Personalising veteran healthcare: recognising barriers to access for minority and under-represented groups of veterans

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ABSTRACT

Veterans are not a demographically homogenous group, yet minority groups continue to be under-represented in research and report feeling less able to access clinical services to seek support. While veteran-specific healthcare has responded to the needs of the majority, the success of veteran mental health services is contingent on serving the whole veteran population. Key to the personalisation of healthcare is the question of access and a need to address specific inequalities and barriers to help-seeking behaviour. In this paper, we explore the issues of access to veteran healthcare at three levels: those barriers common to all veterans; those common to all minority groups of veterans; and those relevant to specific minority groups of veterans. Stigma, military attitudes and culture (eg, stoicism), and access to services and professionals with veteran-specific knowledge are universal barriers across veteran groups. Minority groups report a heightening of these barriers, alongside being 'othered' in veteran care settings, a lack of representation of them or their experiences in service descriptions and advertising, a lack of professional cultural competencies on specific issue, and the veteran environment potentially being retraumatising. Finally, barriers specific to individual groups are discussed. Attending to these is essential in developing holistic approaches to personalised healthcare that meets the needs of all veterans.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Veterans appear to face unique barriers to accessing healthcare.
⇒ Veterans are a demographically heterogenous group, yet there is poor understanding of the care access needs and experiences of minority groups of veterans.

WHAT THIS STUDY ADDS

⇒ This study shows minority groups of veterans may face compound barriers to care access.
⇒ These include an additional heightening of barriers that are common to all veterans, as well as barriers specific to individual minority groups.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Personalised veteran healthcare and improved access to services require a fuller understanding of potential barriers for minority groups, as well as how these barriers may intersect.

INTRODUCTION

Of the 1.85 million veterans in England and Wales, 13.6% are women, 5.8% were born outside the UK and 3.6% report their ethnicity as other than white.[1] Nonetheless, veteran research and healthcare has typically focused on the needs of the demographic majority—namely white, middle-aged, heterosexual men. As healthcare delivery moves towards a more individualised and tailored approach, greater consideration of such demographic differences is essential to ensure parity of access and clinical experience.

Personalised, patient or person-centred approaches to mental healthcare triangulate around the need to fit services and intervention(s) to the individual, rather than the converse.[2] Ensuring equitable access to healthcare is crucial to the move away from a 'one-size-fits-all' model of care provision. As such, improved access is both a driver of and outcome from successful personalised healthcare. Multidomain generalised models of healthcare utilisation typically view barriers and facilitators to access via the interactions of individual-level factors (eg, gender or age), health behaviours and beliefs, and systemic and structural features.[3]

The distinctiveness of veterans as an individual-level group is partly recognised in the UK by the duty of care to veterans and their dependents enshrined in the Armed Forces Covenant, and through the establishment of veteran-specific care pathways. However, veteran status is not the only individual-level characteristic of note. The Equality Act 2010 proscribes discrimination (in all but a limited number of contexts) in the provision of consumer, health and public services based on nine protected characteristics. Nonetheless, differences in healthcare access between sections of the general population persist, to which veterans are not immune.[4]

The confluence of both veteran status and other individual-level characteristics is therefore of relevance in healthcare provision and ensuring it is appropriate to the whole spectrum of the veteran population.

As part of the *BMJ Military Health* special issue on personalised medicine, we outline the barriers to help-seeking and access for minority veteran groups, with a view to informing how equity of access may be developed. These barriers are presented at three levels: those common to all veterans; those common to all minority groups of veterans; and those relevant to specific minority veteran groups.

Table 1 Key barriers to healthcare access common to all veterans and to all minority veteran groups

All veterans	All minority veteran groups
Internal stigma	Accentuation of common barriers
External stigma	Othering in veteran groups (perceived and actual)
Military cultural attitudes (eg, stoicism)	Non-representation in service descriptions and advertising
Access to appropriate healthcare	Professional cultural competency and understanding of specific groups
Professional veteran-specific knowledge	Veteran/military-linked environment possibly retraumatising

Barriers common to all veterans

The barriers to help-seeking across veteran populations are well documented (Table 1). The roles of stigma, military cultural attitudes and systemic difficulties of accessing services or professionals with appropriate military understanding are common across the literature.[5]

Researchers have proposed a multistage journey to successful engagement with mental health support contingent on three key decision points.[6] First, a veteran must recognise that they have symptoms of probable difficulties with mental distress. Second, they must recognise that treatment is needed and warranted, including overcoming any stigma, minimisation of symptoms or belief that others may be more deserving of treatment—all of which may originate in a military culture. Finally, engagement needs to be sustained through being able to access veteran services in a timely manner.

While family and friends play a crucial role in facilitating the recognition that help is needed, they too are at risk of developing psychological difficulties, which may in turn further impact the veteran's health.[7] Supportive interventions for veterans' families and caregivers have been shown to reduce this risk[8] as well as stabilising the context around the veteran. Accordingly, veteran mental healthcare needs to be personalised to their wider social context and not just the individual.

Barriers common to all minority veterans

Minority groups of veterans are subject to the same barriers as the majority (Table 1). However, these barriers appear to be further accentuated on account of their experiences and status as a minority.[9] For example, women veterans reported associating illness and seeking help with weakness in accordance with broader military cultural attitudes. However, such weakness was additionally viewed as confirming negative gender stereotypes and invalidating struggles for workplace equity, thus further reinforcing stigma and military cultural barriers to help-seeking.[10] Meanwhile, Commonwealth veterans reported being treated differently during and after service on account of their racial and ethnic backgrounds.[11]

Consequently, minority groups share a sense of 'othering'[12] from the veteran demographic hegemony, and other minority groups viewed as being more deserving or in receipt of more help.[11] This is evident in an internalised belief that they may not 'fit into' veteran services and the reality that many services are indeed geared towards viewing all veterans through the lens of the majority's needs and experiences.[13] The recommendation of Wood *et al*[14] concerning the marketing and branding of veteran services to women is potentially applicable to all minority veteran groups. Rather than responding to minority groups as an afterthought, equity of access can be facilitated by ensuring that promotional materials feature images and language representative of all veterans and their experiences, not merely combat and men-centric archetypes.

Although healthcare professionals' military or veteran-specific knowledge may be increasing, it is often reported as unlikely to include specific understanding of the unique needs and experiences of minority groups.[15 16] Furthermore, for veterans whose minority status was a salient component of their index trauma (eg, gender-based or homophobic violence), the men-dominated, military-leaning context and environment of veteran services may also become a source of repeat or further traumatisation.[10]

As such, personalised veteran healthcare requires systemic trauma-informed cultural competence—understanding the social and cultural influences on veteran help-seeking behaviour. The minority stress model[17] posits that minority groups experience increased stress as a result of heightened stigma, discrimination and prejudice, and consequently have poorer health outcomes. The model also suggests that strongly identifying with a minority group may also provide a strong sense of belonging, identity and source of support. This dichotomy has been demonstrated in a study of lesbian, gay and bisexual women veterans for whom their sexual orientation was simultaneously a source of increased stress and discrimination during service and also provided a mitigating social support network, although one that was necessarily clandestine for many.[18]

Barriers for specific minority groups

Drawing on the protected characteristics outlined in the Equality Act and wider health research, veterans can be subdivided into several specific minority groups. While these groups of veterans are under-represented by virtue of a paucity of research into their idiosyncratic needs, inferences can be drawn as to significant barriers that may need to be considered in addressing access and provision inequalities (Table 2).

Age groups

As the veteran population is projected to proportionally skew younger over time, it is of note that veterans of working age are more likely to endorse employment-related logistical demands as a barrier to care.[19] Veterans of more recent conflicts and of younger age appear to seek mental healthcare more quickly after leaving service, potentially indicating reduced help-seeking stigma.[20] However, UK veteran-specific pathways are still predominantly used by middle-aged veterans.[20] Those aged younger than 25 years are at increased relative risk of completing suicide and have the lowest contact rates with mental health services in the year before death.[21] It is possible that younger veterans, and specifically those who have been non-voluntarily discharged, may feel less able to access or have a poorer understanding of veteran-specific support services available.

Older US veterans who completed suicide had lower rates of mental health difficulties and higher rates of health problems relative to other age groups, while younger veterans were at more risk of mental health, substance misuse, financial and relationship difficulties.[22] Amidst a paucity of research on age-related differences, such a finding implies that identifying those at risk of suicide and promoting access may best be targeted at different initial health needs and presentations depending on age group. Indeed, the modality of support for successful engagement and outcomes may vary. Emphasising community integration has been shown to be advantageous for older veterans, while functional social support may be preferable for younger veterans.[23] Structurally, multiagency, person-centred approaches that emphasise professional expertise-sharing have been assessed as successfully

Table 2 Key barriers to healthcare access specific to individual minority veteran groups

Minority veteran group	Barriers
Age groups	
Younger	Awareness of services and perception of eligibility
Working age	Competing time demands
Older	Multimorbidity and multiservice involvement
Women	Identification as a veteran Understanding of military sexual trauma (self and professional) Availability of specialist services
Parents and carers	Logistical and competing time demands Mental health interaction with parental role
Physical and non-mental health conditions	Variation of mental health need across injury types Co-occurrence and management of chronic pain Treatment of comorbidities
Race and ethnic minorities*	Cultural attitudes Language barriers Wider social support concerns (eg, housing, citizenship)
LGBT+	Relevance and disclosure of sexual orientation Disclosure of sexual assault and MST Trust in civilian and military-linked providers Denial of military benefits, pensions and records

Religious and faith-based beliefs excluded from table due to a lack of research.
*Excludes UK-born ethnic minorities due to lack of extant research.
LGBTQ+, lesbian, gay, bisexual, transgender, queer or questioning, or another diverse gender identity; MST, military sexual trauma.

meeting the needs of older veterans with multimorbidity, with a specific focus on social connectedness and dementia.[24] As such, while increasing younger veterans' access may require more effective outreach and prevention programmes, older veterans' engagement may necessitate greater interagency and pathway coordination.

Women

Current research has focused extensively on the disproportionately higher likelihood for women veterans of experiencing military sexual trauma (MST; sexualised bullying, harassment or assault)[25] and their higher rates of mental health difficulties.[26] Despite women veterans being more inclined to seek help from formal healthcare, this is more often from non-veteran-specialist services.[9] The reasons are likely myriad. Women may not readily self-identify as veterans, and thus view veteran services as 'not for them'.[10] Additionally, MST may not be recognised or understood by veterans, nor seen as an experience for which veteran-specific care could or should be accessed.[27]

Specifically for gender-based and sexual trauma, women-only services or providers may be advantageous.[10] In addition, women veterans' multiple social demands, such as having caring responsibilities, may also mean that online and other non-in-person flexible delivery methods are likely to be facilitators to positive help-seeking and engagement.[28] However, care must be taken to ensure that the potentially therapeutic impact facilitated by connectedness and camaraderie is not sacrificed. More widely, a lack of knowledge and response of healthcare professionals and settings to wider women's specific needs and concerns, such as access to feminine hygiene products or understanding of the role of menopause, are also reported as salient barriers to accessing care.[10 29] However, while some veterans have reported a lack of specialist women-specific care as a barrier, others believe that they should not be treated differently on account of their gender.[29] Thus, the choice and responding to individual needs is central.

Family and caring responsibilities

The practical demands of caring responsibilities have been linked with an increased likelihood of treatment dropout.[30] Thus, the use of online intervention delivery may be preferable for veterans (and their spouses) who have competing logistical demands on their time.[31] Spouses are also vulnerable to increased rates of mental ill health, and it is noteworthy that spouses who are themselves veterans or serving can be more likely to report barriers to access.[32] These may reciprocally negatively impact the veteran in need of initial support.

Veterans with post-traumatic stress disorder (PTSD) who are parents may also have increased feelings of guilt, negative self-appraisals particularly of themselves as a parent, or a wish to protect their children from their struggles.[33] Whether parenting responsibilities may heighten barriers or act as a motivator to seeking help is uncertain. Nonetheless, the parental role may have implications on engagement with mental healthcare beyond logistical considerations.

Physical disabilities and other conditions

Comorbidity and complexity in veterans is the norm, and the intertwining of mental and physical health conditions is well evidenced. Several confluences are of note for service designers in considering potential barriers and personalisation. First, injured non-amputee veterans report greater rates of depression, anxiety and PTSD compared with amputee and non-physically injured veterans.[34] Veterans with appearance-altering injuries may require military-specific psychological interventions to help them adjust to a changed appearance and the role such injuries can play as a lasting reminder of trauma.[35] This indicates a potential need for variation in mental health interventions across the spectrum of physical injuries and warns service providers against assuming that poorer mental health always follows the most 'serious' or visible physical injuries.

Second, the high rates of chronic pain in veterans—including in the polytrauma clinical triad alongside PTSD and post-concussion brain injury—implies that pain and mental health difficulties potentially should not be seen or treated in isolation. Younger veterans may also require more support with adjustment to chronic pain. Multimodal, holistic interventions for pain, rather than discreet treatment pathways, may be a key facilitator for access and engagement. However, current evidence is lacking, particularly for UK veterans.

Finally, the potential benefits of concurrent approaches to treatment access and delivery is of particular relevance to the elevated prevalence of co-occurring alcohol misuse and mental health difficulties.[36] It has been suggested that veterans may use alcohol as a means of self-regulating trauma symptoms and delaying the point of mental health crisis.[37] Therefore, there may be merit in further exploring the engagement benefits of providing alcohol support interventions concurrent with other mental health interventions, rather than requiring a sequential set of treatments, each of which would be vulnerable to their own access challenges.

Race and ethnic identity

Race and ethnic minority veterans are unquestionably not a unitary population, and current research is dominated by US cohorts for whom findings are inextricably linked to their specific national context. In the UK, veterans from ethnic minority groups are

stated to be disproportionately higher users of statutory veteran-specific health services.[38] However, it is unclear whether this is due to an actual or perceived need for such services. Indeed, this finding may indicate that barriers to veteran healthcare access are in fact reduced for these groups. Alternatively, it may be that for ethnic minority veterans, veteran-specific services serve as an initial care access point for a range of health needs. Additionally, ethnic minority veterans may be at greater risk of some maladaptive behaviours, such as gambling.[39]

There is a long-standing systemic disadvantage in accessing care and support services for ethnic minority UK service personnel and veterans, particular for those whose citizenship status is unclear.[40] Commonwealth veterans reported complex co-occurring issues with housing, finances and physical health alongside their mental health,[11] while language barriers or cultural attitudes to mental health may act as additional barriers for some groups.[41] The lack of research into UK-born veterans from ethnic minority groups, who may not be exposed to these specific stressors but are still vulnerable to epistemic inequalities, is notable.

Taken in tandem with evidence of ethnic minority veterans' wider negative experiences of the UK social security frameworks,[42] ensuring equity of access to the wider healthcare and support systems may be higher initial barriers that need to be overcome before veteran-specific healthcare can be accessed. However, additional work is required to disaggregate different communities and identify their finer-grained needs and how best to respond.

Religious faith

While some faith-based beliefs in general have been shown to act as a sociocultural barrier to help-seeking as the result of ideological stigma to mental health difficulties,[43] caution against crude generalisations is merited and there is a paucity of veteran-specific research. Active religiosity may bring with it a use of faith-based coping such as a prayer, yet faith per se does not seem to impact the concurrent use of secular mental health services.[44] Veterans' increased likelihood of engagement has been shown to be associated with the *weaking* of religious faith, feelings of guilt and a need to reassess existential beliefs about life.[45]

As such, faith can potentially be both barrier and facilitator to engagement with healthcare, as well as an active component in the veteran's ongoing psychological distress and recovery. Therefore, clinical interventions may need to directly consider and engage with veterans' active faith-based beliefs and any changes therein as a result of their trauma and mental health difficulties.[46]

Lesbian, gay, bisexual, transgender and others

Despite the decriminalisation of homosexuality in wider society, lesbian, gay, bisexual, transgender and other identities (LGBT+) service members continued to be discriminated or banned from service for extended periods under military-specific policies such as a 'Don't Ask Don't Tell' in the USA, the 'Gay Ban' in the UK and the Canadian military's 'Gay Purge'. Rates of sexual traumas are also higher.[47]

Enduring and heightened feels of shame and fear have been reported by LGBT+ veterans, particularly around the disclosure of their sexual orientation.[18] Such fear can result in a reluctance to access healthcare, particularly if previous encounters with health professionals in both a military or civilian context have been negative, hostile or homophobic.[18] Once healthcare is accessed, a lack of understanding of needs as well as exclusionary and bullying practices from other veterans, service-users and systems have all been reported.[48] Conversely, LGBT+ veterans also report not being asked about their sexual orientation by healthcare providers who may lack the professional knowledge or confidence to do so, despite the potential relevance to care provision.[49]For veterans dismissed under the UK's 'Gay Ban', wider systemic issues such as lack of clarity around degraded or denied pension rights, incomplete service records, and a lack of trust in the military-linked organisations may also adversely impact veteran-specific healthcare access.[47]

CONCLUSIONS

The barriers and suggestions on how they may begin to be addressed are by no means exhaustive; rather they provide a sample of some of the most salient points of difference in the current literature. Undoubtedly groups have been excluded, such as homeless veterans, those who live in remote or rural communities or those with lower socioeconomic capital. However, such factors may be considered more likely to be rooted in and interact with the social and healthcare systems of specific counties. Minority groups are under-represented by virtue of a lack of existing evidence, so more effort in understanding their myriad nuanced needs and barriers to mental healthcare access and engagement is required.

Ensuring adequate resources and institutional leadership buy-in is central to the success of delivering healthcare personalised to the needs of specific veteran groups. So too is the need for coproduction of services with those who have lived experience. However, for successful operationalisation, there is a fine balance to be found between crudely placing minority veterans together in broadly defined groups, and responding to increasingly finer-grained points of difference to the point of impracticality.

Second, veterans may belong to multiple groups at different points in their life course and an intersectional approach is key.[50] Identity categories should not be treated as fixed, comprehensive or universal, and those who are marginalised in multiple ways should be centralised in both the development and analysis of health services. Third, minority veterans should be included in all stages of the healthcare policy and delivery that goes beyond participation in discussions or workshops and redistributes the power imbalances with other stakeholders. At last, institutional (and we would argue, research) change is delivered in respect to, and contingent on, wider societal change. Thus, the veteran community does not sit apart and has the power to influence wider discussions and vice versa.

Ensuring successful veteran access to and engagement with healthcare may also be contingent on viewing the person as more than a veteran; acknowledging their whole life course and the context in which a care need may arise at any given time.[10] Although in-service experiences are salient for many, personalised veteran healthcare perhaps necessitates a shift from a 'veteran-specific' stance towards a more universal 'veteran-sensitive' and trauma-informed approach. This also requires deeper understanding of the impact of and healthcare engagement with the context and systems in which veterans may access healthcare. While acknowledging the broad range and differences in needs, experiences, challenges and inequalities, a holistic approach may be best placed to effectively respond at as individualised a level as possible.

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