A Qualitative Systematic Review of Enablers and Barriers to HelpSeeking for Veterans that have Completely Left the Military Within the Context of Mental Health and Alcohol

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ABSTRACT

The variation in the definition of a veteran, and the preference for quantitative methods, has created mixed findings regarding the process of veteran help-seeking (HS) for mental health/alcohol issues. To understand HS enablers/barriers for those having ceased military employment, a systematic review of qualitative HS literature is warranted. Six databases were searched. Data were analysed thematically. From 1,154 titles/abstracts screened, six studies elicited four themes: military culture, problem severity, the system, and relationships/support. Enablers/barriers were individual and group specific. Alcohol was often an initial HS barrier whereas mental health symptomology and peer/community support were enablers. Themes collectively suggest HS is a progressive journey. Many studies had reporting issues so fully assessing study quality was challenging. Limited qualitative studies exist concerning those having ceased service altogether. A qualitative approach is advantageous as underlying processes can be explored. Interventions could improve the HS process/journey, at individual and group/community levels.

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Extant armed forces-community literature suggests veterans are more vulnerable to suffering from mental health (MH) difficulties when compared to the general population. Literature relating to both UK and US veteran populations finds approximately 30% are more likely to suffer from common MH difficulties (e.g., anxiety, depression) and posttraumatic stress disorder (PTSD) than the general population (Porcari et a., 2017; Rhead et al., 2020). Elevated rates of MH difficulties in veterans are likely linked to trauma exposure they may have encountered through their armed forces career (Goodwin et al., 2015; Murphy & Busuttil, 2019). The use of alcohol to manage MH struggles associated with career-related trauma exposure tends to be normalised through military culture (Jones & Fear, 2011). Such normalised beliefs associated with alcohol use and self-medication often cascade down to veteran life where higher levels of alcohol consumption could continue (Kiernan et al., 2018). Unsurprisingly, excessive alcohol use and MH difficulty appear together comorbidly in clinical settings, which was evidenced by Murphy and colleagues (2017) during their profiling study of UK help-seeking (HS) veterans. Murphy et al. found that 92.8% suffered likely alcohol misuse combined with two or three additional MH difficulties.

Many veterans with such alcohol and MH difficulties choose to delay or avoid HS for their issues. HS usually refers to seeking support from an "official" source, including (but not limited to) a medical practitioner, charity, psychologist, social worker, or other sources of more official professional support. Hom and colleagues' (2017) review of HS and MH service utilisation of different global military nations reported that across 111 papers, just less than one-third (29.3%) of those veterans with identified MH difficulties sought help. Kline et al., (2021) and Murphy and Busuttil (2018) reported that UK and US HS rates were similarly comparable. The lack of recorded HS behaviour indicates there is a sizeable unmet MH/alcohol need. However, this HS figure is likely to be inaccurate due to the non-disclosure of veteran status within HS environments. For example, veterans within the UK may engage in HS via the National Health Service (NHS); the NHS does not necessarily collect or record veteran-specific data (Finnegan & Randles, 2022). Nevertheless, it is purported across literature that veteran HS rates are low.

Various explanations have been proposed to account for poor HS rates. Some suggested HS barriers have been elicited through military-culture literature, such as having a strong sense of pride, the need to resolve an issue oneself, and a fear of stigmatisation (Britt et al., 2019; Iversen et al., 2011; Sharp et al., 2015; Stecker et al., 2007). Stigma is a common reoccurring barrier-related theme found across military-culture literature (Golub et al., 2013; Hom et al., 2017). Other barriers to HS have been explored through the use of health-related behaviour models such as the

Mental Health Literacy (MHL) Model (Jorm et al., 1997). The MHL Model suggests that poor knowledge of MH, and any associated symptoms, are key HS barriers. Kantor and colleagues (2017) found through their review, which included military community populations, that poor MH education was a clear barrier to HS. Similarly, Johnson and Possemato (2021)'s study, relating to HS in a US primary care context, found that lack of problem recognition in veterans was a strong predictor of non-HS.

Although some veterans are known to avoid or delay HS, a considerable proportion are HS (Murphy & Busuttil, 2018). While there are no veteran-specific health behaviour models to account for why some veterans do HS, the Andersen and Newman (1973) health behaviour model could be considered a useful framework to reflect on veteran HS. The Andersen and Newman model posits that people seek help due to MH difficulties associated with trauma exposure; veterans are classified as being trauma exposed. The Andersen and Newman theory suggests that HS is directed by three factors being present from the time the trauma event occurred onwards. Those three factors are (a) predisposing (e.g., personality, preferences, attitudes); (b) enablement (e.g., environmental aids to HS such as transport or income); and (c) need (e.g., functional impairment linked to poor MH).

Existing veteran literature has found that predisposition, enablement, and need factors do indeed facilitate HS behaviour. Bravo and colleagues (2019) found of 163 US veterans, that they were more likely to engage in HS if they had a pro-mindfulness disposition. The Tsai et al. (2015) cross-sectional study reported that of 1, 202 female US veterans, a frequently occurring indicator of HS, particularly via the US Department of Veterans Affairs (VA), was income. This finding suggested that low income was an HS enabler. Several studies have also found that social, peer, and community support enables HS in veterans via practical and emotional enablement (Huck, 2014; Siegel et al., 2018).

Moller et al. (2020) noted that of 434 Danish veteran survey responses, MH condition was a strong predictor of HS, with this finding holding for over 22 years. If veterans had lived with their MH issue(s) for a protracted time it is likely the prolonged symptom severity and/or functional impairment accompanying poor MH created the "need" for HS.

As veteran HS rates remain low within the context of MH and/or alcohol it is important to continue investigating both enablers and barriers to HS, so findings may be used to encourage veteran HS engagement and improve the HS experiences via well-placed HS programs or interventions. Findings may also be used to challenge existing theories used within the field of veteran HS. Given that the material situated within the domains of traumatology, MH, and alcohol use includes much veteran-related literature, it would be useful to conduct a systematic review of existing findings.

There are currently nine systematic reviews relating to enablers/barriers to HS within the realm of alcohol and MH that capture the veteran population with their inclusion criteria (Clement et al., 2015; Coleman et al., 2017; Hom et al., 2017; Johnson & Possemato, 2019; Kantor et al., 2017; Randles & Finnegan, 2021; Schnyder et al., 2017; Sharp et al., 2015; van den Berk-Clark & Patterson Silver Wolf, 2016; see Appendix 1 for existing reviews). Although these reviews have useful insights there are several weaknesses. One limitation relates to the use of the overarching armed forces community as opposed to focusing on specific sub-populations that are appropriately and clearly defined (i.e., sub-groups of veterans). Review findings that were based on veterans classified as those who were formerly deployed but possibly still employed, such as the US veteran definition (Gribble et al., 2019; Veterans Authority, 2021), are not generalisable to other veteran sub-groups. For example, workplace stigma is more frequently found to act as a barrier for employed veterans as opposed to those who have ceased employment (Clement et al., 2015). The issue of generalisation according to the veteran definition was highlighted by three of the previously conducted reviews (Kantor et al 2017; Randles & Finnegan 2021; van den Berk-Clark & Patterson Silver Wolf, 2016).

Further limitations relate to quantitative methods. The variety and inconsistency of quantitative scales used collectively across studies make consolidation and comparison of data difficult. The lack of consolidation subsequently results in many individual barriers/enablers to HS being produced; it is difficult to identify the most salient, which has implications for intervention development. Even where no consolidation of data is needed, Coleman and colleagues (2017) suggested it is challenging to adequately capture the complexity of HS through scales, or factor in the context surrounding HS. For example, a quantitative approach would not adequately explain the interplay between predisposition, enablement, and need factors, aligned with the Andersen and Newman (1973) behaviour model, and whether this model can adequately account for veteran HS. Instead, a qualitative approach could produce findings that should deepen the understanding of the dynamic process of veteran HS. A qualitative process may account for the context and community/social setting within which veteran HS occurs, which could help explain why and how enablers/barriers become enablers/barriers to HS (Nworah et al., 2014).

Five of the previously conducted systematic reviews did attempt to include qualitative findings by mixing quantitative and qualitative data (Clement et al., 2015; Hom et al., 2017; Kantor et al., 2017; Randles & Finnegan 2021; van den Berk-Clark & Patterson Silver Wolf, 2017). Yet three failed to provide a justification for mixing the data or describe how the data were assessed, aggregated, and interpreted. Such missing information made it difficult to assess the quality of these reviews (Pace et al., 2012; Pluye & Hong, 2014). The two mixed reviews that provided greater transparency unfortunately also had limitations. One review was barrier/stigma focused (Clement et al., 2015) and was limited in its scope. The second review (Kantor et al., 2017) included non-military participants and only retained data relating to the most frequently occurring barriers/enablers.

Given that there is a general paucity of qualitative evidence in the field of veteran HS literature (Nworah et al., 2014), there is merit in conducting a purely qualitative systematic review to capture context, culture, and underlying behavioural processes. Only one qualitative HS literature review exists in the context of MH, which is stigma-focused and mixes US and UK veteran populations from the wider armed forces community (Coleman et al., 2017). Many participants captured within the Coleman and colleagues' (2017) review were serving soldiers and not veterans. It would be useful to conduct a review relating to those who have completely ceased military service as most HS occurs after a period of delay within civilian life (Murphy et al., 2015). It would also be useful to use a veteran definition that is as inclusive as possible for generalisability (Gribble et al., 2019).

To our knowledge this is the first qualitative systematic review to consider an exclusively veteran population defined as those who have completely ceased military service. This review will also consider enablers and barriers to HS within the context of alcohol and/or MH difficulties. This review will explore extant qualitative literature related specifically to (a) the existence of enablers/barriers, (b) how enablers/barriers become enablers/barriers, (c) the process of HS, and (e) future research directions.

METHODOLOGY

MATERIALS
Quality Assessment
The Critical Appraisal Skills Programme (CASP, 2018) critical appraisal tool for qualitative studies was used to assess the quality of all studies. The Consolidated Criteria for Reporting Qualitative Research (COREQ) was also applied regarding the quality and transparency of qualitative articles (Equator Network, 2019). Both CASP and COREQ are suggested as indicators of quality tools within systematic review literature (Boland et al., 2014).

Data Extraction

Bespoke data extraction sheets were developed and piloted to ensure adequacy. The following information was extracted: objectives, participants, design, interview guide, recruitment, briefing, data collection, ethics, debrief, transparency of method, the role of researcher, findings, data to support findings, context or additional information, overall contribution, generalisability, limitations, and funding. Extracted data from included studies were checked and independently cross checked by two researchers.

METHOD

The Centre for Reviews and Dissemination (CRD, 2009), Consolidated Criteria for Reporting Qualitative Research (COREQ; Equator Network, 2019), and the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA; Moher et al., 2009) guidelines were followed regarding the literature search strategy, exclusion and inclusion criteria, data extraction, quality assessment, and data synthesis. A review protocol was registered through PROSPERO reference number CRD42021227508 (CRD, 2021).

Literature Search

All previously published literature was searched (no date parameters were used) on January 3, 2020; the search was then repeated on March 5, 2022. Six databases were searched including PsycINFO, Embase, Medline, Scopus, CINHAL, and PTSDPubs. Keywords such as "veteran," "help-seeking," "alcohol," "mental health," and "qualitative" were used as search terms. Alternative words were also used to maximise the scope of the search (see Appendix 2 for search terms). The reference lists of included papers were also checked for inclusion.

Inclusion and Exclusion Criteria

Articles were appropriate for inclusion if the following criteria were met:

- studies that featured enablers and/or barriers to HS or support service use;
- studies that featured actual HS (did not/did not engage in HS) or retrospective HS (opinions towards HS);
- qualitative studies;
- studies focusing on veterans; not personnel who currently serve in the armed forces (including reserves and National Guard; these populations may be dually serving with the military and living as civilians);
- studies that featured MH and alcohol. This review was part of a wider veteran HS study relating to MH and alcohol specifically, therefore alcohol was of interest as opposed to general substances.

Articles were excluded if:

- substances were referred to generally and alcohol was not mentioned specifically;
- the study was from the perspective of others (i.e., organizations or healthcare professionals);
- they were not primary studies;
- non-English language studies.

Study Selection

All titles and abstracts were screened and independently cross checked by two reviewers. A third reviewer was consulted in the case of disagreement. Screening was piloted with a random sample (20 studies) before conducting a full screen. A full paper review was conducted on those studies that met the exclusion/inclusion criteria.

Population Definition

The UK definition of a veteran was applied to the population of interest. This was a person who had served at least one day in the military, regardless of whether they were actively deployed but were no longer employed by the military (Gribble et al., 2019). This differs from the US definition: a person has served on "active" duty for at least 180 days (Veterans Authority, 2021). The Australian and Canadian definitions stipulate a person has deployed overseas but not necessarily engaged in combat deployment. The UK Ministry of Defence's definition is more inclusive but does stipulate the person has ceased military employment (Gribble et al., 2019).

Data Synthesis

All articles were reviewed and analysed collectively using thematic analysis (Braun & Clarke, 2006). Thematic analysis is a six-stage process:

- Stage one: familiarisation with the data.
- Stage two: generate initial codes.
- Stage three: search for themes.
- Stage four: an involved review of themes.
- Stage five: define and name the themes.
- Stage six: produce a report.

A summative consideration of articles goes beyond concepts and themes contained within a single study, providing a wider view of the content and context of study findings. Original data were not sought or used within this review; the data analysed were the reported results/findings in the studies meeting inclusion criteria. Sections of verbatim text from the results sections of all articles were collectively analysed within qualitative data analytical software, QSR Nvivo 12 (2018). The verbatim text was coded with labels. Reoccurring instances of codes were identified as themes.

Context and underlying processes were considered when defining the themes. Themes were constantly compared with the original data to ensure the themes truly reflected the meaning within the data. The meta-themes were named and described. Overall decisions concerning themes were taken independently by the research team as opposed to being generated by Nvivo.

RESULTS

STUDY SELECTION
The systematic literature search identified 1, 154 articles. After 47 duplicate articles were removed, a total of 1, 107 titles and abstracts were screened. Fifty-five papers were read in full by the research team to include as many studies as possible; six fully met the criteria for inclusion. See Figure 1 (below) for the PRISMA diagram (Moher et al., 2009). A table of characteristics for the six included articles can be found in Table 1 (below).

STUDY CHARACTERISTICS
The six included studies incorporated 130 participants. Sample sizes ranged five to 44 participants. Two studies featured American participants and four studies focused on English participants. Three studies were recruited via the UK National Health Service and one study used participants from an unspecified larger study. The two US studies collected data via the VA and a series of shelters, drop-in centres, the county jail, and substance abuse programs.
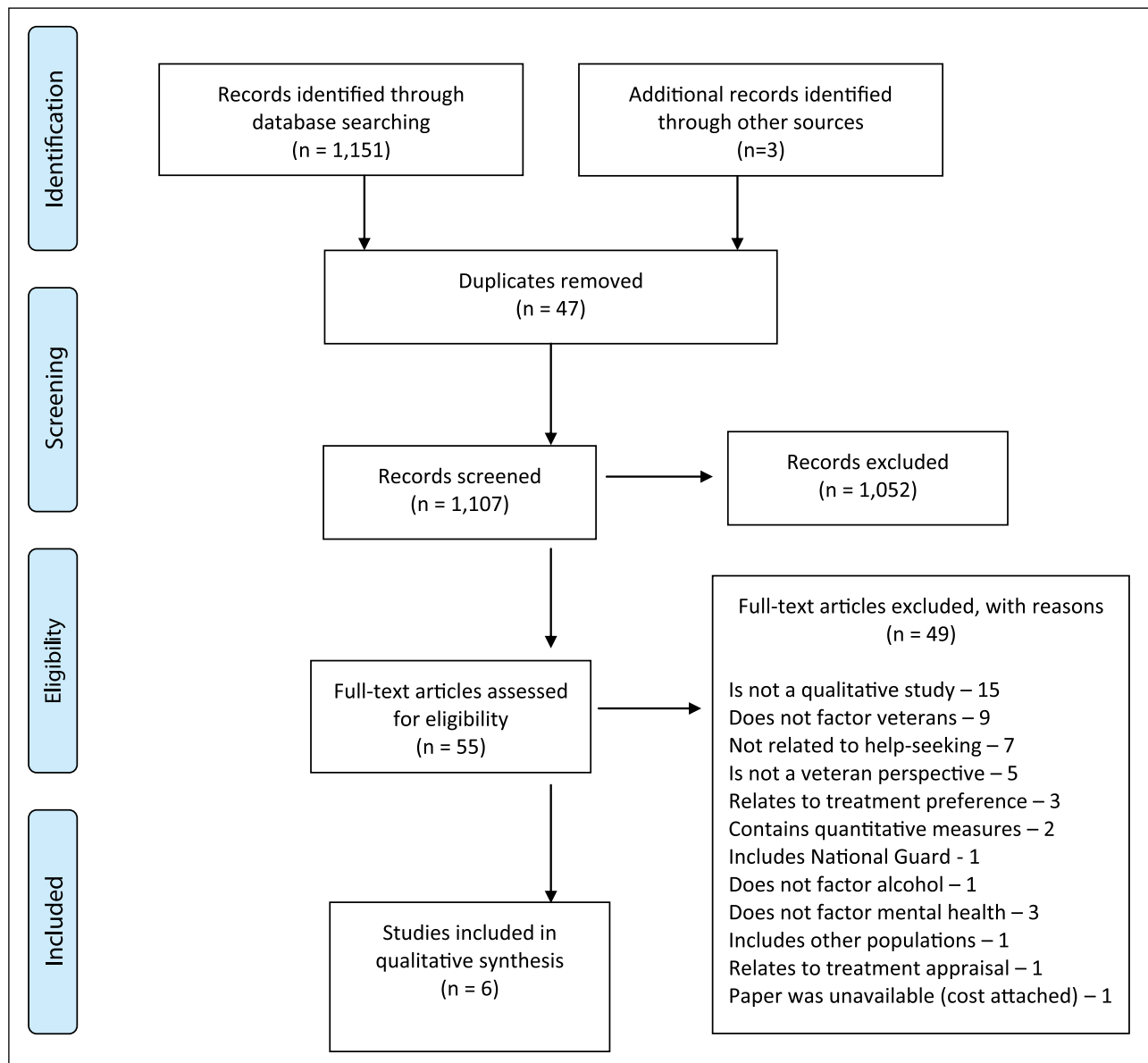

Figure 1 PRISMA flow diagram.

NO	AUTHOR (YEAR)	TYPE OF STUDY	N	STUDY/PARTICIPANT CHARACTERISTICS
1	Claridge (2017)	Semi-structured interviews. Grounded theory and Discourse analysis.	5	English, recruited via the National Health Service, male, age M 24 (SD NR), all had mental health difficulties, aged = < 24 when accessing care, Caucasian, Army, non-officers, deployments NR. Explored masculine relevant discourse as a barrier in the context of help-seeking.
2	Hamilton, Poza, Hines, & Washington (2012)	Three focus groups. Grounded theory	29	USA, recruited from homeless shelters, drop-in centres, transitional housing projects, substance abuse programmes, the county jail, soup lines and a direct outreach programme. Female, homeless, age M 48 (range 36), African American 46%, Caucasian 33%, Associate degree 59%, disabled 65%, Army 69%, high risk alcohol users 24%, deployments captured in sample (without frequencies) were described as Vietnam 'era', post-Vietnam, Gulf War 'era' and 9/11 'era', accessed mental health service 59%. Explored the barriers to psychosocial support for homeless female veterans.
3	Huck (2014)	Semi-structured interviews. Thematic and narrative analysis.	16	English, recruited via the National Health Service and the Charity Veteran Service, aged 20–69 ($M + SD$ NR), all had mental health difficulty, PTSD n = 14, comorbidity n = 8, Caucasian n = 14, non-officers, deployment tours NR but all had deployed on between 1–6 separate tours. Explored the experiences of help-seeking, specifically as barriers and enablers, in UK veterans.
4	Kiernan, Moran, & Hill (2016)	Semi-structured interviews. Framework analysis.	19	English, recruited as part of a larger study, age M 45.05 (SD 7.32), males n = 18, Army n = 14, deployment tours NR but number that had deployed was n = 11, all had history of alcohol issues. Explored the difficulty and/or reluctance to help-seek for alcohol misuse in UK veterans.
5	Mellotte, Murphy, Rafferty, & Greenberg (2017)	Semi-structured interviews. Grounded theory.	17	England, recruited via the National Health Service and the Charity Veteran Service, age M 51 (range 36), Caucasian n = 16, Army n = 15, non-officers, deployment tours NR, all had accessed mental health services, clinically significant levels of depression 80% and anxiety 71%, screened likely for PTSD 47% and likely for alcohol issues 59%. Explored barriers and enablers to pathways to care for UK veterans.
6	Sayer et al., (2009)	Semi-structured interviews. Grounded theory.	44	USA, recruited through the VA, age M 42 (SD 15.99), Caucasian n = 41, male n = 30, Vietnam, Afghanistan, and Iraq veterans all claiming for PTSD related disability. Explored determinants of PTSD treatment initiation of US veterans.

Table 1 Table of Characteristics.

Note: * Veteran Affairs. Veteran may be recruited through the VA (as the VA may hold veteran records), but not all veterans use VA services. VA affiliation does not necessarily equate to VA service use. NR = not reported.

The mean age across all studies was 41 years; it was difficult to determine the overall range/standard deviation. Collectively, participants were 82% Caucasian, 93% male, and 83% had served in the army. Three studies focused on males and one study included solely females. The two US studies reported military deployment eras and two UK studies confirmed their participants had actively deployed to unspecified locations. Five studies included participants who had accessed or were accessing services for MH or alcohol difficulties. Support service access included (but was not limited to) disability-related services for PTSD and homeless support for female veterans. One study featured homeless veterans seeking psychosocial support, 59% of whom had accessed MH services within the last 30 days via homeless assistance services (Hamilton et al., 2012).

The purpose of all studies was exploratory, with two studies focusing on HS barriers only. Five studies reported conducting semi-structured interviews and one featured focus groups. Five types of analysis were conducted across all six studies. Grounded theory was used in four studies, and discourse analysis, framework analysis, and thematic analysis were utilised in three studies. Two studies used two types of analysis within the same study (grounded theory with discourse analysis and thematic with narrative analysis).

Themes

Four main overarching themes were identified by the authors of this current article (military culture–culturised norms; the System; severity of problems; and relationships and support). Each main theme contains concepts that could help explain the process of veteran HS behaviour. Themes elicited highlight how a concept can develop into an enabler or barrier for HS. Table 2 (below) outlines the main enabler and barrier concepts found within the themes. For verbatim quotes to support the themes see Appendix 3.

ENABLERS	
Military culture Culturised norms	Taking control to find a solution
Severity of problems	Reaching a crisis point, i.e., 'rock bottom' Having a mental health diagnosis, i.e., PTSD Noticing the difficulties have become unmanageable
The system	If healthcare professionals have military experience or knowledge Peer-led support services Satisfaction with support services
Relationships and support	The loss of a relationship Social network offering practical and emotional support Peer-led encouragement
BARRIERS	
Military culture – culturised norms	Normalising beliefs and behaviours around healthcare Stigmatising beliefs of self and others towards mental health and HS 'Cracking on with it' – taking control and being self-reliant Normalising excessive alcohol use
Severity of problems	Lack of education or knowledge surrounding problem severity
The system	Access to support services Lack of information, knowledge, and education Veterans are different from civilians, i.e., are misunderstood Dissatisfaction with support services Lack of trust in the System
Relationships and support	Lack of relationships

Table 2 Themes of Enablers and Barriers to HS.

Military Culture–Culturised Norms

Possibly the most salient theme elicited was the impact of military culture on HS. Beliefs and behaviours cultivated through military service, which cascaded down to veteran life were potentially detrimental for MH, yet they were normalised. It was normal to avoid acknowledging there was an MH issue, perhaps due to the stigma surrounding MH or HS. The military conditions its personnel to be self-reliant and the "cracking on with it" attitude led to a normalisation of carrying on regardless of the severity or gravity of the difficulties being managed.

According to military culture it was also normal to believe that excessive alcohol consumption was acceptable, and several veterans would turn to alcohol as a form of self-help. Kiernan et al. (2018) stated that many participants did not acknowledge heavy drinking was problematic, even though excessive alcohol consumption can be viewed as an independent MH difficulty. As self-help through alcohol use was a preferred (and normalised) method of coping, it appears that alcohol acts as a barrier to more adaptive sources of HS.

Continually striving to behave in a military-directed way seemed to act as a barrier to HS. The exception to this was where a problem had become so severe that as a last resort the act of taking control enabled HS; taking control is suggested to be a veteran trait.

Severity of Problems

Some veterans reported they only reached out for help once a problem had become completely unmanageable. Initially there appeared to be a disassociation between experiencing severe symptoms and realising their MH needed urgent attention. A lack of issue recognition was an HS barrier. Eventually the severity of their issues could not be ignored. The study by Huck (2014) found that some veterans felt their situation was at breaking point and if no help was sought the scenario they faced would be death (which is inferred to mean suicide). Some veterans reported they had reached the point of "rock bottom" or a crisis point. It was not the fact that they had the difficulty but the severity of it that was the HS enabler.

In most instances it was members of their social circle or community who noticed the severity of their difficulties rather than the veterans themselves. It seems that despite others pointing out there were difficulties, the veterans only decided to listen and take heed when they considered their problems had become particularly overwhelming.

Despite initial denial over issue severity Mellotte et al. (2017) commented that once HS had taken place and an MH diagnosis was provided some experienced relief. There was relief that the veteran now understood their difficulties

and their problems were legitimate. Veterans often viewed an MH diagnosis as an HS enabler going forward.

The System

The System generally referred to the network of healthcare services, support services, and signposting services that supported veterans. Reoccurring comments suggest that many veterans felt they had insufficient information regarding appropriate support services and how to access them. Furthermore, poor education perhaps led to veterans failing to recognise that they should access specific services when suffering particular difficulties. Therefore, a lack of information and poor MH education was an HS barrier.

Hamilton and colleagues (2012) reported that female homeless veterans felt access to services for complex difficulties was insufficient. Some veterans, but not all, admitted to exaggerating their substance use difficulties as they believed The System would grant them quicker access to support. There seemed to be a need to play The System, otherwise it failed to meet their needs.

Some veterans (particularly UK veterans) who did access The System felt that although veterans and civilians are different, they are treated as a homogenous group, which caused dissatisfaction with the services received. Many felt The System did not recognise that veteran difficulties were unique to them, which could impact the success of treatment. While most were not necessarily critical of individuals and healthcare professionals, many veterans simply did not trust the overarching System. This lack of acknowledgment that veterans and civilians are different, together with a lack of trust, acted as a major HS barrier.

Where healthcare providers and support service sign posters were familiar with veteran culture or veteran attitudes to health, the veteran experience of The System was often more satisfactory. Kiernan et al. (2016) found that peer-led services were particularly beneficial for encouraging engagement with alcohol-related support. Kiernan and colleagues described how useful it was if a caseworker had military experiences, as a shared military connection was more likely to lead to sustained engagement between the veteran and The System. Peer-led support was also helpful in breaking down communication barriers, as many veterans speak a military-centric language, which is full of acronyms and slang terms.

Positive experiences of The System were acknowledged and were not limited to treatment outcomes but included things such as paperwork administration. Veterans acknowledged that positive experiences enabled HS, regardless of whether their positive experience was facilitated by a peer-led service or not.

Relationships and Support

Some studies found relationships deteriorated, as loved ones were unable to cope with veteran behaviour when MH difficulties deteriorated. Where veterans found themselves alone, after pushing away friends and family, some would rather remain in isolation than HS. A lack of relationships seemed to act as an HS barrier. However, there were many instances of loved ones and veterans staying together, despite the relationship difficulties. It was often the wives and children who motivated veterans to HS. On many occasions partners would accompany the veterans to see healthcare professionals, therefore, the veterans felt the family was HS as a collective unit.

Social support from others, including peers and veteran community members, also provided a source of practical and emotional support for veterans. Peer support was found to be particularly encouraging for veterans. Where other veterans (friends and acquaintances) had similar experiences, they were able to offer guidance and advice, which acted as an HS enabler. Peer support also provided comfort to the veterans, as they reflected, they were not alone in their struggles. Social and community support helped redress the impact of military-induced stigma, reduced distrust of The System, and enabled HS.

HS IS A JOURNEY/COMBINATION OF FACTORS

It would be useful to consider the themes collectively, as behaviour is often the result of a combination of factors. Moreover, there was some overlap between themes elicited via this study (i.e., social/peer/community support was linked to both MH awareness and System navigation). Upon collective consideration of the themes, it appears that HS could be a progressive or regressive/ non-progressive journey that contains several barriers/ enablers. For example, MH awareness/literacy indicating an MH and alcohol difficulty requires attention, coupled with a military-shaped attitude of taking control, may lead to HS. Those within a veteran's social/community circle may raise the need for HS and enable HS through practical support once the need for HS has been realised. Where the healthcare System is veteran-friendly or uses peer-led services, this may enable HS once System engagement begins. If veterans have a positive System use experience, they are more likely to HS again and promote HS to others. The reverse is also likely true. Figure 2 (below) illustrates the process or journey of HS according to themes elicited from this study. While Figure 2 portrays a linear journey, elements creating the HS journey may not appear specifically in the order illustrated.
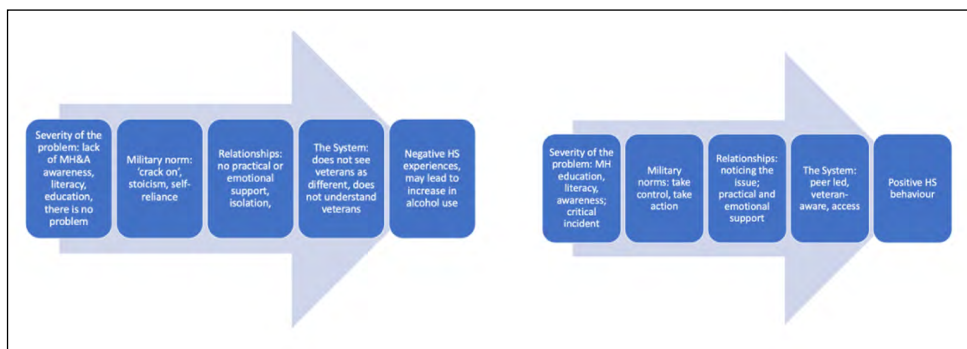
Figure 2 The HS processes for veterans.

QUALITY AND ROBUSTNESS OF RESEARCH— STRENGTHS AND LIMITATIONS

Across the studies the objectives were clear. Five out of six studies appeared to have conducted an adequate number of interviews/focus groups to fulfil the study objectives, which aligned with the suggested methodological requirements associated with each type of analysis (Braun & Clarke, 2013). All studies clearly described the data collection method and confirmed that data were recorded and transcribed verbatim. All studies presented clear findings; the themes were described adequately and many quotes were provided to support the defined themes. Cross checking data/themes with collaborators was reported, which is necessary within qualitative research to ensure trustworthiness. A main strength of the review was that three out of the four themes saw little difference between US and UK veterans, which indicates the findings have generalisability across different veteran populations. A notable difference related to system navigation and being understood as a veteran. This finding was expected on the basis it is assumed US veterans are more likely to utilise veteran-specific services such as the VA. The Sayer et al. (2009) participants were recruited via the VA, therefore, these participants were less likely to report System issues surrounding being misunderstood or communication difficulties.

However, there are several issues with these studies. Most studies failed to report why specific participants were selected, as inclusion and exclusion criteria were often not clear. Ethical considerations were also underreported. No study confirmed they had fully briefed participants and provided an opportunity for them to ask questions on any aspect of the study. Most studies failed to include details of a possible participant and researcher relationship, which could have constituted a conflict of interest.

The main issue with these studies relates to the type of qualitative analysis used. The type of analysis reported was not justified throughout these studies. There was no explanation of why a specific analytical direction was taken and how it was deemed appropriate to answer specific research questions. A further issue relates to analysis type, with none of the included studies making it clear whether the analytical steps were taken correctly. For example, studies that mentioned grounded theory did not describe saturation, theoretical sampling, and theory formation.

DISCUSSION

This is the first qualitative systematic review to consider HS enablers/barriers for veterans experiencing MH and alcohol difficulties. Four main themes were elicited across six studies: military culture–culturised norms, The System, severity of problems, and relationships and support. Support for all four themes as enablers and barriers to HS, produced through this current review, have been found in previous studies of veterans (Britt et al., 2019; Harden & Murphy, 2018; Iversen et al., 2011; Jones & Fear, 2011; Murphy et al., 2017; Stecker et al., 2007).

Andersen and Newman's (1973) health-related belief model suggests that veterans would seek help due to predisposing, need, and enablement factors, and it appeared that these three driving factors exist at an individual level. Some support for this model has been found through themes elicited within this review, as the severity of the problem facilitated HS, whereas poor MH knowledge/awareness reduced HS and acted as a barrier. A study by Sayer et al. (2009) did challenge the Andersen and Newman theory and suggested that veteran HS may be strongly influenced by group-level factors as well as individual-level factors. Sayer and colleagues proposed including system-level influences together with groups or social networks as HS enablers/barriers, to improve the model's utility. Three of the four themes identified in this current review were of a group nature, suggesting that the Sayer and colleagues' adapted model may better account for veteran HS.

An example of a group-level factor elicited through this review relates to the military. The military is generally considered to be a group, or a system, where veterans

were at one point firmly embedded within it and its culture. Predisposed attitudes towards "cracking on with it," stigma over MH difficulties, or excessive alcohol consumption were labelled as military culture-culturised norms, as these attitudes and opinions were shaped through military service. Therefore, any military-connected enablers/barriers (there appear to be more barriers than enablers) could be said to have arisen through system-level influence.

Like the military, The System (healthcare and support) is also viewed as a group, comprising an infrastructure containing many smaller sub-groups. Within this current review, many had sought help via a System, whereby future HS was influenced by those previous System-related experiences. When using The System it was often the communication between veterans and System operatives that became an HS barrier, with veterans describing they frequently felt misunderstood. Zerr (2020) commented that veterans commonly put the onus on System operatives to understand the veteran perspective, which is difficult when those within The System have no or little veteran experience or knowledge. Misunderstandings between veterans and healthcare professionals is one of the most regularly reported HS barriers across veteran health-related literature (Williamson et al., 2020). Yet, some System-level experiences did act as HS enablers. Experiences of HS and System use appeared to be more positive if services were peer-led, which is a point also noted by Clement et al. (2015) and Hom et al. (2017). While the phrase "peer-led" within this context does not necessarily equate to "friend-led," peers are considered peers through their shared understanding of the veteran experience. The use of peers within a healthcare setting creates a sense of inclusivity, understanding, and acceptance. Peer-led services can reduce the effects of misunderstanding within The System and increase the sense of System-based trust.

The third group-level theme related to relationships and social support impacting HS, which aligned with Sayer and colleagues' (2009) view that social networks ought to be added to the Andersen and Newman (1973) model. Within this current review, social support/relationships were a stronger enabler than barrier, which supports literature suggesting that social and community support acts as a key veteran HS enabler (Siegel et al, 2018). Akin to the effectiveness of peer-led support within The System context, peer-led support in the community or a social setting (e.g., veteran members club, friends, and family) is also a particularly useful enabler to HS. Not only may veterans appreciate the similarity between their own and other veterans' experiences but they often trust each other's HS recommendations (Johnson & Possemato, 2019). Within a community or social setting "peer" support may take on the meaning of being more "friend-peer-

support." If the positive, good quality relationships that exist within a social or community context act as strong HS enablers, the impact of community and social support for veteran MH cannot be underestimated (Vest et al., 2022). Much current veteran literature is reflecting a shift towards utilising peers and social community support where possible, which is a reflection of its utility within the realm of HS more generally, as well as for MH support.

The adapted Sayer and colleagues' (2009) model can perhaps provide a better account for veteran HS, however, there are criticisms. Both the original model and adapted model approach HS from the perspective that HS enablers and barriers are dependent on factors in place from the point the trauma occurred; pre-trauma environmental factors are excluded. It would be inaccurate to suggest that veteran HS was not affected by pre-military trauma and other aspects. For example, HS could be influenced by having roots within a culture that has strong masculine values that discouraged HS (Berger et al., 2013). On the basis that trauma is often experienced collectively, communally some veterans may originate from societies and communities where trauma is shaped by social norms that lead people to view violence and warfare as "not that traumatic," but it instead positive or necessary (Smith, 2016). Essentially, without acknowledging that trauma is traumatising conditions such as PTSD would not exist, as there would be no traumatising event(s) to cause mental ill-health.

An alternative theoretical model that could account for veteran HS is Social Identity Theory (SIT; Tajfel & Turner, 1979). SIT proposes a person's thoughts and behaviour are shaped by the groups and communities they have had an affiliation with over a lifespan. Given that a veteran may identify closely with groups that have strong non-HS values, such group affiliation likely acts as an HS barrier. Veterans may hold firm opinions that HS is for "them" (the out-group comprising all non-veterans) and non-HS is for "us" (the in-group comprising those associated with the military). Many veterans hold fast to their military identity, together with its affiliated practices and beliefs (Terry & Koch, 2019), and holding onto their identity through group membership acts as a barrier to HS. The in-group versus out-group thinking/behaviour principle applies to any groups a person may have affiliations with. Many of which pre-date military service. SIT can also account for why social support is so effective in HS settings; the social connectedness experienced via shared identities creates a sense of inclusivity and trust within an HS environment. The socio-cultural influences through group membership across a veteran's lifespan should be considered in future HS research.

Aside from exploring what factors may enable or hinder veteran HS, this review also aimed to explore the HS process. A collective view of the themes elicited across

the studies in this review indicates that HS appears to be a journey. The themes suggest, for example, a veteran will not engage in HS until their symptoms or difficulties are particularly severe. When MH deteriorates it may be those in their social community who encourage HS. If a veteran has no experience or education surrounding MH this hinders HS, yet once they begin to engage with healthcare services their positive experiences begin to act as HS enablers. Peer-led encouragement and peer-led service use can help to counterbalance communication problems, military-induced stigmatised views and trust issues. Many HS barriers may develop into enablers over the HS journey.

The opinion that HS is a journey has also been suggested in existing literature. Jakupcak et al. (2013), Iversen et al. (2005), and Rafferty et al. (2019) implied that HS is a journey and HS changes as the journey progresses. Jakupcak et al. (2013) reported that veterans may progress positively, with some regression to be expected. Veterans can be in a loop of maladaptive, non-HS behaviour for quite some time throughout their HS journey (Rafferty et al., 2019). The progression and regression of the HS journey suggests it is unlikely to be strictly linear.

Using a qualitative methodology allows the process of HS to be explored. The HS journey (and where individual-level or group-level factors sit within that journey) can be understood more fully. The richness of veterans' accounts and narratives surrounding the HS process highlights the dynamism and changeability of HS, with a combination of factors that facilitate or hinder HS. The current review also elicited findings that bring further clarity to the role alcohol plays within the HS journey. Existing reviews have collectively produced mixed findings as to whether alcohol was an HS barrier (Hom et al., 2017; Kantor et al., 2017; van den Berk Clark & Patterson Silver Wolf, 2016), whereas most studies within this current review found alcohol was indeed the preferred choice of initial self-help. It was noted that most veterans had drunk at risky levels to manage their difficulties, with many explaining how normalised excessive alcohol consumption was.

CLINICAL IMPLICATIONS

If those supporting veterans are to provide adequate care, it is essential that a deeper understanding of how HS enablers/barriers operate, why they are considered enablers/barriers, and where they feature along the HS journey. A qualitative approach has been useful for developing insights into HS barriers/enablers. A deeper understanding of the HS processes can be fed into well-targeted interventions, specifically aimed at veterans, perhaps with an emphasis on utilising peer/community/social support. Social support could be used to draw upon adaptive militarised beliefs whilst challenging those that are unhelpful. Social support

may also increase MH/alcohol awareness and improve the HS experience within HS environments. It could be useful to create publicity campaigns that promote the idea of "helping your veteran friend," where "help" acts as a bridge to more formal HS.

There is also merit in continuing to place veterans as peers within healthcare settings. As well as continuing to build trust in The System, peer support can help reduce attrition within intervention programs. MH/alcohol treatment engagement should not only improve veterans' quality of life, but if MH/alcohol difficulties are reduced, future treatment costs are saved. Of course, MH and alcohol literacy awareness may also reduce future MH/alcohol treatment costs, as improved MH/alcohol-related behaviours reduce the need for HS in the first instance. Yet, where there is a need to help seek, improved literacy should reduce the time taken to seek support and the risk of veterans developing complex needs is reduced. If MH needs are less complex treatment should be more resource-efficient in respect of time and financial cost.

While this study related to HS for mental health/alcohol, the findings do have wider implications. Much of the interaction veterans have with anyone or any organisation is likely heavily influenced by their identity, with their identity being partially shaped by historical lifetime experiences. This is arguably why veteran-specific activity groups are well attended; everyone interacting there has some sort of shared identity and there are unspoken understandings between each other. Is not suggested that identity does not allow for change and development. As HS behaviour can be like a journey, veterans' identities may develop and change as their life changes across their transition. Across a veteran's personal development journey they may not identify as an armed forces affiliate to the degree they did upon military retirement. Furthermore, as their life course progresses, what it means to be a veteran may change and their behaviours likely to change with it.

It would be useful for those who have any interaction with veterans to understand that there is no one static definition, conceptualisation, or veteran identity that fully captures who they are or how they would behave. This may lead to challenges when attempting to create veteran-specific services of any kind. In certain scenarios (e.g., in employment) it would be useful to ask the veterans what their identity means to them, the degree to which they identify as a veteran, the degree to which being a veteran matters to them, and what their needs are (if any). Finally, it is worth reiterating the merits of using qualitative research methods; a useful way of establishing what a veteran's identity is and any implications that may have, is to ask them in an open, qualitative way.

STRENGTHS AND LIMITATIONS OF THIS REVIEW

Regarding strengths, many previous veteran HS reviews feature predominantly American studies with American participants, whereas this review included four UK studies. If much data in this review is based on the UK veteran definition, and such a definition is considered fairly exclusive (Gribble et al., 2019), the findings are considered quite generalisable to other veteran populations. By adopting a qualitative approach to HS, the journey process could be explored further. Previous study limitations have suggested that research should consider underlying processes and capture changes over time; this review made such considerations.

However, this review has limitations. The effect of different veteran eras was not explored, as details of deployment location were underreported across the studies. Yet, deployment location may have implications for HS, particularly if different operational tours are associated with shorter or longer time taken to seek support (Murphy et al., 2015). The effect of deployment location on HS within qualitative veteran literature requires further investigation. Only English language papers were included, meaning that potentially only Western veterans' experiences were captured. It was difficult to determine that the appropriate analytical steps were taken across the studies. Furthermore, it does not appear that ethical considerations nor the impact of the researcher on the findings were mentioned. Future qualitative research in the area should be more transparent through improved reporting.

CONCLUSION

Themes elicited from six papers found that veteran enablers/barriers related to military culture, the severity of the issue, The System, and social relationships. All themes included enablers and barriers, but many barriers develop over time into enablers. Themes supported the view that enablers/barriers exist at both individual and group levels, with group-level factors perhaps having a greater influence on HS. Theoretical models, such as the adapted Health-Related Belief model, have been suggested to account for veteran HS. Such a model could be considered useful as it assumes HS links to the impact of trauma exposure, social support, and System-level factors. Yet, this model does not explain the influence of pre-trauma factors on HS, such as the impact of group membership. SIT is suggested as an alternative model to account for veteran HS, which warrants further investigation. Veteran HS appears to be a process that reflected a journey. Understanding how the journey progresses, together with the negative and positive influences on that journey, is important for healthcare policy and practice. This review highlights the strengths of using qualitative methodology to bring enhanced meaning and understanding to the veteran HS journey. However, the robustness and transparency of qualitative research on veteran HS need to improve.

ADDITIONAL FILES

The additional files for this article can be found as follows:

- **Appendix 1.** Table of Previous Systematic Reviews in Chronological Order. DOI: https://doi.org/10.21061/jvs.v9i1.376.s1
- **Appendix 2.** Search Terms. DOI: https://doi.org/10.21061/jvs.v9i1.376.s2
- **Appendix 3.** Table of Quotes to Support Themes. DOI: https://doi.org/10.21061/jvs.v9i1.376.s3

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