

Mental health treatment experiences of commonwealth veterans from diverse ethnic backgrounds who have served in the UK military

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ABSTRACT

Introduction Research has shown that the likelihood of ex-military personnel developing mental health problems following service is around one in five. Little is known about the barriers to accessing mental health in veterans from diverse ethnic backgrounds. This study aims to explore mental health treatment experiences of veterans from commonwealth countries and therefore diverse ethnic backgrounds.

Methods Semi-structured interviews were conducted over the telephone with veterans from commonwealth countries. Veterans were recruited from a mental health charity and were at various stages of treatment.

Results We interviewed six veterans who were from a diverse range of commonwealth countries including St Lucia, Gambia, Ghana, Fiji and South Africa. All had served in the UK army in combat roles. Our findings consisted of key themes: (1) feeling that they are treated differently, (2) they felt as though they were unheard when reaching out for help, (3) systemic pressures such as financial difficulties, missed opportunities and lack of insight about mental health and (4) the importance of involving the wider community in care.

Conclusion Our findings highlight some distinct barriers to mental health treatment that commonwealth veterans experience. The themes reported by the participants appear to suggest they had experience signs of institutional racism. Suggesting the importance of highlighting these issues, and to help overcome these potential barriers to accessing services. Given that commonwealth veterans involvement in the UK military is significant and increasing, the findings in this study should be used to support this population by implementing service provision and policy.

INTRODUCTION

The commonwealth (CW) is a voluntary association consisting of 52 independent and sovereign states of the British Empire, including areas of Africa, Australia, India, South America and Malaysia.¹ In 2018, the Ministry of Defence (MoD) announced they aim to increase overseas military personnel intake, with a specific recruitment focus on CW countries.² Recent MoD statistics reported that black, asian and minority ethnic (BAME) representation in the UK Armed Forces has increased by 70% between 2018 and 2019; this can largely be explained by personnel joining from Ireland and CW countries.³ Eight per cent of UK military personnel (11 180) identified as CW ethnicities, of this the army had the highest proportion (12%),

Key messages

- ▶ From 2018 minority ethnic representation in the UK military has increased by 70% which is partly explained by in personnel joining from commonwealth countries.
- ▶ Veterans struggle with help seeking from mental health services.
- ▶ There is no research on help-seeking and treatment experiences of veterans from commonwealth countries.
- ▶ Our research suggests that veterans from commonwealth countries experience different barriers to mental health treatment compared with veterans from non-commonwealth countries.
- ▶ Many of the commonwealth veterans' reported barriers to accessing treatment that suggested experiences of institutional racism in the civilian health service and in the UK Armed Forces.
- ▶ This study suggests that specific mental health services for commonwealth veterans could improve their engagement and treatment journey.

followed by the Royal Navy/Marines (4%) and Royal Air Force (3%).³

Data exploring psychosocial outcomes following military deployment suggests that the majority of veteran's transition back into civilian life with little difficulties.⁴ However, one in five veterans will experience mental health problems.⁵ Large-scale cohort data have reported that approximately 27.2% of UK service personnel who were deployed to Iraq and Afghanistan experienced common mental health disorders (CMD), such as depression and anxiety, and 9.4% will experience probable post-traumatic stress disorder (PTSD).^{6,7} By comparison in the most recent Adult Psychiatric Morbidity Survey,⁸ one in six adults (17%) of the general population experience CMD and 4.4% experience PTSD, which suggests that veterans may be an increased risk of experiencing mental health difficulties. To the best of our knowledge, there is no current data on the prevalence of CMD in CW veterans.

Studies have found that ex-service personnel have a tendency to underuse mental health services. Specifically, veterans who had screened positively for mental health problems only 31% sought help and accessed treatment.⁹ This finding



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was consistent across US, Australian and Canadian military services.⁹ One explanation for this is due to perceived stigma and lack of trust in services.^{10 11} While these findings are important contributions to military mental health research, the data reported do not report ethnicities of the sample. As such, there is limited research exploring help-seeking of CW veterans after deployment. Given that the UK army predominantly consists of males from a white British background,² it is possible that CW veterans' responses are under-represented in such studies. Additionally, studies have found that ethnicity can also have an effect on help-seeking behaviours. Research has suggested that BAME people often struggle with engaging with UK mental health services and participants who were of black ethnic origin had particularly low rates engaging with treatments after assessments.¹²

Given the paucity of research in this area, the CW community remains relatively poorly understood within the context of the UK Armed Forces. Further research exploring under-represented military personnel from CW countries could contribute to the shaping of clinical services to address any differences. The increasing enrolment of CW recruits in the UK military² coupled with the prevalence of mental health problems and service utilisation of veterans suggest a need to understand more about this distinct population. CW veteran's mental health treatment needs and barriers to accessing services may differ from veterans who are not from CW countries. This study aimed to qualitatively explore the treatment experiences of an ethnically diverse set of individuals from a range of CW countries and who had served in the UK military.

MATERIALS AND METHODS

Data consisted of semi-structured individual interviews. Interviews were conducted over the telephone by the researcher (EJP). This method was chosen to increase the geographical area that CW veterans were able to participate from. Thematic analysis was used to analyse the transcripts. The method of thematic analysis is used for identifying, analysing and reporting patterns (themes) within data. It organises and describes data set in detail and often interprets various aspects of the research topic.¹³ Despite thematic analysis being widely used, there is no distinct agreement about what thematic analysis is.^{13 14} Thus, thematic analysis is independent of theory and epistemology, this allowed for more flexibility during analysis while at the same time being a useful research tool giving a complex account of data.¹⁴ To the best of our knowledge, there have been no published studies using thematic analysis exploring the treatment experiences of CW veterans.

Setting, recruitment and participants

All participants were recruited from a national charity that provides mental health services for ex-military personnel. Clinicians from combat stress (CS) referred suitable clients to EJP. EJP then contacted these participants to explain outline of the study and give clients the opportunity to participate. In total, 15 clients were highlighted as eligible and were contacted, of which 6 agreed to take part, 7 were uncontactable and 2 declined. All participants had either finished treatment at CS or were currently receiving treatment. CS offers comprehensive residential treatment courses for veterans who have been diagnosed with PTSD which include psychoeducation and skills training (eg, cognitive behavioural therapy), as well as individual trauma-focused CBT and psychoeducational groups.

Inclusion and exclusion criteria

The inclusion criteria for this study was partially determined by the inclusion and exclusion criteria for CS' treatment programme. Therefore, participants must have reported a military-related trauma, have a diagnosis of PTSD and have served in the UK Armed Forces for at least 1 hour. All participants must not have a personality disorder, dependence on alcohol or a psychotic disorder. Those with a high perceived risk of suicide or with a suspected traumatic brain injury were excluded. CW veterans at CS are in the ethnic minority and therefore inclusion and exclusion criteria were purposefully left broad. Participants must have been born in one of the 52 independent sovereign states that are part of the CW association and identify as an ethnic minority group when serving in the UK Armed Forces. This information was identified from the patient electronic system used in CS and have consented to be contacted by the research team.

Data collection

Interviews were conducted over the telephone. Reviews,¹⁵ comparing the validity of telephone and face-to-face interviews have found few differences in consistency and quality of data. The interviews began with researcher explaining confidentiality and the purpose of the study. Participants had at least 24 hours to decide if they wanted to participate before being contacted again. Informed consent and the subsequent interviews were recorded on an encrypted digital voice recorder. Participants were all informed that they had the right to withdraw at any point in the study without giving a reason. The semi-structured interview typically lasted between 25 and 45 min, depending on participant's engagement with questions. Four questions were asked, all of which explored participants' experiences of being a CW veteran with mental health problems and if this impacted their treatment journey through services. To account for cultural differences, the questions were piloted with CW veterans before data collection. To increase reflexivity the researcher recorded reflections during and after the interview. The interviews were then typed by into transcripts for analysis.

Data analysis

Data analysis was completed by the researcher and can be described over distinct phases. During each phase, an impartial and secondary researcher checked through findings and themes. First, EJP familiarised themselves with the dataset by reading through all the transcripts and checking the transcripts against the original audio recordings. Immersion within a dataset means reading and re-reading the transcripts, actively searching for patterns and trends. The second phase involved the researcher beginning to generate initial themes, patterns and codes from the data. Codes identify a feature of the data (either semantic content or latent) that is of interest to the research^{13 14} to form into meaningful groups. The coding process mainly used a theory-driven approach using the research questions. The researcher worked systematically through the transcripts giving equal attention to all of the transcripts and coding for as many potential themes and patterns as possible. The third phase commenced after the data had been coded and collated. The researcher at this stage had a long list of codes identified across the whole dataset and began to re-focus the codes across a broader level of themes by collating all the relevant data. The researcher used mind maps and tables to visually represent and assist with combining different codes (key themes) into overarching themes (superordinate themes). The fourth phase consisted of the final refinement of the themes. Once this refinement had been completed, the researcher then

Table 1 Sociodemographic and military information

| Participant | Relationship status | Country of origin | Ethnicity | Service | Rank | Role | Years in military | Discharge reason | Conflicts |
|-------------|-----------------------|-------------------|------------------|---------|---------|--------|-------------------|------------------|----------------------|
| P1 | Married with children | St Lucia | Black- Caribbean | Army | Officer | Combat | 12 | Medical | Afghanistan and Iraq |
| P2 | Married | St Lucia | Black-Caribbean | Army | Officer | Combat | 6 | Medical | Afghanistan and Iraq |
| P3 | Married | Gambia | Black-African | Army | Officer | Combat | 8 | Redundancy | Afghanistan |
| P4 | Married with children | Ghana | Black-African | Army | Officer | Combat | 11 | Medical | Afghanistan |
| P5 | Divorced | Fiji | Black-Caribbean | Army | Officer | Combat | 9 | Dishonourable | Iraq |
| P6 | Married with children | South Africa | Black-British | Army | Officer | Combat | 4 | Unknown | Iraq |

checked again over the quotes and that they were congruent of the superordinate and key themes. A table of superordinate, key themes and corresponding quotations from transcripts was produced.

RESULTS

Sample

Recruitment was carried out at CS and the final sample consisted of six participants. Participant identification numbers were used in replacement of participant names to protect anonymity (Table 1).

Table 1 describes the participant demographic data. All the participants were male, ages ranged from 33 to 41 years ($m=37.17$, $SD=2.93$). Most of the participants (5/6) were married, 3/6 was married with children and 1/6 was divorced. Participants' origin countries ranged from St. Lucia (2/6), Gambia (1/6), Ghana (1/6), Fiji (1/6) and South Africa (1/6). Ethnic origin of the sample included Black Caribbean (2/6), Black African (2/6), Fijian (1/6) and Black-British (1/6). All of the sample identified as CW veterans and had been enlisted in the army.

Results from qualitative analysis

Table 2 describes the key themes found in the interview.

Superordinate theme one: treated differently

This theme explores how participants had experiences of being treated differently compared with other veterans of the same rank. Some participants expressed how they thought they had sacrificed more than veterans who were born in the UK as they had left their home country and were more exposed to frontline duties. The participants reported that they felt they had been discriminated or judged based on their background in mental

health service settings, experiences of not being taken seriously when expressing having difficulties and a relief when a final diagnosis was set.

Subthemes

Prejudged because of background

[Health professional] said the problem with commonwealth soldiers is that we expect you to come here for pensions. You know that really shook me and I knew that it was time for me to leave because she would not, acknowledge that, I'm injured and protect me from normal duty. P6

Assumptions about quality of life

I think they just assume that he's happy he's being treated by the NHS for free as where he comes from its worse. In fact that they make you feel as if they're doing you a favour, you shouldn't be there. That's how I feel about the whole system. P6

Minimum treatments

Where I am now, I have no idea where the nearest treatment place is—nobody is interested in me. Basically there's some medication and there's no indication of that I can get any more help. P4

Anger from peers

In the Armed Forces, I was actually injured, physically beaten up for having an injury and you know when I cry about the injury people said I'm lazy. And then they got annoyed with you and say that I'm giving them more work. P6

Subtheme five: diagnosis

When you're diagnosed with something, it's saying you are not different you know? It's like, if you got that problem then they look after you. Accessing treatment is easy once you got diagnosed. Why? You got rights. P1

Superordinate theme two: feeling unheard

This theme explores a number of ways which the participants felt unheard or their voice did not matter when attempting to access services. The subthemes identified focused on difficulties accessing treatment through feeling that they were not believed by mental health services, and when treatment was accessed, this was not tailored to their individual needs. Some described that they were feeling misunderstood, and that the treatment offered was wasting valuable time.

Subthemes

Not feeling believed

People think, because he comes from a third-world country and he's come to a first world country he's got it good. Who's going to listen to me anyway? If I went in and tried to complain about it, I don't think anything will be done about it. P6

Table 2 Key themes from analysis

| Superordinate themes | Subthemes |
|----------------------|---|
| Treated differently | <ul style="list-style-type: none"> ▶ Prejudged because of background ▶ Assumptions about quality of life ▶ Minimum treatments ▶ Anger from peers ▶ Diagnosis |
| Feeling unheard | <ul style="list-style-type: none"> ▶ Not feeling believed ▶ Communication ▶ Passed around by services ▶ Delays in treatment |
| Systemic pressures | <ul style="list-style-type: none"> ▶ Finances ▶ Promotions ▶ Physical health ▶ Insight ▶ Beliefs |
| Community | <ul style="list-style-type: none"> ▶ Wider networks ▶ Specific services ▶ Shared experiences |

Communication breakdown

People are expecting certain things and they probably misunderstand me. I find that there is that barrier when we (CW veterans) speak to someone and we try to explain to them what the problem is. P6

Being passed around by services

I ended up not seeing anybody else, I think for two or three years, I've just been waiting without any help. And when I phoned them (mental health services), they said, 'We can't help you because we're not equipped to deal with a person like you'. P6

Delays in treatment

The goal posts keep moving come and see me after three months, I'm gonna give you these pills, come back after three months, come back after six months, before you know it five years is gone, and nothing's changed. P6

Superordinate theme three: systemic pressures

This superordinate theme highlights systemic challenges that the participants described impacted on their ability to access and continue to access support. The subthemes are a list of some of the challenges to seeking treatment as a CW veteran and as just a veteran.

Subthemes

Finances

I think in general it takes commonwealth soldiers a bit longer to get any help, particularly with anything to do with finances. If you had a little bit of money it could help you with just normal necessities, you know like food and transport to appointments. P6

Promotions

My regimental signals officer told me that I will never get promoted regardless of how fit I am or how competent. P3

Physical health

I mean, it is a link if you don't feel [physically] well and you can't go and do things, it affects the way you think, you know, because you are in pain. I didn't realise that at the time. P6

Insight

The Fijian boys, if they have any problem they will keep it with them. They will never share their (mental health) problems. Only time they will share is when they are drinking alcohol, which is when they let their anger rule. P5

Beliefs

I did worry about people telling me I'm a murderer. And then I just kept it with me because all the boys (CW vets) they experience the same thing as well. P5

Superordinate theme four: community

This superordinate theme describes how the participants value their friends, family, neighbours and community with similar cultural backgrounds as part of their help-seeking, accessing services and general support through difficult times. The subthemes identify lack of services available for CW veterans, and their experiences of how the wider community thinks about them, and identifying the importance of having shared experiences with fellow CW veterans to increase treatment utilisation.

Subthemes

Wider networks

People ask me a lot of things and people come back to me and say, 'Oh, just heard these people are saying this about you'. So, there were a lot of bad things going on, which also wasn't really helpful, to be honest with you. P4

Specific services

As a commonwealth soldier I don't think we have got anything. I don't think there's any support, I don't think there's anything like that. Ghurkha's get extra support and CW vets do not. P3

Shared experiences

It was my mate, the one who talked to me about this, and he told me all about his treatment. He said it's wonderful and how he's changed. He's born again, to be honest with you. We were the same regiment and he's from Fiji as well which helped me. P5

DISCUSSION

Discussion of findings

Within our study, we observed that CW veterans reported a number of barriers to accessing treatment for mental health difficulties. These can be described within four main themes: (1) feeling as though they are treated differently, (2) feeling unheard, (3) not feeling as if they were taken seriously when they do reach out for support and (4) how wider problems and their community can impact on their help-seeking.

Taken as a whole, these themes suggest that participants reported experiences that are suggestive of institutional racism and discrimination when accessing services for their physical and mental health. The list of barriers to seeking treatment for participants appear to carry a similar message, namely, experiences of being discriminated and unfairly treated based on their background and ethnicity.

The participants reported complex issues with housing, finances and physical health which then understandably appeared to have a negative impact on their treatment journey. Generally, these difficulties commenced while serving and continued outside of service, which reinforced the beliefs that nobody listens and their problems did matter. CW veterans described sharing their concerns within their community, usually with other veterans from the same origin country. Overall, this appeared to have a negative impact on the participants' low self-esteem, self-worth and confidence. This may then have contributed to a sense of hopelessness and feeling as though they do not deserve support. The barriers highlighted in the current study differ from other studies exploring barriers to treatment in other veteran samples. This is often because CW veterans are not included in research or represent a small percentage and therefore the results are skewed towards veterans from white British backgrounds. For example, a qualitative study reported that the main barriers were internalised stigma and negative sense of self. In response to such barriers, interventions were developed to improve help-seeking, such as decompression.¹⁶ This study suggests that perhaps interventions might need to be adapted to improve help-seeking in CW veterans.

Clinical implications for this research

The findings in the current study appear to suggest that CW veterans report different barriers in comparison to UK veterans who had accessed support from the same clinical service. The CW veterans reported experiencing more shame around

admitting their difficulties to their families and professionals.¹⁷ Thus, increasing the knowledge of the early warning signs of mental health problems should be a priority in minority populations, whereas general work around decreasing stigmatising views may be more suited to UK veterans. Trauma symptoms can be best treated as a systemic phenomenon and thus including wider groups such as a partner, and family is valuable.¹⁸ One possible way of including wider systemic networks could be psychoeducational group sessions in the community with the aim of informing communities from ethnic minority backgrounds about how to recognise early signs of mental health problems, perhaps reducing delays in accessing mental health treatments. Due to the integrative community style of living, this preventative approach could have the potential to reach large networks of diverse ethnic minority groups. Participants viewed physical health problems as a priority, while mental health problems can wait. The complexity that CW veterans presented with suggests that services should consider approaches to promote collaborative care to improve the communication and patient journey between physical, mental and social services. Clinicians should continue to work in an integrative manner, be aware of cultural differences (such as language used to express mental health difficulties) and the specific challenges of veterans from minority groups. Overall, general public stigma, peer-led therapy sessions will both contribute to reducing stigma and perhaps contribute to CW veterans with mental health problems seeking help sooner. Sessions aimed at CW veterans would hopefully increase understanding of mental health and how it is treated in the UK, which would hopefully improve engagement with services. Finally, the paper demonstrates the importance of exploring issues of race and discrimination and finding ways to develop inclusive services.

Strengths and limitations

This study has both its strengths and weaknesses. There is a paucity of research exploring the treatment experiences of CW veterans and whether these differ compared with the general veteran population. Additionally, minority groups can be more challenging to engage in research studies, due to additional barriers such as perceived cultural and communication difficulties.¹⁹ This research provides important insights into veteran mental health services and how they could be adapted for ethnic minorities. However, it is important to note that the small sample size is a limitation of the study, where only 15 participants were invited to take part. This was due to first the small percentage of CW veterans in mental health services and therefore the number eligible participants from CS. This will likely have had an impact on the result of this study, and future studies should aim to increase sample size. Additionally, diversity of the sample has limitations due to all participants being male and around the same age. Although the study included participants from a wide range of countries, within the scope of this research it was not possible to engage members from all 52 countries in the CW association. Future studies could engage participants who identify from broader ethnic groups to better understand experiences of veterans from across the CW. Lastly, collecting retrospective data has its limitations. The sample consisted of treatment-seeking veterans who had mostly overcome barriers to accessing services.

CONCLUSIONS

While limitations exist, this study is the first of its kind and suggests that CW veterans report a range of barriers that differ

from the peers from non-CW backgrounds. As such, it is important to consider the issues raised within study to better support CW veterans engage in mental health services.

Contributors EJP and DM contributed to the planning and setting up of the study. EJP was responsible for recruitment, collecting and analysing the data and the write up of the study, under the supervision and guidance of DM. JB worked extensively on the revision of the manuscript after the initial review. All authors are guarantors and responsible for the overall content of the study and made the decision to publish.

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