**Are veterans different? Understanding veterans’ help seeking behaviour for alcohol problems.**

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**Abstract**

Alcohol misuse in the United Kingdom’s veteran community is not an isolated phenomenon. Internationally, alcohol and wider substance misuse would appear to be an historic and current global issue within veteran communities. Although research has been undertaken both in the UK and the US into why veterans are reluctant to seek help for mental health problems, little is understood as to why veterans encounter difficulties in engaging with treatment for alcohol misuse. The aim of this study was to understand why veterans in the United Kingdom are either reluctant, or have difficulty in accessing help for alcohol problems. An applied social policy research methodology was used, employing in-depth semi-structured interviews with 19 UK veterans in the North East of England, who had a history of alcohol misuse. The findings showed that participants appeared to excuse or normalise their excessive alcohol consumption, which led to a delay in meaningful engagement in substance misuse services, resulting in complex and complicated presentations to health and social care services. The findings of this study clearly suggest that veterans who misuse alcohol have a range of distinctive and unique difficulties that subtly differentiate them from the wider civilian substance misuse population, and that the use of peer-support models would appear to mitigate against them disengaging from alcohol treatment services.

**Keywords:** Alcohol, veterans, barriers to care, stigma, qualitative research, peer support.

**Bullet Points**

*What is known about this topic*

• Alcohol misuse in the veteran community would appear to be an historic and current issue.

• Research undertaken on UK veteran’s is limited, despite there being a clear indication that excessive alcohol use is a risk amongst ex-service personnel.

• Little is understood as to why veterans encounter difficulties in engaging with treatment for alcohol misuse.

*What this paper adds*

* Veterans who misuse alcohol have a range of distinctive and unique difficulties that subtly differentiate them from the wider civilian substance misuse population.
* Normalisation of excessive and regular alcohol consumption leads to delayed engagement, and complex case presentation.
* Peer-support models appeared to mitigate against veterans disengaging from alcohol treatment services.

**Introduction**

Alcohol misuse in the United Kingdom’s veteran community is not an isolated phenomenon. Internationally, alcohol and wider substance misuse would appear to be an historic and current global issue within veteran communities (Aguirre, Greenberg, Sharpley, Simpson, & Wall, 2014; Bohnert et al., 2012; Nicola T Fear et al., 2007; Helzer, 1984; Jakupcak et al., 2010; Kehle, 2012; D. P. McKenzie et al., 2006; S. M. McKenzie, Brooks, Maisto, & Possemato, 2013; Seal et al., 2011; Steindl, Young, Creamer, & Crompton, 2003).

It has long been documented that alcohol has been an integral part of British Military life (Hudson, 2007, pp. 67, 94, 131). Consumption in large quantities was not necessarily discouraged and some doctors believed that alcohol gave a degree of protection against various lethal diseases and was safer to drink than water (Howard, 2000). Arguably, alcohol continues to play a part in the modern UK military, where it is used in social bonding and comradeship (Alcohol Concern, 2012; Jones & Fear, 2011), surpassing alcohol use in the general population (Nicola T Fear et al., 2007). Traditional military celebrations, such as promotion ceremonies, mess nights, command parties and ‘hail and farewell’ gatherings typically include alcohol.

Patterns of excessive drinking established during service may be difficult to change upon leaving. Research undertaken on alcohol consumption in the UK ex-service personnel population is limited, despite there being a clear indication that excessive alcohol use is a risk amongst veterans (Bergman, Mackay, & Pell, 2015; Fossey, 2010). Recent research shows that there is no statistical difference in alcohol misuse between serving and ex-serving personnel (Amy C Iversen et al., 2009), which suggest that those misusing alcohol continue to do so after they leave military service.

With alcohol misuse being accepted widely as an ongoing issue within the veteran communities worldwide, recent research has examined the efficacy of treatment models (Jaconis, Santa Ana, Killeen, Badour, & Back, 2017; O’Shea, Watkins, & Farrand, 2017; Oslin et al., 2014; Pedersen, 2017). Although research has been undertaken both in the UK and the US into why veterans are reluctant to seek help for mental health problems (Garcia, 2011; Hines et al., 2014; Amy C Iversen et al., 2010; A. C. Iversen et al., 2011; Langston et al., 2010; Woodhead et al., 2011), little research has been undertaken in recent years to identify and understand why veterans are reluctant to seek help for alcohol misuse problems (Ossip-Klein, Vanlandingham, Prue, & Rychtarik, 1984). More importantly, little is understood as to why veterans encounter difficulties in engaging with treatment, and whether those difficulties differ from those experienced by the wider population. The aim of this study was to understand why veterans in the United Kingdom are either reluctant or have difficulty in accessing help for alcohol problems.

**Method**

An applied social policy research methodology was used, employing in-depth semi-structured interviews with UK veterans who have a history of alcohol misuse. Applied social policy research concentrates on finding solutions to immediate practical problems, and has a key role in providing insight, explanations and theories of social behaviour (J. Ritchie & Spencer, 2002). This study was undertaken as part of the second phase of a larger four-phase study looking to understand the complexities veterans experience in accessing substance misuse care (Kiernan, Moran, & Hill, 2016). The study was undertaken in the North East of England between August 2016 to February 2017 with 19 veterans who had a history of alcohol misuse. Purposive sampling and the maximum variance sampling matrix developed for this study ensured that the 19 participants who took part reflected the experiences of the veteran community accessing substance misuse services within the North East of England. Purposive sampling with maximum variation is a non-probability sample where a deliberate strategy to included cases which vary widely from each other are selected in relation to a particular phenomenon or event (Jane Ritchie, Lewis, Nicholls, & Ormston, 2014). Once informed written consent was obtained, an in-depth semi-structured interview schedule was used which explored the participants’ relationship with alcohol, how or if they sought help, their experiences of engaging with services, and how being a veteran may have impacted accessing and engaging with substance misuse services. The key advantage to a semi-structured interview was that all participants were asked the same question, but most notably the freedom was there to expand and explore any new phenomena that arose (Morse, 1992). Interview transcripts were imported into NVivo, a qualitative data analysis computer software package, where framework analysis was carried out. Framework analysis was designed in the UK specifically for applied or policy relevant qualitative research (Jane Ritchie et al., 2014; J. Ritchie & Spencer, 2002) and was chosen for this study for the capacity it has to handle data in a rigorous, transparent and logical process of textual analysis. The study was granted scientific and ethical approval from Northumbria University Newcastle and the regional National Health Service ethics boards

**Findings**

The cohort consisted of 19 service users, 18 males and one female with a UK military service history. The mean age was 45.05 years (SD = 7.320), ranging from 35 to 64 years of age at interview. On average, participants accessed meaningful help for their alcohol misuse problems 17.37 years (SD = 8.276) after discharge from the UK Armed Forces (see Table 1).

Figure 1 demonstrates data reduction during framework analysis. The thematic framework shows that 10 themes were identified within the data which were further conceptualised into 3 superordinate themes: Normalisation of Alcohol Consumption, Delayed Meaningful Engagement and Complex Presentations.

Insert Table 1 here

Insert fig 1 here

Normalisation of alcohol consumption

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

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

Participant 05

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

Participant 02

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

Participants often drew comparisons with civilian counterparts, noting that it was typical behaviour at that age. There appeared to be a difficulty in understanding or accepting that they had an issue with alcohol, or at least a historic problem, due to the normalisation of alcohol consumption in the military. This cultural acceptance of excessive alcohol consumption suggests that the participants’ relationship with excessive alcohol intake has been normalised, and contributes significantly to their inability to identify that their alcohol consumption is problematic. This appears to be a significant contributing reason for difficulties in service engagement. The study participants reported that they believed that the amount of alcohol they had been consuming, and the regularity at which they consumed it, was not out of the ordinary for service life, and on the contrary, did not view excessive alcohol consumption as a bad thing, but more as a badge of honour in that they could drink heavily but still function the next day.

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

Participant 10

It would appear that excessive alcohol consumption became part of the participants’ veteran identity, and that they were proud of the ability to be able to ‘work hard and play hard’. The participants within this study all had a long history of brief interactions with health and social care services after leaving the armed forces. What was most significant was that when they eventually did engage with meaningful treatment, the primary presentation was not for substance misuse. Most commonly, they presented with mental health issues or social problems, such as homelessness. Only following assessment was substance misuse identified as the primary cause of their problems. This normalised relationship with alcohol, and the failure to identify the effect that it was having on them, led to a denial of the problem and a delayed engagement with services to help.

Delayed Meaningful Engagement with Alcohol Services

It is argued that the participants’ normalised relationship with alcohol prevented the individual from identifying that alcohol was causing them any difficulties. Subsequently, they would rarely, or never, report or discuss their drinking patterns with health or social care services.

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

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

Participant 02

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

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

Participant 19

A lack of understanding of terminology appeared to be a barrier to engagement in services. Participants reported that service providers who have no military experience, or experience of the military *‘*just don’t get it’. As an extension of this seeming incommensurability of world-views, some respondents reported being on the receiving end of inappropriate and unhelpful curiosity from their non-military peers.

As with many health problems, service users have to be willing to engage in services for it to be beneficial. The data suggests that accepting alcohol consumption as a problem potentially challenges their ‘military identity’. Participants often referred to being trained to be resilient, where needing help or reporting sick was often seen as a sign of weakness. Upon leaving the military, participants continued to ascribe to this identity, suggesting that they remained reluctant to access help for fear of being seen as weak.

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

Participant 10

Despite the belief that accessing help is seen as a sign of weakness in the military, if help was needed, participants reported a nostalgic view with regards to how good the military help was in comparison to their civilian experiences

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

Participant 12

*“The army was supportive then… my unit itself was supportive.”*

Participant 18

Additionally, participants had the support of their colleagues. Participant 18 noted support from the Army and their unit after diagnosis for alcohol problems. However, without the same support networks and structures participants had within the military, many personnel struggled with the adjustment to civilian life:

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

Participant 02

When participants accessed services, they did not always feel they received the care they needed, which ultimately led to them disengaging. These prior experiences with health and social care services created a seemingly cyclical effect, impacting upon the participants’ subsequent willingness to engage in services in the future.

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

Participant 12

Meaningful engagement in alcohol services appeared to be facilitated primarily by the acceptance that help was needed. The availability of peer-supported services, where the service provider understood the participants’ personal experiences, also appeared to sustain engagement once initial contact had been made. Almost all participants were referred for alcohol treatment secondary to other significant and multiple problems such as housing issues, unemployment and mental health problems. Paradoxically, even in the presence of such multiple and complex needs, participants still appeared to retain a ‘blind spot’ by failing to connect these problems to patterns of alcohol misuse. The pervasive and normalised relationship with excessive alcohol consumption, and the lack of insight that their addiction had on all other aspects of their life, therefore appeared paramount in delaying meaningful engagement with addictions services, resulting in the complex and complicated case presentations described.

Complex Presentations

The following data is emblematic of the complex, and complicated case presentations alluded to *above*:

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

Participant 03

Typical combinations of presenting problems included mental health problems, physical illness, relationship difficulties and breakdown, housing problems and unemployment. Often it was not until this toxic combination of circumstances precipitated a crisis that the participants committed to meaningful engagement with services. As previously reported, what was most significant was that help was rarely achieved through the veteran primarily seeking help for their alcohol problem: It was frequently left to other services - mental health teams, housing agencies etc. – to identify and define the primary underlying cause as alcohol misuse.

The data suggested that typical participant presentations often challenged service providers and invariably required engagement with multiple agencies. For some, the involvement of multiple agencies seemed beneficial, but the majority of respondents referred to a pervading confusion for both themselves and the service providers. Involvement of service charities was reported by many as being most beneficial, and these agencies were characteristically cited as the ones providing the greatest support. There was a suggestion that service charities provided the most consistent support and helped in the communication with multiple services across sectors, ensuring participants received the ‘right care’.

“*No there isn’t and it never did seem connected. It was a lot more connected this time. (umm) But I think that was primarily down to [CHARITY] pushing rather than the NHS[[1]](#footnote-1) side of it.”*

Participant 02

Some respondents gave voice to the belief that heavy reliance on service charities to provide support and care ought to be the responsibility of state providers e.g. National Health Service, Local Government, Social Services etc.

As highlighted earlier, data appeared to affirm that meaningful service engagement was facilitated by access to peer-led services. Peer-led services were those where the case-worker was linked to, or had prior experience of military service. These respondents typically suggested that more involvement from ex-service personnel (or peer-led services) would be highly beneficial in terms of both accessibility and sustaining engagement. It would appear that knowledge and insight into military life on the part of the provider improved rapport, decreased suspicion, and thus helped to ‘breakdown barriers’. When faced with case workers who had no experience of the military, participants reported being reluctant to explain or discuss their experiences of military service and the (sometimes subtle) significance of these experiences. Too often in such circumstances respondents decided early that they ‘couldn’t be helped’ as the provider ‘did not understand’. The following data was typical of the claim that having veterans as case-workers was beneficial:

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

Participant 05

In addition to citing military service as underlying their alcohol consumption, many participants also reported exposure to alcohol from a young age. Claims by respondents that their own parents endured significant difficulties with alcohol were reported frequently amongst this sample. For instance:

*“It was always around the house and stuff with my parents and stuff like that, they always drank predominantly on a weekend. I knew my mother drank as well slyly during the day, …….So I’d always had alcohol around,”*

Participant 11

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

Participant 13

It is possible that early exposure to alcohol played an important role in ‘preparing the ground’ for the processes of alcohol normalisation frequently experienced during military service. Collectively, these patterns of socialisation may have resulted in later difficulties in acknowledging problematic drinking and subsequent acceptance of help in later life. However, for some respondents, it was clear that joining the military was viewed as an opportunity, offering an escape route from challenging family and/or social circumstances.

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

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

Participant 12

The presence of significant pre-enlistment factors such as alcohol exposure at a young age and using the military as a means to escape challenging environments clearly limits the extent to which strong causal claims can be made about the role of military socialisation in subsequent alcohol misuse and treatment seeking. In presenting ‘common themes’ or ‘typical presentations’ the authors are also acutely aware that individual formulations often reveal subtle differences. Furthermore, whilst military service played a defining role in the identity formation of all respondents in this study, attempting to abstract these experiences from the totality of a person’s biographical experience can lead to unwarranted conclusions. For instance, those respondents who reported that they used the military as a means to escape often also reported returning to the same locations post-discharge, where typically attendant problems still existed (e.g. high unemployment). It is therefore highly likely that the totality of an individual’s formulation will inevitably have a bearing upon the presence of complex presentations and delayed meaningful engagement.

**Discussion**

This study has identified three main findings, which presents a conceptual understanding of why veterans with alcohol problems may be ‘different’ to substance misuse service-users from the wider general population. A normalised relationship with alcohol, which (at very least, partially) appears to stem from the culture of military service, subsequently appears to delay meaningful engagement with alcohol/substance misuse services. The lack of insight exhibited by respondents in relation to the role alcohol has played in their lives, and attendant delay in engagement, frequently resulted in multiple morbidity and complex presentation. Data suggested that the participants’ alcohol misuse impacted upon the totality of their own and families’ lives (physical, psychological, social and financial etc.). Such complexity of presentation typically requires a complex, multi-agency response spanning both health and social care and state and voluntary sectors.

As identified in previous studies (Jones & Fear, 2011), it was clear that for respondents in this study, military socialisation was, and continued to be, a pervasive influence and often the defining feature of identity intrinsically linked to their alcohol use . Almost exclusively, part of this socialisation process involved a normalisation of excessive and regular alcohol consumption. A further (strong) element of military socialisation appeared to include a belief in the virtue of resilience and the belief in self-reliance and the avoidance of help-seeking behaviour. This strong functional view of health, in which injury and illness are viewed as weakness, appears to be an embedded belief in military personnel and veterans, and is clearly a barrier to help seeking (A. C. Iversen et al., 2010). Reflecting upon these beliefs, it is easy to see why respondents not only viewed their alcohol consumption as acceptable and normal, but were also, potentially, very proud of the extent to which they could drink. It is argued that this expressed pride had its roots in a functional view of health and rested upon the belief that as long as they were fit for exercise and work the next morning, their drinking was clearly not an issue. Any suggestion that alcohol consumption was hazardous, harmful or problematic therefore posed a fundamental challenge to identity and a fundamental contradiction to their underlying belief system. Rather, counter-culturally, the ability to ‘drink hard’ was a desirable aspect of their military and veteran identity, and conversely, accepting alcohol consumption as problematic potentially represented a sign of weakness. As noted *above*, even when in obvious and dire need, it was often left to other agencies to formally identify problematic drinking as the common denominator to a cluster of social and health problems. One interesting aspect of this particular finding relates to the thoroughgoing functional view of health. Stacey (1976) suggested that health can variously be viewed as a positive concept – ‘wellness’ or a ‘reserve’ or, conversely, as a negative concept – ‘not ill’ or ‘being able to function’. Functional definitions of health are typified by the paramount status accorded to ‘being able to work’, regardless of illness or incapacity, and the ‘work hard, play hard’ mantra, identified in the participants in this study, typifies this position. However, Bowling (2005) identified that undue emphasis placed upon ‘function’ underplays the extent to which environment – including prevailing culture – negatively influences individuals. Respondents in this study vividly reported a military counter-culture in which the ability to ‘drink hard’ was viewed as a socially desirable facet. That this aspect of military life both existed in reality, and was potentially harmful to military personnel, has received tacit acknowledgement in recent attempts to address alcohol misuse within the UK armed Forces (MoD, 2017).

The study identified that ‘meaningful’ engagement with substance misuse services was common among the service users interviewed. A belief that healthcare professionals who had no connection with the armed forces did not understand veterans, or have the ability to help, was prominent. This belief amongst participants appeared to have led to a reluctance to engage in services meaningfully. One factor repeatedly cited as promoting positive service engagement, was when service providers were peers and had a stock of military credentials on which to base their understanding of service-users. However, even in services where peer support workers were present, service engagement still appeared to present a fundamental challenge to the service users’ military identity and continued to be viewed as an admission of weakness. Previous research on serving personnel similarly found that anticipated stigma served as a barrier to care (French, Rona, Jones, & Wessely, 2004; A. C. Iversen et al., 2011). Iversen et al (2011), when studying mental health stigma in the British Armed Forces, reported that 73% of serving personnel believed that their commanders would treat them differently if they sought help for mental health problems, and 46.5% felt that they would be seen as weak by those (peers, family) who are important to them. Data from this study has identified these same beliefs in the participants and suggests that anticipated stigma remains a salient contributing factor in delaying meaningful engagement in substance misuse services.

A delay in engagement impacted on many other aspects of the participants’ lives and not acknowledging an alcohol problem meant that the route to substance misuse services was varied across the study participants. There is a consensus that veterans presented with a wide range of social, physical and sociological needs caused by or contributing to their alcohol problems (Aguirre et al., 2014; N. T. Fear et al., 2010; Kiernan et al., 2016). Almost all participants in this study had experienced (concurrently) mental health problems, physical illness, housing problems and unemployment. Most of the participants had accessed third sector charities for help, primarily dealing with homelessness, unemployment and the resettlement of ex-offenders. Characteristically, it was these agencies who were able to re-frame the service-user’s difficulties as being alcohol-related. The Transtheoretical Model of Stages of Change (Prochaska & DiClemente, 1983) described how individuals typically cycle through a ‘sequence’ of five discrete phases: pre-contemplation, contemplation, preparation, action and maintenance, before finally attaining long-term abstinence. Data from the current study would suggest that this model, still influential with practitioners, poorly accounts for respondents’ experiences, with some arguably never engaging in active ‘contemplation’, because of the failure to conceptualise their accompanying complex cluster of health and social problems as alcohol related at all.

**Limitations**

An early limitation was identified in participant recruitment. Commissioned NHS services were found to have mainly older veterans, and to achieve the maximum variance sample target for this study, the sampling strategy was changed, and the remaining participants were recruited through partnerships with third sector charities. It is noteworthy that nearly all respondents interviewed were ex-servicemen. Whilst it is believed that men appear to have greater levels of alcohol consumption than women, the absence of female military veterans from this study and other research in this area remains a significant limitation.

**Conclusion**

The findings of this study clearly suggest that veterans who misuse alcohol have a range of distinctive and unique difficulties that subtly differentiate them from the wider civilian substance misuse population. This distinctiveness appears to be underpinned by several significant theoretical insights. Firstly, the effects of military socialisation appeared to be a pervasive influence and often the defining feature of identity within veteran respondents. Almost exclusively, part of this socialisation process involved a normalisation of excessive and regular alcohol consumption. However, the presence of significant pre-enlistment factors such as alcohol exposure at a young age must be considered, as it clearly limits the extent to which strong causal claims can be made about the role of military socialisation in subsequent alcohol misuse. Secondly, a military culture, counter to civilian norms and expectations, appeared to exist in which a belief in the virtue of resilience was central, and that injury and illness are viewed as weakness.

Consequently, delays in ‘meaningful’ engagement with substance misuse services were pervasive among the service users interviewed. In many instances, delayed engagement appeared to be exacerbated by a cycle of mutual mistrust between service providers and veteran service users.

Delayed engagement invariably resulted in complex presentations in which concurrent mental health problems, physical illness, housing problems and unemployment were often present. Most of the veteran respondents were typically unable to contemplate that alcohol misuse may be the common denominator to the ‘presenting problems’ and it was frequently left to other agencies to re-frame the service-users difficulties as being alcohol-related.

Finally, it would appear that veterans presenting with a complex and toxic hybrid of physical illnesses, social and mental health problems could often be poorly-served by the (relatively) fragmented mixed economy of health and welfare provision currently in place within the UK. The confused, often duplicated, plethora of services available coupled with complex care pathways appeared to contribute to veterans disengaging with care. Once again, peer-support models appeared to mitigate against disengagement.

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**Table 1:**

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

|  |  |
| --- | --- |
| Age at interview *(years)* Mean (SD) | 45.05 (7.230) |
| Range | 35-64 |
| Gender Male | 18 |
| Female | 1 |
| Service Royal Navy | 2 |
| Royal Marines | 1 |
| Army | 14 |
| Royal Air Force | 0 |
| Reserve Forces | 2 |
| Age on Enlistment *(years)* Mean (SD) | 17.58 (2.364) |
| Range | 15-22 |

Length of Service *(years)*

Mean (SD)

9.30 (7.113)

Range

5

months

–

24

Early Leavers (≤4 years)

6

Operational Deployments

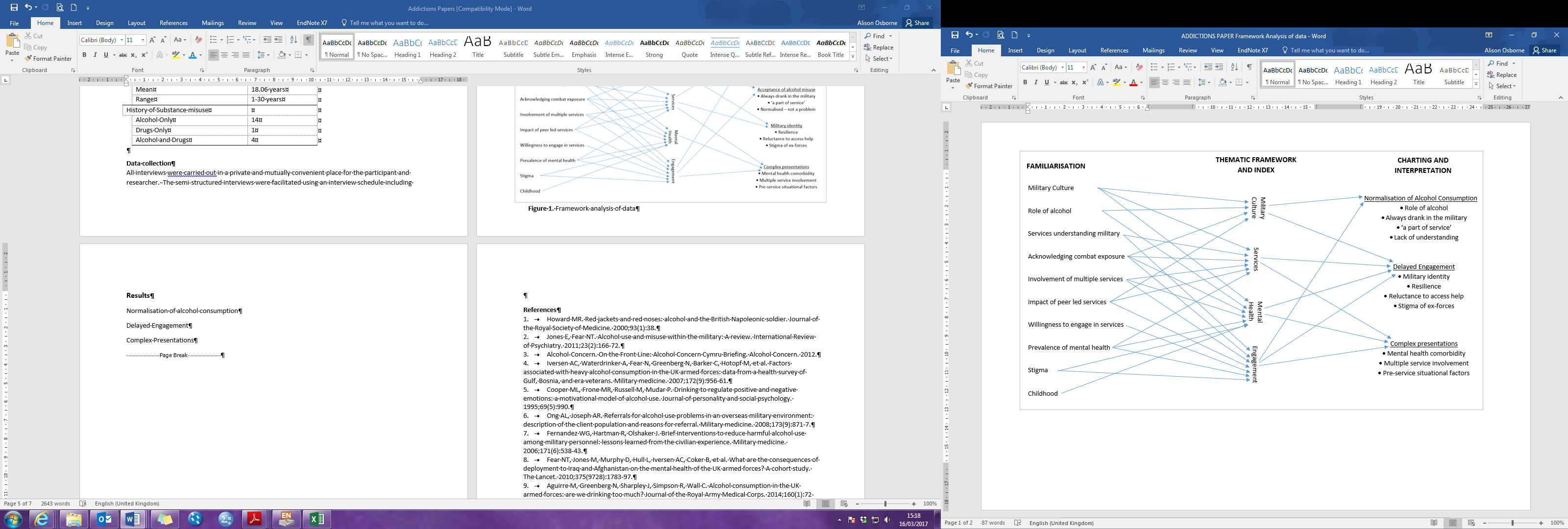
Deployed 11

No deployments 8

Years post service to engage in help *(years)*

Mean (SD) 17.37 (8.726)

Range 1-30

****

**Figure 1.** Framework analysis of data

**Appendices**

**Participant Recruitment**

NTW

**5**

participants

Changing Lives

**12**

participants

Northern Learning Trust

**3**

participants

AF

&

V Launchpad

**2**

participants

**22**

Interviews

**4**

Telephone

Interviews

**18**

Face

-

to

-

Face

Interviews

***2***

*Excluded*

**20**

Interviews

Transcribed

***1***

*Excluded*

**19**

Transcripts

Analysed

### Interview Schedule

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

1. What we want to achieve initially is a comprehensive narrative of the participants’ relationship with alcohol pre, during and post service
   * The respondent’s relationship with alcohol / ‘street drugs’ prior the joining the armed forces.
   * The respondents experiences of ‘drinking culture’ within the military context.  Patterns of alcohol or substance misuse post armed service.
2. Then we want to explore insight and how they have sought help
   * Realisation of patterns of substance use as problematic: Self-realisation vs.

significant others perceptions of ‘problematic’ use.

* + Time frame of the above biographical ‘events’.
  + The decision to act – incentives and disincentives.
  + Expectation of services including service visibility / mode of referral / waiting times / accessibility etc.

1. Next we want to explore their experiences of engaging with services
   * Practicalities of service engagement e.g. competing commitments.  Substance misuse service experiences – positives and negatives.
   * Personal expectations of the service. Desired ‘end point’ – for service-user and for service-users significant others.
   * Personal expectations of ‘recovery’ – what does success look like for service user? Significant others?
   * Service provider expectations vs. service user expectations of outcomes?
2. Finally we want to explore and reflect on the findings of phase 1
   * Do they believe that veterans with substance misuse are different from other substance misuse service user and can they explain why (multiple forms of stigma)
   * Do they feel that clinical staff or professionals understand veterans Exploring stereotypical beliefs by health workers:
     + Their life and experiences within service
     + The nature of the conflicts they may have been involved in o The culture within the military

How does the health system within the military differ from the health system they now find themselves in o Is seeking help for problems different, if so has it been difficult and if so why

1. NHS is the National Health Service in the United Kingdom which provides all the health care needs for veterans, free at the point of delivery. [↑](#footnote-ref-1)