to their peers in fear that there will be negative consequences on finding subsequent employment. It has also been ascertained that 40-60% of personnel who may benefit from professional treatment do not access help or services (Sharp et al., 2015).

When a need to access healthcare arises, participants were cognisant that healthcare professionals refer to them as veterans. The U.K. government define a veteran as someone who has “served for at least a day in HM Armed Forces, whether as a Regular or as a Reservist” (Ministry of Defence, 2011). There was a consensus in the focus group that they did not wish to be identified as a veteran and would prefer ex-forces or ex-services. Many confirmed that if asked ‘are you a veteran?’ by healthcare staff they would not disclose their identity, suggesting this can be a major barrier to identifying and engaging veterans in services for alcohol problems. Burdett et al. (2013) asked 200 personnel who had recently left the military whether they considered themselves to be a veteran. Only 52% of the sample considered themselves to be a veteran and definitions used by U.K. ex-service personnel did not align with the official U.K. government definition. The official definition does not appear to be well used or endorsed by the veteran population or the public. Only 37% of a representative sample of the general population identified all ex-service personnel as veterans (Dandeker et al., 2006). Those who served during World War One and Two were more likely to be seen as a veteran (57%). There is an importance of having a definition that encompasses the veterans own preference. For many participants, their veteran identity is what they believe would make them different to other substance misuse service users. They suggested that a reluctance to access help was unlikely to be restricted to alcohol use.

When accessing healthcare, participants made constant comparisons to military healthcare where they felt they were treated as an individuals and able to develop trusting relationships with staff. NHS services are not bespoke and many felt they were treated as a number rather than a person. Consequently, third sector organisations were preferred, bridging the gap

between military and NHS services. Participants felt they were more valued and more time was spent with them in the third sector organisations. Additionally, in many cases these organisations are affiliated with the military and/or have peer workers. One of the biggest barriers to care was dealing with civilians whom participants thought did not understand the military. As a result, it was suggested that they were more likely to engage with a civilian working in an organisation affiliated with the military than if they were working in the NHS. There was an acknowledgement that many veterans struggle to see themselves as a civilian and consequently will shy away from civilian healthcare. The reported success of civilian staff working in treatment centres for veterans was an unanticipated finding. Much research points towards a need for individuals with prior military experience or knowledge in the treatment services, however it was suggested that civilians providing care under a military associated organisation may be enough to keep veterans engaged.

Barriers between veterans and civilians was a common theme throughout the focus group and was prominent during transition to civilian life. Although rarely discussed, this was not a surprising finding. Relations between those who have served in the U.K. Armed Forces and the general public have been greatly affected by recent conflicts and the way in which these conflicts were reported in the media, consequently the general public's view of military personnel both serving and ex-serving may not be very accurate. Ashcroft (2012) found that 91% of the British public thought that it was common for former members of the U.K. Armed Forces to have some kind of physical, emotional or mental health problems as a result of their service. Literature indicates that although some do struggle in the transition to civilian life as a result of their service, the majority of military personnel do transition well. The participants acknowledged this, noting that transition is a difficult time regardless of the outcome. There are great complexities for veterans accessing healthcare. In addition to alcohol problems (and excessive alcohol use), literature on transition recognises further areas of difficulty as employment, mental health problems, homelessness, and crime (Bergman et al., 2014, Fossey, 2010, Iversen et al., 2005b). Pre-conceived ideas of who ex-military personnel are can cause major issues when seeking employment and accessing healthcare. Identifying an acceptable definition of a veteran/ex-service personnel was viewed as important for these participants.

Resettlement programmes are designed to prepare service leavers for civilian life, however it has been suggested that these programmes only appear to be



aimed at a basic vocational level, ignoring many issues associated with retirement from military life that have the potential to either facilitate or hinder future employment (Higate, 2001). Veterans who took part in the focus group claimed that the resettlement package had not been improved or changed since it was first introduced. Vocational re-adjustment has been highlighted as a prominent issue faced by veterans, particularly transferring military skills to a more peaceful occupation (Rogers, 1944). Early service leavers are not entitled to a full resettlement package and are consequently at a greater disadvantage to other service leavers. Early service leavers are those who are discharged from the military having served less than their contracted four year term (Ministry of Defence, 2016b). The focus group saw early service leavers as the most vulnerable group on discharge and felt that there was a great responsibility for the welfare of these veterans. Literature is unclear as to whether leaving the armed services early increases the risk of alcohol misuse. However, Woodhead et al. (2011) found that early services leavers were more likely than other veterans to be heavy drinkers, to have suicidal thoughts and to self-harm. Although Buckman et al. (2013) found that early service leavers were more likely to suffer from a range of health problems than other veterans, the differences in relation to alcohol misuse ceased to be significant when controlling for age.

Generational changes were discussed and it was proposed that those who served in the 1970s-2000s are those who have the greatest normalisation of alcohol consumption and prejudice towards civilians. Due to shorter postings closer to home, new generations of military personnel are more integrated into society and as a result are more like their civilian counterparts than generations before. Those who are currently serving in the U.K. armed forces are thought to share the same level of alcohol consumption as the general population. Unfortunately, there has been no research that has explored this view. Fear et al. (2007) identified 67% of male and 49% of female personnel in regular service as hazardous drinkers compared to 38% of men and 16% of women in the general population. A later study by Thandi et al. (2015) reports that hazardous alcohol consumption remains high in the British Military and would not support the observations of the focus group. But it should be noted that Thandi's paper appears to report on a study conducted between 2007 and 2009, consequently, the argument can be made that this data is now out of date. It is argued that that participants in the Fear et al and Thandi et al study may be representative of the veteran cohort recruited in Phase Two and Phase Three of this project, rather than those who are still serving and therefore further investigation is needed to determine the changing trends of substance use within the British Armed Forces. It was also worth noting that the military's attitude towards drinking has changed, with real progress being reported towards a zero tolerance alcohol policy.

### Limitations

Phase Three was a small scale qualitative study of veterans from the wider community. Only one focus group was held to further understanding as to why veterans are reluctant to access help for alcohol problems. Multiple focus groups would have allowed for greater in-depth discussions about the role transition may play in excessive alcohol consumption and identifying with being a veteran. As in phase two of this study, it is noteworthy that all participants were male – and thus the limitations identified *above* also apply to the findings of phase three.



### Conclusions

The findings that have emerged from Phase Three of this study provided a triangulated validation of the insights provided by the service-users interviewed during Phase Two. In particular, these respondents – who themselves did not have significant problems with alcohol misuse – reinforced the concept of a normalised relationship with heavy drinking during military service. There was some acknowledgement within the group of changes within drinking culture within the U.K. military and a suggestion that younger servicemen and women spend relatively more time socialising with their civilian friends than previous generations. Respondents also reported awareness of a concerted effort from within the military to ‘tackle’ drinking culture.

In addition, these participants provided insight into the difficulties associated with transition to civilian life, and even if, to all outward appearances a ‘successful’ transition had been achieved, these difficulties remained salient. Focus group participants suggested that transition experiences provided a further warrant for alcohol consumption and continuation of alcohol-based coping mechanisms established during military service. Phase Three of this study yielded further important insights that perhaps illuminate ‘reluctance’ to seek help. One particular aspect of transition that was referenced concerned the nature of the NHS in general, with participants identifying their own experiences as relatively impersonal. NHS staff were implicated as being particularly ill-informed in relation to military life and culture. NHS and social care services were reported as difficult to negotiate because of their inherent complexity, but it should be noted that this claim may equally apply to the population at large. Focus Group participants expressed a certain degree of antipathy towards civilian life – and civilian culture. Finally, Phase Three findings illuminated the importance of asking the ‘right’ question when determining if an individual is ex-forces (e.g. ‘Have you ever served in the U.K. Armed Forces?’ rather than ‘Are you a veteran?’).

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## 6. Phase Four

### 6.1 Aims

The aim of Phase Four was to facilitate the design of an integrated model of care which would enable alcohol misuse services to adapt and evolve so that they better fit the needs of veterans. This was achieved by staging a one-day planning symposium which involved all those from the north-east region who delivered services to veterans (see Table 2). Most significant was that this day was not about the research team providing answers, but more about facilitating the service planners, commissioners and providers with the correct information and data so that they might develop a more nuanced and effective model of care delivery. The delegates were given two clear constraints for the day:

1. There was no additional funding available, so any model of care had to be delivered within the current budgets
2. No development of parallel services, bespoke to veterans were allowed. The aim of the day was to design a pragmatic solution which integrated veteran service users into existing care delivery. It was argued that parallel services are expensive and difficult to sustain, and an implicit purpose of this day was to design a sustainable service.

### 6.2 Participants

148 Health and social care planners, commissioners and providers for the North East of England who were involved in alcohol and substance misuse services, were contacted via telephone and email (see Table 2 for responses).

Engaging certain sectors in the symposium was challenging. As a result, 43 out of the 148 delegates contacted attended, with 73 not responding at all. Service users and veterans from the wider community were also invited, with a final total of 50 attendees on the day.

There were four area tables, where possible, participants were on the table for their area of work. These tables included representation from Northumberland, North Tyneside, Newcastle, Gateshead, South Tyneside and Sunderland. On all tables, there was at least one veteran who worked in the sector. In addition, there was a table for service users and veterans from the wider community for the area tables to call upon to gain an insight into their experience. An 'expert' table was also present with individuals who had expert knowledge in areas of NHS, Criminal Justice, Public Health and Third Sector. There were 8-10 participants per table and these were each supported by a facilitator and when needed, service users and members from an expert table.

**Table 2.** Invitation responses for symposium (%).

	Contacted	No Response	Responded but did not attend	Attended
CCG	22	15 (68.2%)	3 (13.6%)	4 (18.2%)
Public Health (inc. Consultants)	25	14 (56.0%)	7 (28.0%)	4 (16.0%)
Local Authority	27	12 (44.4%)	12 (44.4%)	3 (11.1%)
NHS	32	21 (65.6%)	3 (9.4%)	8 (25.0%)
Treatment Providers	11	6 (54.4%)	1 (9.1%)	4 (36.4%)
3 <sup>rd</sup> Sector	19	2 (10.5%)	2 (10.5%)	15 (79.0%)
Criminal Justice System	4	1 (25.0%)	0 (0%)	3 (75.0%)
Armed Forces Reps	8	2 (25.0%)	4 (50.0%)	2 (25.0%)
<b>Total</b>	<b>148</b>	<b>73 (49.3%)</b>	<b>32 (21.6%)</b>	<b>43 (29.1%)</b>

### 6.3 Data Collection

The symposium was held at the Northern Design Centre in Gateshead during March 2017.

Participants took part in three workshop exercises during the symposium (see Appendix D for agenda). The aim of these workshops was:

1. *Existing Landscape: Current Commissioning and Provision of Services for Veterans:* To map the current substance misuse care pathways for veterans within their area.
2. *Improving Care and Care Pathways within Existing Infrastructure and Resources:* To explore how care delivery could be improved within current provision.
3. *Forward View Plans – From Intent to Reality:* Design a model of care delivery for veterans with substance misuse within their areas.

Facilitators transcribed the information given by the delegates from the workshops on to flipcharts and a diagram from each workshop was created in Microsoft Visio, representing all area groups.

## 6.4 Findings

On collection of the flipcharts from the workshops, data was collated to create overall diagrams for each workshop to best display current provisions and how to move forward. Three diagrams were created:

- Existing Landscape: Current Commissioning of Services for Veterans (figure 7)
- Veteran's Experience of Accessing Services (figure 8)
- Improving Care and Care Pathways: Forward View Plans (figure 9)

### Existing Landscape: Current Commissioning of Services for Veterans

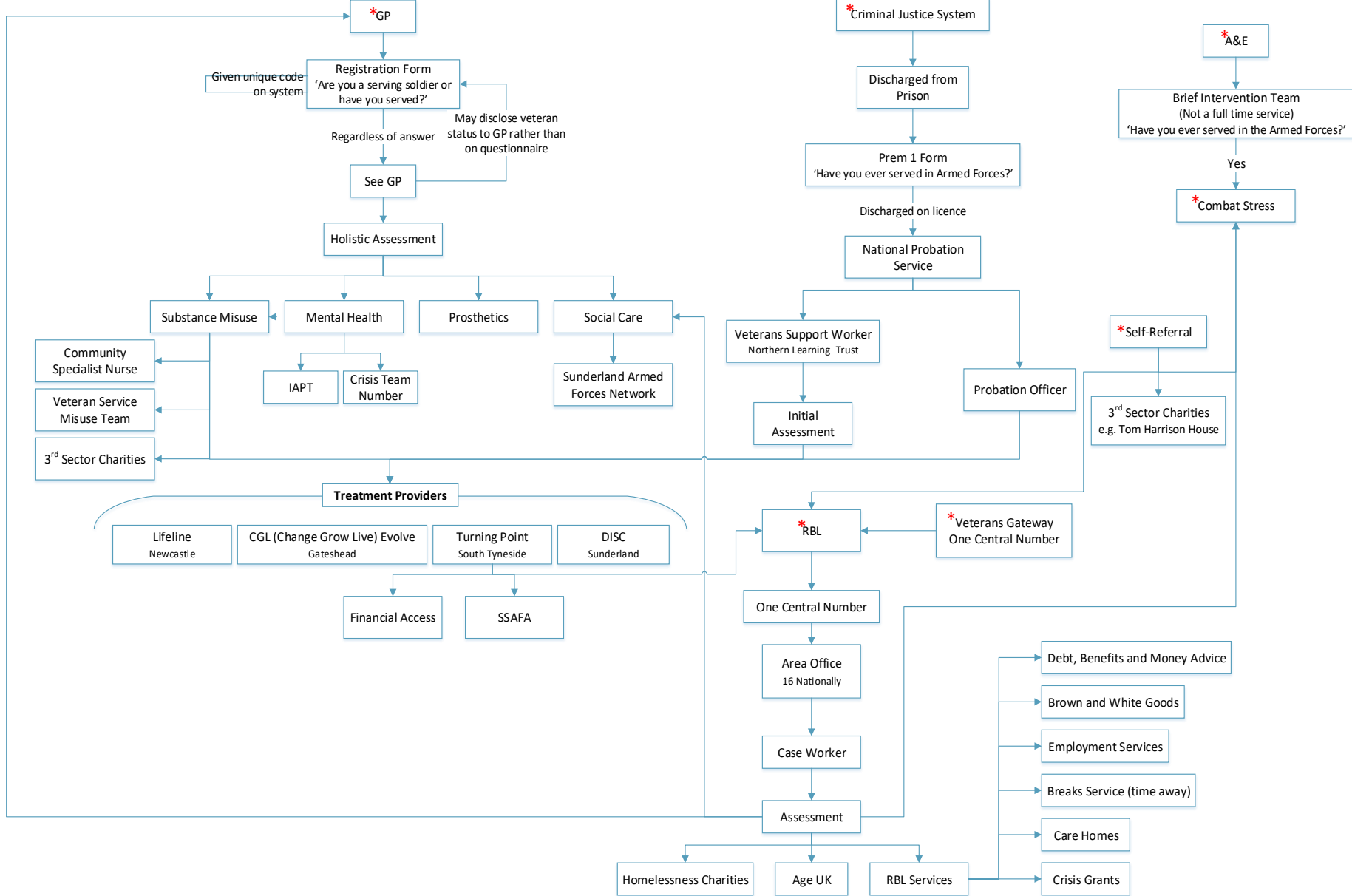
Figure 7 represents an example of current healthcare pathways for veterans with alcohol problems as identified by planners, commissioners and service providers in the North East of England. Initial diagrams from each table presented a very simple pathway for veterans accessing healthcare for alcohol problems. However, on collation of the diagrams, existing pathways were shown to be both more extensive and convoluted. It was clear that service commissioners, planners and providers held a limited and over-simplified view of the current provision.

Data suggested there are currently multiple entry points to accessing help. What appears key is the repeated referral to the GP and NHS treatment providers from other organisations. For example, if a veteran is identified as having an alcohol problem through the Criminal Justice System or third sector charities such as the Royal British Legion, they are then referred to GP and treatment providers only after initial assessment.

Furthermore, once engaged with treatment providers veterans are often referred to/back to third sector charities for further support. This may be for a number of reasons: the veteran may need other support not exclusive to alcohol problems or they may find veteran-specific third sector charities more sensitive to their needs.

The main 'take away' message from this diagram is that pathways in which veterans are expected to navigate to access appropriate help for their alcohol problems are convoluted and non-uniform. There are multiple points in the process in which veterans may 'fall through the gaps' having been referred to multiple different agencies. What is unclear from this diagram is whether communications between agencies exist, and if so, how effective are these communications?

Figure 7. Collated diagram for 'Existing Landscape: Current Commissioning of Services for Veterans'.





### Veteran's Experience of Accessing Services for Veterans

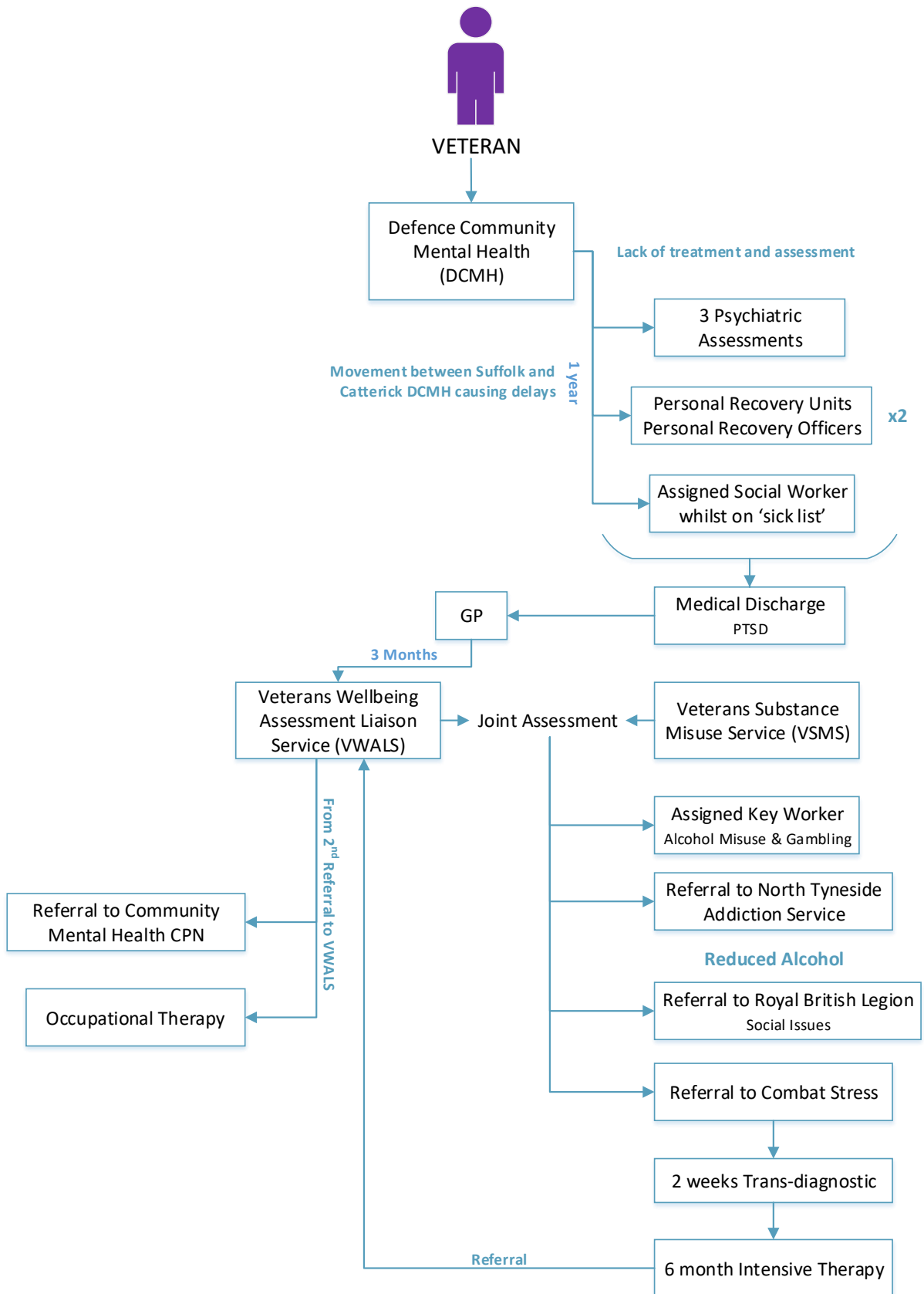
During table discussions of existing provision, service users were invited to give their experience of accessing help for alcohol problems as a veteran. Figure 8 demonstrates one veteran's experience. This veteran was first identified whilst still serving in the U.K. Armed Forces and consequently, his experience of services was more comprehensive than others in the study. However, it is also important to note that each service users' experience was vastly different. Those who accessed help independently had the least comprehensive pathways, often with multiple re-referrals, fewer agencies involved, or little to no contact.

On identification whilst in the Military, the veteran represented in Figure 8 received support from the Defence Community Mental Health teams; however, there were three separate psychiatric assessments by multiple Personal Recovery Units and Officers. It took a full year before he was medically discharged with a diagnosis of PTSD. On discharge the veteran was referred to the GP. From this point, the diagram approximates the complex and convoluted realities represented in Figure 8.

On joint assessment with Veterans Welfare and Liaison Service (VWALS) and Veterans Substance Misuse Service (VSMS), the veteran was referred to multiple secondary care and third sector organisations before a re-referral to VWALS. This course of events produced evident confusion for the veteran himself as a consequence of multiple agency involvement. An explanation for why he experienced multiple referrals was never provided. For many present at the symposium, this veteran's experience of services was a surprise as it contrasted greatly with their over-simplified view of existing provision.

As identified in the 'Existing Landscape' diagram (figure 7), there were multiple points in the process at which the veteran could have 'fallen through the gaps'. Communication between agencies post-referral was unclear, although a re-referral to VWALS suggested there was a lack of communication. It is worth remembering that this veteran had a complex presentation including a diagnosis of PTSD. This case serves as a vivid example of how a veteran with multiple presentations is faced with the difficulties of navigating complex health and social care pathways such as typically exist within existing provision.

Figure 8. Collated diagram for 'Veterans Experience of Accessing Services'.



### Improving Care and Care Pathways: Forward View Plans

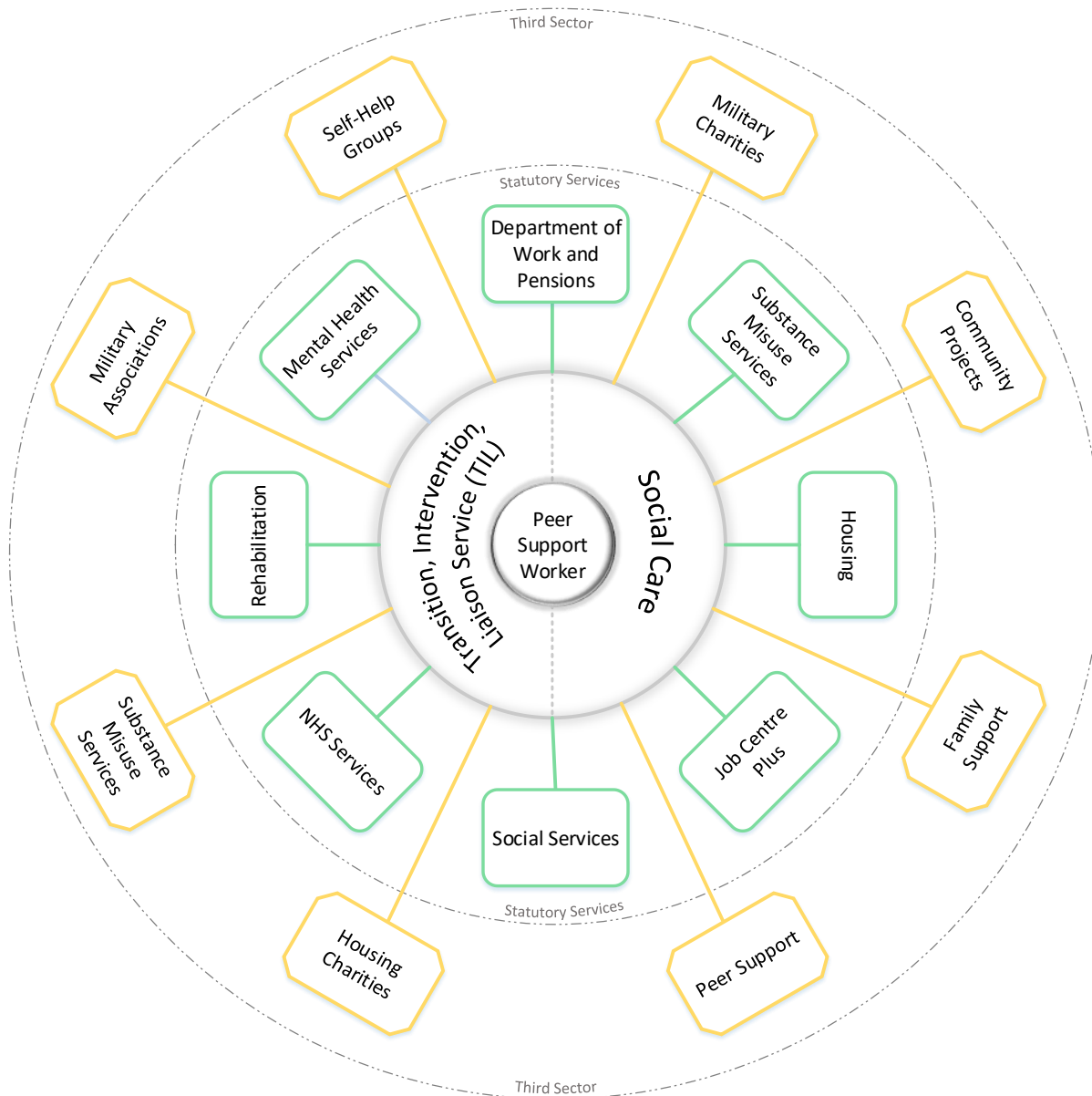
As an outcome of the symposium activities, the delegates designed and recommended a 'hub and spoke' model of care delivery. There was a conscious move away from a linear pathway of care, as the evidence from Phase One and Phase Two suggested that this creates 'cracks in the pavement' for veterans to fall into. The delegates felt that a hub and spoke model would be the most effective way of integrating health and social care delivery for optimal future healthcare services. A key consideration was that this could be achieved easily without integrating health and social care budgets. Many delegates felt that any model that relied on integration of budgets would make the process too complicated to succeed. A 'veterans' hub' (see Figure 9) was placed at the centre of this model, where veteran peer support workers might be integrated with the Transition, Intervention and Liaison (TIL) Veterans' Mental Health Services team.

The delegates anticipated the model working in the following way: Once a service user has been identified as a veteran requiring mental health or substance misuse services, they would be referred to a 'veterans' hub'. This hub would be physically located within local Transition, Intervention and Liaison (TIL) Veterans' Mental Health Services. Here, each veteran would then be assigned a multi-agency peer support worker to maintain contact with the veteran for the full duration of their engagement in services. In particular, the hub would have specialist substance misuse peer support workers (funded from social care), working alongside the TIL team. The role of the support workers would not be to deliver care, but rather to facilitate access to the most appropriate current provision, advocate on the veterans behalf in finding them the most appropriate alcohol misuse care and support the veteran throughout their recovery journey. At the centre of this model of care is the TIL and alcohol misuse peer support workers working together as a team. They will be able to negotiate the most appropriate care on behalf of the veteran, navigate the services and referral processes for them, but most importantly, be there as a constant support to reduce the risk of service disengagement. Even if a veteran did disengage from treatment, they would not disengage from the hub, and the role of the support worker would then focus on re-engagement. It is believed that this model would prevent veterans becoming lost in the system as described in Phase Two of this study, or being moved around services as outlined in Figure 9. This model of care would allow support to remain under the responsibility of one organisation, whilst at the same time supporting other aspects of the veteran life that are known to also be affected by alcohol problems such as physical health, finance and housing. Potentially, this arrangement would allow for effective integrated health and social care without the complications of integrated budgets. Budgets would remain in their respective 'silos' but provide personnel to the integrated veteran's hub. This arrangement would also allow for

negotiation of barriers between sectors with support and treatment being provided by the most appropriate service for the veteran, whether that be statutory services and/or third sector services.

**Figure 9.** Hub and spoke model for ‘Improving Care and Care Pathways: Forward View Plans’.

Note: Transition, Intervention and Liaison Service is the Veterans’ Mental Health Service.



### 6.5 Discussion

As an outcome of the symposium, it might be concluded that current pathways for veterans accessing help for alcohol problems appear to be variable at best, occasionally ineffective, and potentially damaging at worst. Figures 7 and 8 depict the rather haphazard arrangement of current provision, and one veteran’s chaotic experiences of accessing effective help. There are multiple entry points and multiple points in the process at which veterans may fall through

the gaps. Taken at face value, these diagrams outline a current provision that is very complicated and largely uncoordinated. It was also evident from the symposium that service commissioners, planners and providers did not have this overview as their initial diagrams tended to over-simplify existing provision. Many were surprised on hearing first hand experiences of service users that accessing and navigating through care pathways was not an easy business. Veterans typically experienced confusion, delays and multiple assessments and referrals, each one increasing the likelihood of disengagement from services.

It is important to acknowledge that the veteran must be motivated to engage with healthcare services as a first step towards accessing meaningful help. Any unwillingness to engage may increase the likelihood of re-referrals. Multiple re-referrals to primary and secondary healthcare as well as third sector organisations are likely to cost far more (in both financial and human terms) than a single successful referral. It is important to ascertain why veterans may be reluctant to engage in the first place before changes to current provision can take place. Phases one to three of this project attempted to explore why veterans are typically reluctant to access healthcare provision. In summary, it appeared that complexity of services, a normalisation of alcohol consumption, complex case-presentations and a lack of understanding of veterans (on the part of providers) served as the principal reasons for a lack of effective engagement. These findings were presented at the symposium to service commissioners, planners and providers with further support from service users' first-hand experiences of accessing help. In an attempt to combat the confusion and lack of continuity experienced by service users, a 'hub and spoke' approach to health and social care for veterans was proposed.

Results from Phase Three supported the importance of asking the 'right' questions when attempting to identify veterans. It was suggested that at entry to healthcare service, individuals should be asked, 'have you ever served in the U.K. Armed Forces?' This was deemed the best, most inclusive question for identification. In contrast, it was acknowledged that on some healthcare questionnaires, 'are you a veteran?' is a standard question. In Phase Three there was a consensus that participants would not disclose their identity to an individual who used the term 'veteran' as they did not identify with this term. Burdett et al. (2013) asked 200 ex-forces personnel if they would describe themselves as a veteran. Only 52% said they would, despite being classed as a veteran according to the U.K. government. The wording of questions can be a major barrier to identifying and engaging veterans in healthcare services.

In the proposed 'hub and spoke' model, upon identification of a veteran, a multi-agency support worker would be assigned to the veteran to see them through accessing and engaging

in the relevant services. An initial assessment should be taken, asking four simple questions that cover the veteran's physical health, mental health, social situation and alcohol / substance use. With this holistic view, recognising the greatest areas of need will aid in signposting veterans to the relevant services. Complex presentations were common amongst service users participating in Phase Two. Findings from Phase One and in other research (e.g. Aguirre et al., 2014, Fear et al., 2007) concur that this is a typical presentation pattern. Unfortunately, England's current health provision runs substance misuse services in public health, parallel to other health services, despite alcohol misuse rarely occurring in isolation. We contend that the use of peer support workers offers one possible solution to ensuring consistency throughout the veterans' engagement in services and effective communication across the sectors.

Symposium participants suggested that the 'hub and spoke' model would be cost effective in the long run, potentially reducing the number of veterans 'falling through the gaps' or disengaging from services due to difficulties presented by navigating complex systems. Many organisations already employ a veteran's support worker, and these workers could potentially become multi-agency workers in order to ensure effective communication between and across services and that veterans receive the right care for their needs. The hub itself would be overseen by all those involved, from primary and secondary care to third sector organisations, moving towards an integrated model of health and social care.

### Limitations

One definite limitation of the symposium was a lack of top-level representation from statutory health and social care agencies. The research team had difficulty engaging certain elements of the statutory health and social care sector, with Clinical Commissioning Groups appearing particularly reluctant to engage. In contrast, third sector agencies were the most responsive and had the greatest level of representation at the symposium event. This is perhaps reflective of the general trend in which third sector organisations in the U.K. have taken on a growing share of services previously delivered through statutory agencies (Milbourne and Cushman, 2013). In England alone in 2010, over a quarter of charities and social enterprises were active in health and wellbeing, with just under a fifth stating this as their primary focus (Baggott and Jones, 2014).

### Conclusions

Phase Four brought together findings from the first three phases in order to develop a proposed model from which to evolve current services. A 'hub and spoke' approach was identified as potentially the most cost effective and beneficial means of engaging veterans in healthcare services. The research team aim to trial the 'hub and spoke' model within one local

authority area in the North East of England in order to ascertain the practicality and sustainability of this approach to health and social care for veterans.

Attempting to tackle issues around initially identifying people seeking help as veterans, and then keeping that population engaged in services could potentially help to alleviate missed opportunities to provide meaningful, effective assistance. However, in the context of the current configuration of health and social care services, getting veterans to access services initially, remains difficult. Further research is needed to determine how this can be resolved.



## 7. Project Conclusions

The aim of this project was to explore why veterans are reluctant to access help for alcohol problems and the extent to which they may be different from other substance misuse service users within the general population. Research was conducted through a sequential process over four phases. The initial three phases consisted of interviews and focus groups with service planners, commissioners, providers, substance misuse service users and veterans from the wider community. The fourth phase was a planned symposium where findings from the first three phases were presented to substance misuse service planners, commissioners and service providers with input from veterans and service users.

Findings from this project suggest that veterans with alcohol problems have unique difficulties that set them apart from other substance misuse service users within the general population. From both Phase Two and Phase Three, it was clear that there is a normalisation of excessive alcohol consumption during military service that often remains on discharge. Veterans in Phase Three provided further insight into the difficulties experienced on discharge through the transition to civilian life. It was noted that looking in from the outside, a successful transition appeared the norm, however the focus group participants suggested that transition experiences provided a further warrant for alcohol consumption and continuation of alcohol-based coping mechanisms established during military service.

This normalisation of alcohol consumption was found to contribute to a delay in engagement with substance misuse service. A delayed engagement in accessing care lead to complex presentations where all aspects of the veterans' lives (physical, psychological and social) were impacted. Consequently, when veterans did engage in substance misuse services, they were often referred for alcohol treatment through other services such as social housing, unemployment and mental health.

Service providers' lack of understanding of the unique needs and experiences of veterans, was consistently identified as a main barrier to care in the first three phases. Focus Group participants expressed a certain degree of antipathy towards civilian life and civilian culture, further reinforcing this barrier. Complex care pathways and the lack of integrated health and social care was cited as contributing to a disengagement with care. Support for this was found in Phase Four where a diagram showed that the current care pathway for veterans with alcohol misuse was extensive and convoluted. This was in contrast to service commissioners, planners and providers limited and over-simplified view of the current provision. Successful engagement in care was associated with service providers who had veteran workers within their provision.



Phase Four facilitated the development of a model from which to evolve current services. Utilising findings from the first three phases, it was proposed that a 'hub and spoke' approach would be potentially the most cost effective and beneficial means of engaging veterans in healthcare services. Veterans will be assigned a multi-agency worker who will assist in accessing and engaging in relevant services. An initial assessment will ascertain the veteran's status on physical health, mental health, social situation and substance misuse. Essentially, the hub and spoke model has the potential to reduce the number of veterans who disengage/disappear from services due to difficulties in navigating complex services.

#### Limitations

The main limitation of this project was that it did not address female veteran drinking habits, only one female took part in Phase Two of the project. Females have remained fairly unrepresented throughout the literature partly due to females being a smaller group within the Armed Forces and the nature of sampling.

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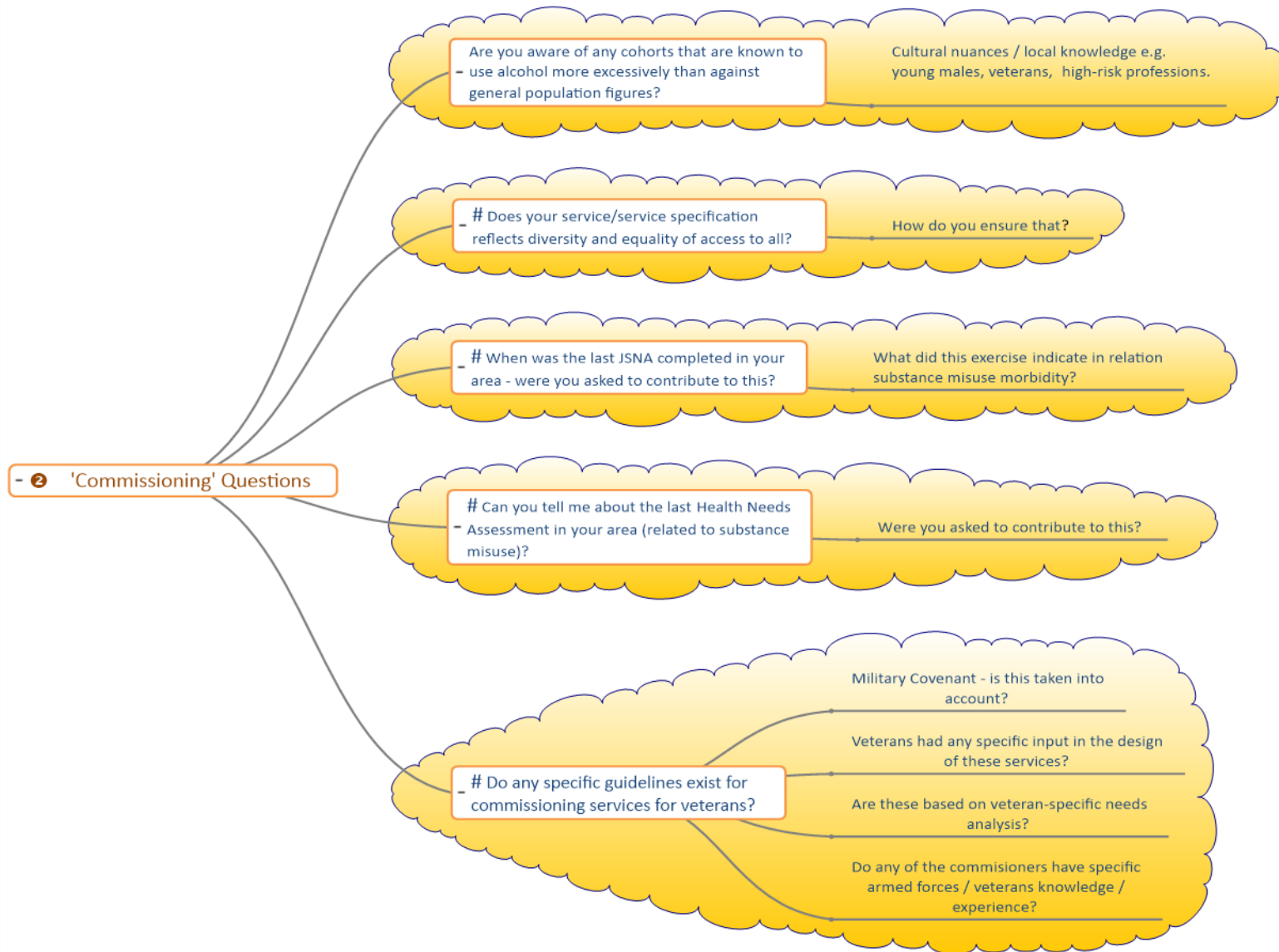
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## Appendices

Phase One Interview Schedule	Appendix A
Phase Two Interview Schedule	Appendix B
Phase Three Focus Group Schedule	Appendix C
Phase Four Symposium Agenda	Appendix D

## Phase One Interview Schedule



### *Phase Two Interview Schedule*

The following topics will be considered during the course of the semi-structured interview.

1. What we want to achieve initially is a comprehensive narrative of the participants' relationship with alcohol pre, during and post service
  - The respondent's relationship with alcohol / 'street drugs' prior the joining the armed forces.
  - The respondents experiences of 'drinking culture' within the military context.
  - Patterns of alcohol or substance misuse post armed service.
2. Then we want to explore insight and how they have sought help
  - Realisation of patterns of substance use as problematic: Self-realisation vs. significant others perceptions of 'problematic' use.
  - Time frame of the above biographical 'events'.
  - The decision to act – incentives and disincentives.
  - Expectation of services including service visibility / mode of referral / waiting times / accessibility etc.
3. Next we want to explore their experiences of engaging with services
  - Practicalities of service engagement e.g. competing commitments.
  - Substance misuse service experiences – positives and negatives.
  - Personal expectations of the service. Desired 'end point' – for service-user and for service-users significant others.
  - Personal expectations of 'recovery' – what does success look like for service user? Significant others?
  - Service provider expectations vs. service user expectations of outcomes?
4. Finally we want to explore and reflect on the findings of phase 1
  - Do they believe that veterans with substance misuse are different from other substance misuse service user and can they explain why (multiple forms of stigma)
  - Do they feel that clinical staff or professionals understand veterans Exploring stereotypical beliefs by health workers:
    - Their life and experiences within service
    - The nature of the conflicts they may have been involved in
    - The culture within the military
    - How does the health system within the military differ from the health system they now find themselves in
    - Is seeking help for problems different, if so has it been difficult and if so why



### Phase Three Focus Group Schedule

Focus Group to explore and understand the perceived reluctance to access care

From the first 2 phases of the study, it is evident that alcohol is seen as part of the culture of the military. What may be seen as alcohol misuse is not always recognised and drinking behaviour is attributed to service, used for socialisation and coping.

**Would you agree/disagree with this? What are your experiences of alcohol in the military?**

Why is it an integral part of the culture? Is it encouraged?

How does it affect social cohesion?

How does this transition to civilian life?

*"...they associate their heavy drinking beginning in the army. That it was very much seen as a way of life, and perhaps, kind of, more acceptable..... they've had that culture of heavy drinking.... which they associate with being in the army."*

INDEPENDENT SECTOR PROVIDER

*"...veterans just keep on going and not see themselves as having a problem because that's what they did in the military. So why can't...? Why is it a problem now? You know, but when you look at in the military there were controls and there were gaps in their drinking patterns."*

PUBLIC SECTOR PROVIDER

*"it's all work hard, play hard. It's all around that. You hear it all the time and it's... its norm to you because it's pumped into you. And it's not just like oh well we might go down the bar, it was like everybody will be in the bar and you just stay there."*

SERVICE USER

*"What do you think behind all of that then encouraging all that alcohol?  
I think it's just another bonding thing as well. Because it gets you together and it's social... it's social, yeah. Instead of you imagine if you were training all the time and you didn't socialise together, then you'd just become these robots and these machines. So it's another way... it's another way of getting us to bond together and to get to trust of each other. You know what I mean? It's just another way of..."*

SERVICE USER

**What makes ex-serving personnel different to civilians?**

Personal experience of transition - how does it compare to those who have an alcohol problem?

Impact of service - how and why problems can develop during and after service

Are their alcohol problems different?

*"No. No it was never as a veteran. They always just spoke about my childhood and saying that the loss of parent and the homelessness, it was never really looked into that I was a veteran. And I'd never even seen myself as a veteran to be honest. You always think of someone old and it's only recently that I've started saying veteran because I... you just don't see yourself as that. You just say that you had a job and unless you are in for twenty-four years, that you're not a veteran. But you are."*

SERVICE USER

Some service users described not identifying with being a 'veteran', just ex-service. **What would you define a veteran as?**

Research suggests that veterans are reluctant to access healthcare for alcohol problems. **Why do you think this may be the case?** Findings from phase 1 of the study talking to planners, commissioners and service providers, identified some barriers to care, such as complexity of services, stigma, institutionalisation, a lack of understanding of the experiences of modern warfare and its potential consequences and understanding veterans.

Findings from phase 2 talking to service users, further support the lack of understanding of the military and its cultures as a barrier to accessing and engaging in services.

*"Maybe not acknowledging what it's like being a veteran, not necessarily because you're a veteran. Does that make sense? You... acknowledge the fact that you have seen combat, you have seen this, that and the other. You have been through that and this and whatever. Whereas a normal person that is going through the same thing hasn't. So there's other triggers that's going to cause your drinking. There's other triggers that's going to do this, that and the other. So acknowledging that side..."*

SERVICE USER

*"I still don't think people pick out the veterans. They don't understand what a veteran is, so they don't know what to pick out. And they're scared of asking the questions, because they don't know what to do with the answers."*

PUBLIC SECTOR PROVIDER

*"But that was again I was talking to somebody who had no idea what it was like being in the military so there was no way I was going to talk to them. "*

SERVICE USER

*"Well they should know how veterans talk to start with. That would help. You know we've got our weird and wonderful language with things. "*

SERVICE USER

**Why do you think service leavers are reluctant to access healthcare for alcohol problems?**

**If you required help for alcohol issues, do you know how to access this?**

**What would stop you from engaging in treatment?**

Military identity developed during service is still present during and often after transition to civilian life. Phase 1 findings suggest that veterans are viewed as 'institutionalised' and that they fail to engage with services as a consequence of being institutionalised. **What is your view on being 'institutionalised'?** Is this being used as an excuse to pass blame for inadequate access to services?

*"...they don't understand how to access services because they used to go to the medical officer every morning and get it sorted out. And they didn't have to do anything. They didn't have to negotiate services...in the military you just go and present to your medical officer and... And he says what... Are they fit or not fit ..."*

PUBLIC SECTOR PROVIDER

*"But you didn't know anybody, you don't know anything when you leave the army. You don't know how to go get the dentist and get the doctors and sort the housing out. And you've got to figure it out as you go."*

SERVICE USER

Service users further identified a stigma attached to help seeking. They were reluctant to access help for fear of being seen as weak as this goes against their (military) identity and

some noted experiences of stigma towards them as a veteran. [Do you think there is a reluctance to access healthcare due to stigma?](#)

*“you’ve been conditioned to you know to think that you are the best and that you are the finest fighting force in the... to admit that you’re suffering with something is quite a difficult thing to do. Because I think there’s a lot of ego around it, there’s a lot of (umm) I suppose so-called honour and this macho view on... on life and how you conduct your life. I think that’s a big... a big reason why people don’t (umm) ask for help. Because asking for help is seen to be weakness, I should know that, I should do this, I shouldn’t feel this way. That’s a silly thing to feel. None of them works”*

SERVICE USER

*“I don’t know about the rest of the forces, but when you’re in the army it doesn’t get spoken about. You’d be thought of as weak if that was the case so (umm) feelings never got spoken about. And then when you’re only young, you can’t really speak to anybody, you haven’t got anybody to talk about it to, you know it just kicked.”*

SERVICE USER

*“Stereotyped the veterans?*

*Yeah (umm) I see ‘You’ve shot...’ I’ve been shot at, but I’ve never shot at anybody, which I have been shot at in [Northern Ireland] “*

SERVICE USER

It is often found that personnel hit ‘rock bottom’ before accessing help for alcohol problems, and in many cases this happens accidentally through other avenues such housing. [Why do you think veterans don’t access services until it is the last resort?](#)

Impact of service

Type of individual – personality, mentality?

Interviews with veteran service users acknowledged multiple service and agency involvement in care, where there is a reliance on civilian and military charities as well as the NHS to provide care. Within this, many service users appeared to engage more in peer led services, [how would the type of provider influence your engagement in services?](#)

*“Now to me I can’t open up the same to a civilian that I could... whereas I found through Help for Heroes (umm) my... my support worker (umm) is a veteran. And this Veterans at Ease is run by veterans and it will only employ veterans, which obviously because... for me I can relate to them and they can relate to me. And you have an instant bond and there’s a trust because you’ve all been through the same thing. Not necessarily the same trauma, but because you’ve been soldiers or you’ve been whatever... whatever service you’ve been in. So you have this... have this common bond so it’s easier to open up and trust and listen than it is with a civilian. Which is something maybe the civilians don’t understand. Because... because... even though... I left the army in 1991, but I’m still a soldier. I’m a veteran. I’ll never be a civilian. That never... leaves you, you know what I mean. Because I still... I still walk the streets like I’m in [Northern Ireland].”*

SERVICE USER

[What kind of support might be needed to help veterans access services?](#)

[What type of services may be best to support veterans with alcohol problems?](#)

## Phase Four Symposium Agenda



<b>Closing the Gap Collaborative Commissioning of Substance Misuse Services to Improve Access for Veterans</b>		
<b>09.00 to 09.30</b>	<b>Registration and Refreshments</b>	
09.30 to 09.40	Opening the Symposium	Marcus Hawthorn Royal British Legion Area Manager (Northern)
09.40 to 10.00	Introduction: Research Design and Findings	Dr Matthew Kiernan Associate Professor in Mental Health & Veteran Studies Lieutenant Commander RN(Retd) Co-Founder The Northern Hub for Veteran and Military Families Research  Dr Michael Hill Principal Lecturer and Director of Postgraduate Research Co-Founder The Northern Hub for Veteran and Military Families Research
10.00 to 10.15	Purpose of the Day	Jane Greaves Senior Lecturer Member of The Northern Hub for Veteran and Military Families Research
10.15 to 11.00	Interactive Roundtable Session <i>Working Together: Setting the Scene and Task Discussion</i>	
<b>11.00 to 11.30</b>	<b>Refreshment Break</b>	
11.30 to 12.30	Facilitated Workshop 1 <i>Existing Landscape: Current Commissioning and Provision of Services for Veterans</i>	
<b>12.30 to 13.00</b>	<b>Lunch</b>	
13.00 to 14.00	Facilitated Workshop 2 <i>Improving Care and Care Pathways within Existing Infrastructure and Resources</i>	
14.00 to 15.00	Facilitated Workshop 3 <i>Forward View Plans – From Intent to Reality</i>	
<b>15.00 to 15.15</b>	<b>Refreshment Break</b>	
15.00 to 15.45	Collective Workshop Feedback	
15.45 to 16.00	Closing Remarks and Next Steps	





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