Improving Access Executive Summary | 2017

Understanding Why Veterans Are Reluctant To Access Help for Alcohol Problems

Executive Summary

The Northern Hub for Veterans and Families Research at Northumbria University, 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 study, Improving Access: Understanding Why Veterans are Reluctant to Access Help for Alcohol Problems, was funded by the Royal British Legion. 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.

Essentially, 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-service personnel 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[1], this represents a potentially important, but as yet, largely unaddressed public health issue.

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

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

also expressed the view that 'front line' staff dealing with substance and alcohol misuse had little understanding of 'veterans' culture' and the specific issues facing UK military veterans – although it was not clear on what basis they held this opinion.

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.

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 string belief in the value of veteran-specific services.

Phase Four 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 and keeping appointments. 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. The peer support worker could act as a key case-worker for each individual presenting with alcohol misuse problems, responsible for co-ordinating 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 Four 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.

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