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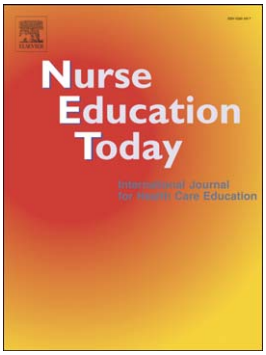

Understanding why veterans are reluctant to access help for alcohol problems: Considerations for nurse education

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UNDERSTANDING WHY VETERANS ARE RELUCTANT TO ACCESS HELP FOR ALCOHOL PROBLERMS: CONSIDERATIONS FOR NURSE EDUCATION

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Abstract

Background

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To effectively engage veterans with substance misuse services, nurses need to understand their unique needs and the potential barriers that prevent them from accessing care. Nurses need to have an understanding and awareness of the cultural sensitivities associated with having been a member of the armed forces

Objectives

The aim of this study was to investigate the perceived barriers to care amongst those planning, commissioning and delivering services for veterans with substance misuse problems, and to identify and explore subject areas which nurse educators should consider for inclusion in nursing and health education programmes.

Design

The findings reported in this paper come from one phase of a larger three phase research project and used an applied qualitative research approached based on methods developed for applied social policy research.

Settings

The study was undertaken in the north-east of England

Participants

The study consisted of a purposive sample of planners, commissioners of services, and service providers in the North East of England

Methods

Data was collected using a semi-structured interview schedule. Framework analysis was used to analyse the data.

Results

Complexity of services and care, complexity of need and a lack of understanding of veterans were identified as factors that made accessing substance misuse care difficult. To help nurses better understand the unique needs of veterans three educational topics were identified for consideration in pre-registration nurse education: Understanding military and veteran culture and the nature of modern warfare, the military 'veteran as institutionalised' hypothesis and stigma

Conclusions

Health and social services can struggle to truly understand the unique needs and experiences of the veteran community. We have identified three broad subject areas that should be considered as the theoretical basis for a veteran specific education programme within pre and post-registration nurse education.

Highlights

Complexity of services makes substance misuse care difficult for veterans to access.

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Health and social services struggle to understand the unique needs of the veteran community.

Institutions educating nurses should consider veteran specific education within their programme.

Key Words

Veterans, armed forces, alcohol, substance misuse, barriers to care, stigma, nurse education, qualitative research.

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Introduction

To effectively engage veterans with health services, nurses need to understand their unique needs and the potential barriers that prevent them from accessing care. Algire et al (2013) suggest in order to provide clinically appropriate care for veterans, health care providers need to understand the characteristics of today's veteran population and have an awareness of the cultural sensitivities associated with having been a member of the armed forces. In addition Coll et al. (2011) argues the importance of health care staff understanding the "military mind set" so they are able to engage and develop therapeutic relationships with this client group.

Although the barriers to care for veterans appear to be well understood, there appears to be very little translation of this into nurse education. Future nursing programs worldwide need to be responsive to the changing health needs of veterans and incorporate appropriate educational resources in the curriculum to prepare professional nurses to care for veterans and their families (Allen et al., 2013; Beckford and Ellis, 2013).

This study will explore some of the complex issues which require further thought in engaging veterans into substance misuse services, identifying key areas that should be considered within the nurse education curriculum.

Background

The ex-Service population within the United Kingdom has been estimated to be around 3.8 million (Woodhead et al., 2011) and the impact of mental Health issues among veterans is now recognised as a serious concern with recognition that there are higher rates of homelessness, alcohol abuse, domestic violence, relationship breakdown and criminality among former military personnel with untreated mental health problems (Green et al., 2014; Iversen et al., 2009; Murphy et al., 2008; Walker, 2010)

Epidemiological studies confirm that alcohol misuse is a common issue in the UK Armed Forces (Cucciare et al., 2013; Hooper et al., 2008; Leo et al., 2014) and the health implications of excessive alcohol consumption are significant (Aguirre et al., 2014; Department-of-Health, 2012; Fear et al., 2010). This is not to impute any simple causal inference between military service and alcohol misuse, nevertheless, the need to tackle problem drinking within the armed forces has been widely recognised and alcohol use disorders remains one of the most frequently reported mental health problems for veterans (Alcohol-Concern, 2012; Alcohol Murphy et al., 2008; Walker, 2010). Despite this, rates of help-seeking for alcohol misuse remain particularly low despite the high prevalence (Iversen et al., 2011; Samele, 2013).

Despite some investment in alcohol services the cost of alcohol related harm alone, to the NHS was £3.5 billion in 2012 and it is anticipated that this will increase (National Treatment Agency, 2013). Moreover treatment for alcohol problems is not adequate to match the current demands of the population in the UK and is largely failing to address problem drinking (Centre for Social Justice, 2013). In order to be responsive and understand the unique needs of veterans to successfully engage them in addressing their alcohol misuse, as well as to reduce barriers to services for veterans, there needs to be adequate availability of resources. Leo et al (2014) concur with this suggesting the availability of effective interventions in primary care for alcohol misuse for veterans remains a significant health need.

Furthermore it has been suggested that engaging and treating Veterans in traditional models of mental health may be difficult for a range of reasons, including the stigma of mental illness and treatment and barriers to care such as navigating complex mental health systems (Macmanus and Wessely, 2013). An understanding of armed forces culture is particularly

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important as due to the social norms associated with mental health and alcohol use in the armed forces, personnel often do not seek help (Jones et al., 2013).

It is anticipated that undertaking this critical piece of research will contribute to an understanding of the barriers faced by veterans in seeking help for alcohol misuse, and help to develop a stronger programme for education around veteran awareness in not only pre-registration nurse education, but also the wider community of health professional.

Aim

The aim of this study was to investigate the perceived barriers to care amongst those planning, commissioning and delivering services for veterans with substance misuse problems, The aim of this study was to investigate the perceived barriers to care amongst those planning, commissioning and delivering services for veterans with substance misuse problems, and to identify and explore subject areas which nurse educators should consider for inclusion in nursing and health education programmes.

Methods

The findings reported in this paper come from one phase of a larger three phase research project (see Figure 1). The aim of the research project as a whole was to investigate the reasons why veterans, or ex-armed forces personnel, were disengaging or failing to engage with services for their alcohol related substance misuse problems. The findings in this paper focus on the initial phase of the project which explored barriers to care for veterans, and whether those planning, commissioning and delivering services had an understanding of the potential needs and experiences of the veteran community. Data from phase 1of the study was analysed to explore the potential educational needs of student nurses in relation to veteran specific care and understanding the veterans' needs.

This study used an applied social science methodology as applied research concentrates on finding solutions to an immediate practical problem (Ritchie and Spencer, 2002), and has a key role to play in providing insight, explanations and theories of social behaviour (Ritchie and Spencer, 2002).
This overall study used a triangulated approach over 3 phases (Figure 1) to understanding why veterans' are reluctant to access care.

Figure 1: Methodological approach of overall study (**Insert near here)**

The study was granted scientific and ethical approval from Northumbria University Newcastle and the regional National Health Service ethics boards. All participants were given a written information sheet and provided written consent.

Sample and Data Collection

Phase 1 of the study, the data reported in this paper, identified a purposive sample of planners, commissioners of services, and service providers in the North East of England. The study included both state and independent sector service providers that had been commissioned to provide substance misuse services. Semi-structured interviews were used to understand the decision making process for substance misuse provision from commissioning to delivery with a specific focus on the participants knowledge, beliefs, and understanding of the veteran client group.

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Analysis

Framework analysis of qualitative data sits at the heart of applied policy research methodology. Framework analysis has been developed to help achieve specified aims and outputs as well as to facilitate systematic analysis of data (Ritchie and Spencer, 2002); it was chosen for its capacity to handle data in a rigorous, transparent and logical process of thematic analysis. The framework approach was developed in the UK specifically for applied or policy relevant qualitative research to meet set objectives of investigation within limited time periods (Bryman and Burgess, 1994; Kiernan et al., 2015; Pope et al., 2000; Ritchie et al., 2013). To aid in the analysis of textual data NVivo 10 Server software was used.

Results

The study population consisted of 6 respondents, a service planner and commissioner from both public health and the local authority, a service provider from the state sector and three independent service providers commissioned by the state sector. All interviews were conducted face to face in the participant's place of work. Figure 2 demonstrates the initial thematic themes identified within the data, which were grouped into 3 subordinate themes creating the superordinate theme of 'general barriers to care'.

Figure 2: Thematic analysis and identification of educational topics **(insert near here)**

Complexity of Needs

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

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

Respondent 5 Independent Sector Provider

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

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

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

Respondent 5 Independent Sector Provider

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

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

Respondent 2 Public Sector Provider

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

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

Respondent 1 Independent Sector Provider

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

Respondent 2 Public Sector Provider

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

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

Respondent 2 Public Sector Provider

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

Respondent 6 Independent Sector Provider

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Complexity of services

The data suggests that recent changes within health and social care delivery have compounded the complexities in navigating service by placing substance misuse service in social care rather than health. This has seen a reduction in funding and the loss of personnel in addictions planning,

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

Respondent 4 Public Sector Planner

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

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

Respondent 1 Independent Sector Provider

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

Respondent 6 Independent Sector Provider

This is a significant finding with regards holistic care provision for veterans, The data has identified that veterans have difficulties in acknowledging they have a substance misuse problem, are very poor at seeking help and have difficulties in navigating health and social care services outside of the military. These issues are only going to be compounded if service providers are actively working against shared care in order to sustain client numbers to ensure that their services are recommissioned.

Understanding Veterans

Although respondents differ on the opinion of whether veterans are a vulnerable group, there is general consensus that they are a client group with unique needs. Respondents from the public sector were very clear on the need to identify veterans or encourage veterans to let service providers no that they are armed forces veterans,

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

Respondent 2 Public Sector Provider

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

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

Respondent 2 Public Sector Provider

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

how we address the culture is to make sure we have good information, advice and guidance for people at the very basic level to make sure people understand, one, what services are available in relation to need and not just what services are available. Because I think, if I'm truly honest, I think a lot of frontline professionals don't know where to refer people to either…….and I think there's a huge amount of work to do around skilling up the population, both in mental health services - and ……those more generic universal providers that need to understand more about those conditions and where somebody is at in order to refer appropriately.

Respondent 4 Public Sector Planner

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

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

Respondent 6 Independent Sector Provider

Discussion

The general precepts of multi-stage research are that insights derived from one phase of a study subsequently inform further phases (Bryman, 2001). Several 'hypotheses' have emerged from the initial phase of this study, and it is our intention to use these to inform subsequent phases of this ongoing study. However, the data reported in this paper does little

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to disabuse the reader of the general lack of awareness of military veterans health needs. Given the potential complexity of veterans' needs, consideration should be afforded to raising awareness of these issues within pre-registration healthcare curricula and beyond.

The following discussion explores three themes of educational topics which should be considered for inclusion within pre-registration nursing curriculum, each derived from the above findings (Figure 2).

The problematic relationship between sociology and the nursing curriculum is noted here, and has been subject to extensive review and debate elsewhere (Aranda and Law, 2007). In making this claim, we do not intend to enter the fray in which the protagonists are preoccupied by wider philosophical and political questions as to the nature of nursing or (sociological) knowledge and the relationship between the two disciplines: rather, we simply make the pragmatic observation that (a) addressing these matters in an educational context bears the potential to expand nursing consciousness in relation to veterans' health care needs, and (b) that these insights owe a heavy intellectual debt to the discipline of sociology.

Understanding the Experience of Modern Warfare and its Potential Consequences

Healthcare professionals, and indeed the population at large, might be accused of a lacking adequate knowledge and insights into veterans' health needs. One possibility is that the roots of such lack of awareness arise from widespread misconception of the demands and experiences of contemporary military service. Castles and Miller, (1998) coined the term 'new wars' in order to characterise recent asymmetrical conflict situations. When the UK Government deploys armed forces, they inevitably put military personnel in 'harm's way'. In terms of new wars, the nature of such 'harms' include bearing witness to a variety of attendant atrocities e.g. child soldiers, civilian population expulsion, exemplary violence, torture, and sexual assault. We would contend that the potential for psychological sequalae for military personnel is clear and present. Whilst much has been (rightly) claimed concerning 'signature' physical injuries associated with recent conflicts, it is at least possible that 'signature' psychological consequences also exist. What our data reveal is that those commissioning (or in charge of delivering) services rarely raised these matters as topically relevant during the course of the interviews. Even those nominally identified as 'veterans champions' on occasions exhibited, in our view, a naivety in relation to the contemporary military experience. This raises the possibility of a substantial gap between the discursive rhetoric of the 'champion' role and the realities of service provision.

One recurrent strategy used to provide a rationale for the lack of veteran-specific services concerned the idea that existing services were individually focussed and/ or holistic, and therefore uniquely tailored to every individual's needs whether veteran or not. For the authors, this claim is reminiscent of historical claims of 'colour-blindness' in relation provision of services to ethnic minority client groups. In this instance, the denial of the social significance regarding ethnicity was employed in order to pre-empt declarations of the 'end of discrimination' (Neville et al., 2006). In practice, it is well documented that such approaches merely constituted yet another form of racism, conscious or unconscious, by justifying status quo positions whilst simultaneously downplaying the specialist needs of a population (Neville et al., 2000). Our contention is that it is clearly the role of nurse educators to raise awareness of these specific populations' health needs.

The Military 'Veteran as Institutionalised' hypothesis.

The 'Veteran as Institutionalised' hypothesis presupposes that military veterans fail to engage with services as a consequence of being institutionalised, thus having reduced agency and wherewithal by which to negotiate complex health care systems. Nurses in

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general, and mental health nurses in particular are no strangers to the risks associated with institutionalisation. It was Goffman (1961) who first delineated the disabling nature of institutional practices within the 'total' institution: Regulated block treatment, regimentation, depersonalisation, strictly enforced hierarchical difference and loss of individual identity in favour of the collective. Indeed, it is not difficult to reconcile many, if not all, of these features with military service. The consequences of life confined within such social contexts are, typically, a diminution of agency to the extent that individuals, once 'de-carcerated' rather than 'de-institutionalised', can no longer effectively negotiate the contingencies of life. There are, however, other (contradictory) possibilities at play within the 'veteran as institutionalised' claim.

A subtle (yet more pernicious) possibility is that the 'veteran-as-institutionalised' hypothesis provides a convenient short-hand mechanism by which to blame ex-service personnel for their own inability to access effective services (Crawford, 1978). Our data recurrently points to the complexity of mixed economy service provision for military veterans. It is entirely possible that ex-service personnel find services difficult to negotiate precisely because they are!

It is possible that the 'veteran as institutionalised' model, once accepted, might serve as a set of stereotypical 'instructions' by which health care staff can pre-define 'what veterans are really like'. Smith (1978) referred to such stereotypical thinking as providing a set of 'cutting-out' instructions in which attention is increasingly and selectively focussed upon those aspects of a person in ways which merely serve to confirm the original stereotype. Following Smith's formulation, the 'veteran-as-institutionalised' construct would therefore comprise a form of self-fulfilling prophecy: The health care professional expects poor engagement and compliance, selectively attends to any evidence of such, and thus confirms their original stereotype. Any actions that ex-servicemen (or women) might subsequently take are subject to exclusive interpretation through an a priori lens of assumption - that they really are 'institutionalised'. In totality, this mind-set has the potential to effectively divert attention from the poor resourcing and organisation of services themselves.

Stigma

Scambler (2009) described stigma as a 'social process, experienced or anticipated, characterised by exclusion, rejection, blame or devaluation that results from experience, perception or reasonable anticipation of an adverse social judgement about a person or group'. The tangible ways in which stigma might operate in order to influence veterans' service-user experience include:

- Self- exclusion as a consequence of an individual's perceptions or beliefs about how others might potentially view them in the future;
- Enacted stigma – the reinforcing effects of previous poor experiences of invalidation or exclusion by service providers; and,
- Courtesy stigma - stigma by association or regular affiliation with other groups of stigmatised service-users (in this case, people who misuse drugs and/or alcohol)(Goffman, 1963)).

The collective consequence of all of these stigmatising mechanisms may be to deter military veterans from seeking the help they need. Alternatively, potential service-users may simply 'act-up' or accentuate stereotypically expected behaviours or conduct, or simply self-blame for their own predicament (Major and O'Brien, 2005). A further possible reaction to stigma entails internalisation of negative beliefs such as 'incompetence', 'moral weakness', 'alienation' and low self-efficacy (Rüsch et al., 2005). These authors characterise effective anti-stigma initiatives as involving, variously, protest, education, and contact.

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Once again, nurse educators are well placed to inoculate practitioners against such stigmatising practices by means of education and contact. Contact-based education programmes for healthcare students (and, e.g. police officers) have proved effective in challenging stigma at a structural level (Happell et al., 2014; Livingston et al., 2012).

Limitations

The findings presented above represent merely one phase of a larger study. However, taken on face value, the data reported in this paper could be seen as clearly demonstrating some of the institutional beliefs that have the potential to make it more difficult for veterans to access appropriate care for their substance misuse problems.

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

Although the authors were relatively fortunate insofar as all invited participants accepted the invitation to respond, a more extensive study of commissioning practices may have made judicious use of exclusion criteria – and exclusion criteria were not applied in the study reported here. It could be argued that the transparency of the framework method provides a good degree of trustworthiness and would support the potential transferability of the findings. The aim of qualitative research is for analytic ('moderatum') rather than statistical generalizations (Payne and Williams, 2005). Given the sampling limitations expressed above, such generalisations might be made valid only with caution.

As with many forms of 'categorical analysis', framework analysis (Ritchie and Spencer, 2002) might be accused of over- assuming a measure of truth-value assignation by too readily assuming that 'what was said' during the course of the interview actually corresponds to 'what *actually* happened' during the commissioning and service delivery processes.

Conclusion

This study suggests health service planners, commissioners and providers can struggle to truly understand the unique needs and experiences of the veteran community, which subsequently has the potential to create barriers in accessing substance misuse care. We have identified three broad subject areas that should be considered as the theoretical basis for a veteran specific education programme within pre and post-registration nurse education. It is also our conclusion that any nursing education programme addressing the needs of veterans needs to consider the use of veterans and first-hand personal narratives of ex-service personnel to ensure that students hear first-hand the difficulties that veterans experience when suffering health and social difficulties. It is also argued, that whilst this is a UK based study, the findings nevertheless have the potential to be transferable to other veteran populations on an international scale.

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Understanding why veterans are reluctant to access help for alcohol problems: considerations for nurse education.

Figure 1: Methodological approach of overall study

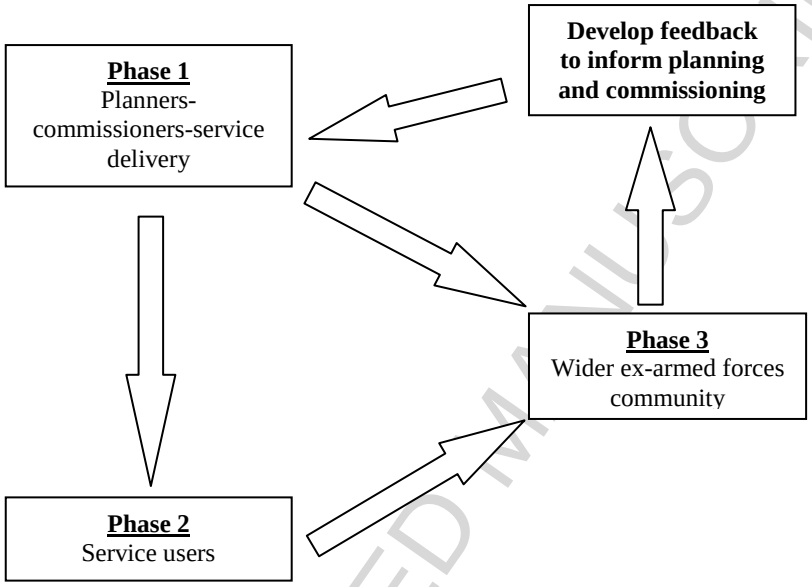

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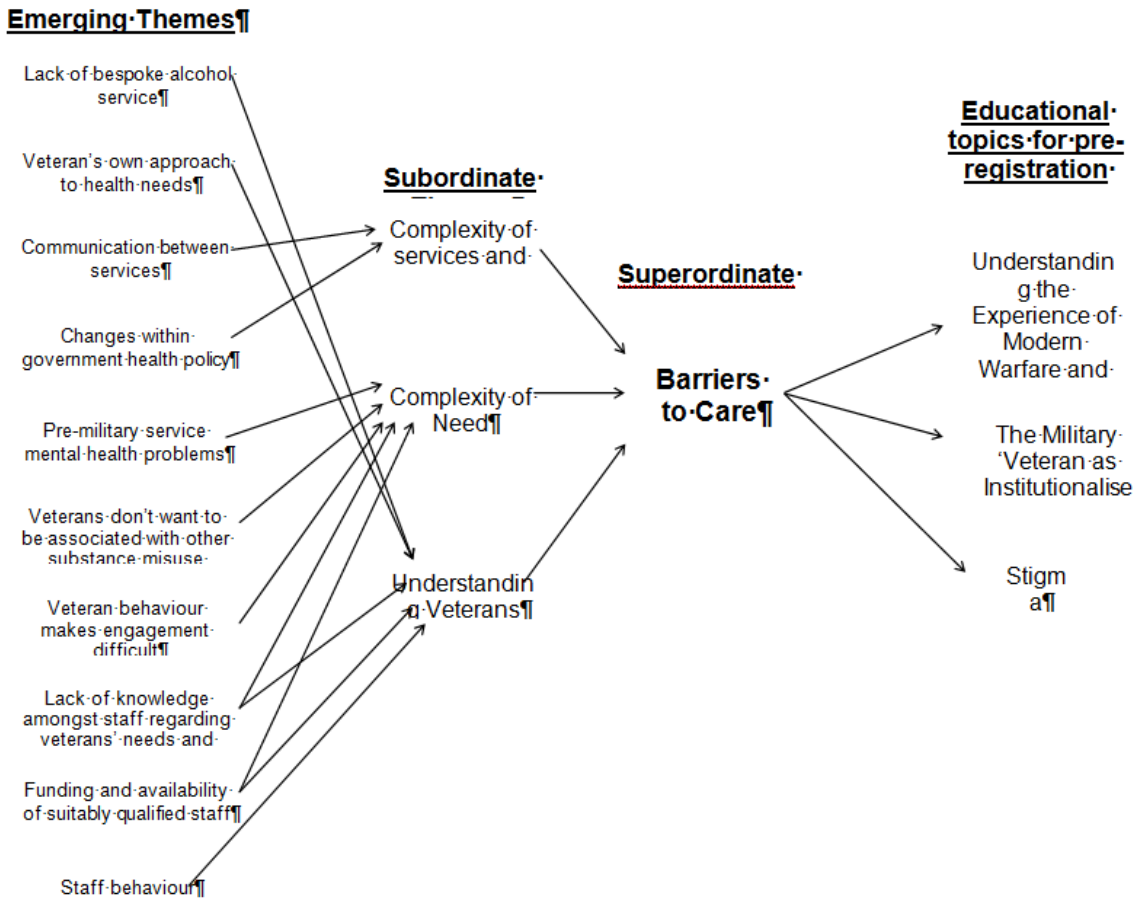
Figure 2: Thematic analysis and identification of educational topics



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