Mental health service acceptability for the Armed Forces veteran community

Abstract

Background: Despite developments in mental health services for Armed Forces veterans and family members, barriers to access associated with poor levels of acceptability regarding service provision remain. Adapting a Step 2 mental health service based on low intensity cognitive behavioural therapy (CBT) interventions to represent a familiar context and meet the needs of the Armed Forces veteran community may serve to enhance acceptability and reduce help-seeking barriers.

Aims: To examine acceptability of a Step 2 low intensity CBT mental health service adapted for Armed Forces veterans and family members provided by a UK Armed Forces charity.

Methods: Qualitative study using individual semi-structured interviews with Armed Forces veterans and family members of those injured or becoming unwell whilst serving in the British Armed Forces. Data analysis was undertaken using thematic alongside disconfirming case analysis.

Results: Adapting a Step 2 mental health service for Armed Forces veterans and family members enhanced acceptability and promoted help-seeking. Wider delivery characteristics associated with Step 2 mental health services within the Improving Access to Psychological Therapies (IAPT) programme also contributed to service acceptability. However, limitations of Step 2 mental health service provision were also identified.

Conclusion: A Step 2 mental health service adapted for Armed Forces veterans and family members enhances acceptability and may potentially overcome help-seeking barriers. However, concerns remain regarding ways to accommodate the treatment of post-traumatic stress disorder (PTSD) and provide support for family members.

Key words: Acceptability; anxiety; Armed Forces; depression; IAPT; mental health; Step 2.

Introduction

Estimates suggest that 82% of UK Armed Forces veterans with mental health problems receive no treatment [1]. This indicates that mental healthcare provision within the UK for Armed Forces veterans remains underdeveloped and lacks acceptability [2]. Attempts to close the treatment gap have resulted in the development of six National Health Service (NHS) regional community mental health pilot services for Armed Forces veterans adopting varied delivery models for comparison with specialist Armed Forces veteran services [3]. Rather than directly delivering treatment however, three of the regional community mental health pilot services focused on providing general support or signposting to NHS mental health services. The remaining three pilot services were derived from existing services specialising in post-traumatic stress disorder (PTSD).

The emphasis placed by these community mental health pilot services on treatment for PTSD and signposting to NHS mental health services is however surprising. Consistent with research focussing on wider groups of first responders [4], studies have consistently identified the prevalence of depression and common anxiety disorders to exceed that for PTSD in Armed Forces veterans [5] and serving personnel [6]. Furthermore, attempts to close the treatment gap by signposting to NHS service provision may be challenging given reluctance amongst Armed Forces veterans to seek mental health treatment [7]. Negative perceptions regarding mental health services [8], stigma [9], service providers considered untrustworthy [10], and beliefs that mental health difficulties can be handled by the individual [11], contribute to low rates of seeking mental health treatment [7]. Additionally, efforts to improve mental health

service provision for family members is increasingly important given that they represent an underserved group [12] with obligations specified within the Armed Forces covenant including family members accompanying active service personnel overseas [13].

Enhancing service provision for Armed Forces veterans and family members for the treatment of common mental health problems may therefore require extending service provision beyond NHS mental health services and treatment for PTSD. To address this, the Help for Heroes charity has implemented the 'Hidden Wounds' mental health service. 'Hidden Wounds' is a single source mental health service for the treatment of common mental health problems experienced by British Armed Forces veterans, family members and family members of currently serving personnel aged 18 and over, registered with a General Practitioner (GP). The service is provided by the UK charity Help for Heroes in two recovery centres in Northern and Southern England.

'Hidden Wounds' operates according to protocols established for Step 2 mental health services implemented by the Improving Access to Psychological Therapies (IAPT) programme across England [14,15]. Step 2 mental health services deliver evidence-based low intensity cognitive behaviour therapy (CBT) interventions for the treatment of common mental health problems as part of a stepped care model of service delivery [14]. Given the lack of a low intensity CBT evidence-base for PTSD and social anxiety, treatment of these conditions is provided by Step 3 mental health services delivering high intensity psychological therapies [14]. Whilst operating according to protocols established by the IAPT programme, 'Hidden Wounds' was

adapted to meet the needs of Armed Forces veterans and family members to address help-seeking barriers in this group [8]. Informed by guidance regarding the development of low intensity CBT interventions [16], imagery and language used within the written CBT self-help interventions was adapted to meet the needs and preferences of Armed Forces veterans [8]. Diagnostic, technical and complex terminology was minimised [17] and case studies used to guide intervention use [16] written to reflect the Armed Forces community. Finally, to ensure understanding of the Armed Forces and specific demands and challenges faced by Armed Forces veterans and family members, Psychological Wellbeing Practitioners (PWPs) undertaking assessments and supporting interventions within the 'Hidden Wounds' service received cultural competency training [18].

Representing an appropriate methodological approach to appreciate self-identified needs and barriers to help-seeking [19], this paper adopts a qualitative methodology to examine the acceptability and attitudes held by Armed Forces veterans and family members towards the 'Hidden Wounds' service. Understanding positive and negative features of this service will help inform service developments to reduce the mental health treatment gap experienced by the Armed Forces veterans community [1].

Methods

Ethical approval was granted by the Psychology Department, University of Exeter.

Participants were recruited into the study following assessment for a common mental health problem within the Step 2 'Hidden Wounds' mental health service.

Following referral, an assessment with a 'Hidden Wounds' PWP was undertaken to identify the presenting mental health problem. Where a mild to moderately severe common mental health problem with a Step 2 evidence-base established by the National Institute for Health and Care Excellence (NICE) [20] is identified (depression, generalised anxiety disorder, panic disorder, obsessive-compulsive disorder, simple phobia), treatment is delivered via low intensity CBT interventions. Consistent with the delivery of low intensity CBT, choice of guided support [21] to facilitate intervention engagement over the telephone, face-to-face in the recovery centre or via video-conferencing was offered. Due to lack of a NICE Step 2 evidence-base, the service does not support interventions for PTSD, social anxiety disorder or for those presenting with risk. In these cases, psycho-education is provided alongside signposting to Step 3 mental health services for evidence-based high intensity psychological interventions or in the case of elevated risk the service protocol is followed.

The sample was recruited at the end of the assessment session where the PWP introduced the study to all potential participants. Those willing to consider participation were supplied with a research pack including study information, ethical details concerning participation and encouraged to contact the researcher to arrange a suitable time to undertake a telephone based semi-structured interview. An interview guide based on research examining the acceptability and barriers to Armed Forces veterans accessing mental health services [8,10] informed the semi-structured interview. Specific questions addressed the experience of accessing and using 'Hidden Wounds', attitudes towards the low intensity CBT intervention adapted for the presenting mental health

difficulty, service suitability in meeting the needs of Armed Forces veterans and family members and service acceptability. All interviews were recorded on a digital-audio recorder, encrypted for secure storage and anonymised during transcription.

Qualitative data was analysed using thematic analysis to identify themes strongly linked to the data without fitting into a pre-existing coding frame [19]. Data items were labelled to generate initial codes with potential themes and sub-themes identified by aggregating similar coded groupings into broader overarching categories. To ensure individual themes represented the final analysis, relevant data extracts were collated within a thematic map. Analysis continued until no further modifications emerged and all relevant text was coded. Finally, a representative title was created for each theme and sub-theme to capture core features of the data. These were used to inform final analysis of the data with highly representative data extracts identified. Throughout analysis significant efforts were taken to ensure rigour [23]. A sub-section of transcripts (n=5; 29%) were independently second coded by AJ and TB with discussions undertaken in the case of discrepancy [19]. Discrepancies only arose with respect to specific content attributed across the sub-theme, *Common factors associated with the PWP* and *CBT related specific factors*. This discrepancy was resolved through further discussion with PF. Attention was paid to items inconsistent with emerging themes and sub-themes during code generation, with instances recorded and reported as disconfirming cases during final analysis. Consistent with quality standards for qualitative research, efforts were taken to ensure analysis was coherent throughout and accounted for relevant data [24].

Results

Interviews were undertaken with 14 male Armed Forces veterans and 3 female family members (Table 1), within the number of participants recommended for qualitative research between 12 and 20 [22].

TABLE 1 HERE

Given the lack of evidence-based treatment at Step 2, ten participants received only an assessment prior to being referred to other services, with the remaining seven participants receiving additional treatment using low intensity CBT.

Three main themes with sub-themes and disconfirming cases emerged from the data. Excluding a single participant (P15), ensuring imagery, language and case studies adopted within the written low intensity CBT self-help interventions represented an Armed Forces context helped to promote acceptability of the 'Hidden Wounds' service. Specifically, such adaptations enhanced the confidence that Armed Forces veterans and family members would be understood (Table 2).

TABLE 2 HERE

However, a disconfirming case (P14) highlighted that there was an over-emphasis on images of Armed Forces veterans with physical injuries adopted by 'Hidden Wounds'. It was felt this could still lead to a perception that the service is reserved for those seeking mental health support arising as a consequence of being

physically injured during active service. Whilst adapting ‘Hidden Wounds’ to ensure it reflected an Armed Forces context enhanced acceptability, having the service provided by a community-based organisation working outside the Armed Forces was equally important. Having it located within ‘Help for Heroes’, an organisation recognised as representing the interests of Armed Forces veterans and family members, served to promote trust by fostering a belief that discussion of mental health difficulties would remain confidential.

Whilst specifically adapting ‘Hidden Wounds’ to reflect an Armed Forces context enhanced acceptability and promoted help-seeking, features more commonly associated with NHS Step 2 mental health service provision within the IAPT programme further enhanced acceptability. In particular, being assessed quickly following referral was highlighted as a key feature associated with service acceptability and especially important for Armed Forces veterans and family members representing elevated risk. In some cases, gaining quick access to the Step 2 service was directly contrasted with perceptions established by GPs that there would be a long wait for NHS mental health services. Furthermore, care co-ordination, assertive follow-up for patients not meeting service inclusion criteria, and signposting to community organisations that may provide wider sources of support enhanced acceptability. Providing a choice of face-to-face, telephone or video-conference based support for the CBT self-help interventions was also felt to promote engagement, with significant variation in preferred modality of support across participants. Alongside benefits associated with not needing to travel to a recovery centre to receive treatment, providing choice regarding support options was

also felt to maximise privacy. However, four of the seven participants (P11,P13,P15,P16) assessed within the Step 2 service as experiencing active symptoms associated with PTSD (Table 1) identified lack of treatment following assessment as a significant limitation. Failing to provide treatment for PTSD served as disconfirming cases with respect to acceptability of the 'Hidden Wounds' service.

Wider characteristics of Step 2 service provision were identified as helpful in maintaining engagement. A range of PWP common factors were highlighted as particularly helpful. Specifically, these were associated with employing language to promote engagement prior to introducing technical terminology, establishing a sense the participant was being understood and demonstrating empathy. Following engagement, patient-centredness was also felt to be maintained through the use of CBT related specific factors. Such factors were related to psychoeducation promoting a clearer understanding of the mental health difficulty being experienced, easy to follow and interactive written CBT self-help interventions, alongside a questioning style enhancing self-awareness and acknowledgement of the mental health difficulty. It is noteworthy that the sessions identified as not being engaging were felt to be unstructured, lasting too long or reflecting more of a general discussion about life in the Armed Forces.

Whilst participants highlighted several characteristics associated with Step 2 service provision enhanced acceptability, remaining internal and external barriers were identified and represented the final theme; continued barriers with service provision. In

particular, several participants highlighted that a lack of awareness regarding symptoms or difficulties experienced may be related to a mental health problem delayed help seeking. Additionally, following transition from military to civilian healthcare provision, barriers to help-seeking also included a lack of awareness regarding service availability or ways to access services (P14). Extending treatment provision to address common difficulties experienced by family members of Armed Forces veterans were also highlighted (P10). Particular areas identified included bereavement and meeting the needs of family members supporting an Armed Forces veteran with a mental health difficulty following deployment (P16). Frustration that support was not offered in these areas was augmented by a perceived lack of clarity regarding treatments offered (P16).

Discussion

This study assessed the acceptability of a Step 2 mental health service adapted to meet the needs of Armed Forces veterans and family members. With the exception of a single participant, results of this study indicate that adaptations ensuring the service reflected an Armed Forces community enhanced acceptability and promoted help-seeking. However, having the service delivered by an organisation outside of the Armed Forces was additionally important in promoting confidence that service use would remain confidential. Features enhancing acceptability were also related to common and specific factors associated with NHS Step 2 mental health services available as part of the IAPT programme. Significant limitations identified with Step 2 service provision were however identified by Armed Forces veterans seeking treatment for PTSD and family members caring for someone with a mental health difficulty. Persisting barriers to help-

seeking also arose from a lack of knowledge that symptoms or difficulties experienced may be related to a mental health problem and poor knowledge regarding mental health service availability following transition to civilian healthcare.

Prior to considering factors associated with acceptability, it remains necessary to maintain an awareness regarding limitations associated with generalising results from qualitative research [25]. Furthermore, it should be considered that results of this study cannot be used to reach any conclusions regarding effectiveness of the service for the treatment of common mental health problems. However, results may inform adaptations to implement within mental health services for Armed Forces veterans and family members for subsequent randomised controlled studies to examine effectiveness.

Ensuring a ‘good fit’ between the mental health service and the Armed Forces may serve to minimise difficulties Armed Forces veterans have in developing therapeutic relationships and encourage mental health help-seeking [26]. Furthermore, ensuring the CBT self-help interventions were written in a manner sensitive to the needs of veterans [8,17] with case studies representing an Armed Forces context, may address concerns associated with not being understood [10]. This may challenge beliefs that mental health service providers are untrustworthy [8,10]. Despite considerations regarding analytical generalisability [25], results may additionally help inform and extend current mental health developments targeted at other emergency service first responders [27].

General characteristics associated with Step 2 service provision implemented within the IAPT programme [14] were also helpful in enhancing acceptability. In particular, gaining access to the Step 2 service within six weeks of referral was positively identified. Participants contrasted their experience of gaining improved access to the 'Hidden Wounds' service with beliefs held regarding unacceptable waiting times with NHS services that serve to establish negative perceptions towards NHS mental health treatment [8]. Furthermore, factors associated with the low intensity CBT clinical method employed in Step 2 IAPT services [28] addressed concerns held by Armed Forces personnel that they would not be understood [10]. Combined with the provision of psycho-education, common factor skills alongside highly structured low intensity CBT assessment and treatment sessions facilitated a shared understanding of the presenting mental health difficulty. That characteristics of the low intensity CBT clinical method contributed to acceptability was further reinforced by disconfirming cases (P9) highlighting dissatisfaction when therapeutic drift [29] was evident with sessions becoming more of a general discussion surrounding Armed Forces life.

However, whilst several features of IAPT Step 2 service provision [14] were associated with acceptability, failing to provide treatment for PTSD following assessment was identified as problematic. Furthermore, being required to signpost outside of the 'Hidden Wounds' service to NHS Step 3 or adapted Armed Forces third sector provision to receive evidence-based high intensity CBT for PTSD was associated with the potential to cause additional distress. Consideration is therefore required regarding ways to enhance Step 3 service provision for Armed Forces veterans

experiencing PTSD. Given that the 'Hidden Wounds' service is only provided from two Help for Heroes recovery centres in Northern and Southern England, seeking to enhance the acceptability of mental health provision through NHS mental health services for the treatment of PTSD may therefore be required. Potentially education and training programmes to enhance the cultural competence of mental health professionals when working with Armed Forces veterans [18] may be one way to improve the acceptability of NHS mental health service provision.

That 'Hidden Wounds' should provide greater support for Armed Forces family members was also identified. Programmes placing greater emphasis on providing sources of peer-based support to family members of Armed Forces veterans are currently being implemented in Canada through third sector organisations [30]. In particular, the Helping Others Provide Empathy (HOPE) program supports people experiencing bereavement; family members of Armed Forces veterans experiencing PTSD are supported by the Operational Stress Injury Social Support (OSISS) program with the Integrated Personnel Support Centre (IPSC) programme aiming to improve awareness of other service availability. All of these programmes have potential to inform UK based services for family members and close gaps in service provision [2]. Within IAPT Step 2 services, signposting to other mental health services and community-based support is already a role undertaken by the PWP supporting treatment [14,15]. Within the 'Hidden Wounds' service this role could be supported by the web-based *Contact* service (www.contactarmedforces.org.uk) already available for Armed Forces family members, veterans and personnel.

In conclusion, a third sector Step 2 mental health service adapted to meet the preferences of Armed Forces veterans and family members has the potential to enhance acceptability and facilitate help-seeking for common mental health difficulties. This may represent a solution to closing the mental health treatment gap in these occupational groups [1,2].

Key points

- Adapting a mental health service to meet the needs of Armed Forces veterans and family members enhances acceptability and promotes mental health help-seeking.
- Delivery characteristics associated with Step 2 mental health services employed within the Improving Access to Psychological Therapies programme contribute to service acceptability.
- Limitations of Step 2 mental health service provision for Armed Forces veterans and family members are associated with lack of treatment for PTSD and limited support for family members caring for someone with a mental health difficulty.

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1 Table 1: Participant characteristics

Participant ID	Age	Sex	Probable Diagnosis	Service Use	Status	Service	Rank on Discharge
P1	54	Male	Depression	Support	Veteran	RAF	Senior Officer
P2	52	Male	Depression	Support	Veteran	Army	Senior NCO
P3	48	Female	Depression	Support	Family		
P4	51	Male	Mixed Anxiety/Depression	Support	Veteran	Army	Junior
P5	47	Male	Agoraphobia	Assessment	Veteran	RAF	Senior Officer
P6	53	Male	Problem Drinking	Assessment	Veteran	Marine	Senior Officer
P7	54	Female	Panic Disorder	Support	Family		
P8	30	Male	Panic Disorder	Support	Reservist	Marine	Junior
P9	36	Male	Health Anxiety	Support	Veteran	Navy	Junior
P10	37	Female	Bereavement	Assessment	Family		
P11	53	Male	PTSD	Assessment	Veteran	Army	Junior
P12	50	Male	PTSD	Assessment	Veteran	Army	Junior
P13	57	Male	PTSD	Assessment	Veteran	Army	Junior
P14	42	Male	PTSD	Assessment	Veteran	Army	Junior
P15	61	Male	PTSD	Assessment	Veteran	Army	Senior Officer
P16	51	Male	PTSD	Assessment	Veteran	RAF	Senior Officer
P17	60	Male	PTSD	Assessment	Veteran	Army	Senior NCO

Table 2: Themes and Subthemes with Disconfirming Cases (representative quotes in italics)

Themes	Subthemes	Disconfirming cases
Adaptations promoting acceptability and help-seeking	**Service provision within a trusted and familiar context** *This [service] was set up with the military in mind as opposed to me going to the National Health where I believe they wouldn't have understanding of, you know, the military ways or things like that…I wouldn't be going down that route because I just don't think they would understand a soldier.* (P2)	**Desire not to be treated in an environment reflecting the Armed Forces** *I've raised it actually with my private therapist 'You know, do you know about the Armed Forces?' And she said, 'No, I don't. I just want to know about you'. I think that was a great sort of clearing of minds between us, that she's saying 'Look you know you've got problems. I'm not part of the Armed Forces'. And that's also why I realise that Combat Stress was the last thing I wanted. I didn't want to be in the environment of the Armed Forces at all. It's quite the opposite.* (P15)
	Low intensity CBT interventions representing the Armed Forces *Yes, you could kind of relate to it [workbook]. There were bits in the story I could go 'Yes, you know I can see that relating to me'. It should be set up for an Armed Forces Veteran rather than, I don't know, somebody working in a factory.* (P1)	**Over emphasis within 'Hidden Wounds' on imagery of people with physical injury led to perception that service should be restricted to Armed Forces veterans requiring mental health support arising from physical injury during active service** *You just feel you're not deserving of it [Hidden Wounds], there are guys who are really badly injured.* (P14)
Positive characteristics of Step 2 services	**Improved access** *If I went to the NHS I'd probably have to wait for three months when at that point I couldn't even go out and buy food. Without this service, something bad could've happened. I was confused, you never think you'd do anything stupid like doing that to yourself….but without the help I got straightaway I'd have been struggling for*	

	a fact, I know that. (P8)	
	Benefits of providing choice of face-to-face, telephone and videoconference support *It was good to be given the choice of how you wanted to work, this helped me choose the easiest way for me to work.* (P7)	
	Benefits of assertive follow-up and care-coordination *It's nice to know that they're not just giving you information and leaving you, that somebody is following-up to make sure that you're okay and I think that's very important.* (P10)	
	Common factors associated with the PWP. *I was so ill, all the anxieties and everything, and I spoke to this lady [the PWP] and her voice was lovely and soothing. And she listened to me and seemed to understand me, it was just the best thing I have ever experienced. Marvellous.* (P7)	**Characteristics of PWP not supporting engagement** *I think it was someone probably half my age with you know a tenth of my experience and I felt great respect to her. You know she's qualified and all the rest I'm sure, but I just felt I was talking to someone who had not got a clue as to actually what has happened to people like me and many, many other people.* (P15)
	CBT related specific factors *They [sessions] were very well conducted, very professional, you know, the right sort of questions I think to get some sort of gauge of who I am and what I am and where I am. I think they were helpful, the questions were, you know, making you think and better understand the problem.* (P3)	**Dissatisfaction with poor assessment structure** [The assessment] *went off on a tangent… talking about military and all of that….I remember being on the phone for quite a long time.* (P9)

Remaining barriers	**Lack of knowledge that symptoms or difficulties may be mental health related** *Because at first it's hard to admit there's something wrong you know. And I were confused as well. I didn't know what were going on with me.* (P8)	
	Poor knowledge of service availability following transition from Armed Forces to civilian healthcare *A lot of guys get out without any treatment in-house as in DCMH* [Departments of Community Mental Health] *and they're just lost. I think there's a grey area between your last day of service and when you get your service leaver's pack.* (P14)	
	Following assessment, lack of treatment for PTSD *In part* [for PTSD] *it was unhelpful that you had to then be referred on to somebody else…I found it quite disappointing and hard that I'd managed to speak to somebody and got everything off my chest but then had to go and do it again with somebody else. I think that was quite hard.* (P11)	
	Little support for family members *I've seen some very good stuff from the Canadian military for families about how to deal with people coming home from deployment. So, I know there's stuff out there you can give to dependants, to relatives to help them deal with the therapy or to help them deal with the process.* (P10)	