

# Stigma and barriers to care in service leavers with mental health problems



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## FOREWORD

If you had a headache, you'd take a paracetamol. If the headache got worse, you might go to the chemist, and take something stronger. If it continued, you'd have no qualms in seeing your GP, and you'd be able to tell the doctor exactly what ailed you. Your pathway to receiving health treatment is clear and relatively accessible, and your symptoms and treatment would be easy to describe to health professionals, friends and families.

But if you're suffering from mental ill health, you might not recognize it, nor have the words to describe to others what's wrong. You might not even realize you need treatment, and in any case you could harbour doubts about the efficacy of what was being offered.

It has become conventional wisdom that what prevents ex-Service personnel obtaining mental health care is mainly the stigma supposedly attached to an admission of being mentally unwell. What this excellent report shows is that the barriers to accessing mental care are far more complex than simply stigma; the three-phase journey presented here can be interrupted by such issues as mundane bureaucracy or the more troubling poor experience of initial treatment.

Rather helpfully, this study has also identified facilitators to accessing care, and I commend the approach the research team has taken in engaging early with many stakeholders so that their findings can be tested, and adopted as soon as practicable.

In a year when public debate on mental health services across the country has never been greater, this report can only add to an understanding of how access to them can be improved, leading we hope to better health and wellbeing for ex-Service personnel and their families. Of course, the other part of the equation is ensuring there is sufficient care available for all those who need it. And that, perhaps, is a story for another day.

**Air Vice-Marshal Ray Lock CBE**

*Chief Executive, Forces in Mind Trust*





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## King's Centre for Military Health Research

King's College London

Previously the Gulf War Illness Research Unit, King's Centre for Military Health Research (KCMHR) was launched in 2004 as a joint initiative between the Institute of Psychiatry and the Department of War Studies, King's College London. KCMHR draws upon the experience of a multi-disciplinary team, and is led by Professor Sir Simon Wessely and Professor Nicola Fear. It undertakes research investigating military life using quantitative and qualitative methods. Its flagship study is an ongoing epidemiological multiphase investigation of the health and well-being of approximately 20,000 UK Armed Forces personnel. The study, funded by the UK Ministry of Defence (MoD), has been running since 2003 and is currently coming to the end of the third phase of data collection. The primary aim of the study is to investigate the post-deployment health of those who have deployed to the conflicts in Iraq and Afghanistan. However, the study

is also investigating a range of topics relevant to serving and ex-serving personnel in general, and will find out more about help seeking for mental health problems, experiences of mental health care and concerns which prevent people from seeking the help they need. Data from our studies have been used to analyse various military issues, and papers have been published in peer reviewed, scientific journals. Our findings are regularly reported in the press, and have also been used to inform military policies.

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It is important to highlight that the quotes and opinions of the participants included in this research do not necessarily reflect those of the research team, or KCMHR more generally.

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## **Background**

Military service can place personnel at a greater risk of developing mental health difficulties yet both serving personnel and military veterans (defined herein as anyone who has served a day in the Armed Forces) are reluctant to seek help for mental health difficulties. Although much research has been conducted on potential barriers and facilitators to help seeking, the majority of this research is drawn from the US, where there are significant differences in both military and veteran experiences in comparison to the UK. Such research typically focuses on: the stigma of mental health; an individual's perceived lack of need for treatment; negative treatment perceptions; and logistical barriers to accessing mental health services. The relationship between such barriers and facilitators to help seeking is still unclear with contradictory findings throughout the scientific literature.

## **Objective**

This research explores the barriers and facilitators to care for the UK veteran population, as well as the dynamics between these factors and help seeking behaviour. In addition to this, the importance of barriers and facilitators at different stages in a veteran's journey to mental health support will be investigated, from recognition of a mental health problem through to the maintenance of mental health treatment. Case studies examining veterans with multiple interactions with mental health services will be conducted to distinguish patterns of recurrent barriers and potential levers to expedite progression to successful mental health treatment.

## **Method**

Sixty-two in-depth telephone interviews were conducted with male UK military veterans who had left the Armed Forces in the last five years. All participants had taken part in a previous research study where objective mental health measures had been collected alongside information on their perceptions of their own mental health. All veterans included in this research had screened positive for a degree of mental health distress on self-report questionnaires covering common mental disorders (anxiety or depression), Post-Traumatic Stress Disorder, or alcohol misuse. Based on the participants' perceptions of their own mental health, veterans were divided into three participant groups: those who stated that they were not currently experiencing a mental health problem; those who stated that they had a current mental health problem but were not seeking formal mental health treatment; and those who were currently in formal mental health treatment. Interviews focused on



exploring veterans' perceptions of their own mental health, barriers and facilitators to help seeking, and any mental health care experiences. Preliminary results were shared with key providers of veterans' mental health (both charity and government funded organisations) at a stakeholder meeting to discuss the implications of this research for the future provision of services for UK veterans.

## Results and Discussion

The veterans who participated in this research represented the major groupings identified in the Ministry of Defence (MoD) Biannual Diversity statistics of those who had left the Armed Forces in the last five years, in terms of service, rank and so forth, with the exception of female personnel who were not included in this research. This decision was made due to the low number of females in the Armed Forces and the resultant need to over-recruit from this population in order to get meaningful qualitative data to represent the female military veteran population.

The research allowed for the development of a theoretical model of the 'journey to mental health support' outlining the key stages through which a veteran may travel on their journey to engaging in effective mental health treatment. This journey begins with a veteran identifying a problem and defining this as a mental health problem. After this they must evaluate the decision to seek mental health support against their perceived need for treatment, their perception of the treatment they will receive (and likelihood it will help), and against the stigma and fear they may feel at this stage of the journey. Once the decision to seek support has been made, veterans must identify services for which they are deemed eligible, and they must continue to maintain this entitlement to treatment, as well as retaining a belief in the efficacy of treatment.

Although the stigma around mental health was highlighted as a concern by all veterans, this did not translate to a significant impact on help seeking, with only a small number of veterans stressing stigma as a barrier that had blocked them from seeking care. Instead, the decision to seek care was mainly concentrated on the perceived need for treatment. Those not in mental health treatment failed to identify problems they were having as being indicative of a 'mental health disorder' as they had not yet reached a crisis point where they could no longer cope. Those veterans who were in mental health treatment typically had reached a point where the severity of their condition meant that their need for treatment was highlighted regardless of their intention, either due to a

crisis event or another's intervention. Once engaged in mental health treatment, positive beliefs about the efficacy of that treatment have a substantial impact on the veteran's maintenance of that support.

Almost half of the veterans discussed more than one experience with mental health distress over their lifetime. For a small group of veterans this was due to multiple, separate episodes of mental health problems, with them achieving successful progression through the journey to mental health support with each episode. For the remaining veterans their interaction with the journey to mental health support remained relatively stable over time and took the form of one of three patterns:

- 1 Some veterans consistently failed to seek mental health support due to their own inability to identify that they had a mental health problem and recognise their need for treatment.
- 2 Another group of veterans were put off seeking mental health support due to negative initial experiences with care, with their resultant negative beliefs about the utility of treatment acting as a block to their future progression through the journey to mental health support.
- 3 The most frequently discussed recurrent barrier to care was centred on the provision of mental health support. Veterans were able to partially progress through the journey to mental health support by firstly identifying that they had a problem, and secondly by reaching out for support. However, time and time again these veterans failed to engage successfully in mental health support due to eligibility issues and to waiting lists (affecting their ability to access services), and to services being withdrawn by providers when veterans were deemed 'fixed', despite the veterans continuing to experience significant symptoms which clinicians appeared to overlook.

Notably absent from these patterns were concerns over stigma. Stigma barriers appeared to only impact veterans during their initial interaction with mental health services. After this, stigma barriers failed to impact veterans' subsequent decision to seek mental health support.

When veterans were asked about what they wanted in terms of mental health support, discussions focused on education to help them identify a mental health problem, and on enforcing some degree of mental health check-ups or support rather than leaving it solely to the veteran. Veterans appeared to want support that helped them deal with the root cause of a problem, and that that support be provided by someone who understood them, both in terms of military experience, and in terms of personal experience with mental health problems.

## **Implications**

This study has developed a theoretical model of the core stages of a veteran's 'journey to mental health support', identifying salient barriers and facilitators at each of the eleven stages. The importance of these barriers and facilitators, and their impact on help seeking behaviour, varies across these stages. Veterans embarking on their journey appear to need support to identify and define potential mental health problems. Once they have identified potential mental health problems, veterans appear to need encouragement to recognise the need and the benefits of treatment seeking. During the latter stages of their journey to mental health support veterans need assistance in identifying the most appropriate treatment option for their individual circumstances, and the ability to maintain a belief in the efficacy of their ongoing treatment. Many veterans are able to progress successfully through this journey yet others are repeatedly blocked by an inability to define what constitutes a mental health problem, by negative treatment experiences, or by difficulties in accessing mental health support, which cumulatively can result in years of unsuccessful treatment experiences.

This evidence helps to identify the most important barriers and facilitators to target to improve help seeking, as well as modelling the importance of such barriers and facilitators across phases on the journey to mental health support. This research has identified key levers for potential interventions to improve help seeking for mental health problems within the UK military veteran population.

Discussions of such potential levers with representatives from the major providers of veterans' mental health support in the UK (NHS; Samaritans; MoD; Combat Stress; Help for Heroes; Walking with the Wounded; The Royal British Legion; Royal Foundation; SSAFA; CONTACT; the RAF Benevolent Fund) enabled the identification of key questions that need to be answered to inform future practice and policy as summarised below:

## **Phase One: Recognition**

### **Can we introduce mental health/ mental hygiene training?**

Integrating mental health training into basic military training would ensure that all military personnel, and hence all future veterans, would receive some degree of education on maintaining good mental health.

### **Can we emphasise the potential impact of transition on mental health**

Emphasising the potential impacts of transition out of the Armed Forces, particularly with regards to mental health, to a greater degree during the military transition process may help veterans to be forewarned and forearmed.

### **How can we foster personal responsibility for mental health?**

Encouraging veterans to take responsibility for their own mental health may help veterans to detect potential mental health problems, ensuring they understand that monitoring their own mental health is the most effective way to identify a potential problem.

### **How can we involve the wider military family?**

The wider Armed Forces Community (including dependants and partners), should be involved in mental health initiatives, so that they can help veterans and serving personnel identify a mental health problem, and also be supported with their own mental health.

### **How we can ensure that veterans' difficulty in defining a mental health problem does not act as a 'recurrent' block to seeking mental health support?**

Greater emphasis on relapse prevention at the end of a therapeutic treatment cycle may help veterans to recognise any warning signs in the future and help them to understand what to do if they notice these warning signs. This is particularly pertinent to those veterans who have only sought help due to outside intervention and may never have recognised the warning signs in themselves.



## **Phase Two: Decision to Seek Support**

### **How can we encourage the media to positively change perceptions?**

Developing media guidelines to encourage the media to change the way they portray mental health, especially military mental health, may help to reduce the stigma of mental health and help to debunk myths around mental illness. However, changing media perceptions is likely to be a long-term process.

### **How can we best change the language around 'help seeking'?**

Employing positive language around 'equipping' an individual to maintain, and recover, a good state of mental health (much as they do their physical health), as opposed to the language of 'fixing' someone, in order to help reduce the stigma of mental health self-awareness and help seeking.

### **How can we best educate veterans on the benefits of treatment?**

Educating veterans on the success of mental health treatments and the positive improvements treatment can have on their quality of life may help to dispel negative treatment beliefs. Much work is already being undertaken in this area, for example CONTACT have successfully engaged many high profile people to talk about the difficulties that they have experienced and their recovery process.

### **How do we 'sell' the wealth of current support options to veterans?**

Packaging the wealth of support options currently available to veterans in a way that better 'sells' these services as meeting the veterans' needs may encourage help seeking behaviour.

### **Can we prevent negative treatment experiences blocking decisions to continue with (and future decisions to seek) mental health support?**

A greater emphasis on the follow up of any treatment dropout, including conversations with the patient about potential concerns with the therapeutic relationship or the type of therapy they are receiving, alongside offers of a second therapist or treatment option, may help to maintain the veteran's engagement in support.

### **Why are stigma concerns less relevant after initial interactions with mental health services?**

Further research is needed to understand why stigma barriers only face most veterans during a veteran's first interaction with mental health services and why these barriers are typically absent from future interactions. Such research may help to understand how to help veterans overcome the issue of stigma during their initial interaction with mental health services and how such learning may benefit those who have yet to access services for the first time.

## **Phase Three: Accessing and Maintaining Support**

### **How can therapists 'learn' to speak 'veteran'?**

Providing mental health professionals with some element of military cultural training might help to counter veterans' negative perceptions that therapists do not understand veterans or the military generally.

### **Would employing veterans as 'peer guides' help?**

Employing veterans as guides to help others through their journey to mental health support might help to support and encourage veterans' help seeking behaviour.

### **Would 'recovery stars' or 'recovery wheels' help?**

Recovery stars, or recovery wheels, which have been effectively employed within the health domain, could help veterans to both understand their own mental health and to track their progress through treatment.

### **How can we ensure that provision of mental health services does not repeatedly block veterans accessing support?**

Re-evaluating the definition of 'fit for duty' within the military mental health domain may help individuals to counter feelings that care, within the military, is withdrawn before their issues have been resolved. For care more generally, placing an emphasis on transitioning to self-regulation, as opposed to treatment 'ending', may help individuals to feel that they can return to mental health services for further support if required.









### **Problem statement**

Active military service involves exposure to a range of risk factors including physical and psychological threats. Exposure to such threats has been linked to mental health problems, such as common mental health disorders, Post-Traumatic Stress Disorder (PTSD) and alcohol misuse.<sup>1-3</sup> Previous data from the King's Centre for Military Health Research Health (KCMHR) health and well-being cohort study suggests that prevalence of mental health disorders in UK military personnel remains relatively constant, although a minority, often combat personnel and reservists, report symptoms of probable mental health disorders.<sup>1</sup>

In the last decade, various initiatives have been implemented to improve mental health care provision for UK ex-Service personnel. For example, several veteran specific NHS mental health services have been launched, a 24-hour veterans' helpline has gone live, a specific Veterans and Reserves Mental Health Programme has been implemented, and the Veterans' Gateway, a one-stop shop for veterans support, has been initiated.

Despite the mechanisms in place for ex-Service personnel to access mental healthcare, there is considerable evidence to illustrate that many veterans are reluctant to access the medical and welfare support systems currently available. Findings suggest that only one in five UK ex-Service personnel with mental health problems receive professional medical help.<sup>4</sup> Additionally, there is evidence that suffering from a mental health problem is a predictor for leaving the Armed Forces.<sup>5</sup> Once out of the Armed Forces, mental health problems are linked to worse outcomes in veterans<sup>6</sup> and have also been shown to detrimentally impact the mental health of those around the veteran.<sup>7</sup>

### **Barriers and Facilitators to Mental Health Help Seeking in the Veteran Population**

Although there has been a wealth of research into barriers and facilitators to seeking mental health support within the military and veteran population, there is a limited amount of research on the UK veteran population, with work predominantly focusing upon the US. The following section draws out the core barriers preventing veterans seeking mental health support as discussed in contemporary literature.

### **Barriers**

The majority of research on veterans' barriers to care concentrates on the endorsement of pre-defined barriers to help seeking focused on four areas:

- ♦ Inability to identify a need for treatment
- ♦ Stigma of mental health and of help seeking
- ♦ Negative beliefs about mental health care
- ♦ Logistical barriers to care

## Stigma

Stigma around mental health is focused on a number of internal and external beliefs about those who are mentally ill: that they are weak, crazy, and dangerous, as well as perceptions that they are somehow personally responsible, or even faking their illness in some way.<sup>8-13</sup>

In addition to this, stigma can also surround the action of help seeking itself, with beliefs that individuals should solve their own problems and that mental health support is only for those with extreme problems.<sup>8, 12, 14-17</sup>

This stigma can cause those with a mental illness to view themselves in line with these negative beliefs, as well as believing that others will see them in this light and that as a result they will be subject to discriminatory reactions. Fears include the notion that people will be treated differently and ostracised, as well as the potential impacts on their career if they are seen as less capable or unable to lead.<sup>8-10, 18</sup> These stigma beliefs may be grounded in reality and those with mental illness, or seeking help for mental illness, may indeed be subject to such discriminatory reactions.

Such stigmatising beliefs are said to be heightened within the military population because the military persona is characterised by attributes that sit at the polar opposite of these stigmatised beliefs.<sup>13, 15-26</sup> Military personnel are trained to bring out and enhance certain characteristics, both physical and mental, such as strength of character; self-reliance; self-sufficiency; and being someone on whom others may place their trust, and ultimately, their lives.<sup>8-10, 18</sup> Although these beliefs are centred on a 'military' persona, such beliefs are said to be deeply engrained and enduring, continuing long after personnel leave the Armed Forces and become a veteran.<sup>16</sup>

## Perceived lack of need for treatment

Research has shown that stigma is not the only barrier to care; another potential barrier to seeking mental health support is a perceived lack of need. Veterans believe that they do not need to seek mental health support because their symptoms are not severe enough, or do not impact their life, or will sort themselves out given time.

## Beliefs about mental health and mental health care

Current military veteran literature also highlights barriers concentrated on negative beliefs about the provision of mental health care, including beliefs that:<sup>12, 13, 16, 17, 20, 27</sup>

- ♦ Mental health support will not help
- ♦ Mental health providers do not have the resources to help
- ♦ Mental health providers will rely on medication rather than resolve a problems root cause
- ♦ Medication may cause side effects including addiction

*And:*

- ♦ Mental health support will result in a painful 're-experiencing of trauma'
- ♦ Mental health support sessions will not remain private and confidential
- ♦ Mental health support will involve a loss of control
- ♦ Mental health professionals are not trustworthy
- ♦ Mental health support does not work, in light of their own, and others, previous negative treatment experiences

## Logistical barriers

Practical barriers to care have also been explored within the literature, with a number of veterans discussing such barriers as preventing them from engaging in effective mental health support. These include:<sup>11, 13, 16, 17, 19, 27</sup>

- ♦ Lengthy waiting times
- ♦ Poor awareness of available services
- ♦ Limited hours of operation/ time constraints
- ♦ Inconvenient locations/ transport problems
- ♦ Excessive paperwork or hassle to engage in support
- ♦ Eligibility concerns (e.g. being told that they are not eligible for IAPT as they have multiple mental health problems)

## Facilitators

Prior research also explores potential reasons that lead to veterans deciding to seek help, which can be termed as facilitators in the decision making process. These facilitators tend to be focused on similar core areas that, as described above, can also be barriers preventing veterans seeking mental health support.

## Stigma

In recent years, there has been significant effort focused on reducing the impact of stigma on mental health help seeking. It appears that such stigma campaigns have been successful to the point that anti-stigma perceptions are cited as a key facilitator in encouraging mental health help seeking. These anti-stigma perceptions focus on:<sup>12, 17</sup>

- ♦ Highlighting PTSD especially as a socially acceptable mental illness
- ♦ Encouraging beliefs that it is socially acceptable to get help
- ♦ Campaigns to reduce stigma, improve access to support, and promote mental health recognition, again especially PTSD

In addition to the impact of anti-stigma campaigns, the impact of stigma on help seeking may also be reduced due to individuals no longer caring what others think,<sup>16,17</sup> especially with advancing age, time from discharge, or with the recognition of a need for treatment without it necessarily having to reach crisis point first.

### Perceived need for treatment

Veterans who are able to recognise a need for treatment state that this recognition acts as a facilitator encouraging them to seek mental health support. This perception can occur due to:<sup>13, 14, 16, 17, 28</sup>

- Recognition of a problem
- Severity of a problem, for example suicide ideation
- Encouragement from others

### Treatment beliefs

Although negative treatment beliefs may discourage some veterans from seeking mental health support, other veterans cite positive treatment beliefs as a potential facilitator to seeking care.<sup>11, 16, 17, 25, 28</sup> These beliefs include:

- Belief that treatment will help
- Belief that the system is trustworthy
- Perception that good quality care is available

## Relationship with Health Care Utilisation

Research exploring the impact of such barriers and facilitators on actual help seeking behaviour is both less prevalent and less conclusive.

### Stigma and Help Seeking

There is an unclear relationship between stigma and help seeking with recent quantitative and qualitative reviews providing opposing findings. The qualitative review<sup>9</sup> deduces that increased levels of stigma act as a barrier to help seeking, whereas the quantitative review<sup>10</sup> concludes that there is no significant association, and any small association that exists suggests that increased levels of stigma are associated with increased help seeking. There are a number of potential explanations proposed to rationalise the difference in findings:<sup>8-10</sup>

- Existing research employs un-validated and unitary measures of stigma
- Help seeking behaviour may increase the importance of stigma since those seeking help are more exposed to the potential impacts of stigma
- An intention gap whereby a person's symptoms are so severe that they are forced to get help despite the barrier of stigma
- Additional factors, such as support from loved ones, outweighing the impact of stigma

### Perceived Need and Help Seeking

Increased levels of symptoms have been consistently associated with recognition of a mental health problem and treatment utilisation, which suggests that severity of mental health problem acts as a consistent facilitator to seeking mental health support.<sup>21, 22, 29-31</sup>

### Treatment Beliefs and Help Seeking

The relationship between treatment beliefs and help seeking behaviour also appears unclear. Research has indicated that higher levels of positive treatment beliefs are associated with treatment utilisation<sup>29</sup> as well as higher levels of negative treatment beliefs being associated with a lack of treatment utilisation.<sup>30</sup> In contradiction to this, other research has shown that beliefs about mental health treatment are not associated with treatment utilisation.<sup>21</sup> Research by Edlund suggests conflicting findings may be due to the notion that the decision to seek mental health support is an accumulation of positive versus negative beliefs about mental health care, when no single positive or negative belief on its own could predict treatment seeking behaviour.<sup>28</sup>

## Journey to Mental Health Care

It has been proposed that the contradictory research on the relationship between barriers and facilitators with help seeking may be due to different barriers and facilitators gaining significance at different points on an individual's journey to mental health support. Certain barriers may be more of an impediment in recognising a mental health problem whereas other barriers may become more prominent for those trying to maintain mental health treatment. Both Iversen<sup>15</sup> and Jakupcak<sup>32</sup> promote models of journeys based on the concept that veterans face different barriers at different stages along their journey to mental health care. Iversen<sup>15</sup> discusses a journey that involves five core stages:

- 1 Self-recognition (recognition of an issue in oneself)
- 2 Identification by system as having problem (recognition of an issue by others)
- 3 Signposting to correct support (identifying appropriate support)
- 4 Attendance at support (commitment to support)
- 5 Appropriate assessment and care (maintenance of support)

Jakupcak<sup>32</sup> explores a similar model, popular in the broader literature, known as the 'stages of change' model.<sup>33</sup> This model has frequently been applied to issues such as addiction. This model also proposes five core stages:

- 1 Pre-contemplation (denial of a problem)
- 2 Contemplation (considering making a change)
- 3 Preparation (ready to make a change with a potential plan in place)
- 4 Action (making a change)
- 5 Maintenance (maintaining a change)



Both of these models recognise that veterans go through a variety of stages in their journey to maintaining effective mental health support. They recognise that this journey may begin with a denial of any problem before admitting to suffering with a mental health problem, although this stage is more drawn out in the stages of change model<sup>33</sup> compared to Iversen<sup>15</sup> phases. The Iversen<sup>15</sup> model lays a greater emphasis on the reaction of the 'system' to an individual seeking help, whereas the stages of change model<sup>33</sup> is focused on internal processes along this journey. Both models highlight the importance placed on the veteran to take positive steps to maintain this support.

### Research Objective

There were three main research objectives for this study:

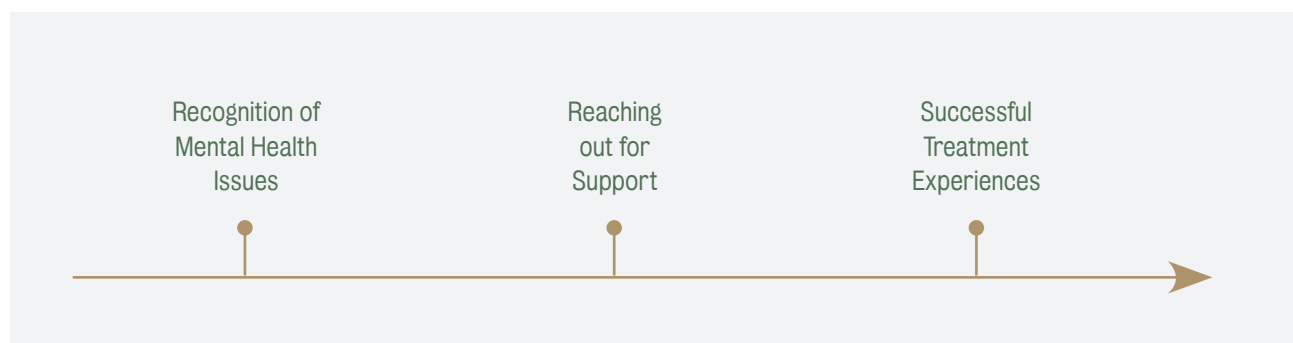
- 1 To identify important barriers and facilitators to care for mental health problems in the UK veteran population
- 2 To define the relationship between barriers and facilitators to care and help seeking behavior
- 3 To compare these barriers and facilitators to help seeking across veterans at different points on the journey to successful mental health support

This research aims to explore the barriers and facilitators acting upon a veteran's decision to seek mental health support and assess the degree of impact each factor has upon this decision.

The final research aim is to investigate these barriers and facilitators across veterans who are at different points on the journey to successful mental health support to assess whether the same barriers or facilitators are influential at different stages. Within this research, it is suggested that this journey begins at recognition of a problem, moving on to reaching out for support, and ending with a successful treatment experience.

### Summary of Contemporary Literature

- Stigma of mental health and help seeking: internal beliefs about mental health care effectiveness and eligibility to receive it; and logistical barriers are commonly cited barriers and facilitators to seeking mental health support
- Whilst research into barriers and facilitators to care consistently emphasises the importance of a small number of established factors, research into the effect of these factors on help seeking behaviour is still in its infancy and requires further analysis
- There are a number of outstanding questions to answer:
  - Whether the established barriers and facilitators to care hold true for the UK veteran population
  - The relationship between barriers and facilitators to care with help seeking behaviour
  - How barriers and facilitators to care vary depending upon an individual's position on their journey to mental health support



**Figure One: Journey to successful mental health support**



### **Design**

This project employed qualitative interviews with UK veterans in order to provide an in-depth exploration of barriers and facilitators to seeking mental health support. Telephone interviews were decided upon as the most appropriate medium, both with regards to logistical issues, and in order to achieve a sense of anonymity for the veterans to help foster a heightened degree of openness.

### **Participant Selection**

Participants were identified from the KCMHR health and well-being cohort study.<sup>1,2</sup> This study has been running since 2003 (the beginning of the Iraq conflict) with the third phase of data collection currently under review. Over 20,000 serving and veteran personnel have completed the questionnaires, which were designed to explore the general health and well-being of the UK military and veteran population, as well as to evaluate the impact of deployment. Over 8,000 personnel took part in the third phase of the health and well-being study from which the participants from this research were drawn. From this sample males who had left the Armed Forces in the last five years were identified. Five years was deemed an appropriate time-point to ensure that the research evaluated reasonably current resettlement procedures in addition to allowing veterans' time to experience civilian mental health services.

In order to ensure that this research reflects the opinions of each of the major sub groups within the Armed Forces, recruitment was stratified to approximately map to the Biannual Diversity data for those who left the UK Armed Forces in the five year period between 2011 and 2016. The participants who took part in this research spanned all of the major categories into which the Armed Forces can be divided, with the exception of female personnel. This ensures that the research reflects the opinions and experiences of all male veterans leaving the Armed Forces, across age groups, ranks and service, as well as for both regular and reserve troops.

Participants were then selected based upon their scores on mental health screening measures. Within the health and well-being cohort study, participants complete three self-report questionnaires exploring different mental health conditions. Each of these measures is designed with a cut-off point, after which scores are said to be indicative of a mental health condition (see Figure Two below).<sup>34, 35, 36, 1</sup>

**Figure Two: Mental Health Measures**

Health Issue	Measure
Common mental disorders (anxiety/ depression)	12 item General Health Questionnaire (GHQ12)
Post-Traumatic Stress Disorder	17 item National Centre for PTSD Checklist (PCL-C)
Alcohol misuse	10 item WHO Alcohol Use Disorders Identification Test (AUDIT)

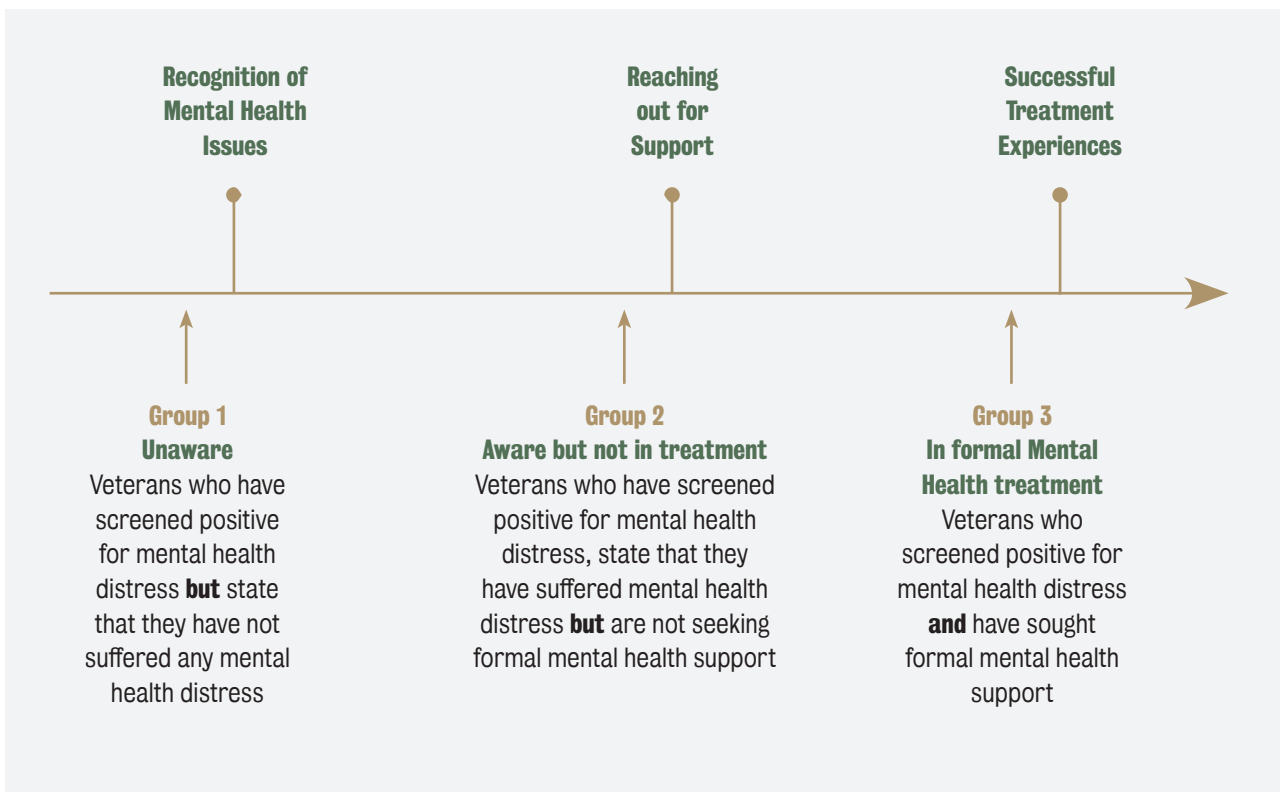
Participants whose mental health screening scores exceeded these cut off points were chosen for inclusion in the study. Potential participants were then divided into three groups based on their perception of their own mental health. This division was again based on their responses to questions in the earlier health and well-being cohort study questionnaire.

Group One participants were veterans who had ticked a box in the questionnaire to say that they had not suffered any stress, emotional or mental health problem in the last three years thus placing these veterans at the beginning of the journey to mental health support, before recognition of mental health problems, despite scoring above the threshold. This group is labelled 'unaware'.

Group Two participants were those who ticked a box

to say that they had suffered a stress, emotional or mental health problem in the last three years and also stated that they had not received any formal mental health treatment for that issue. This placed these veterans before the 'reaching out for support' stage on the journey; these veterans are labelled 'aware but not in treatment'.

Group Three participants were those who ticked a box to say that they had suffered a stress, emotional or mental health problem in the last three years and that they had received formal mental health treatment for this issue. Formal mental health treatment was defined as seeing a GP or Medical Officer (MO); a hospital doctor, or a mental health specialist. This group were labelled as 'in formal mental health treatment' (see Figure Three below).



**Figure Three: Participant Group Allocation**



## Participant Recruitment

Once selected for participation in the study, veterans were sent a postal pack comprising of an invitation letter, consent form, information leaflet, and a booklet containing potential sources of support for veterans. Approximately two weeks later, postal packs were followed up with a telephone call enquiring as to whether or not the veteran would like to take part in the research. The participant recruitment procedure can be found in Appendix One. The recruitment procedure allowed a response rate of 58% to be achieved. Interviews took place between May 2016 and December 2016 and lasted between 45 minutes and 1 hour and 45 minutes.

## Interview Protocol

The interview protocol for this study was developed based on a review of the contemporary military literature on barriers and facilitators to seeking mental health support, as well as broader research on barriers to seeking mental health support in the general population.<sup>8, 10, 37-45</sup> The protocol was created as a semi-structured interview to enable the interview to be as open as possible, without highlighting any particular barriers/ facilitators, or leading participants to discuss particular areas e.g. self-stigma. Figure Four below provides an overview of the areas explored in the interview protocol (see Figure Four).

## Quantitative Data

All participants in Group Two and Group Three had already taken part in an earlier clinical interview study where they answered a range of questions exploring mental health-related stigmatisation and perceived barriers to care. Participants in Group One, who had not participated in the earlier clinical interview study, were asked to complete the same quantitative

measure of barriers to accessing mental health care as part of this research. The measures were derived from the Barriers to Access Care Evaluation (BACE) measure,<sup>46</sup> and the Self-Stigma Of Seeking psychological Help (SSOSH).<sup>47</sup>

## Ethical approval

Ethical approval was granted by the Psychiatry, Psychology and Neuroscience (PNM) Research Ethics Subcommittee (RESC) at King's College London (Ref PNM RESC HR-15/16-2125). The KCMHR cohort and clinical interview study were also granted ethical approval by the UK Ministry of Defence Research Ethics Committee (ref: 448/MODREC/13 and ref: 535/MODREC/14 respectively).

## Analysis

All telephone interviews were audio recorded and transcribed in full, and anonymised, by a professional transcription service (all participant quotations contained within this report have been assigned a pseudonym). The interview transcripts were then analysed according to the principles of Thematic Analysis. This analysis involved inductively identifying patterns and themes within the data with the aim of developing a new theory from progressively more abstract summaries of the data.<sup>48</sup> As illustrated below in Figure Five, the analysis began with reading each interview transcript, developing draft codes for sections of script, and integrating these into coding hierarchies. This process took place for each interview transcript before merging the coding categories across interview transcripts and creating a final coding hierarchy and overarching theory. For further information on Thematic Analysis, the reader is referred to Braun and Clarke.<sup>48</sup>

**Figure Four: Interview Protocol**

Military History	<ul style="list-style-type: none"><li>• Roles and Responsibilities</li><li>• Enjoyment of Service</li></ul>
Transition	<ul style="list-style-type: none"><li>• Leaving the Armed Forces</li><li>• Resettlement Support</li></ul>
Current Life	<ul style="list-style-type: none"><li>• Life outside the Armed Forces</li><li>• Quality of Life</li></ul>
Mental Health	<ul style="list-style-type: none"><li>• Perceptions of Mental Health and Treatment</li><li>• Mental Health History</li></ul>
Pathways to Care	<ul style="list-style-type: none"><li>• Potential barriers and facilitators</li><li>• Actual barriers and facilitators</li></ul>
Treatment Experience	<ul style="list-style-type: none"><li>• Treatment Pathways</li><li>• Transition of Care</li></ul>

**Figure 5: Thematic Analysis Process**

- Step 1**  
Transcribe interview
- Step 2**  
Familiarise self with interview
- Step 3**  
Create preliminary codes
- Step 4**  
Develop parental themes
- Step 5**  
Repeat above steps for each interview
- Step 6**  
Merge and refine codes and themes across interviews
- Step 7**  
Finalise coding hierarchy and overarching theory

### Methodological Summary

- Veterans who had left the UK Armed Forces in the last five years and whose scores on self-report mental health measures were indicative of mental health issues including PTSD, depression and anxiety (Common Mental Disorders) and alcohol misuse were selected for participation
- Participants were divided into three groups:
  - Unaware of any mental health problem
  - Aware of a mental health problem but not in formal mental health treatment
  - Aware of a mental health problem and in formal mental health treatment
- 62 qualitative, telephone interviews conducted, exploring barriers and facilitators to seeking mental health support
- Analysed employing Thematic Analysis





### **Group Differences**

No differences were found between the three groups of participants in terms of age, rank, service or engagement type, but differences were identified in terms of probable mental health condition. Participants in Group Three (i.e. those in formal mental health treatment), and those in Group Two (i.e. those who are aware but not seeking help), are the only participants identified with probable PTSD caseness. 'Caseness' here refers to their scores on the self-report measures meeting or exceeding the cut off points set to be indicative of a mental health condition. None of the participants in Group One (i.e. those who stated that they did not have a mental health problem), indicated probable PTSD caseness. This suggests that perhaps PTSD caseness is equated with an increased level of recognition of PTSD, or treatment need, or both, in those affected. This aligns with earlier research indicating that increased symptom severity increases the likelihood of help seeking as outlined in the Introduction, although additional research is needed to explore this further.

Differences between the three participant groups were also found in the scores on the self-report screening measures. Scores for participants in Group One were lower for both GHQ (common mental disorders) and PCL (PTSD), than those scores of participants in Group Two and Group Three. This means that participants in Group Two and Group Three reported a greater level of symptoms of mental health conditions than participants in Group One. In line with the contemporary literature, it would be expected that those with more severe conditions (as indicated by higher mental health scores) are more likely to be aware of their mental health condition, and as symptoms continue to increase in severity, seeking mental health support becomes more likely.





### **Journey to Mental Health Support**

In line with current literature, a journey depicting distinct phases en-route to maintaining effective mental health support emerged from the interviews. This journey is outlined opposite in Figure Six.

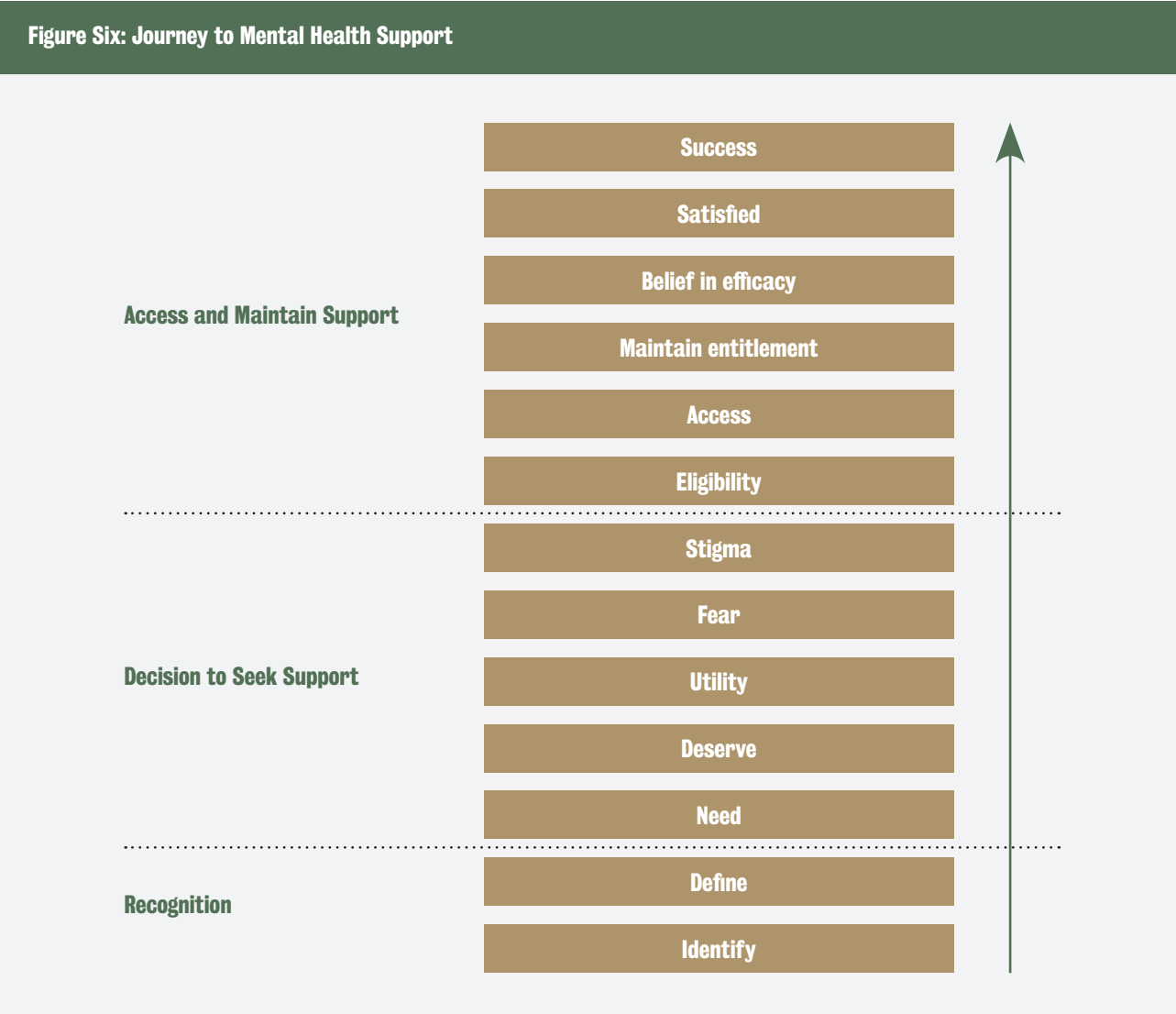
It is important to note that veterans may or may not traverse each of these stages, and their journey may not be linear, this pathway is a simplified representation of the potential stages that a veteran may face on a journey to care. The first stage on this journey *identifies* that something is not right, that the individual is experiencing some level of mental health symptoms. The second stage is *defining* these symptoms as potentially a mental health problem. At the end of this recognition period, people have become aware that they have a mental health problem. Once veterans reach this stage they will have moved from Group One (unaware), to Group Two (aware but not in treatment).

The next stage, the decision to seek support, concentrates on recognising a *need for treatment*, followed by the development of the belief that that they actually *deserve treatment* as well as believing in the *utility of that treatment*. In addition to this, veterans must also evaluate the potential negative impact of both *fear* and *stigma*. By the end of this stage veterans have made the decision to seek mental health support.

Once veterans decide to seek support they still have to be deemed *eligible* for mental health care and they have to negotiate *access* to that care, at which point they move into Group Three (in formal mental health treatment). However, once veterans are receiving mental health support they must continue to ensure that they maintain their *entitlement* to that support and they must continue to believe in the *efficacy* of the care that they are receiving to prevent treatment dropout. At the end of this stage participants are *satisfied* that they are engaging in effective treatment and continue at this stage until support at that time is no longer needed, defined here as *success*.

The initial group designation placed veterans relatively evenly across the three groups (i.e. close to 20 in each) and their corresponding stages. However, after conducting the interviews with veterans not all of these groupings were found to be appropriate as some veterans were actually at different stages on their journey to mental health support. Figure Seven on page 20 indicates where veterans sat on this journey to mental health support after interviews had been conducted.

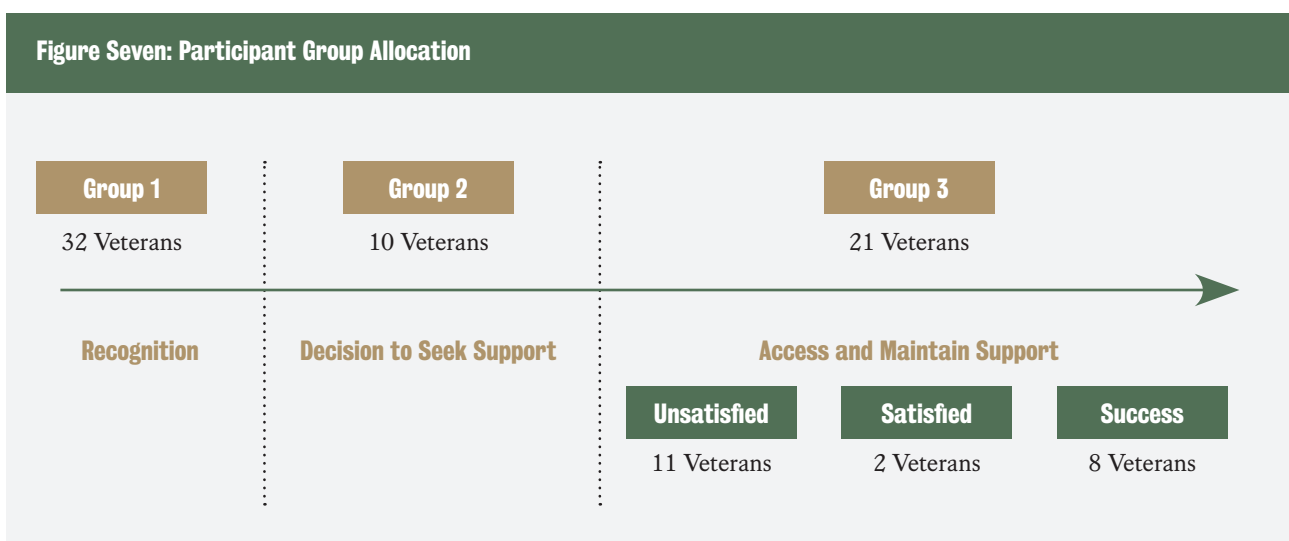
**Figure Six: Journey to Mental Health Support**



To explain the difference between pre- and post-interview allocation, initial group allocation placed around 21 veterans in the ‘decision to seek support’ phase, or Group Two, but after the interviews were conducted only 10 veterans remained in this phase. This change was due to veterans recognising a stress, emotional or mental health problem but then during discussion elaborating that they believed this problem to be ‘stress related or emotional’ and not actually a mental health problem, thus moving them backwards into Group One, the ‘recognition’ phase, subsequently grew to include 32 veterans.

It is important to highlight that almost 50% of Group Three veterans were either currently in mental health support they were satisfied with (two veterans) or had already achieved a degree of treatment success and no longer required support (eight veterans). This illustrates the positive aspects of the mental health care system for UK veterans, highlighting the ability of this system to work effectively.

The next three sections of the report will outline the barriers, and then the facilitators, which may impact a veteran’s pathway through this journey, followed by an analysis of individual veterans’ journeys overtime.

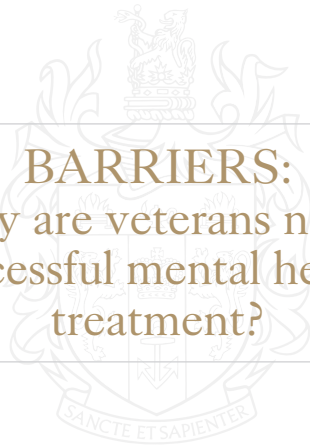




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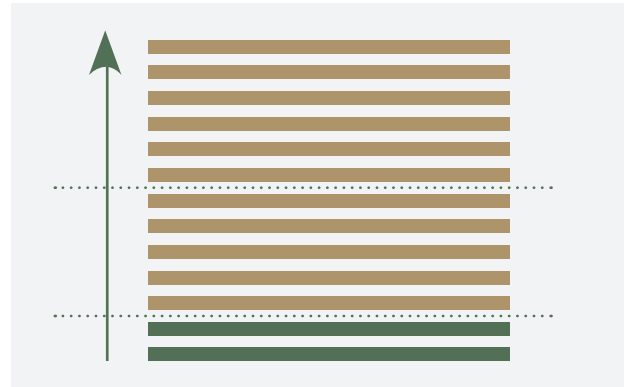
**BARRIERS:**  
Why are veterans not in  
successful mental health  
treatment?

---



Each of the overarching phases of the model: recognition; decision to seek support; and accessing and maintaining support, are divided into a number of core stages. Each phase is split into a series of stages during which a specific barrier may impede a veteran's journey to mental health support.

**Phase One: Recognition**



The first phase of the journey involves recognition and veterans considered two barriers to seeking mental health support addressing *identification* and *definition*.

**Identification**

*Identification* of a mental health problem was a commonly discussed barrier to care for veterans. Participants at this stage were unable to identify that anything was wrong. They had an inability to see any symptoms of impaired mental health, believing that they had no stress, emotional, or mental health problems at all.

*"No, no. My world is rosy" (Joshua: Group One)*

**Definition**

The second stage in recognition is the *definition* of a problem as 'mental health' and the inability to do this signified a substantial barrier on the journey to seeking mental health support. Participants at this stage were able to identify that there were perhaps some problems but they were unable to define these as mental health-related. Many believed that the symptoms they were experiencing were normal, for example a normal part of life or normal for a soldier.

*"I mean I have down days, I have up days but nothing... I'd say beyond the spectrum of normality or acceptability" (Matthew: Group One)*

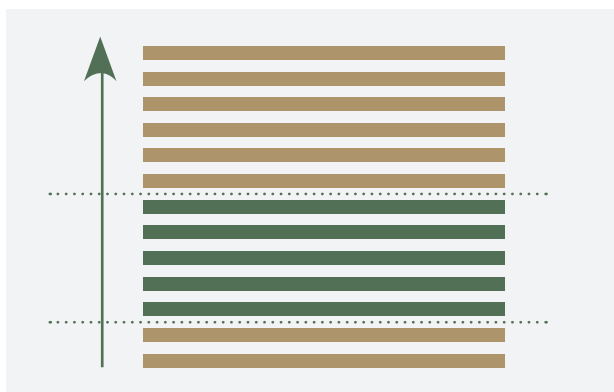
The majority believed that their symptoms were not severe enough to be mental health difficulties, or because they could self-manage them they self-defined them as not 'mental health' problems.

*"Well I suppose yes, looking at it in a cold fashion, I would... I would do because it... I know sort of things have affected me to some degree. But (umm) I wouldn't say that they're in anyway (umm) severe or even, I don't know, not even moderate"* (Richard: Group One)

Finally, some participants spoke about being unsure how to define mental health or believing that only a professional could define a problem as mental health.

*"I think it's... I don't think it's stress. I think emotion and mental health I... I haven't got the skills to separate the two so I'm not really sure which it is"* (William: Group Three)

## Phase Two: Decision to Seek Help



The second phase of the journey involves the decision to seek support and veterans considered a number of potential barriers to seeking mental health support related to need for treatment, beliefs around whether they *deserved* treatment, the *utility* of treatment, as well as *stigma* and *treatment fears*.

### Need

Veterans' inability to recognise a *need* for mental health treatment represents a prominent barrier to seeking mental health support. In the same way that the lack of severity of their symptoms, and their ability to self-manage symptoms, may block a veteran from *identifying* a mental health condition, it can also block them from identifying a *need* for treatment.

*"Well I'm sort of functioning. I mean I'm holding a job down and... and doing the usual things, I've sort of convinced myself there that everything was fine as well"* (John: Group Two)

### Deserve

Veterans also spoke of not *deserving* care, stemming from the military ethos that they should be self-reliant and not burden anyone else with their individual problems.

*"So that idea of self-reliance, not saying that you don't seek*

*help, or you rely on other people, but you at least attempt to look after yourself. You take personal responsibility for your actions, you don't expect a hand-out"* (Ron: Group Two)

Issues here also focused on the notion that others had much more serious problems to deal with than they did, which could be seen as a form of downward comparison.

*"I didn't accept because I just thought... I didn't deep down feel that... I don't know whether it's because I feel like... you know I don't necessarily feel like these are that serious an issue. They're not... there's guys with real issues and you know there's people with real issues that need... you know that's it... I just don't really feel like it's big enough an issue for me to actually go and do that"* (James: Group Two)

### Utility

Veterans cited negative perceptions around the utility of treatment as a reason some veterans may choose not to seek mental health support. The general perception that a therapist would not understand, or that it would be impossible to build a trusting relationship with a stranger, were common, as too was a reluctance to take medication which veterans saw as something prescribed widely but that which served only to cover up the problem rather than resolve it.

*"You meet someone for the first time (umm) and you feel awkward because you've never met them, you've got to try and know them. They've got to try and get your trust to open up (umm.) And then it's just... its slow... it's awkward"* (Charles: Group Two)

### Fear

*Fear* was another barrier at this stage with veterans describing how they were afraid of having to open up and be vulnerable, as well as wanting to 'keep the box closed'.

*"I was a bit guarded, I was a bit well I don't want to... I don't want to take the... I don't want to take the lid off this bottle! I don't want to open this can!"* (Brian: Group Three)

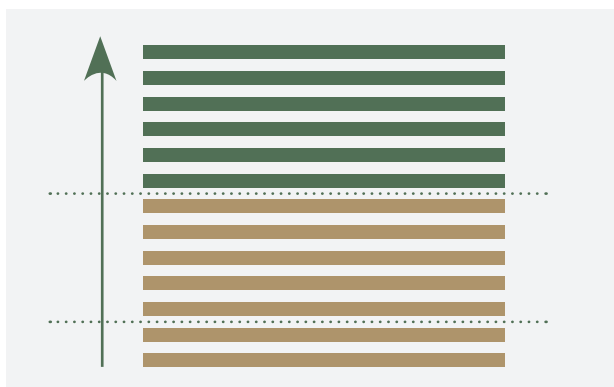
### Stigma

The *stigma* of mental health was another barrier discussed by veterans at this stage. Veterans spoke of refusing to admit a mental health problem because of the associated perceptions around weakness or the label of mental health calling to mind an image of a 'crazy person'. Veterans spoke about concerns that they would be seen as 'fakers' or 'malingerers' and not believed by those around them. Each of these stigmatising beliefs was coupled with a concern about the potential impact admitting a mental health problem could have, especially on their career, both within the military and when employed in the general population.

*"You just sort of think only you know weak people, conniving, trying to get something, go down those routes. It's a terrible thing to say, but you know it was just... you know if you... I did... as I say I just had a great sixteen*

years help, really confident, felt really... you know I was doing something really worthwhile and special with my life. And (umm) you know never a day's kind of self-doubt (umm) and then... and then you know you, as I say, you've stumbled upon hard times and you have everything to help out... and you feel terrible, but you still have that feeling, its... you know it just weak people and (umm) if you've just spent years doing phys and being in a gym you know sort of demonstrating that you're not weak"(Kevin: Group Three)

### Phase Three: Access and Maintain Support



The third phase on the journey involves accessing and maintaining support and at this phase veterans discuss barriers centred on *eligibility* and *accessibility* as well as maintaining *entitlement* and believing in the *efficacy* of treatment.

#### Eligibility

Veterans' *eligibility* concerns were related to fears that if they did seek mental health support they would be told that there was nothing wrong with them, that they were wasting time and that they needed to 'man-up.' Veterans had experienced approaching organisations for support only to be told that they did not have the 'right' mental health condition for that organisation.

*"And then... a letter come through from IAPT service saying we can't treat you because you've got more than one underlying issue. So they said they can't treat you because we can only treat people with one underlying issue and I just thought... to be honest it was a smack in the face because I like all I want is a bit of help and no one's willing to help me" (Robert: Group Three)*

#### Access

Concerns around *accessing* support were discussed as veterans were very aware of long waiting lists currently in place in the NHS which can lead to the perception that the effort to seek support is worthless as there is no support available, or the support will not be available at the time that they need it.

*"Again I think it was the waiting time. I think it was (umm) I'm... I'm a very private person generally (umm). I don't like to speak to anybody about it so if it's almost not instant, if it's not there, I'll just walk away generally. You know so it's got to be... it's got to be fairly quick to be honest (umm). Yeah I think it's... I think it's just the times I had to wait, you know in four to six weeks' time is no good for me. I'll just brush it under the carpet and move on" (Michael: Group Two)*

Communication issues preventing access to services were also highlighted. These focused on veterans becoming lost in the system with no-one getting back in touch with them regarding their request for support. Problems with appointments interfering with work schedules and a lack of support in local areas were also cited in relation to access.

#### Entitled

Even once veterans were able to access care, they talked of problems in continuing to prove their ongoing *entitlement* to help. One veteran who felt in need of support was told by medical professionals that he no longer needed care, while another had their care stopped at transition out of the Armed Forces, as soon as they had registered with a GP, which left them waiting months for care via a NHS referral, with no support in the interim.

*"I was anxious because I knew I wasn't right properly. But I was obviously listening to the professional. I have to take on board what they say don't I? (Steven: Group Three)*

#### Efficacy

A number of veterans had concerns over the *efficacy* of the care they had received. Typical beliefs were that military mental health care failed to deal with the root cause of issues, acting instead as just a temporary fix. Generally, care was said to feel scripted, with therapists simply trying to place veterans in a box rather than actually listen to what was wrong.

*"I felt it was scripted and you know they were just... there was nothing personal about it because they were just "how are you feeling?", you know and ticking boxes. It wasn't getting to the root of my problems, it was more like just a standard procedure for you know to deal with stress and stuff" (Robert: Group Three)*

Veterans were also frustrated at not having a diagnosis, or a diagnosis that they could understand, referencing this as blocking them from understanding how treatment would help them.

*"Well I didn't know how it was or what...what... I didn't understand it all" (Steven: Group Three)*



**Figure Eight: Barriers divided as Actual barriers and Potential considerations**

Theme	Sub theme	Discussion
Identify	Nothing is wrong	
Define	See symptoms as normal	
Need	Symptoms are not severe enough	
Deserve	I don't deserve treatment	
Utility	Treatment won't help	
Fear	I am afraid	
Stigma	I won't admit	
Eligible	I am not eligible	
Access	I can't access	
Entitled	I am no longer entitled	
Efficacy	Treatment isn't working	

### Impact on Help Seeking

The section above describes several types of barriers that a veteran may face on their journey to mental health support. Not all barriers were discussed equally by participants. Figure Eight above indicates the degree to which veterans discussed each of the barriers in relation to having a marked impact on their decision to seek care. The greater the degree of green shading in the right hand column, the more veterans discussed that particular barrier.

Most veterans appear to be able to *identify* in themselves that something is not right but *defining* that as a mental health problem represents a prominent barrier to care.

The phase two barriers associated with deciding to seek care (i.e. *deserve, utility, fear and stigma*) are discussed by around half of the veterans, with most veterans citing a culmination of two or more of these barriers as preventing them from reaching out for mental health support. Problems recognising a need for treatment was the most prominently discussed barrier to care at this phase.

Interestingly although all veterans spoke about the stigma around mental health as a potential concern that people *may* have when contemplating seeking help, this did not translate to an equally pervasive impact on help seeking. That is, less than half of the veterans cited stigma as having an actual impact upon their decision to seek care.

By the time veterans reach phase three (accessing and maintaining support) the barriers around *eligibility, access, maintaining support* and believing in the *efficacy of treatment* appear to have a lower degree of impact on veterans' help seeking behaviour.

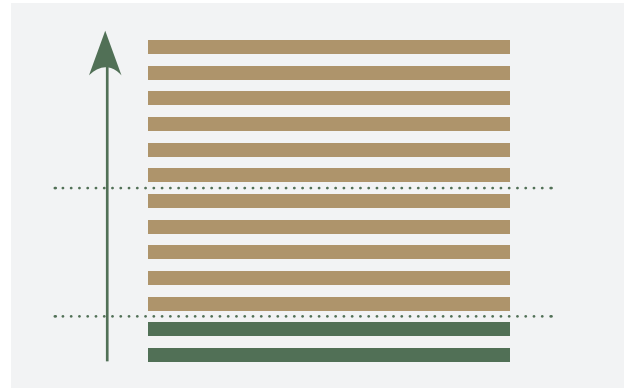
Two main 'choke' points appear to exist along the journey to mental health support: initial recognition of a problem, and a need for treatment. These 'choke' points are followed by making the decision to reach out for support.

### Barriers: Key Findings

- Barriers aligning to each step of the journey to care block veterans from seeking mental health support
- A belief that symptoms are not severe enough to be defined as mental health, or to warrant treatment, is the dominant barrier to care for Group One and Group Two veterans
- Access and eligibility issues centred on limitations in the provision of mental health support block those in Group Three seeking mental health support

Each stage of the journey to mental health support is also associated with a series of facilitators that enable veterans to progress on their journey. The following section will describe these facilitators in detail before discussing their impact on help seeking behaviour.

### Phase One: Recognition



The initial phase on the journey to mental health support requires a veteran to both *identify* a problem, and to *define* that problem as a mental health problem.

#### Identify and Define

Veterans discussed the detection of a broad array of mental health concerns as instrumental in their *identification* and *definition* of a mental health problem. Symptoms such as problems sleeping, isolation or excessive anger reactions were commonly mentioned.

*“Because I... I don’t sleep... I don’t sleep (umm) I wake up or I’d go out for a while and try and do something, but I just couldn’t sleep. So I’d wake up in the wee hours and I’d stay awake for two or three hours or whatever” (Gary: Group Two)*

Veterans also spoke about the severity of the problems they were facing as enabling them to recognise that they had a mental health problem, either through experiencing suicidal ideation or an incident where they felt that their actions were placing another person in danger.

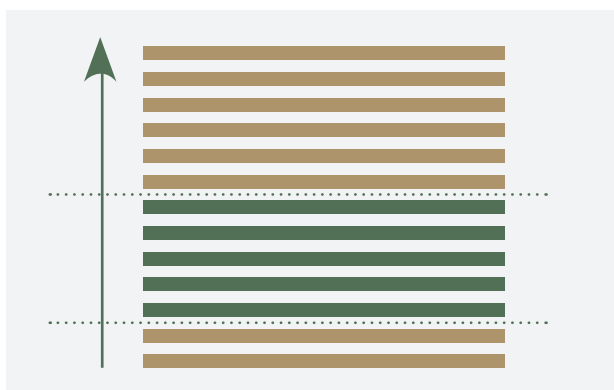
*“I did actually take an overdose at one stage (umm) and I think that was probably my wakeup call (umm) taking the overdose” (Michael: Group Three)*

Veterans discussed the role that other people can play in the identification and definition of a problem by helping them to understand that they might have a mental health problem. This was typically discussed in relation to a significant other, wife or girlfriend, but also included co-workers and health care professionals.

*“I was talking to my wife I think, because she said that I had... I had massive issues and she wanted me to get help” (Ken: Group Three)*

## FACILITATORS: How do veterans engage in successful mental health treatment?

## Phase Two: Decision to Seek Mental Health Support



Facilitators at the second phase focused on identifying a *need* for treatment, recognising that the veteran was *deserving* of treatment, believing in the *utility* of treatment, as well as overcoming the barriers of *stigma* and *fear*.

### Need for treatment

Recognition of a need for treatment was tied up with veterans' perception of mental health symptoms, in that once veterans recognised that their symptoms had reached a point of severity that they could no longer cope with, they sought help. The severity of these symptoms, in terms of suicidal ideation and actions that posed a risk to others, were frequently discussed as facilitating the decision to seek support. This suggests that in order to recognise a *need* to seek treatment, veterans wait until their symptoms reach a point where they have no choice, in that a crisis event has occurred.

*"Well I was at crisis point when I went to see the GP (umm). So you know there wasn't even an option not to"*  
(Christopher: Group Three)

### Deserve treatment

Veterans did not discuss any facilitators that enabled them to feel deserving of treatment.

### Utility of Treatment

Veterans spoke about positive beliefs about the *utility* of treatment, especially in terms of past positive experiences of support, as helping their decision to seek support.

*"It was a lot easier to reach out because I already knew that reaching out would help"* (Ryan: Group Three)

### Stigma

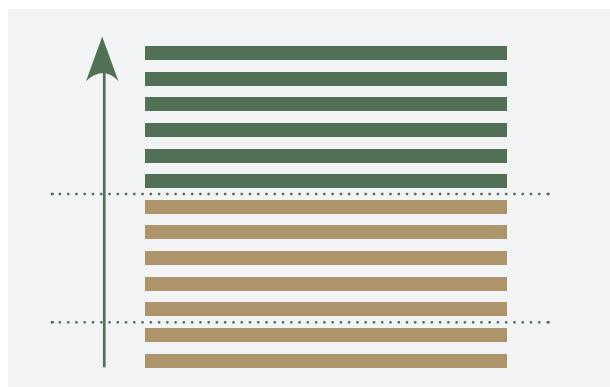
Veterans also mentioned facilitators related to *stigma*, stating that seeing others seek help, or the anti-stigma campaigns run in recent years, helped them decide to seek help.

*"And don't forget they did all this talk training and they had all these briefs and padres and sergeant majors and stuff and they tried to encourage you, if you don't stand up for yourself and open up about it. Which is what I wanted to do I thought. So I spoke to..."* (Charles: Group Two)

### Treatment Fear

Veterans did not discuss any facilitators relating to overcoming a fear of treatment.

## Phase Three: Access and Maintain Support



At this phase facilitators should be centred upon *access*, *eligibility* and *entitlement*, as well as the *efficacy* of treatment and the veteran's level of *satisfaction* with treatment experiences.

### Access

Veterans spoke about there being a large amount of support available for veterans and that such availability of support to *access* might encourage veterans to seek support.

*"I know from the... many wonderful... charities that are in the UK, there's... from what I've seen there's thousands of people there to support the ex-Serviceman and things like that....if you're in the UK you could suggest many of the multitude of mental health charities that are there for the Armed Forces"* (Donald, Group 1)

### Eligibility and Entitlement

Veterans did not discuss particular elements that allowed them to become *eligible* or *entitled* to care. Rather they discussed their pathway to care, and which agencies had enabled them to access mental health support. The most common route to care involved a veteran either going to a Medical Officer (MO) or to a GP, depending upon whether their mental health problem began whilst they were still in Service, and whether they got a referral. These options were typically the first port of call, with veterans accessing services, such as Combat Stress,



often under the direction of their GP, in order to sidestep the long waiting times for NHS services. A number of veterans had contacted Combat Stress directly under guidance from friends or via a representative at the Royal British Legion. A small number of veterans accessed private medical care and this was typically to ensure a higher standard of care, or again, in order to avoid long NHS waiting times.

### Efficacy

Positive beliefs about the *efficacy* of treatment were discussed by veterans. Treatments where veterans were given an understandable diagnosis that helped them get to grips with their problem were commonly mentioned.

*“The time spent at Combat Stress was... was really... no it was very good because it educated me as to what the... you know what the condition was, (umm) how you can overcome some of the symptoms, really the main thing was getting a label I’m now beginning to understand” (Jason: Group Three)*

Veterans also particularly liked treatments where they could see a tangible practical benefit, such as sleep therapy or being taught coping techniques that worked almost instantly.

*“The grounding stuff I suppose today what they’ve taught me... to try and... its (umm) when like I have nightmares and stuff like that... and I feel all overwrought with anxiety and stuff like that, I still use their... the techniques they taught me (umm) the what, whys and when’s and stuff” (Steven, Group Three)*

### Satisfied

Veterans described experiences which reinforced the notion that it was ‘okay to seek support’ as having a positive impact on their *satisfaction* with their treatment experience. These experiences included positive reactions from colleagues and friends, as well as seeing others receive mental health care.

*“Then just as I was going through the end of it, one of... one of my one of my mates..., he came in and he was... he was going through the same counselling. So it was quite a ‘what are you doing here’? The last person you expect to see. A very strong man. Somebody I’d certainly looked up to and I thought crikey it happened to him... if he’s here you know I’m normal” (Paul: Group Three)*

Veterans also believed that there had been a dramatic increase in rates of mental health problems, particularly in light of recent conflicts in Iraq and Afghanistan, which again helped to normalise mental illness (although interestingly this belief in the dramatic increase of

mental health conditions is not grounded in fact). Both of these beliefs led veterans to believe that people would be more supportive of those seeking help and as such people would be more willing to come forward and ask for support.

*“Say like from you know [the first Gulf War] you know... it was only a handful you know. It wasn’t really accepted. You know people were sort of shunned because of it, but now... but since 2003 because we’ve been constantly you know in the fight shall we say, it’s become more prevalent. It’s become more... you know people are seeing it in more people. So because it’s becoming you know more noticeable, you can actually see that it is a real thing. And then it’s about you know education and... and sort of advising people that you know it’s happening. So I think that’s you know that’s one thing of you know that’s come out of [Iraq] and the [Afghans] sort of conflicts that you know (umm) is pushing it to that sort of to the forefront of people’s minds” (Daniel, Group Three)*

### Impact on Help Seeking

The section above describes all types of facilitators that might encourage a veteran to progress on their journey to mental health support. Not all of the facilitators were discussed equally by participants. Figure Nine overleaf indicates the degree to which veterans discussed each theme. A greater degree of green shading in the right hand column equates to a higher level of participants discussing the theme.

Replicating the results of the barrier section, most veterans appear to be able to *identify* in themselves that something is not right. This acts as a major facilitator to making initial progress along the journey to mental health support. Reaching a point where they are able to *define* those symptoms as mental health concerns and recognising a *need* for treatment are discussed as facilitators for around half of the veterans. Belief in the *utility of treatment* as well as anti-*stigma* messages are also discussed as potentially facilitating veterans to seek help for mental health problems. Facilitators associated with the other phase two stages, *deserving* treatment or overcoming treatment *fears*, were not discussed. Veterans did discuss phase three stages including eligibility, access and maintaining entitlement to treatment, as having a positive effect on their satisfaction with the treatment experience. Belief in the *efficacy* of treatment was a commonly discussed facilitator to maintaining mental health support. The most discussed factors initially facilitating veterans to seek support are centred on the recognition of a mental health concern requiring treatment, which the analysis shows is typically taken out of the veterans’ hands either by the intervention of others or by the occurrence of a crisis event.

**Figure Nine: Participant Discussion of Facilitators**

Theme	Sub theme	Discussion
Identify	Identify symptoms	
Define	Recognise severity of symptoms	
	Recognition from others	
	Recognise impact on life	
Deserve	I do deserve treatment	
Utility	Treatment will help	
Fear	I am not afraid	
Stigma	It is okay to admit	
Eligible	I am eligible	
Access	I can access	
Entitled	I am entitled	
Efficacy	Treatment is working	

### Facilitator Summary

- Help-seekers tended to report severe symptoms which manifested as suicidal thoughts or as them posing a danger to others
- The severity of these symptoms typically led to others forcing them to seek help
- This suggests that veterans currently receiving mental health treatment have not made a conscious decision to seek help, but rather are receiving support because they have reached such a crisis point
- Once in mental health support positive beliefs about the efficacy of treatment have a substantial impact on veterans' maintenance of support



**REPEAT  
EXPERIENCES:**  
Why do veterans have  
multiple interactions with  
mental health services?

Exploration of why veterans are, and are not, in successful mental health support highlighted that almost half of the participants had experienced multiple interactions with mental health distress. For these participants an analysis of their lifetime experiences with mental health distress was conducted, mapping their progression through multiple journeys to mental health support. This analysis aimed to explore the reason that these veterans were having multiple mental health experiences.

Analysis of these journeys identified a number of patterns to these interactions. Only one veteran illustrated no recurrent pattern, with a number of varied barriers impacting his multiple interactions with mental health services.

Veterans' progression through the journey followed one of four patterns:

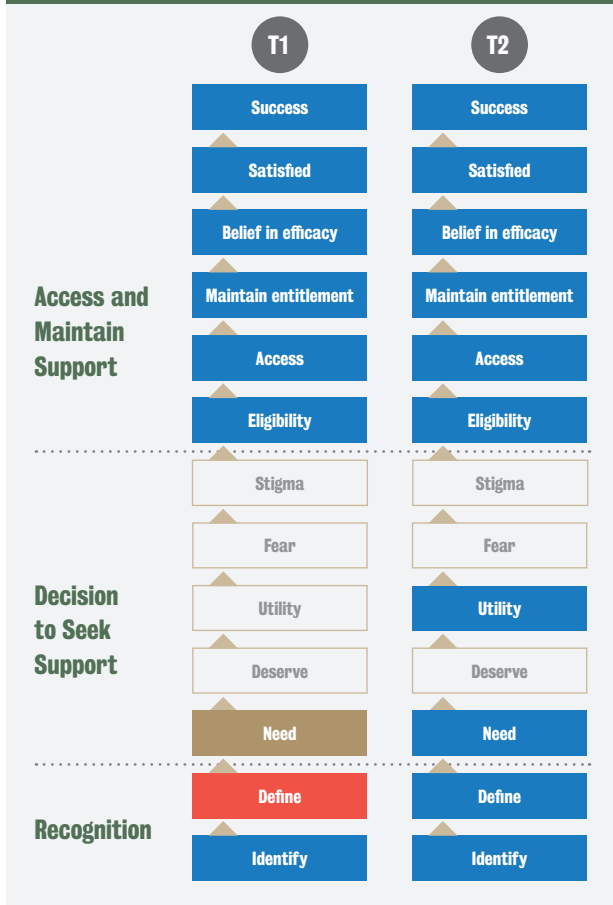
- 1 Multiple experiences of mental health distress
- 2 Failure to recognise treatment need
- 3 Negative treatment experiences
- 4 Provision barriers

#### **Multiple mental health experiences**

For a group of veterans their multiple interactions with mental health services could be explained by their multiple and separate experiences of mental health difficulties. These veterans were able to progress through the journey to mental health support successfully in each episode. Their multiple interactions with the journey to mental health support were caused solely by their recurrent experience of mental health distress. Figure Ten overleaf provides an illustration of a representative lifetime, mapping a veteran whose experiences followed this pattern. Please note that the examples provided in this section have been created from an amalgamation of veterans' experiences and do not represent a single veteran's experience in order to maintain the anonymity of participants.

Blue colour coding represents positive steps veterans were able to take (i.e. facilitators), orange colour coding represents barriers, and the brown shading is applied at the need stage when veterans progress to recognise a need for support, which has been prompted only through outside intervention (e.g. by their wife forcing them to seek support).

**Figure Ten:  
Pattern One: Multiple Mental Health Experiences**



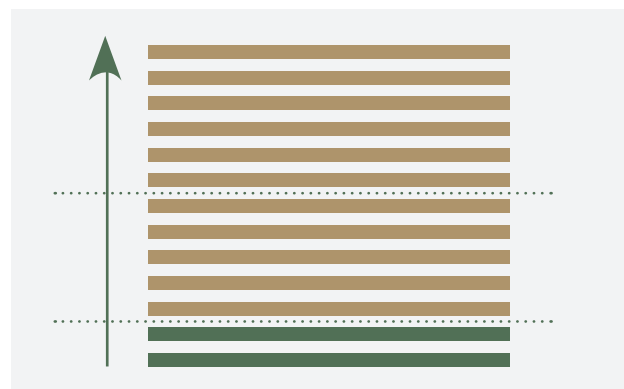
The first time this veteran experienced mental health difficulties (T1 in Figure Ten above), he was unsure what was wrong, unable to define a problem or to recognise a need for treatment until directed to do so by outside intervention. After this point, he was deemed eligible to immediately access treatment which he believed in the efficacy of. He was able to maintain this support, which had a significant positive impact on him, until he felt he no longer needed support, successfully completing his journey to mental health support.

Years later (T2 in Figure Ten above), with no mental health concerns in the intervening years, he noticed some of the same symptoms re-appear. In this second experience, he was able to identify and define the problem and independently recognise a need to seek support, facilitated by the knowledge of mental health problems and positive

beliefs about the utility of treatment gained from his first interaction with mental health services. Again, he was able to expediently access mental health support, facilitated by his ability to concisely convey the problem to his doctor, receiving treatment he believed to be effective which he was able to maintain until he felt that he no longer needed support, again successfully completing his journey to mental health support.

This type of pattern, as illustrated by T1 and T2, represents an ideal scenario whereby a veteran makes progress from their first interaction with mental health services where they experienced a barrier, to their second interaction with mental health services where they were then able to resolve that barrier previously experienced and move more smoothly through the journey to successful mental health support. In this instance, the veteran was able to recognise the symptoms of mental health distress expediently in the second episode, progressing from the inability to identify a need for treatment that delayed his initial experience with mental health services.

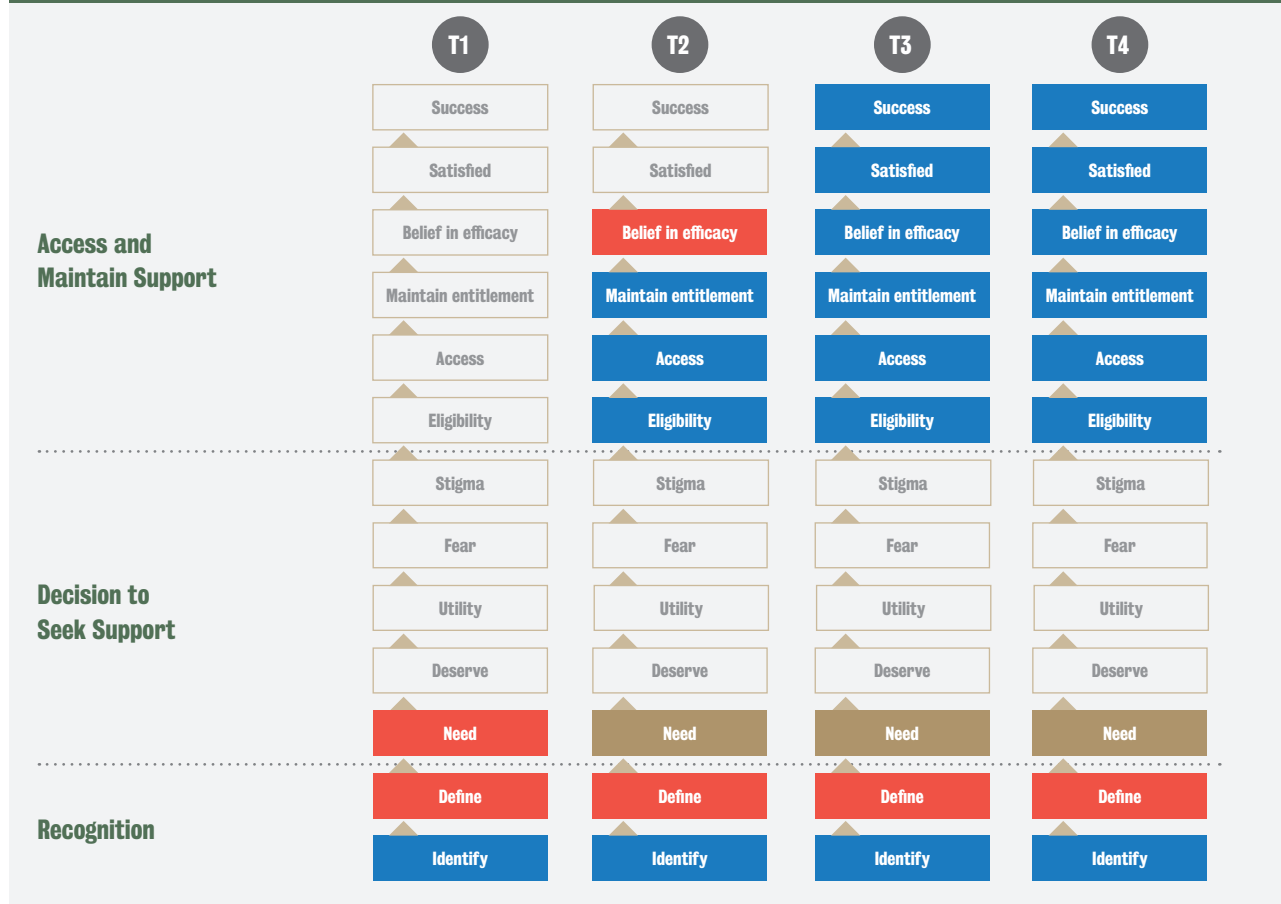
**Phase One:  
Recognition: Failure to Recognise Treatment Need**



At the other end of the spectrum is the worst case scenario: those veterans who fail to progress through even the first phase of the journey to mental health support despite multiple, sometimes successful, interactions with mental health services. These veterans repeatedly fail to independently recognise a need for treatment and as a result either receive no support, or support is delayed until they seek help due to another's intervention. Figure Eleven overleaf provides an example of this pattern, again developed from a consolidation of veteran stories.



Figure Eleven: Pattern Two: Failure to Recognise Treatment Need



This veteran recalls being able to identify symptoms of mental health difficulties after his first deployment. At the time he did not understand mental health problems and was unable to define these symptoms as mental health difficulties, therefore failing to recognise a need for treatment (T1).

A similar experience ensued after several years where he was able to identify symptoms but unable to define these as a mental health problem. However, at this time his chain of command recognised his need for treatment and he was referred into mental health support and deemed eligible to access and maintain treatment. After some time this treatment was stopped as he did not believe in the efficacy of the treatment, doubting that it was having a positive effect on his symptoms.

After a period of several years (T3) the veteran again identified some symptoms of mental health distress but was unable to define these as a mental health concern and failed to recognise a need to seek help until he was referred into support by his wife. Again he was found eligible to

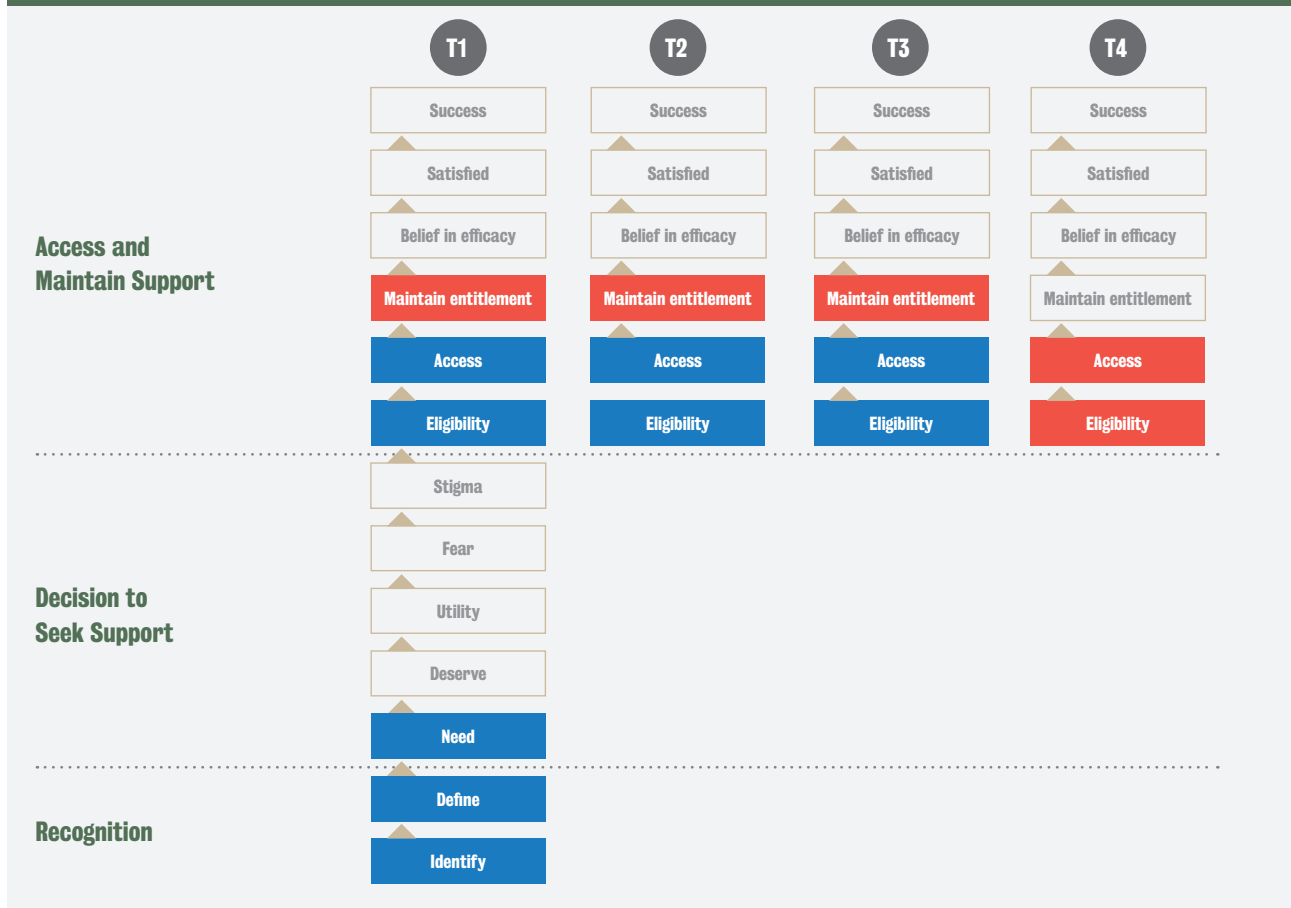
access and maintain support. At this stage he received a diagnosis and believed he was receiving effective treatment which continued until he felt he no longer needed support, successfully completing his journey to mental health support.

Following his transition out of the Armed Forces (T4), he again identified some symptoms of mental health difficulties but once more was unable to define these as a mental health problem and failed to independently recognise a need to seek help. Outside intervention led to his referral to mental health support, which continued successfully until he felt he no longer needed support.

For this veteran, each experience with mental health distress saw him re-enter the journey to mental health support at the initial step and become stuck in a recurrent loop centred on an inability to define a mental health concern and a subsequent failure to recognise a need for treatment. Even positive treatment experienced previously failed to teach the veteran to recognise warning signs that some degree of mental health support might be beneficial.



**Figure Thirteen: Pattern Four: Provision Blocks**



Forces at which point he was told that he was no longer entitled to support.

After his transition out of the Armed Forces (T4) he had been consistently trying to receive mental health support, both via the NHS and via charity services, but faced multiple issues around eligibility and access to these services.

For veterans within this final pattern group, a strong drive to seek mental health support was maintained, even across multiple potentially negative experiences with mental health services. In this example the

mental health services repeatedly failed to meet the demand for support. These failures are characterised by two distinct problems: firstly, veterans spoke about military mental health care being terminated before they felt that their issues were resolved, commonly referring to military mental health support as a ‘band aid’ that failed to deal with their underlying issues; and secondly, once they had transitioned out of the Armed Forces the main barrier to care was problems with eligibility for services or with access to services due to excessively long waiting lists.

**Figure Fourteen: Participants Experience of Recurrent Barriers**

Pattern	Experienced
Multiple Mental Health Experiences	
Failure to Progress to Recognise Need	
Blocked by Negative Treatment Experiences	
Provision Blocks	

**Impact on help seeking**

The section above describes the types of recurrent barriers that a veteran may face on their journey to mental health support. Not all barriers were experienced equally by participants and Figure Fourteen above indicates the degree to which veterans experienced each of the patterns. The greater the degree of green shading in the right hand column, the more veterans experienced that particular recurrent barrier.

As highlighted in the earlier Barrier section, problems around defining a mental health problem and recognising a need for treatment act as a recurrent problem blocking veterans from seeking mental health support.

The impact of negative treatment experiences can push veterans backwards on their journey to mental health support, leading them to question the utility of seeking professional support.

But the majority of veterans were able to successfully progress through the journey to mental health support, recognising a problem and deciding to seek support, the issue being a repeated blockage caused by problems with the provision of mental health support.

**Stigma as a First Time Barrier or Delay Only**

Throughout the analysis, the absence of a pattern centred on stigma became apparent. Although stigma had been cited as a barrier to care for around half of the veterans interviewed, stigma was not found to act as a recurrent barrier to care. In fact, the impact of stigma as a barrier or delay to seeking mental health support was notably absent from any second experience with mental health distress. Stigma appears to be a barrier or delay that is particularly pertinent to veterans’ first experience with mental health care. So why does stigma have most impact on the first experience with mental health care? There are a number of potential explanations that may explain this:

- The mental health support veterans receive is positive and the benefits of treatment outweigh any stigma concerns the second time around

- Veterans receive no, or little, stigmatising reactions after that first treatment experience and so stigma becomes an unfounded concern with little impact on future experiences
  - During treatment veterans’ exposure to others undergoing mental health problems allows them to develop beliefs that mental health problems are ‘normal’
  - Veterans’ increased understanding of mental health developed via interaction with mental health professionals helps to break down any stigmatising beliefs
- Future research should explore the reasons behind this further since any methods that serve to eliminate stigma concerns for a veteran’s second experience could be useful in developing interventions to act against stigma concerns on a veteran’s initial experiences with mental health.

**Repeat Experience Summary**

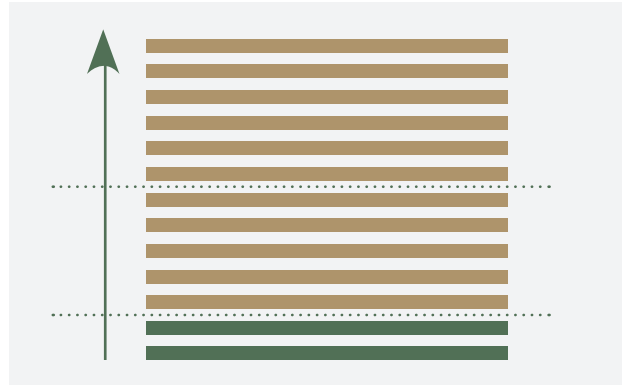
- Almost half of veterans discuss more than one experience of mental health distress
- Failure to independently define a problem and recognise a need for treatment act as recurrent problems
- Negative treatment experiences push veterans back on the journey to mental health support, with consequential negative beliefs about the utility of treatment blocking progress to successful support
- Failures in the provision of mental health support are a dominant recurrent barrier to seeking mental health support
- Stigma barriers appear to be only apparent during a veteran’s initial experience with mental health distress, after which concerns around stigma appear to be resolved





At the final part of the interview, all of the veterans were asked to describe what mental health support might look like in an ideal world, that is, what improvements they felt were needed to enhance existing services. Again, these can be divided across the journey to mental health support.

**Phase One: Recognition**



At the recognition phase, veterans spoke about a number of improvements that would help them to both identify and define a mental health problem.

**Identify and Define**

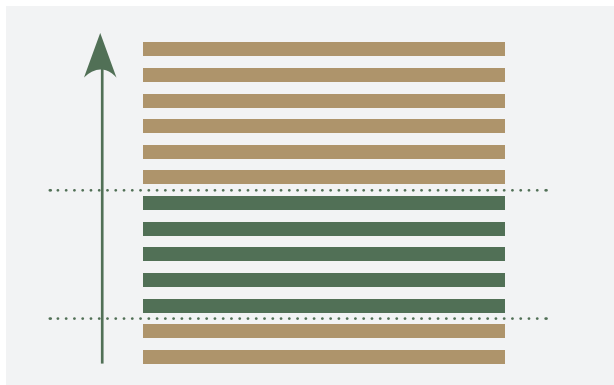
Veterans stated that they wanted help to identify symptoms of mental health through education, and wanted the responsibility of identifying symptoms themselves to be removed and replaced instead by enforced mental health check-ups, or even scheduled and enforced counselling sessions post deployment and while transitioning out of the Armed Forces.

*“Some sort of formal sort of you know ‘Here sit down, this is what you might encounter, this is something and (umm) these are the people that you can go to speak to”*  
*(Daniel: Group Three)*

*“I think the families as well because it’s very... it’s easier for them to spot it. But it’s harder for you as an individual to spot these symptoms whereas families can probably see it in you, and you know make you aware of it. So it’s not only the soldier, I think the military families... the military community needs to be a lot more aware of it”*  
*(Jason: Group Three)*

*“After... after every tour or every six month after a tour they should go for a screening. So to see how they are and stuff like that and if they... (umm) if anything was picked up then they can go for treatment as early as possible”*  
*(Steven: Group Three)*

## Phase Two: Decision to seek support



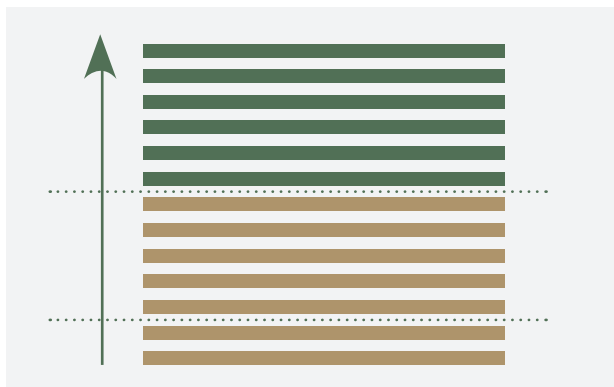
At the decision to seek support phase, the improvements veterans suggested focused solely on stigma.

### Stigma

Veterans discussed the need to continue the drive to reduce the stigma around mental health, both in terms of general anti-stigma campaigns, and in developing new campaigns that raise awareness of the fact that other people, indeed high profile people, access mental health support.

*"I think it's... it's knowing that other people use the system. I think that's probably what it is. You're not on your own... Because it normalizes it. It just makes it... it makes it what you do. As opposed to you're... you're the odd one out, you're the strange one. It just says that 'yeah lots of people do this'"*  
(Edward: Group One)

## Phase Three: Accessing and Maintaining Support



Eligibility, access and efficacy were discussed by veterans at the access and maintain phase in terms of potential improvements to mental health care.

### Eligibility and Access

The need to simplify eligibility criteria and improve communication of available support was also frequently discussed by veterans. A number of veterans particularly emphasised a desire to receive regular updates from the military after transitioning out of the Armed Forces. These updates could offer support options, but could also ensure that they had up to date information when they needed it, and maintain some degree of the communication with the Armed Forces.

*"But I wouldn't say like a monthly newsletter or something like that, but something similar. Do you know that so they're aware that there is help available?"*  
(Frank: Group One)

Veterans also commonly spoke of the need to improve access to services, such as shortening waiting lists, fast tracking veterans, and even allowing veterans to continue to use military health facilities post transition.

*"You know I... I would... I think you know if you are a veteran or you know for a period of time after your Service, maybe you know not... let's not call it thirty years, but say eighteen months or two years that you should still be able to walk onto a camp and see a medical officer or a you know someone in the medical profession, a military medic and then they... they direct you. I think there should be some sort of aftercare service (umm) that... that veterans can go to in the immediate you know post-departure or post-leaving the Service"*  
(Joseph: Group One)

### Efficacy

In terms of the type of treatment that veterans wanted, predominant themes were around more informal support or more drop-in centres. Veterans wanted somewhere they could use as a first point of call to get an initial evaluation of their mental health and almost legitimise their need for support. They also wanted somewhere they could receive support that was less 'medical'.

*"I think for people suffering from low level mental health issues, a drop-in centre, a phone line you could possibly ring and get some advice and support (umm) without having to formalise the case by going to the GP.....So if you could just... so if you could go and have a quick chat with someone about it and they could guide you that way, I think that would be a lot better because you're not making a big fuss out of it"* (Thomas: Group One)

It was important that this support enabled them to identify the root cause of their issue, but they wanted the format to be centred on them talking, and a professional (who should have a shared background both in terms of mental ill health and military understanding) helping them to uncover what their problem might be, rather than the format where they felt they were being asked the same scripted questions to fit them in a particular box.

*“And somebody who’s been in a situation not too similar to what the patients been in and you can share... share what you’ve been through and how one persons coped with helping the person who’s finding it more a struggle. You don’t have to have been in the same hole” (Gary: Group Two).*

### What Veterans Want Summary

- Veterans wanted support to help them to identify a mental health issue, either directly or via some form of enforced mental health support
- They wanted treatments that were centred on dealing with the root cause of problems with mental health professionals who understood them
- Veterans also wanted further efforts to continue to de-stigmatise mental health generally as well as provide less formal support that allowed them to get some guidance on if they needed support and did not lump them together with those with more severe mental health problems

## Results Overview

### Key findings

- A belief that symptoms are not severe enough to be defined as mental health problems, or to warrant treatment, is a dominant barrier to care
- Veterans who decide to seek support do so only when symptoms have reached the most severe degree where they are suicidal, a danger to others, or where they are forced to seek support by others
- Many veterans are stuck in recurrent loops where specific barriers (such as problems recognising a need for treatment, negative treatment experiences, and problems accessing services) continue to block their progression to successful mental health support
- Failure to recognise treatment need and negative treatment experiences continuously act as a block to accessing services for some veterans, but the most common recurrent barrier to care is problems in the provision of care offered to veterans
- Stigma concerns appear to be resolved through veterans' interaction with mental health services, as they appear to be notably absent when veterans have multiple interactions with mental health services
- Veterans want informal support to help them to identify a mental health problem, acting as a triage to provide guidance on whether more formal support is necessary
- When treatment is required, veterans want it to resolve the root cause of their problems and be delivered by mental health professionals who have experienced mental ill health and who understand the military





This study aimed to explore the lived experiences of veterans facing mental health problems to better understand their views on seeking help for their difficulties. Whilst this important topic has been the focus of many previous research studies, few have looked at this topic directly from the viewpoint of the veteran themselves. Given the importance of the topic, which is frequently the subject of political and media attention, this study specifically aimed to:

- 1 Identify important barriers and facilitators to care for the UK veteran population
- 2 Define the relationship between barriers and facilitators to care and help seeking behaviour
- 3 Compare these barriers and facilitators to help seeking across veterans at different points on the journey to successful mental health support

In line with these research objectives, this study has developed a theoretical model of the core stages of a veteran's 'journey to mental health support' identifying salient barriers and facilitators at each stage. The importance of these barriers and facilitators, and their impact on help seeking behaviour, can be seen to vary depending on the particular journey stage, which would indicate that a 'one-size-fits-all' policy to encourage help seeking behaviour may not be the most appropriate solution to increasing help seeking behaviour. Veterans embarking on their journey appear to need support to help them recognise that they have a potential mental health problem. Once they have recognised they have a potential mental health problem, veterans require encouragement to help them understand that they have a mental health problem that needs treatment and to understand the benefits of treatment seeking. Following on from this, veterans need assistance in identifying the most appropriate treatment option for their individual circumstances.

An exploration of veterans with multiple experiences of mental health distress over time revealed three core barriers acting as recurrent blocks to successful mental health support experiences: persistent problems with failing to recognise that they had a mental health problem; negative treatment experiences resulting in discouraging perceptions on the utility of treatment; and failings in the provision of mental health support. All three of these core barriers were shown to result in these particular veterans (i.e. those with multiple experiences of mental health distress) becoming stuck in recurrent, unsuccessful interactions with mental health services, which served to prolong their experiences of mental health distress, sometimes over decades. In contrast, stigma concerns of these veterans with multiple experiences of mental health distress seemed to be resolved through veterans' interactions with mental health services, with stigma barriers appearing to be notably absent from any subsequent journey to mental health support.

## Barriers and Facilitators

Previous research into help seeking behaviour within the military, and military veteran, population has focused on four main categories of barriers:

- The stigma of mental health;
- Problems recognising a need for treatment;
- Negative beliefs about mental health treatment; and
- Practical barriers to accessing mental health support

And three main categories of facilitators:

- Reduction in stigma around mental health;
- Recognition of a need for treatment;
- Positive beliefs about mental health treatment

The findings of this research study reinforce the importance of these categories of barriers and facilitators within the UK military veteran population and also provide a greater granularity of analysis. Through this greater granularity eleven 'core' themes in the 'journey to mental health support' emerge:

- 1 Identifying a problem
- 2 Defining that problem as a mental health problem
- 3 Recognising a need for treatment
- 4 Feeling deserving of treatment
- 5 Believing in the utility of treatment
- 6 Resolving fears around treatment
- 7 Overcoming the stigma of mental health
- 8 Identifying mental health services for which you are eligible
- 9 Accessing mental health services
- 10 Maintaining entitlement to services
- 11 Continuing to believe in the efficacy of treatment

## Impact on help seeking

Within the established scientific literature (at the time of this study), the relationship between barriers and facilitators with help seeking behaviour is unclear, for example, whilst the established literature frequently cites stigma as being a major barrier to seeking help, contemporary reviews portray contradictory conclusions on whether or not stigma is positively or negatively associated with help seeking behaviour. Our findings suggest that although veterans commonly talk about stigma as a potential concern, in reality the impact of stigma on help seeking is more modest than suggested in the literature. Perceived need for treatment has a more dominant impact on whether or not a veteran decides to seek help. Veterans fail to seek help when they do not perceive a need for treatment and only seek help once a

need for treatment is abundantly clear, either via other peoples' intervention or the occurrence of a crisis event.

## Journey to mental health support

The impact on help seeking of each of the barriers and facilitators to care identified within this research is tied to our theoretical model of the 'journey to mental health support'. Our findings suggest that the importance of barriers and facilitators varies depending upon a veterans' stage on the journey. Previous work by Iversen<sup>15</sup> and by Jakupcak<sup>32</sup> discussed the potential utility of employing generic journeys such as the 'stages of change' model which describes the stages a patient progresses through from denial of a problem to maintaining a change.<sup>33</sup> Within our research we have been able to show that within the concept of a 'journey', different barriers and facilitators affect UK military veterans as they progress through those different journey stages. More than this, our research has enabled the development of a robust theoretical model of this journey, derived specifically from UK military veterans for UK military veterans, that indicates the importance of different barriers and facilitators at each stage of this journey.

## Summary

In summary, this research builds upon the existing literature in four main ways:

- 1 Identifies important barriers and facilitators for UK military veterans
- 2 Illustrates the varying impact of these barriers and facilitators on help seeking behaviour
- 3 Categorises the barriers and facilitators into the stages at which they are most important on a veteran's 'journey to mental health support'
- 4 Identifies recurrent barriers that result in veterans experiencing continual unsuccessful interactions with mental health services

This evidence helps to identify the most important barriers and facilitators to target to improve UK veteran help seeking, as well as modelling the significance of such barriers and facilitators across the different phases on the journey to mental health support. This research has identified key levers for potential interventions to improve help seeking for mental health problems within the UK military veteran population as they affect this population over the course of their individual journeys to mental health support, and these will be explored further in the Path Forward section.

## **Evaluation of Research**

As with any research project this study has particular strengths as well as a number of potential limitations.

## **Strengths**

### **Qualitative exploration: giving veterans a voice**

Due to the qualitative nature of this research, this study enabled veterans to voice aspects of their lived experience that they felt were important. As opposed to quantitative measures where veterans rate categories deemed important by others, in this research the topics of discussion were led by the veterans themselves.

### **Large sample size**

The sample size utilised within this research study represents a high number of participants for a qualitative piece of research. This ensures that we can be confident that saturation was reached, meaning that we have heard the major opinions on barriers and facilitators to care within the military veteran population sampled.

### **Heard from all major sub-groups in the UK Armed Forces**

The MoD Biannual Diversity Statistics (statistics released by the MoD that report on the characteristics of those who have left the Armed Forces in the last five years), were utilised in the recruitment phase of this research to ensure that the research includes views from the major sub-groups in the UK Armed Forces and thus can be confident that the key issues affecting help seeking have been identified. This is with the exception of female members of the UK Armed Forces, as discussed in the Limitations section below.

### **Maps to, but extends, existing veteran research**

As mentioned above, this research illustrates which barriers and facilitators are important, which impact help seeking, and where on the journey to mental health support they are most pertinent. The findings support those broad categories of barriers and facilitators identified in earlier research, but extend this by providing greater detail, indicating the relationship that these factors have upon help seeking behaviour, as well as the way in which their salience changes as a veteran progresses through the 'journey to mental health support.'

## **Limitations**

### **Response bias**

This research is based only on those veterans who chose to respond to the KCMHR health and well-being cohort study, and for Groups Two and Three, also then to respond to the clinical interview study. Recruiting participants from this particular population ensured that we were able to identify those veterans with a probable mental health condition at one of the three distinct phases on their journey to mental health support. However, there is no way to know to what degree, if any, this self-selection aspect potentially skewed the results.

### **Mental health status**

Participants were selected based on whether they scored positively on self-report screening measures. Although these have high levels of reliability, scores on these measures do not equate to a clinical diagnosis. For Group Three participants, details of clinical diagnosis were requested and whilst all participants reported that they had such a diagnosis, again this was based on self-report and could not be verified.

### **Males only**

The study is limited in that it only uses male participants. This decision was made due to the low number of females in the Armed Forces and the resultant need to over-recruit from this population in order to get meaningful qualitative data to represent the female military veteran population.



The results of this research have significant implications for the ways in which support for mental health is provided for military personnel after leaving the Armed Forces, as well as whilst they are still serving. To ensure a broad and realistic discussion of the implications of this research, a stakeholder event was held towards the end of this project. Representatives of major providers of veterans mental health support attended including:

- ♦ NHS
- ♦ Samaritans
- ♦ MoD
- ♦ Centre for Mental Health
- ♦ Royal Foundation
- ♦ CONTACT
- ♦ Combat Stress
- ♦ Help for Heroes
- ♦ Walking with the Wounded
- ♦ The Royal British Legion
- ♦ SSAFA
- ♦ RAF Benevolent Fund

After hearing the research findings, stakeholders worked together to discuss the results of the research and the potential impacts on practice and policy. Rather than identifying paths forward from the research, this session culminated in the development of key questions that need to be answered in order to inform future practice and policy. As such, each of the questions posed in this section can also be viewed as an implication for research. The questions are centred around the different phases on the journey to mental health support.



### **Phase One: Recognition**

The key finding to emerge from the 'recognition' phase was that veterans were unable to identify and define a mental health problem. **Key Question:** How can we educate veterans on mental health problems?

#### **Can we introduce mental health/mental hygiene training?**

Can mental health training be integrated into basic military training to ensure that all military personnel, and hence all future veterans, receive education on mental health? One potential concept around which to build this training, as suggested by stakeholders, is the notion of 'your mind as your best weapon' and the resultant emphasis on maintaining such a weapon in the same way you would maintain your rifle. Further research would be needed to identify the most effective method of providing such training, and to define the content. Social, Personal and Emotional Awareness for Resilience (SPEAR) is an existing intervention, developed for the Royal Air Force, which advocates an organisational approach to mental well-being. The framework involves education around mental health, mental health support information, and the use of practical toolkits, which together aid the identification of general mental health indicators and protective and risk factors. The Academic Department of Military Mental Health (ADMMH) is currently conducting a randomised control trial of SPEAR in the RAF in order to assess its effectiveness, the results of which are due in early 2018. **Key Question:** Are existing tools effective or is a new tool needed?

#### **Can we emphasise the potential impact of transition on mental health?**

The potential negative impact of transition out of the Armed Forces was highlighted by stakeholders as a key message that should be conveyed to veterans to enable them to prepare for, and be more aware of, both the potential negative impacts of this transition and ways in which to combat such effects. Serving personnel should be engaged in appropriate conversations about mental health during the transition process, to include not only current mental health, but also to prepare transitioning personnel for the potential impacts of the transition process on mental health. **Key Question:** Who should deliver this message, when, and what format should the delivery take?

#### **How can we foster personal responsibility for mental health?**

A key issue emerging from the research was veterans' preference to have someone else identify a mental health problem for them, namely by a mental health professional or a significant other. This was tied to veterans' inability

to define what might constitute a mental health problem, rather than from some sense that they do not feel they are personally responsible for themselves. It is important that veterans feel able to take personal responsibility for their own mental health and understand that monitoring their own mental health is the most effective way to identify a potential problem early. **Key Question:** How can we best encourage personal monitoring of mental health?

#### **How can we involve the wider military family?**

Stakeholders discussed the importance of the wider Armed Forces Community (including dependants and partners), both in terms of how they can help veterans and serving personnel identify a mental health problem, but also in terms of the additional need to be aware of, and look after their own mental health. What is the best way to involve this wider military family in any mental health measures implemented for veterans and serving personnel? Should they also receive mental health training to help them identify mental health problems both in themselves and in veterans? And if so, how would this be implemented and who would deliver it? One existing solution that may hold salience for the wider military family is Community Reinforcement and Family Training (CRAFT). CRAFT is an intervention to educate concerned significant others of those with potential substance abuse or mental health problems on how best to encourage that person to seek mental health support, as well as to monitor and improve their own well-being. KCMHR and Help for Heroes are currently running a randomised control trial to test the effectiveness of this intervention for UK military veterans the results of which should be available in early 2019.

**Key Question:** Is CRAFT effective at encouraging help seeking behaviour and improving the well-being of the concerned significant other?

#### **How we can ensure that veterans' inability to define mental ill-health doesn't act as a 'recurrent' block?**

In order to prevent veterans from continuing to be blocked by an inability to define a mental health problem in themselves and an inability to then recognise a need for treatment, there are a number of potential avenues to explore. Each of the suggestions made earlier in this section applies to this question. We can increase the education that veterans receive on mental health, we can provide them with the skills required to monitor their own mental health, and we can involve the wider military family. In addition to this, we can place a greater emphasis on relapse prevention at the end of a treatment cycle ensuring that veterans are aware of warning signs to look out for and what to do if they see them. **Key Question:** How can we best emphasise the importance of relapse prevention in the current treatment cycle?

## **Phase Two: Decision to Seek Support**

Veterans appear to have delayed help seeking until they have reached a 'crisis point' due to issues with recognising a need for treatment, and/or issues with believing that they are deserving of treatment. Negative perceptions on the utility of treatment as well as treatment fears and stigma concerns also impacted veterans' decisions to seek mental health support. **Key Question:** How can we help encourage veterans to seek help before reaching a crisis point?

### **How can we encourage the media to positively change perceptions?**

Veterans' perceptions of mental health, and their view on how others saw mental health, equated only to extreme cases (i.e. seeing those who are mentally ill as 'crazy'). This not only impacted the veterans' ability to identify less severe mental health problems in themselves, but also served to heighten the potential impact of stigma on their decision to seek help. One possible solution to this might be to encourage the media to change the way in which they portray mental health, especially military mental health. For example, Time to Change have developed a series of media guidelines to try to assist the media in reporting on mental health in a way that raises awareness and helps to debunk myths around mental illness. The Royal Foundation, CONTACT (a group of key providers of veterans' support including MoD, NHS and charities, along with academics) and the work of Prince Harry have also made important progress in reducing the stigma and debunking the myths of military mental health. Campaigns such as 'Don't Bottle it Up' and 'No Health without Mental Health' are great examples of successful campaigns. All of this work represents a solid foundation on which military mental health media guidelines could be built. **Key Question:** How do we best produce mental health guideline content, who should be involved, who should deliver it to the media and in what format?

### **How can we best change the language around 'help seeking'?**

Another way in which to address the stigma of mental health might be to change the language we use around mental health help seeking. For example, instead of talking about 'fixing' someone (which implies that someone is 'broken'), the language should perhaps focus on 'equipping' veterans with tools to manage or maintain their mental health, much as they would maintain their physical health. **Key Question:** What is the most appropriate language to use around mental health and help seeking behaviour?

### **How can we best educate on the benefits of treatment?**

Negative treatment beliefs, particularly beliefs that treatment would not help, were highlighted within the research. How can we best educate veterans that

treatment can be successful, that there can be significant improvements to their quality of life, and that seeking and receiving treatment does not need to have a negative impact on their career? Continuing and increasing campaigns where high profile people talk of their own struggles with mental health were posed as potential solutions, and not just using case studies from those with military careers, but also those from other high profile areas in order to illustrate the universal impact of mental health problems. Much work is already being undertaken in this area; for example, CONTACT have successfully engaged many high profile people to talk about the difficulties that they have experienced and their recovery process. **Key Question:** What additional campaigns can be employed to complement existing programs?

### **How do we 'sell' the wealth of current support options to veterans?**

Veterans did not feel that the support they wanted was currently available despite the wealth of support options open to veterans. Perhaps the problem is the way in which providers 'package' their mental health support. Are there ways to improve the way in which current support is 'branded' to make it appear more relevant to veterans? The Veterans' Gateway, a one-stop-shop for veterans' support, was launched earlier this year which should aid in helping veterans identify and access the variety of support options available to them. In addition to this, the NHS transition, intervention and liaison (TIL) veterans' mental health service has received significant investment in order to provide both those transitioning out of the Armed Forces, and current veterans, with joined up care. The service aims to provide an assessment within two weeks of referral and provide care for even the most complex cases. **Key Question:** What is the best way to exploit existing resources that can help veterans to make an informed choice about what they want, and can recommend evidence based treatments?

### **How can we ensure that veterans' negative treatment experiences do not lead them to doubt the utility of treatment seeking?**

In order to prevent negative treatment experiences from blocking veterans from seeking mental health support, further emphasis could be placed on following up any 'dropout' from treatment. If veterans fail to attend mental health support sessions, a more rigorous follow up protocol could be introduced. During this follow up veterans should be given the opportunity to discuss any potential concerns they have with the therapeutic relationship or the type of therapy they are receiving. A second therapist, or treatment option, should be offered to attempt to maintain the veteran's engagement in support. **Key Question:** How can we foster a greater sense of importance around following up treatment drop-out?

### **Why are stigma concerns less prominent after an initial interaction with mental health services?**

Barriers relating to the stigma around mental health appear to be a more prominent issue for veterans during their first interaction with mental health services. During subsequent interactions with mental health services concerns over the stigma of mental health appear to no longer be an issue. **Key Question:** How does this resolution occur and what lessons can be learnt to help veterans overcome the issue of stigma during their initial interaction with mental health services?

### **Phase Three: Accessing and Maintaining Support**

Once veterans had decided to seek help, the main barriers blocking them from receiving effective mental health support were issues with eligibility and access, as well as concerns over the efficacy of the treatment that they were receiving. **Key Question:** How can we ensure that veterans can access appropriate, evidence based support that they believe is effective?

### **How can therapists 'learn' to speak 'veteran'?**

Negative perceptions around therapists not understanding veterans, or the military generally, were a key barrier to both the decision to seek help, and to the perception of treatment experience as having a positive impact. Stakeholders discussed providing some form of course where therapists could 'learn' veteran. Future research should focus on developing a succinct online package that would help therapists, and potentially GPs, develop a cultural understanding of veterans. Walking with the Wounded, in collaboration with Health Education England, have developed a series of training sessions and an e-learning package to provide GPs with Veteran Healthcare Awareness which should help to eradicate this problem. Nick Wood at the University of York St John has also developed similar training, in various forms, to help support providers of veterans' mental health support. **Key Question:** How can we develop and propagate similar packages for therapists to ensure appropriate understanding throughout veterans' treatment pathways.

### **Would employing veterans as peer 'guides' help?**

Stakeholders discussed the potential that veterans themselves could be trained as 'guides' to help others through the journey to successful mental health support. 'Care navigators' are a similar concept, where non-clinical staff are trained to listen to and guide a patient to appropriate care; the care navigator concept has been shown to work well in physical health contexts. **Key Question:** What is the best way to implement such a strategy?

### **Would 'recovery stars' or 'recovery wheels' help?**

Existing tools were discussed by stakeholders that could be utilised to not only help veterans understand their own

mental health, but also to track their progress through treatment whilst simultaneously highlighting the efficacy of the treatment. Recovery stars, or recovery wheels, have been utilised within the health domain for several years. These tools help to identify an individuals' situation in relation to various key areas in their life, such as their social networks, work, and their self-esteem. At the beginning of a treatment process, an individual can mark their current situation against each of the key areas, then, on an ongoing basis, mark down their progress as their situation changes throughout the treatment process.

**Key Question:** What is the best way to integrate recovery stars or recovery wheels into the current treatment cycle?

### **How can we ensure that provision of mental health services does not repeatedly block veterans accessing support?**

In order to prevent problems with provision of mental health treatment from blocking veterans from seeking mental health support, there are a number of potential avenues to explore for both military mental health provision and civilian mental health provision, as described below:

#### **Military Care**

Within the military, veterans felt that the support they received failed to resolve their issues thereby acting as a temporary 'band aid' only. Perhaps the definition of 'fit for duty' currently used to assess when military personnel are ready to cease mental health support needs to be reassessed, including a discussion with the individual about the level of ongoing support they feel they require and the types of ongoing support the military can provide. Changes to the way in which the end of mental health support is communicated to military personnel may also help to prevent them from feeling that they are deemed permanently 'fixed' and therefore should require no further support. Potentially using language associated with transition from formal mental health support to self-regulation may be beneficial, emphasising the need for a continual monitoring of symptoms so that individuals feel they can return for further support at a later date as and when required. **Key Question:** How can we ensure that serving personnel feel that they can return for further support?

#### **Civilian Care**

Once serving personnel transitioned out of military care, the veterans in this study described their struggle in accessing NHS services due to what they felt to be excessive waiting lists, and were also faced with repeated eligibility issues from charity providers. As mentioned earlier, it is hoped that the Veterans' Gateway will aid in easing access to and in understanding the variety of support options available to them, and that the NHS TIL veterans' mental health service will help to streamline the transition of care and access to care for military veterans in the UK. **Key Question:** What mechanisms can be used to exploit existing resources that can help veterans to make an informed choice about what they want, and can recommend evidence based treatments?

## Path Forward

- How can we educate veterans on mental health problems?
  - ◊ Can we introduce mental health training to educate on different conditions and symptoms?
  - ◊ Can we emphasise the importance of the potential impact of transition out of the Armed Forces on mental health?
  - ◊ How can we foster personal responsibility for mental health?
  - ◊ How can we involve the wider Armed Forces Community?
  - ◊ How can we ensure that veterans' inability to define mental health does not act as a 'recurrent' block?
- How can we encourage veterans to seek help for mental health problems before reaching crisis point?
  - ◊ How can we encourage the media to positively change perceptions?
  - ◊ How can we change the language around 'help seeking'?
  - ◊ How can we educate on the benefits of mental health support?
  - ◊ How do we 'sell' the wealth of current support options to veterans?
  - ◊ How can we ensure that veterans' negative treatment experiences don't lead them to doubt the utility of treatment seeking?
  - ◊ Why are stigma concerns less prominent after an initial interaction with mental health services?
- How can we ensure that veterans can access appropriate support that they believe is effective?
  - ◊ How can therapists 'learn' veteran?
  - ◊ Would employing veterans as peer 'guides' be beneficial?
  - ◊ Would 'recovery stars' and 'recovery wheels' help support veterans?
  - ◊ How can we ensure that provision of mental health services does not repeatedly block veterans accessing support?



The inability to recognise a mental health problem, and then recognise a need for treatment, represents a major barrier to seeking mental health support. Veterans currently seeking mental health support appear to do so due to the severity of their symptoms which effectively take this decision out of their hands (e.g. as instigated by others prompting them to seek help). Future research must focus on aiding veterans in their own self-detection of potential mental health problems at an earlier, potentially less severe stage, and encourage them to seek appropriate and timely support, in order to both improve their quality of life and enable a more positive treatment prognosis.

Problems in the current provision of mental health support have been shown by this research to act as a recurrent barrier to a number of veterans, which effectively locks them into persistent, unsuccessful treatment experience loops with mental health services. The way in which veterans can access and maintain support, should be streamlined and made transparent to the veteran. Providers of veterans' mental health support should take note of veterans' desire for more informal mental health support in helping them to identify problems as mental health-related; which in turn should help veterans understand how to deal with the less severe mental health problems, and also help them understand the distinct difference in the kind of mental health support provided for those at the more extreme end of the mental health spectrum.



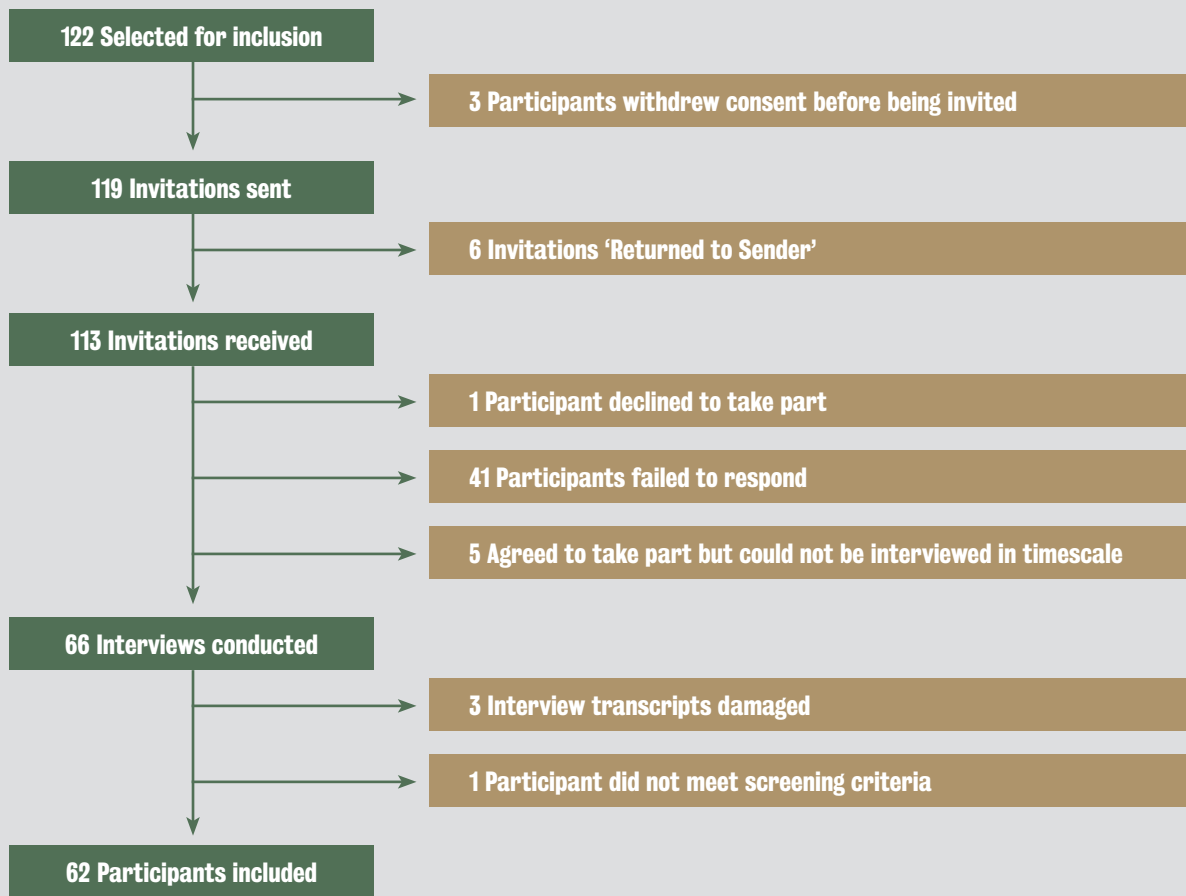


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**Appendix One:  
Participant Recruitment Procedure**

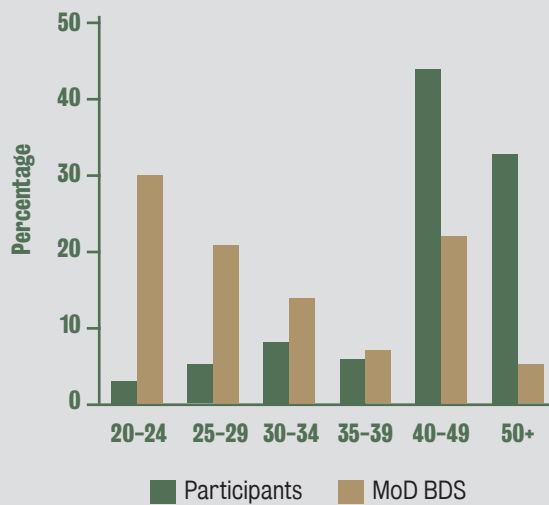
**Figure Fifteen: Participant Recruitment Procedure**



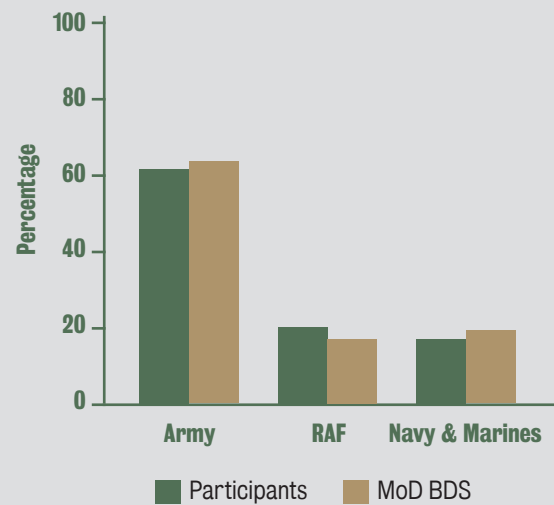
## Appendix Two: Participant Details

The dark green bars on the figures below illustrate the groupings of the participants who took part in this research study. The brown bars represent the same groupings as applied to the Biannual Diversity data reporting on those who have left the Armed Forces in the last five years.

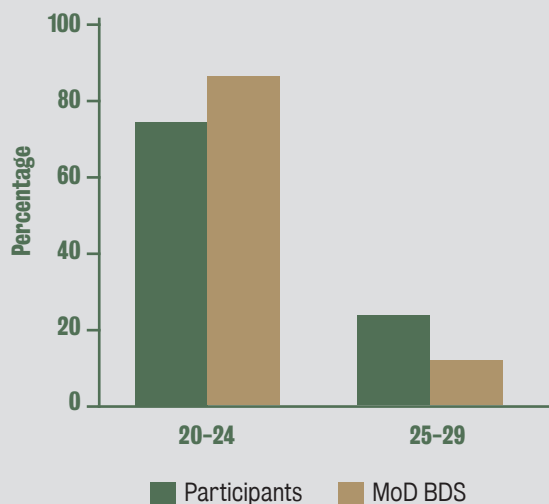
**Figure Sixteen: Participant Age**



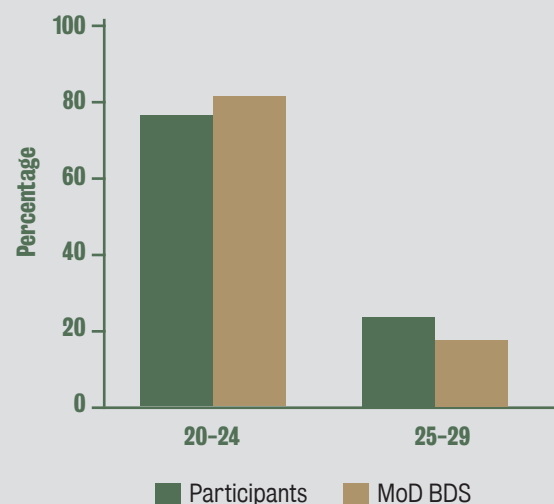
**Figure Eighteen: Participant Service**



**Figure Seventeen: Participant Rank**



**Figure Nineteen: Participant Engagement Type**



No differences were identified between MoD BDS data and participants with regards to rank, service or type of engagement but a difference with age was found in that older participants were more widely represented in the research participant population. This age difference is expected, as we interviewed veterans identified via the KCMHR cohort study which is in itself an aging population, and also due to the pronounced problems recruiting lower age groups to take part in research.

### Mental Health Condition

As outlined earlier, participants were identified for inclusion based upon their scores on self-report mental health screening measures. Participants with higher scores were recruited in order to increase confidence that such scores equated to a probable mental health problem. As such, it is important to highlight that these scores are not representative of the Armed Forces as a whole. Figure Twenty below includes the thresholds used to represent ‘caseness’ in this research for each of the mental health measures employed.

Figure Twenty-One below illustrates how many

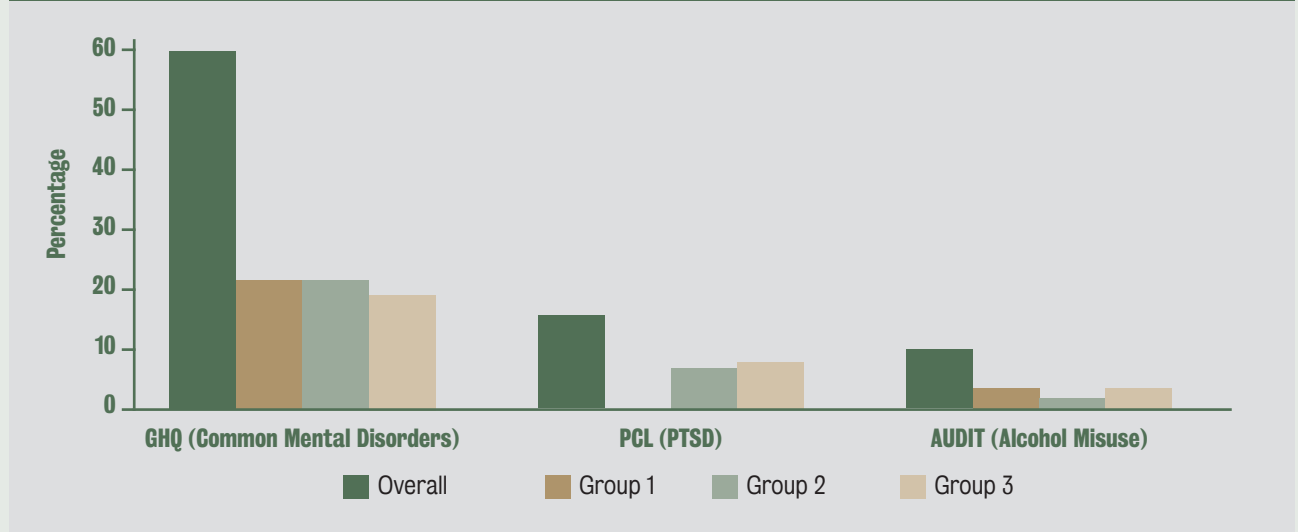
participants scored for ‘caseness’ in different mental health screening measures. ‘Caseness’ here refers to their scores on the self-report measures either meeting or exceeding the cut off points set to be indicative of a mental health condition. The data below is shown for all participants as well as broken down by group membership. In contrast to the above demographic information, there were differences in the mental health conditions of participants in the three groups.

The lighter coloured bars represent Group One (unaware), Group Two (aware but not in treatment) and Group Three (in formal mental health treatment) participants, respectively. The level of common mental health disorders and alcohol misuse remains relatively consistent across the three groups; however, differences can be seen in the rates of PTSD. Participants in Group Three, those in formal mental health treatment, and Group Two, those who are aware but not seeking help, are the only participants with PTSD caseness. None of the participants in Group One (i.e. those who stated that they did not have a mental health problem) indicated PTSD caseness. This suggests that perhaps PTSD is equated with an increased level of recognition in those affected. Further research is needed to explore this further.

**Figure Twenty: Mental Health Measures and Caseness Thresholds**

Health Issue	Measure	Threshold
Common mental disorders (anxiety/ depression)	12 item General Health Questionnaire (GHQ12)	11 or more
Post-Traumatic Stress Disorder	17 item National Centre for PTSD Checklist (PCL-C)	50 or more
Alcohol misuse	10 item WHO Alcohol Use Disorders Identification Test (AUDIT)	16 or more

**Figure Twenty-One: Participant Mental Health**



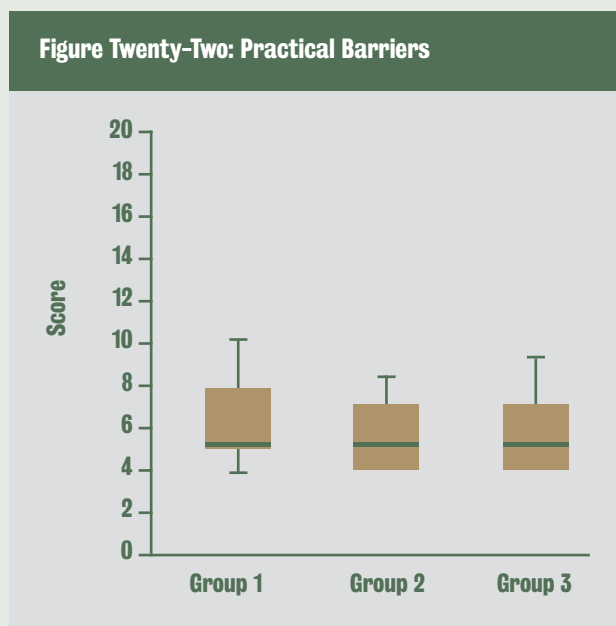


## Appendix Three: Quantitative Measure of Barriers to Care

Veterans were also asked to complete a quantitative measure of stigma either as part of the earlier clinical interview study in which they participated (Group Two and Group Three) or as an addition at the end of the interview for the current study (Group One). The measures used assess four types of barriers: practical/ logistical barriers to care; stigma barriers; attitudes that may prevent access to care; and self-stigma blocking access to care. Each measure contains a series of statements to which the veteran rates their agreement that the item would impact their decision to seek mental health support. Agreement was rated on a scale of 'strongly disagree' scored as one, to 'strongly agree' scored as five.

### Practical Barriers

Figure Twenty-Two below presents the practical barrier scores across the three groups of participants: Group One (unaware), Group Two (aware but not in treatment) and Group Three (in treatment). The thin, vertical green lines illustrate the total range of scores for veterans in that group (i.e. the lowest and highest scores). The brown boxes represent the first to third quartile of scores, showing where the majority of participants' scores sat. The thick green line in the middle of the coloured box indicates the median score for that group.

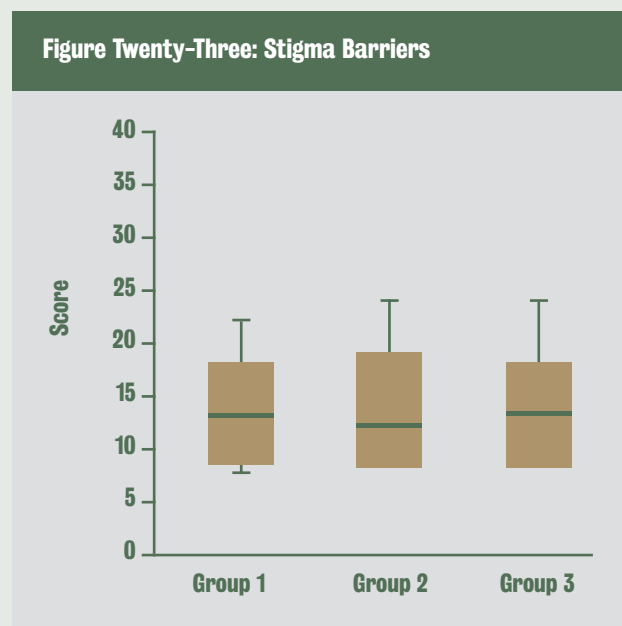


The total possible score for practical barriers would be a score of 20, which would equate to a veteran 'strongly agreeing' to each of the four practical barrier items. A score of 12 indicates that a veteran has rated each item as 'neither agree nor disagree', therefore a score of over 12 is indicative of practical barriers having some impact on a veteran's decision to seek support. The results indicate that practical barriers have a limited impact on a veteran's decision to seek mental health support and that there is no difference in the impact of this barrier across the three participant groups.

With regards to the qualitative analysis, 'practical barriers' (such as fitting appointments in with work) were discussed but appeared to impact veterans seeking mental health support at a low level only, yet conversely, the quantitative measure indicates that practical barriers did indeed prevent veterans from seeking mental health support. This suggests that the statements currently used in quantitative measures of practical barriers do not align completely with the practical concerns that veterans have around help seeking. Further research is needed to explore this in more detail.

### Stigma as a Barrier

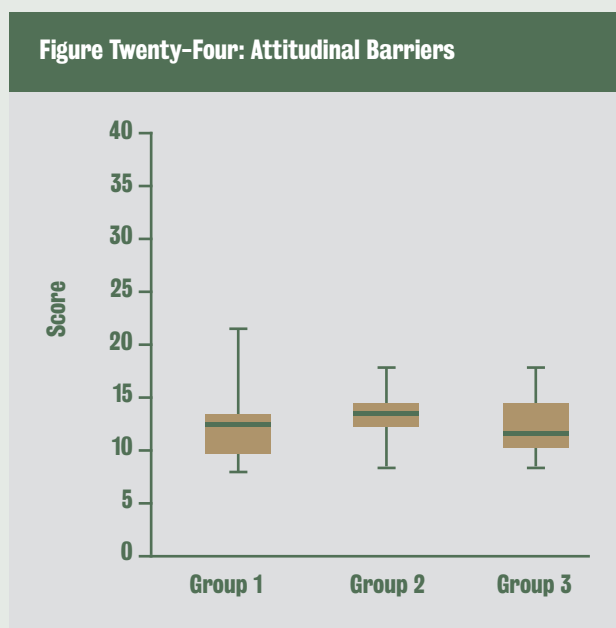
Figure Twenty-Three below is laid out in the same way as Figure Twenty-Two above but here reports on the results of statements focused on stigma (i.e. concerns a veteran may have about how others would view them if they chose to seek help).



The total possible score for stigma barriers would be a score of 40 which would equate to a veteran 'strongly agreeing' to each of the eight stigma barrier items. A score of 24 indicates that a veteran has rated each item as 'neither agree nor disagree'; while a score over 24 indicates stigma barriers have had some impact on a veteran's decision to seek support. The results indicate that stigma barriers have a low degree of impact on a veteran's decision to seek mental health support and that there is no difference in the impact of this barrier across the three participant groups.

### Attitudinal Barriers

Figure Twenty-Four below is laid out in the same way as Figures Twenty-Two and Twenty-Three above but here reports on the results of statements focused on attitudes (i.e. negative attitudes around mental health treatment).

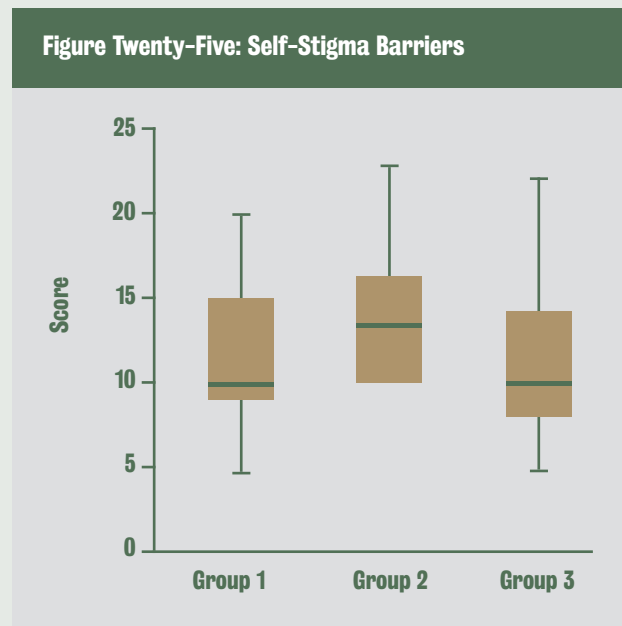


The total possible score for attitude barriers would be a score of 40 which would equate to a veteran 'strongly agreeing' to each of the eight attitude barrier items. A score of 24 indicates that a veteran has rated each item as 'neither agree nor disagree'; while a score of over 24 indicates that attitude barriers have had some impact on a veteran's decision to seek support. In general, the results indicate that attitude barriers do not have a substantial impact a veteran's decision to seek mental health support, and there is no difference in the impact of this barrier across the three participant groups.

### Self-Stigma

Figure Twenty-Five below is laid out in the same way as Figures Twenty-Two, Twenty-Three and Twenty-Four above but here reports on the results of statements focused

on self-stigma (i.e. concerns a veteran may have about how seeking help would affect the way they see themselves).



The total possible score for self-stigma barriers would be a score of 25 which would equate to a veteran 'strongly agreeing' to each of the practical barrier items. A score of 15 indicates that a veteran has rated each item as 'neither agree nor disagree', while a score of over 15 indicates self-stigma barriers as having had some impact on a veteran's decision to seek support.

In general, the results indicate that self-stigma barriers have a low degree of impact on the majority of a veteran's decision to seek mental health support. Group One and Group Three have almost identical scores, but Group Two does appear to have higher scores in relation to self-stigma, although this difference is not statistically significant. The majority of these scores still sit under 15 which equates to Group Two disagreeing less vehemently that self-stigma scores are a barrier to help seeking, as opposed to them endorsing self-stigma as a barrier to help seeking.

As with the practical barriers to care, the quantitative measures of stigma-focused barriers to care do not appear to align to the qualitative exploration of barriers to care. The quantitative measures indicate that stigma, both public and self-stigma, have a low degree of impact on a veteran's decision to seek mental health support. However, the qualitative exploration indicated that stigma acted as a definite barrier blocking care for a proportion of veterans. However, it is important to highlight that these represent median scores. It is possible that a veteran scored a five (strongly agree) for a specific item but that this was lost in the general consensus of 'strongly disagree.'





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