Help-seeking for self-reported alcohol problems among serving and ex-serving personnel: a cross-sectional study

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ABSTRACT

Background: Research has found low levels of help-seeking for alcohol problems among serving and ex-serving military populations. This study aimed to understand the prevalence of, and factors associated with, help-seeking for self-reported alcohol problems among serving and ex-serving UK military personnel.

Methods: Regular and full-time reserve service (FTRS) serving and ex-serving personnel in a large UK military cohort (n=6,199) were asked if they had had an alcohol problem in the past 3 years and if and where they had sought help. Associations between help-seeking from formal medical services (general practitioner (GP)/medical officer (MO), hospital doctor) and socio-demographic, military, life, and health factors were examined.

Results: 8.5% (n=461) self-reported an alcohol problem, of which 71.1% had not sought help. Formal medical services were the most accessed support overall but were significantly less likely to be used by older personnel. Those meeting current caseness for probable alcohol misuse (AUDIT ≥16) (adj. OR 0.54, 95% CI (0.31-0.95), p=0.032) were less likely to have previously accessed formal support.

Conclusions: Help-seeking for self-reported alcohol problems among UK serving and ex-serving personnel remains low. Future research should prioritize understanding pathways into help-seeking and target stigma regarding accessing clinical support among both serving and ex-serving personnel.

Keywords: armed forces; military; veteran; alcohol use; help-seeking

LAY SUMMARY

Prior research has found low levels of help-seeking for alcohol problems among serving and ex-serving military populations. This study aimed to understand what factors might be associated with help-seeking for self-reported alcohol problems among serving and ex-serving UK military personnel. We found that help-seeking for alcohol problems among veterans and personnel remains low. While fewer than 10% self-reported alcohol problems, more than 70% of these personnel/veterans did not seek help for this issue. Formal medical services were the most accessed form of support when seeking help but were less likely to be used by those with current alcohol problems. Future research should prioritize understanding pathways into help-seeking and target stigma regarding accessing clinical support among both serving and ex-serving personnel.

INTRODUCTION

Research has shown high levels of alcohol misuse among US and UK military personnel compared to the general population [1, 2], and that these patterns of high alcohol consumption may continue once personnel leave Service [3-5]. Help-seeking for alcohol problems among serving and ex-serving military personnel has consistently shown to be low, especially in comparison to that for other mental health, emotional or general medical problems [6-9].

Recognition of alcohol problems is a key step in the process between alcohol misuse and help-seeking [10], although there can be an average of a decade's delay between recognition and seeking support [11]. Prior studies have tended to examine help-seeking among serving military personnel meeting caseness for alcohol misuse despite problem recognition itself being the key predictor of seeking assistance for health issues

[11, 12]. However, such an approach misses a large proportion of the population who do not recognise an issue and therefore would not have any intention of seeking support. Recognition is more likely when alcohol misuse is severe [13] but this appears to be more complicated in military populations. Recent estimates suggest that 10% of UK regular personnel meet criteria for alcohol misuse [4] yet only 49% recognise they may have an alcohol problem [13]. Of these, only a third might be expected to go on to seek support [8].

Among military personnel, poor recognition of alcohol problems as well as in-service drinking culture, a lack of awareness of available services, and potential stigma have all been attributed to lower help-seeking [14, 15]. Differences in help-seeking for alcohol issues are noted across military groups, with greater help-seeking among older serving and ex-serving personnel, women, veterans who are currently employed, and serving/ex-serving personnel not in relationships [6, 8, 16]. Another potential factor in help-seeking is the presence of mental health co-morbidities, with greater help-seeking for alcohol problems found among serving and ex-serving military personnel with a co-morbid mental disorder such as post-traumatic stress disorder (PTSD) or depression [8, 17]. In addition to differences in who seeks help for alcohol problems, there may be differences in the sources of support utilized. Research has found that personnel who are still in service may prefer to use civilian mental health professionals or self-help groups, avoiding military services and perceived implications to their career [18]. Conversely, ex-serving personnel may prefer informal support, such as from friends and family, for alcohol problems over help from medical or other professionals [19]. This may be due to a continued reliance on informal sources based on their time in Service or a lack of awareness about veteran-specific services and charities as well as symptoms of alcohol misuse and poorer mental health [20].

By studying those who self-report and recognise an alcohol problem rather than just those meeting a diagnosis for alcohol misuse, we can seek to better understand the prevalence and pathways of help-seeking among those who have or have recently recognised they may have an alcohol problem. This study aims to estimate the prevalence of help-seeking for self-reported alcohol problems among serving and ex-serving UK military personnel and identify sources of support for this issue. Associations between help-seeking from formal medical services and socio-demographic, military, health, and life factors were examined to determine how help-seeking may differ among certain groups.

METHODS

Participants and procedures

Data is drawn from the third phase of the King's Centre for Miliary Health Research (KCMHR) Health and Wellbeing cohort [21, 22]. In brief, this study was established in 2003 to examine the impact of deployment to Iraq and Afghanistan on the mental health of serving members of the UK Armed Forces. Participants who consented to follow-up at phase 1 or 2, along with an additional replenishment sample of new recruits to ensure the final sample reflected the structure of the UK Armed Forces, were contacted to participate in phase 3 between October 2014 and December 2016 (n=8,093). Participants completed a self-administered paper or electronic questionnaire which covered (a) socio-demographics (e.g. age, gender, marital status); (b) military information (e.g. Service branch, current or previous rank, deployment status, serving status, engagement type); (c) mental health and help-seeking; (d) lifestyle factors (e.g. alcohol and tobacco use); and (d) adverse life events (e.g. childhood externalizing behaviours, family relationship adversity and stressful life events in the past 3 years

(e.g. divorce, bereavement)). Further details can be found in Stevelink, Jones (4).

A total of 6,199 participants responded to the item on self-reported alcohol problems. Due to differences in mental health and alcohol services available to regulars and reservists and varying norms about alcohol within the military community, analyses were limited to regular and full-time reserve service (FTRS) serving and ex-serving UK military personnel.

Ethical approval

Ethical approval was granted by the UK Ministry of Defence Research Ethics Committee (448/MODREC/13) and the King's College London Research Ethics Subcommittee (PNM/12/13–169). Participants at all phases provided informed consent for collection of their data.

Outcomes

Self-reported alcohol problems were determined by asking participants at phase 3 if they had had an alcohol problem in the past 3 years (yes/no) [23, 24]. Those responding 'yes' were asked which sources of support they had accessed for this issue, with responses categorised as formal medical *(general practitioner (GP, a primary care provider)/medical officer (MO), hospital doctor, mental health specialist (e.g., psychiatrist, psychologist, counsellor))*, or non-formal *('other' (not defined), telephone helplines or online therapy services)*.

Factors associated with help-seeking from* formal medical services *for self-reported alcohol problems

Examination of factors associated with help-seeking for self-reported alcohol problems

was conducted to identify which groups were more likely to access support. Sources of support were restricted to formal help-seeking compared to non-help-seekers, with participants reporting accessing non-formal support (8.3%, n=33) excluded due to low numbers. Factors of interest included (1) socio-demographics *(age (years), gender, marital status, number of children)*; (2) military factors *(Service branch, rank, serving status, combat role)*; (3) health, including tobacco use *(no/yes)* and mental health *(common mental disorders (CMD, General Health Questionnaire (GHQ-12, caseness ≥4));*[25] *probable post-traumatic stress disorder (PTSD, PTSD Checklist (PCL-C, caseness ≥50));*[26]*;* (4) alcohol misuse *(Alcohol Use Disorders Identification Test (AUDIT, caseness ≥16)* [27]; and (5) life events *(life stressors in the past 3 years (e.g. bereavement, divorce, arrest, accidents (0-1, 2, 3+),* negative childhood relationships *(e.g. I came from a close family, I used to get shouted a lot at home, I used to be hit/hurt by a parent/caregiver regularly; 0-1, 2 or more)* [28]; and childhood externalizing behaviours *(often used to get into physical fights at school, plus truancy, suspension/expulsion from school, and/or 'I did things that should have got me (or did get me) into trouble with the police'; no/yes)* [29].

Analyses

All tables present weighted percentages and odds ratios along with unweighted cell counts estimated using survey commands in Stata (version 14.2) [30]. Response weights were calculated as the inverse probability of responding once sampled, according to variables shown to predict response [4]. Statistical significance was determined as $p<0.05$.

Weighted tabulations were used to estimate the prevalence of self-reported alcohol problems in the last 3 years among serving and ex-serving personnel and the

sources of help accessed for this issue (Table 1) - multiple responses were allowed due to the multifaceted nature of help-seeking.

Univariable logistic regression analyses were conducted to identify variables significantly associated with formal medical help-seeking for self-reported alcohol problems among serving and ex-serving personnel for inclusion in adjusted models. Significant factors were combined in the final model to identify socio-demographics, military characteristics, health factors, and life events associated with formal medical help-seeking for self-reported alcohol problems compared to those who did not seek help (Table 2).

RESULTS

Prevalence of help-seeking for self-reported alcohol problems and sources accessed

The overall prevalence of self-reported alcohol problems among serving and ex-serving personnel in the last 3 years was 8.5% (n=461). 71.1% of serving and ex-serving personnel who self-reported an alcohol problem in the past 3 years had not sought help (Table 1). Formal medical services, especially primary and secondary health professionals such as GPs and MOs, were the most common sources of support endorsed by participants. A minority of participants self-reporting an alcohol problem in the past 3 years (11.4%) accessed non-formal services such as telephone or online helplines or ‘other’ forms of support.

TABLE 1 ABOUT HERE

There was some overlap in the types of support sought for self-reported alcohol problems within the formal medical support category. Of those seeking help from a hospital doctor, 67.7% (n=7) also sought help from a GP/MO. Among those who sought help from a mental health specialist, 55.4% (n=31) also sought help from GPs/MOs (supplementary Table 1). There was no overlap in help-seeking from online or telephone services and 'other' forms of support, but all had accessed some form of formal medical service.

Factors associated with help-seeking from formal medical services for self-reported alcohol problems

After adjusting for factors significantly associated with help-seeking from formal medical services for a self-reported alcohol problem in univariable analyses, help-seeking among serving and ex-serving personnel decreased with increasing age (adj. OR for trend 0.97) (Table 2). Previous formal help seeking was less likely to have been reported among those meeting caseness for alcohol misuse (AUDIT≥16) (adj. OR 0.54, 95% CI (0.31-0.95), p=0.032). Marital status and tobacco use were no longer associated with help-seeking after inclusion in the adjusted models. No military factors or other health outcomes (Table 2), or life events (supplementary Table 2) were found to be associated with help-seeking from formal medical services in the last three years.

TABLE 2 ABOUT HERE

DISCUSSION

The findings of this study indicate that less than 10% of serving and ex-serving military personnel reported alcohol problems in the last 3 years. 71.1% of serving and ex-serving personnel self-reporting alcohol problems did not seek help but among those who did,

209 the most common sources of support were formal medical services, in particular GPs
210 and mental health specialists. Few participants had sought help from telephone helplines
211 or online therapy services. Help-seeking from formal medical services decreased with
212 increasing age and was less likely among those meeting caseness for alcohol misuse
213 (AUDIT≥16).

214 Although alcohol misuse is greater among serving and ex-serving military
215 personnel compared to the general population [3, 4], the overall proportion of help-
216 seeking for self-reported alcohol problems for this population is similar to that reported
217 in prior phases of the KCMHR cohort (31%) [8, 19]. This suggests that despite the
218 introduction of brief interventions to increase awareness of alcohol misuse, reduce
219 alcohol consumption, and encourage help-seeking among military personnel [31], help-
220 seeking for alcohol problems among serving and ex-serving personnel remains low.
221 Additional targeting of alcohol use within both the Armed Forces community and UK
222 general population, who also show low-levels of recognition of alcohol problems [13, 32]
223 may be needed, with the aim of reducing stigma around support for alcohol problems.
224 Such campaigns should extend to ex-serving personnel as well as those still in service,
225 as our findings suggest alcohol behaviours may be maintained after transition [3, 4].

226 Formal medical services such as GPs, MOs, or mental health specialists, were
227 the most common source of support among serving and ex-serving personnel who had
228 accessed help. Overlap between sources of formal medical support are likely to reflect
229 the process for accessing secondary and tertiary health care in the UK, which requires
230 onward referral from a GP. Few participants had sought help from telephone helplines
231 or online therapy services. This may reflect a preference for clinical treatment options
232 for alcohol problems but may also reflect greater severity in symptoms requiring a more
233 appropriate clinical approach. Unlike formal medical services, there was no overlap in

help-seeking between online or telephone services and 'other' forms of support, suggesting particular and specific pathways into support for perceived alcohol problems among serving and ex-serving personnel military personnel. Future research should attempt to better understand how and when military personnel and veterans may choose to use these services, given the focus on online services for health and well-being.

Older serving and ex-serving personnel were less likely to seek help for self-reported alcohol problems from formal services, potentially reflecting greater misuse among older men within the UK coupled with greater stigma and reluctance to seek help for alcohol problems [33]. Serving and ex-serving personnel currently meeting AUDIT caseness were significantly less likely to have previously accessed formal support. This may be because those meeting caseness have not yet reached a level of crisis or functional impairment that demands formal supports or perceptions about potential stigmatizing views from medical professionals should their support be sought [15, 34], particularly if they have been consulted about alcohol misuse previously and have to admit that such attempts have not worked.

Despite prior research suggesting greater help-seeking for alcohol problems in those with a co-morbid mental disorder [8, 17], no associations were found between help-seeking from formal medical services and probable post-traumatic disorder or depression. This lack of an association may be due to the temporal nature of the data collection, with mental health symptoms reflecting self-report data at the time the survey was completed whereas self-reported help-seeking was reported for the previous 3-year period. The lack of association may also reflect differences in sources of help-seeking, with the current study specifically asking about care received for an alcohol problem rather than for co-occurring mental health and alcohol problems for which some participants may have received parallel treatment. Similarly, no military, life

event, or childhood factors were associated with formal help-seeking for self-reported alcohol problems. As with other research conducted with this cohort, other factors play a larger role in help-seeking in the UK military than those specific to occupational experiences [8, 9] but may also be due to a lack of power. Future studies should conduct similar analyses on larger sample sizes to confirm findings and explore the potential role of key factors and to understand how help-seeking differs between those who do and do not recognize an alcohol problem. Further research is also needed to understand decisions regarding help-seeking for alcohol problems among serving and ex-serving personnel, especially when there are mental health comorbidities. There is also the need to better understand how help-seeking for alcohol problems may vary among those who have had prior issues and continue to meet caseness for alcohol misuse and whether other services and supports may be preferred by personnel and veterans who find themselves in this situation.

Strengths and limitations

This study provides insights into help-seeking among serving and ex-serving personnel who self-report an alcohol problem. The use of data from a large cohort study provides robust estimates of the proportion of serving and ex-serving personnel recognizing, and seeking help for, an alcohol misuse problem and how this might differ across groups.

There are limitations that should be considered. The KCMHR cohort study was established in 2003 to examine the health and well-being of UK military personnel deployable to Iraq, with subsequent phases including personnel deployable to Afghanistan. Findings may therefore not be representative of all military personnel. The data used is cross-sectional and as a result, we cannot determine the direction of the association. The one-item question on problem recognition could have been more specific to help elucidate meaning to participants. However, similar wording has been

used in prior studies with good effect ("Have you ever thought you had a drinking problem?"/ "Do you currently think of yourself as a problem drinker?") [23, 24]. It would also be less meaningful to ask people about getting support for their alcohol use, among those who did not think their drinking was problematic.

Available responses may not have adequately captured all potential sources of support for serving and ex-serving personnel who self-report an alcohol problem. We were unable to examine the role of gender due to low numbers but given differences in help-seeking between men and women [6, 8], future research should attempt to understand how help-seeking for self-reported alcohol problems may vary within the Armed Forces community by gender. Future research should also look at help-seeking by serving status, prevented in this study due to the low number of respondents self-reporting alcohol problems in the last 3 years.

CONCLUSION

The overall prevalence of help-seeking for self-reported alcohol problems was low among serving and ex-serving personnel. The most accessed sources of support were formal medical services (e.g., primary and secondary care health care professionals), with minimal use of online or telephone services for this problem.

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