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Awareness of and willingness to access mental health support among UK serving and ex-serving military personnel who reported a mental health difficulty

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Abstract

Background: Awareness of and willingness to access mental health services are important first steps in help-seeking behaviour. However, evidence suggests UK armed forces personnel are not always aware of and willing to access sources of mental health support. This study aimed to explore which sources of support UK armed forces personnel are most aware of and willing to use for a self-reported mental health problem and to explore the possible differences between serving and ex-serving personnel.

Methods: Data was taken from a cross-sectional study comprising 1432 UK serving and ex-serving personnel, who had self-reported a mental health, stress or emotional problem in the past 3 years.

Results: Military personnel, irrespective of serving status, were most aware of and willing to access formal medical services. In contrast, there was a low awareness of and willingness to use ex-serving-specific support services amongst ex-serving personnel.

Discussion: Future service delivery and policy should focus on improving the variety of sources of support that ex-serving personnel are aware of and willing to use, to enable them to make informed choices about where to seek help if needed.

Key words: armed forces, mental health, help-seeking behaviour, mental health care utilisation, veterans, military personnel, UK

Lay Summary:

Awareness of and willingness to access mental health services are important first steps in seeking help for a self-reported mental health, stress or emotional problem. Evidence shows that UK military personnel, in particular ex-serving personnel, are not always aware of and willing to access sources of mental health support. This study aimed to explore which sources

of mental health support UK military personnel were aware of and willing to use if they self-reported a mental health, stress or emotional problem. It also explored the possible differences between serving and ex-serving military personnel. All UK military personnel were most aware of and willing to access formal medical services. However, there was a low awareness of and willingness to use ex-serving-specific support services, Veterans and Reserves Mental Health Programme, NHS Veterans Service and Veterans UK helpline amongst ex-serving personnel. Future service delivery and policy should focus on improving the variety of sources of support that ex-serving personnel are aware of and willing to use.

Introduction

Awareness of available mental health support is an important step in seeking help[1]. However, evidence suggests that armed forces personnel in the United Kingdom (UK) are not always aware of what support is available. A study showed that 16% of UK personnel agreed with the statement that they did not know where to get help[2]. Furthermore, evidence shows this problem is worse amongst ex-serving personnel (20.8%) than serving personnel (11.5%)[2]. This is important given that ex-serving personnel have an increased prevalence of probable mental disorders such as post-traumatic stress disorder (PTSD) and alcohol misuse compared to serving personnel[3]. After leaving the military, personnel transition from military care providers to the National Health Service (NHS), state provided healthcare system[4]. During this transition, the number and type of support services available to the individual changes and many UK ex-serving personnel report being confused by the large variety of services available to them[4,5]. However, there is limited data on which services UK personnel are most aware of and this makes it difficult to determine what can be done to provide further clarity for them.

Awareness is not the only important variable in help-seeking behaviour as making personnel aware of services does not guarantee that they will access them. A randomised controlled trial showed that the odds of an individual seeking help, for a self-reported mental health problem, was not significantly higher if they were instructed on where to access services compared to if they were not[6]. Therefore, personnel require a willingness to access services in addition to an awareness.

Past research shows that most military personnel are willing to access mental health support. A United States (US) based study showed that just under two-thirds of service personnel reported being willing to access mental health support if they perceived themselves to have a

mental health difficulty[7]. However, there are a number of factors which have been shown to affect willingness to access help amongst armed forces personnel. Important factors include stigma and perceived barriers to care. In particular, self-stigmatisation is associated with a decreased willingness to seek help for a mental health problem[8]. Self-stigmatisation is "the incorporation of others' prejudices and stereotypes about people with mental illnesses into beliefs about oneself"[9].

In addition, willingness to access help appears to vary depending on the source of support. A UK study showed that military personnel are more likely to access non-medical sources of support, such as friends and family, over medical sources[10]. A low willingness to access medical services may be problematic as formal support services such as the medical officer (MO) or general practitioner (GP) act as the gate keeper for some services[4]. Therefore, establishing which sources of support UK armed forces personnel are willing to access is important for gaining a comprehensive understanding of help-seeking behaviour.

This study aimed to explore which sources of support UK armed forces personnel are most aware of and willing to use for a self-reported mental health, stress or emotional problem, and to explore the possible differences between serving and ex-serving personnel.

Materials and Methods

Royal Navy, Royal Marines, Army and Royal Air Force (RAF) personnel were selected from an existing cohort of serving regular, reserve and ex-serving personnel who had participated in phase 3 (2014-16) of an ongoing military health and wellbeing cohort study[11-13]. Phase 3 participants were asked to complete a survey (written or online) about their socio-demographic and military characteristics, deployment experiences, lifestyle factors, and various measures of health and wellbeing (phase 3; n=8093). The current study comprises of

phase 3 participants who consented to future contact and answered 'yes' to the question 'have you had a mental health, stress or emotional problem in the past three years?'.

There was a total of 2017 participants who fulfilled the inclusion criteria for this study. From these individuals, 1714 (84.9%) were randomly selected for a telephone interview. For more details see Stevelink et al. 2019[13].

Procedure

A structured interview schedule was administered by telephone after verbal informed consent was obtained and recorded. In total, 1450 participants were interviewed (response rate 84.6%)(1 participant had died and 263 participants did not complete the interview of which: 189 declined, 73 failed to respond and 1 participant was unable to complete the telephone interview). Two interviews were lost during a computer server failure (n=1448). After completing the telephone interview, participants received £25 as a reimbursement for their time. Data collection took place between February 2015 and December 2016.

Study Materials

The interview schedule comprised of several questions regarding awareness of and willingness to use sources of mental health support. Awareness of help sources was assessed by asking the participants if they had heard of each source of mental health support. Participants were asked to respond with either 'Yes' or 'No'. If they were aware of a source of help, they were then asked if they would be willing to use that source of help. Participants were asked to respond with either 'Yes', 'No' or 'Don't Know'. Additionally, participants were asked to list other sources of help they had used for their mental health, stress or emotional problem. However, the numbers were small and were not included for analysis in the current study. Participants could report the usage of multiple sources of help.

Analysis

Participants who did not report a current or past mental health problem were excluded (n=16). A total of 1432 participants were included in the analysis for this study. If a participant responded as 'don't know' to whether they would be willing to access a source of help, it was re-coded as 'missing'. For all analyses, serving and ex-serving personnel include regulars and reserves. Descriptive analyses provided an overview of the characteristics of study participants, sources of help used, awareness of and willingness to use help sources. A Pearson's chi-squared test of independence was used to determine if there were significant differences between serving and ex-serving personnel for awareness of and willingness to use sources of support. For this, comparisons were made between the percentage of serving and ex-serving personnel who were aware of and willing to use formal medical, formal non-medical and informal support.

Sources of help were combined into three categories: informal support, formal non-medical support and formal medical support. Informal support included help from a family member, friend, colleague, helplines and accessing the Big White Wall (this has now been rebranded as Togetherall, a digital mental health support platform). Formal non-medical support included help from the Chain of Command, Trauma Risk Management practitioner (TRiM) (a trained peer who provides basic support and can encourage seeking help from a healthcare professional following trauma), military charities, NHS Veterans Service, any formal therapy provided by charities and other non-medical health specialists (counsellor, padre, social worker or welfare officer). Formal medical support included help from a general practitioner (GP), medical officer (MO), hospital doctor/nurse and mental health specialist (psychiatrist, psychologist and community psychiatric nurse). For friends and family (informal sources of support), participants were not asked about awareness or willingness so these were labelled not reported for these categories. The TRiM practitioner and chain of command can only be accessed by serving personnel, so this was labelled as not applicable for ex-serving

personnel. Similarly, the NHS Veterans Service, Veterans and Reserves Mental Health Programme (VRMHP) and the UK Veterans helpline cannot be used by serving personnel, so they were labelled as not applicable for this. However, serving personnel were asked if they were aware and willing to use these services as they will one day be ex-serving personnel who may wish to access these services.

Non-response was accounted for by response weights. These weights were based on variables associated with responding (age, rank and service). They were calculated as the inverse probability of responding once sampled. Tables present unweighted cell counts and weighted percentages. A p value ≤ 0.05 was defined as statistically significant. All statistical analyses were performed with survey (svy) commands, applied to account for weighting, using the statistical package STATA v.14[14].

Ethical approval

Ethical approval for the study was granted by the UK Ministry of Defence Research Ethics Committee (reference: 448/MODREC/13).

Results

Population demographics

1432 individuals were included in the analyses for this study, all of whom had a self-reported a stress, emotional or mental health problem. The majority of participants were older than 40 years (54.3%), male (84.8%), Army (66.0%), and slightly over half were serving (55.0%). At the time of interview, 42.9% of participants reported a past stress, emotional, alcohol or mental health problem, 57.1% reported experiencing a current problem. Further, 18.4% met the criteria for a probable anxiety disorder, 7.8% for a probable depressive disorder, 8.8% for probable PTSD, and 18.7% for alcohol misuse (Table 1). Help-seeking behaviour was high amongst UK serving and ex-serving military personnel, with the majority of personnel

seeking some form of help for a self-reported emotional, mental health or alcohol problem (n= 1328, 92.8%) (data not shown).

[table 1 near here]

Awareness and willingness to use sources of mental health support

There were similar patterns in awareness and willingness to use sources of mental health support between serving and ex-serving personnel. They were most aware of and willing to use formal medical sources of support, specifically the GP/MO and mental health specialists. They were least aware of and willing to use the Big White Wall, a source of informal support. (Table 2 and 3). This finding is excluding family and friends as they were not reported in the awareness and willingness categories.

Despite serving and ex-serving personnel reporting high awareness and willingness to use formal medical sources of support, they reported comparatively low rates of using these sources. Serving and ex-serving personnel reported highest rates of using informal sources, specifically family members and friends/colleagues. (Table 2 and 3).

In serving personnel, there was a high awareness of serving-specific services, the TRiM practitioner (86.4%) and Chain of Command (95.4%), compared to low rates of willingness to use these services (50.5% and 49.8% respectively). Further, the TRiM practitioner was only accessed by 3.2% of serving personnel. (Table 2)

In ex-serving personnel, there was a low awareness and willingness to use ex-serving specific services. In particular, there was low awareness of the NHS Veterans' Services (26.8%) and the VRMHP (21.2%). These services were used by few ex-serving personnel: NHS Veterans Service (1.8%), Veterans UK helpline (1.2%) and VRMHP (0.3%). (Table 3).

[table 2 and 3 near here]

Comparison between serving and ex-serving personnel

Serving personnel were significantly more aware of formal non-medical sources (17.5% vs 7.2%, $X^2 = 20.74$, p=<0.001) and informal sources (16.0% vs 8.9%, $X^2 = 6.99$, p= <0.001) than ex-serving personnel. (Figure 1). Serving personnel were significantly more willing to access sources of informal support (25.8% vs 23.6%, $X^2 = 3.64$, p=0.01) than ex-serving personnel. However, this difference was minimal. (Figure 2).

Serving personnel were more likely to access formal non-medical support (51.3% vs 40.5%, $X^2 = 16.64$, p= <0.001) and informal support (88.3% vs 82.9%, $X^2 = 8.32$, p=0.004) compared to ex-serving personnel. In contrast, ex-serving personnel were more likely to access formal medical support (59.2% vs 50.7%, $X^2 = 10.12$, p= 0.002) than serving personnel. (Figure 3).

[Figure 1, 2 and 3 near here]

Discussion

Main findings

In UK serving and ex-serving military personnel, there were similar patterns in awareness and willingness to access sources of mental health support. Irrespective of serving status, personnel were most aware of and willing to access formal medical services, in particular the GP/MO. However, they both reported comparatively low use of these formal medical sources of support. Serving and ex-serving personnel were most likely to use friends/colleagues and family members as sources of support.

Despite the similarities, there were some significant differences in awareness and willingness to use support services between serving and ex-serving personnel. Ex-serving personnel had a lower awareness of formal non-medical and informal sources of support than serving

personnel. Ex-serving personnel also had a lower willingness to use informal services than serving personnel. In particular, there was a low awareness and willingness to use ex-serving specific services such as the NHS Veterans Service, the VRMHP and the Veterans UK helpline.

There was a high awareness of and willingness to use formal medical services amongst UK military personnel. It is important that UK military personnel are aware and willing to access services such as the GP/MO as they act as the gate keeper to some other services[4]. Despite this, the number of personnel who accessed formal medical services was lower than the reported awareness and willingness to use them. This may be explained by the fact that not all personnel will require formal support for a self-reported mental health, stress or emotional problem. A high self-efficacy (the individual's belief in their ability to manage their motivation and behaviour) amongst ex-serving personnel has been shown to decrease the likelihood of seeking treatment for a mental health problem[16].

However, the disparity between rates of access to formal medical services and awareness and willingness to use them could also represent associated stigmas and barriers to care. These barriers include: having a preference to speak to professionals that have an understanding of military life, difficulty making appointments, and poor perceived efficacy of treatment[17]. These are likely to be important barriers to formal medical services as many health professionals in these services do not have an understanding of military life. Furthermore, making appointments for NHS services such as the GP can be difficult and waiting times can be high. Similarly, evidence shows that personnel who report symptoms of a mental health problem experience higher levels of stigmatising beliefs than those who are asymptomatic[18]. Hence, it is important to consider these potential barriers and stigmas with regards to armed forces personnel seeking help from formal medical services.

There were important differences seen in awareness and willingness to use services between serving and ex-serving personnel. Ex-serving personnel had a lower awareness of formal non-medical and informal sources of support than serving personnel. In particular, there were low levels of awareness and willingness amongst ex-serving personnel to access services specifically designed to support them: the VRMHP, NHS Veterans Service, and the Veterans UK helpline. This finding is important given the evidence that ex-serving personnel have an increased prevalence of mental disorders such as PTSD and alcohol misuse compared to serving personnel[3]. Furthermore, it is concerning as it extends to a low awareness and willingness to use both NHS services (NHS Veterans Service) and charity services (Veterans UK helpline) that are designed for ex-serving personnel.

A possible explanation for the low levels of awareness and willingness to access ex-serving specific services amongst ex-serving personnel is that they are appropriately aware of and willing to use other services. The results from this study show that in ex-serving personnel there is a high awareness of and willingness to use formal services such as the GP. The GP is an appropriate first step for ex-serving personnel to seek help from as they can appropriately signpost and refer personnel to further services if required[4].

On the other hand, a low awareness and willingness to use ex-serving specific services may indicate that ex-serving personnel are not aware of the wide range of services that are available to them. Once personnel leave the military, they have to transition care providers from the military to the NHS[4]. Previous studies have shown that ex-serving personnel report the number of services available to them as confusing[5]. This may present a number of difficulties including not knowing where to access help and not knowing what type of help each service offers. Not only this, but this finding may suggest that GPs are not aware of which services they can make appropriate referrals to if required. The Royal College of General Practitioners (RCGP) has identified that GPs need support in better identifying ex-

serving personnel and referring them to dedicated services through the veteran friendly accreditation scheme[19].

Strengths and Limitations

This study had a large sample size, with a high response rate (84.9%). A wide range of sources of support were examined and reported on in this study, resulting in a comprehensive picture of help-seeking behaviour in UK armed forces personnel. However, a structured interview approach limited the number of services that personnel were asked about awareness of and willingness to use. The questions used to determine awareness, willingness to use and help-seeking behaviour were not part of a validated questionnaire. Personnel were also required to retrospectively report their help-seeking behaviour. This means that the findings may have been subject to recall bias due to the period of time between using services and reporting awareness and willingness to use them. In addition, data was collected between 2014 and 2016 and since then, the service provision landscape has changed[13]. For example, 'Op COURAGE' has been introduced, providing specialist care and support for ex-serving personnel, reservists and their families[20].

Implications

This study suggests that consideration should be given to improving awareness and willingness to use ex-serving-specific services amongst ex-serving personnel so that they can make informed choices about which services to access. The study has shown that ex-serving personnel have a low awareness and willingness to access services designed for them (VRMHP, NHS Veterans Service and Veterans UK helpline). This is particularly important given that ex-serving personnel are more likely to fulfil the criteria for a probable mental disorder than serving personnel.

The UK Government has already made some steps towards improving awareness of support services in ex-serving personnel through developing new services such as Op COURAGE. which has been designed to help make the transition from the military to NHS services as easy as possible[21,22]. However, simply increasing the number of services available to ex-serving personnel may not address the issue surrounding access to these services.

In addition to this, there is a GP practice accreditation scheme aimed at helping to improve the care and treatment of ex-serving military personnel in primary care. It is a scheme that works to assist GPs in referring ex-serving personnel to appropriate services[19,23]. This may help in making sure that ex-serving personnel are aware of the wide variety of services available to them. However, this is a voluntary scheme and GP practices are not required to participate. Furthermore, it assumes that all ex-serving personnel will access the GP when they identify a mental health problem.

Conclusions

In conclusion, UK serving and ex-serving personnel, who acknowledge having a stress or emotional problem, were most aware of and willing to access formal medical help compared to formal non-medical and informal help (excluding friends and family). In ex-serving personnel there was a particularly low awareness of and willingness to access VRMHP, NHS Veterans Service and Veterans UK helpline; ex-serving-specific support services. Therefore, future service delivery and policy should focus on improving the variety of sources of support that ex-serving personnel are aware of and willing to use, to ensure that they can make informed choices about where to seek help from.

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Declaration of Interest

NTF is a trustee of a charity supporting the mental health and wellbeing of serving personnel, veterans and family members.

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Authors Bio

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Table 1. *Demographic characteristics of study participants (n=1432)*

	Total Participants (n=1432) n (%)
Age at time of interview (in years)	
<30	173 (13.6)
30-39	463 (32.2)
>39	796 (54.3)
Gender	
Male	1213 (84.8)
Female	219 (15.2)
Serving status	
Serving	783 (55.0)
Ex-serving	649 (45.0)
Engagement	
Regular	1167 (81.3)
Reservist	265 (18.7)
Service	
Naval Services	195 (13.1)
Army	928 (66.0)
RAF	309 (20.9)
Rank	
NCO	867 (60.8)
Officer	378 (25.2)
Other ranks	187 (14.0)
Health perception	
Excellent/very good	663 (46.2)
Good	527 (37.0)
Fair/poor	242 (16.9)
Probable anxiety	
Yes	260 (18.4)
No	1171 (81.6)
Probable depression	
Yes	110 (7.8)
No	1321 (92.2)
Probable PTSD	
Yes	124 (8.8)
No	1308 (91.3)
Alcohol misuse	
Yes	266 (18.7)
No	1166 (81.3)

NCO = non-commissioned officer. Probable anxiety measured with screening tool GAD-7 = general anxiety disorder 7-item. Probable depression measured with screening tool PHQ-9 = 9-item patient health questionnaire. Probable PTSD measure with screening tool PCL-5 = 20-item PTSD checklist for DSM-5. Alcohol misuse measured with screening tool AUDIT-C = 3-item alcohol use disorders identification test. 'yes', refers to a probable emotional, alcohol or mental health problem. Numbers may not add up to total due to missing data. n = unweighted cell counts. % = weighted percentages

Table 2. *Awareness and willingness to use sources of support in serving military personnel*

Source of Help	Serving personnel (n=783)		
	Aware n (%)	Willing n (%)	Used n (%)
Any Formal Medical Support			
GP/MO	778 (99.4)	711 (93.2)	370 (47.0)
Hospital doctor/nurse	715 (91.4)	545 (80.7)	22 (2.8)
Mental health specialist	773 (98.7)	670 (89.5)	245 (31.3)
Formal Non-Medical Support			
Other non-medical professional	763 (97.4)	574 (79.1)	234 (29.8)
TRiM Practitioner	680 (86.4)	308 (50.5)	25 (3.2)
Chain of Command	747 (95.4)	336 (49.8)	270 (34.7)
Service charities	718 (91.5)	403 (62.5)	49 (6.2)
Combat Stress	649 (82.7)	404 (68.7)	11 (1.5)
NHS Veterans Service	229 (29.3)	123 (58.8)	NA
Veterans and Reserves Mental Health Programme	205 (26.1)	115 (61.6)	NA
Informal Support			
Veterans UK Helpline	461 (59.1)	228 (55.3)	NA
SSAFA/Combat Stress 24 Hr Helpline	584 (74.5)	356 (67.3)	6 (0.8)
The Big White Wall	196 (24.8)	83 (48.7)	9 (1.2)
Family Member	NR	NR	577 (73.7)
Friends/Colleagues	NR	NR	505 (64.7)

NR = not reported. NA = not applicable. GP = general practitioner. MO = medical officer. TRiM practitioner = trauma risk management practitioner. SSAFA = Soldiers, Sailors, Airmen and Families Association. The category 'aware' refers to those participants who were aware of each source of support. The category 'willing' refers to those participants who reported that they were aware of that source of support. The category 'used' refers to those participants who accessed the source of support. Numbers may not add up to total due to missing data.

n = unweighted cell counts. % = weighted percentages

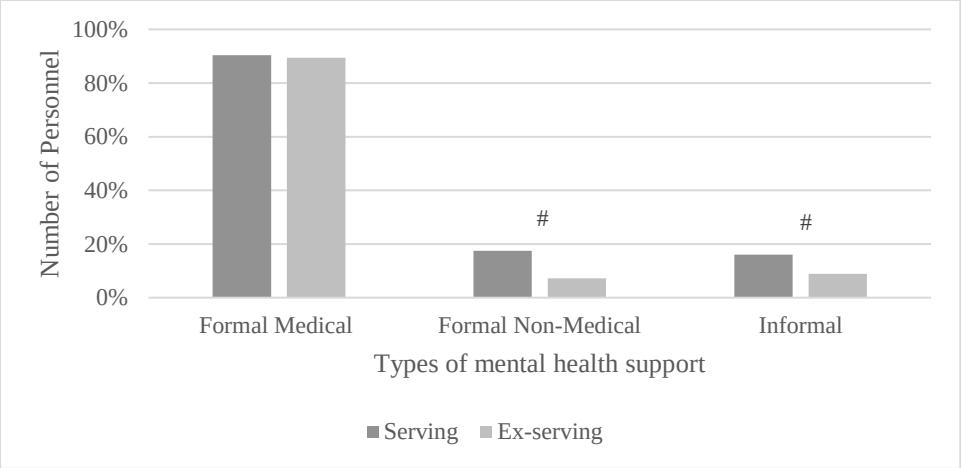
Table 3. *Awareness and willingness to sources of support in ex-serving military personnel*

Source of Help	Ex-serving personnel (n=649)		
	Aware n (%)	Willing n (%)	Used n (%)
Formal Medical Support			
GP/MO	648 (99.6)	599 (94.0)	342 (52.6)
Hospital doctor/nurse	587 (90.4)	452 (79.5)	41 (6.3)
Mental health specialist	637 (98.1)	550 (89.3)	225 (34.6)
Formal Non-Medical Support			
Other non-medical professional	605 (93.2)	413 (72.4)	155 (24.1)
TRiM Practitioner	NA	NA	NA
Chain of Command	NA	NA	NA
Service charities	607 (93.5)	409 (71.7)	50 (7.7)
Combat Stress	501 (77.1)	339 (72.3)	38 (5.9)
NHS Veterans Service	174 (26.8)	126 (75.1)	12 (1.8)
Veterans and Reserves Mental Health Programme	138 (21.2)	97 (78.8)	2 (0.3)
Informal Support			
Veterans UK Helpline	373 (57.3)	238 (70.9)	8 (1.2)
SSAFA/Combat Stress 24 Hr Helpline	437 (67.3)	299 (73.4)	14 (2.3)
The Big White Wall	88 (13.6)	44 (58.1)	14 (2.2)
Family Member	NR	NR	463 (71.2)
Friends/Colleagues	NR	NR	354 (54.5)

NR = not reported. NA = not applicable. GP = general practitioner. MO = medical officer. TRiM practitioner = trauma risk management practitioner. SSAFA = Soldiers, Sailors, Airmen and Families Association. The category 'aware' refers to those participants who were aware of each source of support. The category 'willing' refers to those participants who reported that they were aware of that source of support. The category 'used' refers to those participants who accessed the source of support. Numbers may not add up to total due to missing data.

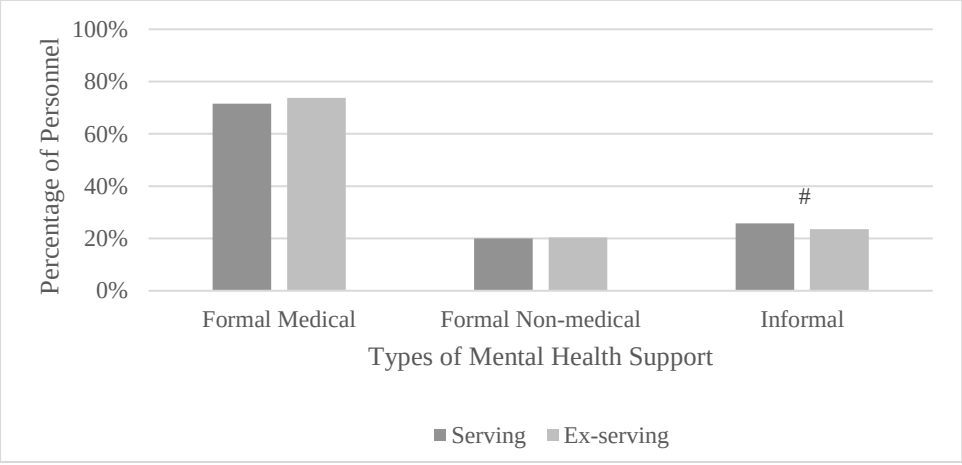
n = unweighted cell counts. % = weighted percentages

Figure 1. *Percentage of serving and ex-serving personnel who were aware of formal medical, formal non-medical and informal sources of mental health support **



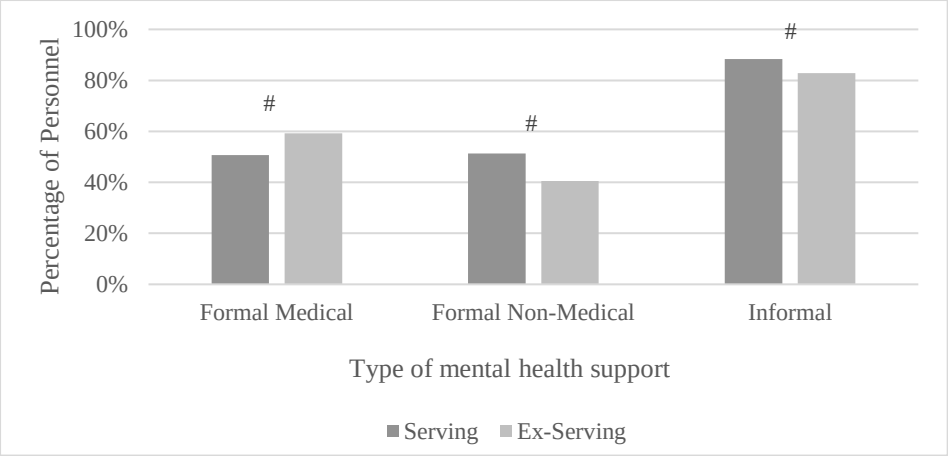
** This figure includes the percentage of serving and ex-serving personnel who were aware of all sources of support in each category. For example, formal medical includes all military personnel who said 'yes' to being aware of all three services: GP/MO, hospital doctor/nurse, and mental health specialist. Percentages do not add up to 100% as participants could be aware of more than one source of help*
The '#' indicates that the P value was <0.05 and that the difference between serving and ex-serving personnel was significant. Numbers may not add up to total due to missing data. The testing was done per source of support, so responses were only counted once.
% = weighted percentages

Figure 2. *Percentage of serving and ex-serving personnel who are willing to access formal medical, formal non-medical and informal sources of mental health support**



**This figure includes the percentage of serving and ex-serving personnel who were willing to access all sources of support in each category. For example, formal medical includes all military personnel who said 'yes' to being aware of all three services: GP/MO, hospital doctor/nurse, and mental health specialist Percentages do not add up to 100% as participants could be willing to use more than one source of help*
The '#' indicates that the P value was <0.05 and that the difference between serving and ex-serving personnel was significant. Numbers may not add up to total due to missing data. The testing was done per source of support, so responses were only counted once.
% = weighted percentages

Figure 3. *Percentage of serving and ex-serving personnel who sought help from formal medical, formal non-medical and informal sources of support**



**This figure includes the percentage of serving and ex-serving personnel who sought help from at least one source of support in each category. For example, formal medical includes all military personnel who said 'yes' to seeking help from at least one of three services: GP/MO, hospital doctor/nurse, and mental health specialist. Percentages do not add up to 100% as participants were allowed to list multiple sources of help The '#' indicates that the P value was <0.05 and that the difference between serving and ex-serving personnel was significant. Numbers may not add up to total due to missing data. The testing was done per source of support, so responses were only counted once.*

% = weighted percentages