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for Military Social Research

**“I don’t
feel like
that’s
for me”**

Overcoming barriers to
mental healthcare for
women veterans

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Essex Partnership University
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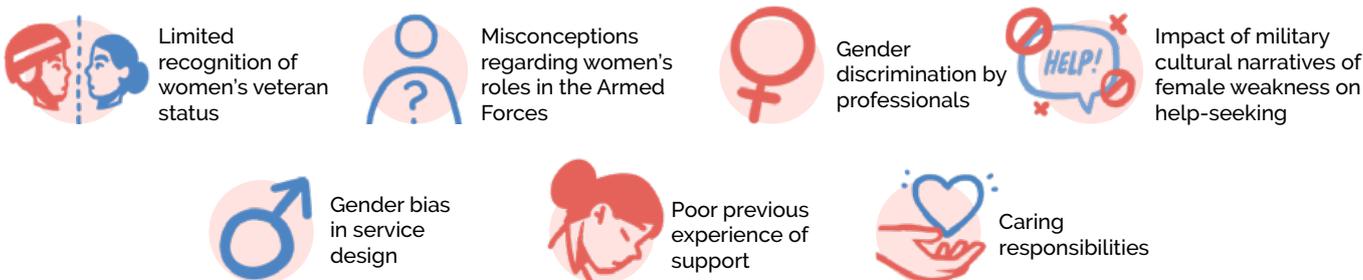
We want to thank all those who took part in this project as a participant and members of our women veteran co-design group. Thank you to our wider project team from Essex Partnership University Trust for your hard work and guidance. We would also like to thank Paula Edwards and Salute Her for their contribution to the project. Without the support of all of the above, this research would not have been possible.

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Introduction

Approximately 13.6%, or approximately 250,000 of the 1.85 million veterans in England and Wales are female¹, with numbers expected to increase alongside the number of women recruited to the UK Armed Forces². Despite this, veteran research focused on mental health support needs and help-seeking experiences continues to be predominantly focused on men.

Furthermore, whilst research highlights that UK women veterans are more likely to seek formal mental health support than their male peers³, evidence suggests that women are underutilising specialist veterans' services⁴. Emerging UK research highlights that women veterans experience gender-related barriers when accessing support, including: a lack of recognition of their veteran status, misconceptions regarding women's roles in the Armed Forces, the impact of military cultural narratives of female weakness on help-seeking, gender discrimination by professionals, caring responsibilities, previous poor experiences of support, and gender bias in service design^{5,6,7,8,9,10}. Additionally, US research supports these findings and highlights discomfort or feeling unwelcome in male-dominated veteran treatment environments¹¹.



To provide a better understanding of these issues, this project set out to explore the mental healthcare support needs and experiences of women veterans in England, and to develop practical guidance for mental healthcare professionals working with women veterans, co-designed with women veterans. This report summarises the key findings of this research project, and links to practical guidance for mental healthcare professionals working with women veterans.

1 House of Commons Library (2023). Women Veterans Analysis.

2 [Defence demonstrates significant progress made for women in the Armed Forces - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/defence-demonstrates-significant-progress-made-for-women-in-the-armed-forces)

3 [Jones, N., Jones, M., Greenberg, N., Phillips, A., Simms, A., & Wessely, S. \(2020\). UK military women: Mental health, military service and occupational adjustment. *Occupational Medicine*, 70\(4\), 235–242.](#)
[Stevellink, S.A.M., Jones, N., Jones, M., Dyball, D., Khera, C.K., Pernet, D., MacCrimmon, S., Murphy, D., Hull, L., Greenberg, N., MacManus, D., Goodwin, L., Sharp, M.-L., Wessely, S., Rona, R. J., & Fear, N. T. \(2019\). Do serving and ex-serving personnel of the UK armed forces seek help for perceived stress, or emotional or mental health problems?. *European Journal of Psychotraumatology*, 10\(1\), 1556552.](#)

4 [Godier-McBard L.R., Cable G., Wood A.D. and Fossey M. \(2022\) Gender differences in barriers to mental healthcare for UK military veterans: a preliminary investigation *BMJ Mil Health* 2022;168:70-75.](#)

5 [Graham, K., Murphy, D., & Hendriks, L. J. \(2022\). Exploring Barriers to Mental Health Treatment in the Female Veteran Population: A Qualitative Study. *Journal of Veterans Studies*, 8\(3\), pp. 151–164.](#)

6 Godier-McBard, L et al (2022) Ibid

7 [Edwards P. and Wright T \(2019\) No Man's Land: Research study to explore the experience and needs of women veterans in the UK.](#)

8 [GodierMcBard, L.R., Gillin, N. and Fossey, M.J., \(2022\). 'Treat everyone like they're a man': Stakeholder perspectives on the provision of health and social care support for female veterans in the UK. *Health & Social Care in the Community*, 30\(6\), pp.e3966–e3976.](#)

9 [Campbell, G. M., Williamson, V., & Murphy, D. \(2023\). "A Hidden Community": The Experiences of Help-Seeking and Receiving Mental Health Treatment in U.K. Women Veterans. *A Qualitative Study*. *Armed Forces & Society*.](#)

10 [Hooks, C., Morgan, L., Fossey, M., Buxton, E., & Godier-McBard, L. \(2023\). 'Where are all the women?' Recognition and representation – UK female veterans' experiences of support in civilian life.](#)

11 [Godier-McBard, L.R., Wood, A., Kohomange, M., Cable, G. and Fossey, M., \(2022\). Barriers and facilitators to mental healthcare for women veterans: a scoping review. *Journal of Mental Health*, pp.1-11.](#)

Project methods

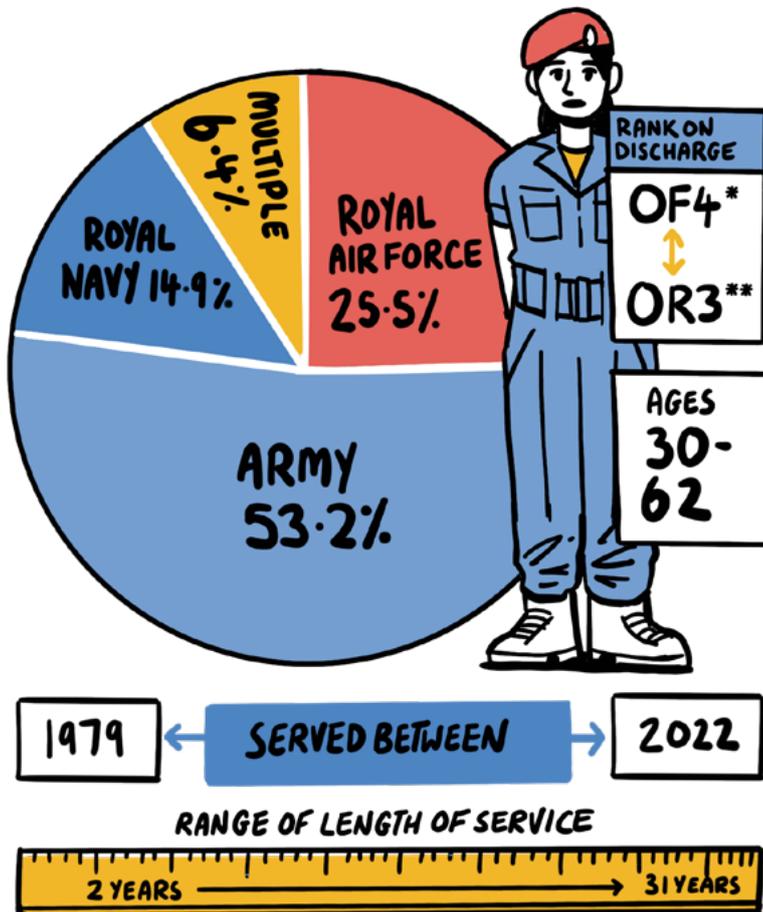
Semi-structured interviews and focus groups were carried out with 48 women veterans and 12 mental healthcare professionals in England. The project was guided by a **co-design**¹² group of women veterans.

Co-design is a method that is used in research and service design in which decision-making is shared equally, in this case between women veterans and the project team.



The veteran sample was open to all those who identified as a woman and had served in the UK Armed Forces, had experienced a mental health challenge in the last 5 years, and were currently living in England. Women did not have to have a formal diagnosis, nor have sought treatment to take part. The mental healthcare professional sample was open to all professionals who provided mental healthcare to veterans in England in their current role, or a previous role within the last 5 years.

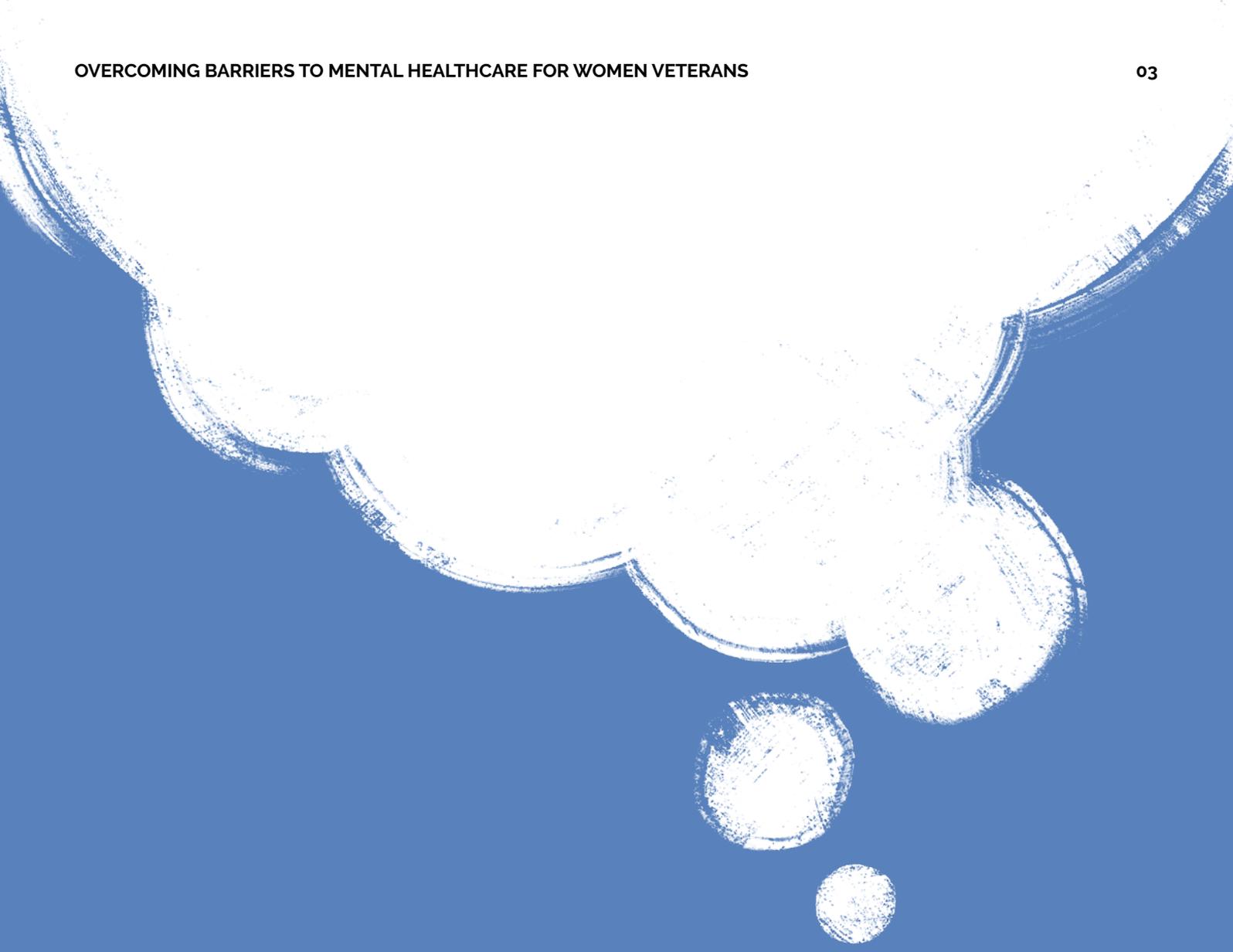
Women veteran sample characteristics



Interviews and focus groups were analysed by the project team and the interpretation of findings was conducted in conjunction with the women veterans' co-design group, including the development of guidance and recommendations for working with women veterans in mental healthcare services.

More details on the methodology used in this project can be found in [Appendix 1: Project methodology](#).

* OF4 – SENIOR COMMISSIONED OFFICER
 ** OR3 – JUNIOR NON-COMMISSIONED PERSONEL



What are women veterans' mental health needs?

Our findings revealed several ways in which the women veterans' mental health needs were unique, in relation to their experiences during military service and in the civilian world.

What types of mental health challenges did women veterans report?

Women reported experiencing common mental health disorders (i.e., anxiety and depression) and (Complex) Post Traumatic Stress Disorder (IC-PTSD). Mental health challenges were not exclusively related to combat or deployment, but often to gender-related bullying, discrimination, sexual violence, and traumatic experiences and interrogations related to their sexuality for those who served during the historic 'gay ban'. Some women reported suicidal thoughts and feelings, and suicide attempts post-service, which acted as a catalyst for accessing support.



“I got diagnosed with PTSD in the end, just due to what’s happened in the Army, really, certain things. But it was the bullying and harassment that really pushed it over the edge for me”.

Army Veteran served 2004 to 2022

The impact of military service on women veterans' mental health

Women reported several aspects of service that impacted their mental health, including traumatic events during deployment, non-combat-related workplace stressors, gender-based discrimination, sexual harassment and sexual assault, and family life challenges. These challenges were exacerbated by a lack of effective support during military service, and the stigma and desire to conceal mental health problems that were cultivated during military service.



“I knew I wasn’t performing at my best, but I think you get very good at hiding it. So, what happens is you push yourself even harder in order to cover your mental health and make it appear normal and then actually the reality is that that burns through the mental resilience quicker”.

Army Veteran served 1980 to 2011

Derogatory attitudes towards women in the military were commonly reported¹³. This included the perception that women are less emotionally resilient than men, and inappropriate references to women's menstrual cycles and hormones in relation to their mental health. These attitudes exacerbated the stigma around mental health for women and left many feeling unable to ask for support for their mental health.



“I remember just getting really upset. And then someone popped their head around the door, and ‘Oh time in the month’, and shut the door [...] And blokes will joke about that all the time. Go ‘Ohh blob week, ohh’ and one of them even put on a sign on the door”.

Army Veteran served 1999 to 2022

Women also reported experiencing bullying and sexual harassment by colleagues and superiors, with formal reporting often resulting in further poor treatment.



“[He] sexually harassed me daily and if I didn’t respond to that, he would bully me and the whole platoon and say it was my fault”.

Army Veteran served 1983 to 1985

A number of women veterans experienced sexual assault and rape during service, perpetrated by colleagues and superiors. Most did not formally report this due to a lack of support and trust in the reporting system. Those who did report encountered dismissive and hostile attitudes towards victims at many levels, impacting their willingness to seek support in the future. The impact of these experiences led some women to leave service by choice or by medical discharge.



“You shouldn’t have been drinking... it was all my fault. And he said, it wouldn’t really be beneficial to proceed with your complaint”.

Army Veteran served 1987 to 2005

“[I] kept quiet about all my sexual harassment, just because you don’t want to be seen as a troublemaker. You’d just be a stupid woman that shouldn’t be there anyway”.



Army Veteran served 1989 to 1996

Many women left service due to difficulties in balancing service life with having a family, including lengthy separations and long work hours, and being a dual service family (i.e., their partner was also serving). The stress associated with these experiences had a long-term impact on women's mental health and sense of identity as both mothers and military women.



“Be a forces wife and be a successful soldier. I can do it and I can be bang average at it, but I can only be that person that goes – “I can’t come to that because I’ve got childcare issues. I can’t do that because I’ve got childcare issues”. I cannot be the soldier I know I am. And so I went, “I’m done”. And that completely destroyed my sense of self because my sense of worth is so wrapped up in what I do professionally”.

Army Veteran served 1999 to 2016

The impact of transition and civilian life on veterans' mental health

Women reported several challenges during transition that impacted on their mental health. Unplanned transition was particularly challenging, including medical discharge and discharge based on sexuality during the historic 'gay ban'. The quick nature of these discharges did not enable women to plan effectively for civilian life, and left women with feelings of anger, betrayal, and grief for their military careers.



“It was awful. It was heart-breaking, cause I was very, very happy. I was having the best time of my life [...] I was flying high. I was doing really well. I was doing my captaincy, just a few months after I was thrown out. So it’s awful”.

Army Veteran served 1982 to 1988

Women experienced difficulties in adjusting to the civilian workplace, which they didn't feel reflected the standards and values of the military. Some struggled to adapt to societal expectations of women in the workplace, particularly around gendered communication styles. Some experienced further gender-based discrimination, sexual harassment, and bullying in the civilian workplace. Overworking and burnout was common, a legacy of their desire to prove themselves as women in a male-dominated military environment.



“I had to work so hard to not write “Ladies, this is not difficult. Full stop”, which if I’ve been in the military, I would have done. It would be “Gentlemen, this is not a difficult task. What is the problem? Blah blah blah.” Yeah and absolutely I would have done. I have to work so hard to reset myself”.

Army and Royal Air Force Veteran served 1997 to 2018

Women reported a lack of social support post-service, compounding difficulties they experienced in coping with mental health challenges and leading to loneliness and isolation. This was often due to moving locations on transition and struggling to make new connections. Women felt that they didn't fit in with the gendered expectations of either the civilian or veteran communities. Many women chose not to engage with veteran events or groups, either because these were perceived as male spaces or because they didn't identify with being a veteran.



“You get spat out into a civilian world where you're, you're not a typical woman anymore”.

Royal Navy Veteran served 1999 to 2012

“It's probably gonna be loads of guys... and don't get me wrong I'm used to working in male environments [...] There's just not the same network for women”.

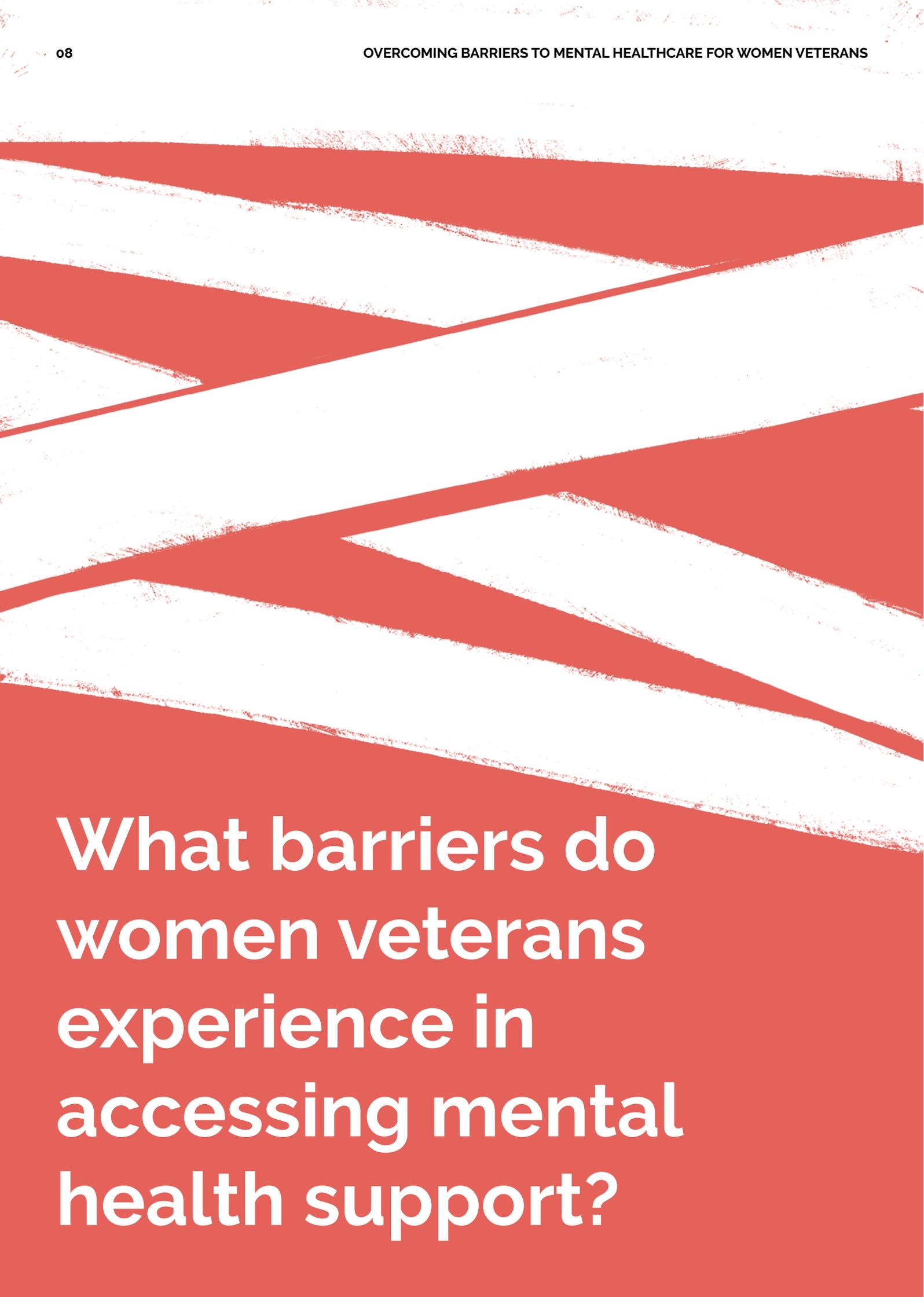
Army Veteran served 1991 to 1998

Some women reported experiencing financial difficulties after leaving service, causing significant distress. This extended to long-term financial instability for those who lost their career due to their sexuality during the historic ban. Accessing the benefits system for support caused significant stress, particularly for those denied support. Those who received benefits found it difficult to live on the money provided. Pursuing compensation for injury and illness sustained during service was challenging, particularly for those related to bullying, sexual harassment, or sexual assault. Appealing negative decisions could be costly.



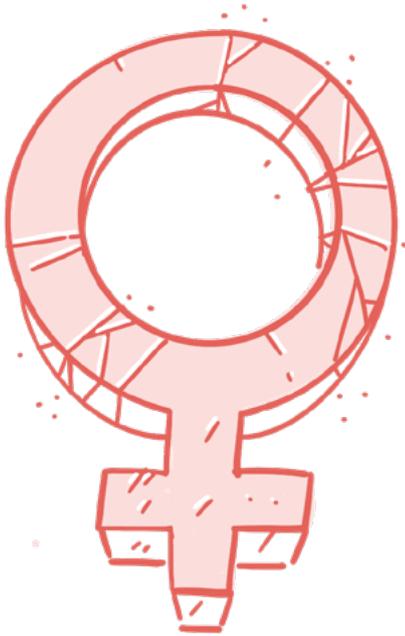
“I was told it's not service related. I, what's the word, pursued it again. Not service related. So I didn't get anything from it and I'm thinking it's \$%@!# destroyed my life. It's destroyed my life, but no one can see that it's service related”.

Royal Navy Veteran served 2014 to 2017



**What barriers do
women veterans
experience in
accessing mental
health support?**

Women veterans and mental healthcare professionals reported several barriers to access or effective engagement with mental health support/treatment. Barriers represented a legacy of the military culture, women's perceptions and experiences of veteran mental health services, and/or the practicalities of accessing support.



Stigma and female 'weakness'

Women veterans described how the perception of female 'weakness' that they experienced during military service, compounded the stigma associated with mental health help-seeking. They shared feeling as though they were not 'bad enough' or deserving of support and related this to not wanting to appear as weak and emotional women.

“There is still so much stigma around the military and mental health. And yeah, so if big boys don't cry, if girls cry, then that can't happen [...] You almost have to be doubly stronger than the men to be equal to them, if that makes sense”.

Army Veteran served 1996 to 2018

Veteran identity

Many women didn't identify with the term 'veteran', and so did not feel that veteran-specific services were for them or that they would be eligible to access them. Varied reasons for women not identifying with the veteran label included:

- Negative experiences during their military service.
- Stereotypical perceptions of a veteran: often older, male, served during certain conflict eras.
- A sense of not being worthy, i.e., short service or non-combat related roles.
- Other aspects of identity seen as more prominent, i.e., mother, carer, wife, professional identity.

Additionally, many women reported not being asked by healthcare professionals (i.e., their GP) if they were a veteran, or that their military experiences were overlooked even when their veteran status was known. This resulted in women not being referred to veteran-specific mental health support.

“It was only up until recently that I kind of viewed myself as a veteran, so I kind of dismissed anything to do with the military in terms of accessing any support”.

**Royal Air Force Veteran
served 1989 to 1996**

“No one's ever mentioned it. But I know it's definitely on there 'cause I remember ticking the box, going “oh this is new, isn't this great”. But yeah, it's never been mentioned at all”.

**Army and Royal Air Force Veteran
served 2003 to 2018**

Lack of understanding of women veterans' needs

Some women believed that veteran services would not have a good understanding of the gendered aspects of their military experience (i.e., gender-based discrimination, harassment, or violence) and the impact on their mental health. They discussed not being recognised as a veteran, misconceptions around women's roles in the Armed Forces, and how their military service was not considered as a factor impacting their mental health. Women also felt that non-veteran services would lack general military understanding.



“It wasn’t very nice when I was out there, do you think that that might have contributed to it?” and he was like, ‘Well, you’re a woman, so you wouldn’t have been frontline anyway’”.

Royal Navy Veteran served 1999 to 2012

Poor experiences of support

Women highlighted poor previous experiences of mental health support during and after military service that discouraged them from seeking further help, including feeling uncomfortable in the treatment environment, feeling judged, shamed, and not listened to. Some reported breaks in confidentiality from support professionals during military service that impacted their trust in civilian service providers. Mental healthcare professionals described poor handovers between services, which left some women feeling rejected by services, reminiscent of poor treatment during military service.

“Biggest barriers I say was the shift from one service to another to another and again, all veterans felt this, but the female veterans I worked with felt rejected, that we were failing them, that they were being let down, that nobody cared about them, and it mimicked and mirrored how a lot of them were treated by the military. So just totally reinforced every belief that they had”.

**Mental Health Care Professional NHS
Veteran Specialist Services**



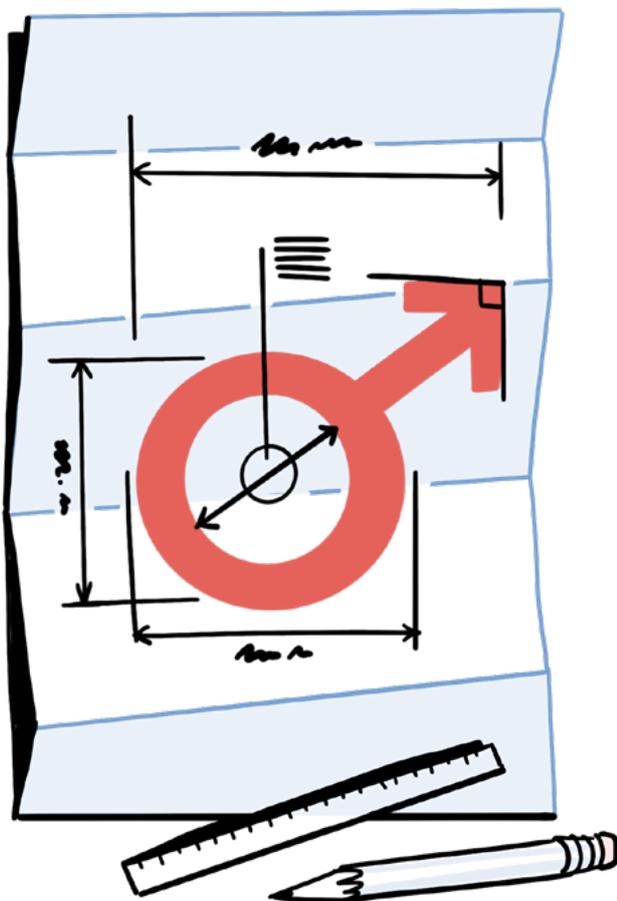
Awareness of available support

A lack of awareness of specific mental health support for veterans presented a significant barrier to accessing services for women veterans. Additionally, there was uncertainty around eligibility for services, particularly whether a mental health challenge would be considered related to military service, or “service attributable”. Women often held the perception that veteran services were designed to support those with combat-related trauma.



“There’s the lack of awareness of what a service like ours, for example, can offer to women, and it’s something about, umm, how visible we are and kind of information we’re getting out there”.

Mental Health Care Professional NHS Veteran Specialist Services



Services designed around male veterans

Services were often described as “male-dominated” spaces, perceived as having been designed for men and being predominately accessed by men. Some women discussed feeling uncomfortable in predominantly male support groups, due to the replication of negative aspects of military culture, such as sexist ‘banter’, or feeling judged by male peers. For some, this was reminiscent of the military environment in which they experienced gender-based discrimination or violence.

“They’re laddish, you know, I don’t wanna go to them [...] They’re still in the army in their head but, I went to a photography group and it’s kind of get your kit off love, and I’ll take a picture of you, that sort of thing”.

Army Veteran served 1983 to 1985

Male-dominated service branding

The dominance of male service personnel and veterans in the imagery used in service branding and websites was highlighted. The often-loaded military language used in the names and branding of veteran services was also discussed, including combat and battle analogies. Both aspects of branding led women to question if these services were for them, could meet their needs, and whether they would even be eligible to access them. Evocations of strength, courage, and heroism in service branding gave the perception that these services primarily offered combat-related trauma interventions, leaving some women unsure if they would be able to access support for non-combat related mental health challenges.

“So really your onus is on supporting men in battle. You’re not going to be able to understand me talking about my sexual assault, sexual harassment, or discrimination. And it would almost feel like that, that organisation as a whole would be rolling their eyes on the end of the phone”.

Army Veteran served 1999 to 2022



Practical barriers

Practical barriers to accessing services were highlighted, including the inconsistency of services across regions, long waiting lists, difficulty getting GP appointments, organising appointments around work, navigating fractured services, and difficulties with transport. This was compounded by navigating a civilian system that was unfamiliar. The gendered nature of barriers related to caring and family responsibilities was also highlighted, which are more commonly experienced by women than men.

“Taking the time off work or carving it out of your life to then go and visit the doctor or whoever it is. It all falls lower down the priority list than hanging the new curtain, going to work, looking after the kids, taking the dogs for a walk. All the other things that have to be ticked off on your list of things to do”.

Army Veteran served 2004 to 2014



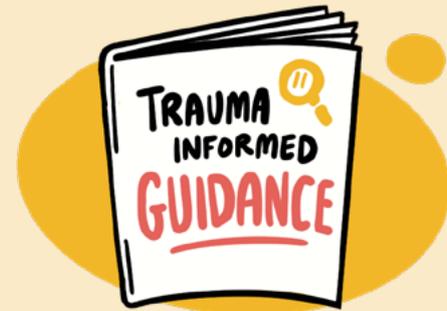
What do women veterans want from mental health services?

Women and mental healthcare professionals discussed several factors that would support and encourage women veterans access to mental healthcare services. A number of these factors related to being aware of and sensitive to women veterans differing mental health support needs and ensuring services have the infrastructure to meet them.

Trauma-informed care

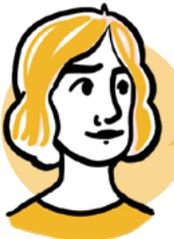
Both women and mental healthcare professionals spoke about the importance of trauma-informed care¹⁴, such as taking sufficient time when discussing emotional topics or experiences, avoiding re-traumatisation by ensuring familiarity with women's medical notes and communicating to women the reason why they are being asked to reshare their stories, and creating a welcoming environment.

A good therapeutic relationship could be fostered by listening to women, giving them time to open up and develop trust in the relationship, and validating their experiences. Women wanted mental healthcare professionals who were honest about treatment and what to expect. Women also described the positive impact of the validation of their experiences during military service, where they had previously felt dismissed by mental healthcare professionals, their chain of command, or colleagues.



You can access trauma-informed guidance for mental healthcare professionals working with women veterans

[BY CLICKING HERE](#)



“She listened to me. She didn’t judge me as the Army did, she didn’t judge me like “well he was drunk, what do you expect?”.

Army Veteran served 1987 to 2005

Cultural competence and clinician understanding

Women spoke about the benefits of mental healthcare professionals having a good general understanding of the military, as well as women's unique experiences of service life (i.e., motherhood, gender and sexuality-based discrimination, sexual harassment, and sexual assault/rape). Women also wanted clinicians that understood women's health needs in general (i.e., menopause, perinatal mental health) and how they may impact mental health.

“If they’re not aware of what that scenario is like, it’s gonna be harder for them to actually relate to some of the stuff that women are saying because they won’t understand that, you know, the toxic conversations and everything else which were common, you know there were day-to-day sort of language that was there and everything else”.

Army Veteran served 1979 to 1985

Choices in treatment

Maximising choice and respecting service user preferences in treatment was very important to women veterans. Whilst not all women veterans expressed a preference for a female or veteran clinician, or female-only groups, women felt that services should ask service users if they have a preference, and work to accommodate this. Reasons for preferring a female clinician or female-only treatment group included experiencing male-based discrimination, harassment or violence in service, or feeling more comfortable talking to a woman/women about women's health issues. The need for more consultation with women veterans when designing, reviewing, and improving services was also highlighted.



“My partner and I were trying for a baby, didn’t work, we had lots of miscarriages, and it turns out that I was going through early menopause. I just couldn’t have sat there and told a male GP [...] I think you have to be a woman to understand being a woman, especially in a male-dominated environment, that what you’re saying is not a whinge, but it’s a general concern for yourself”.

Army Veteran served 1999 to 2022

Improving awareness of veteran-specific services

Women spoke about the need to better target the promotion of veteran mental health services to women via social media and advertisements, and via role modelling (i.e., other women veterans who have accessed the service), and to ensure that it is clear that women are eligible for support.

“You probably got lots of pockets of female veterans out there needing something, but not knowing that it’s not just them. You know, so it’s that bit, isn’t it? So it’s that awareness raising, and the sharing of stories, and the role modelling, and all the stuff that you do for everything else”.

Army Veteran served 1996 to 2018

Proactive support

Women discussed several ways in which proactive support could help overcome barriers to accessing services, for example, service providers reaching out to make appointments. Women felt that a formal system for 'checking in' during transition (i.e., phone-based check ins at 6 and 12 months) may prompt women to consider support where they may not have, or help women to navigate the complex civilian healthcare system. Furthermore, the benefit of preventative psychoeducation was a common suggestion, to give women the tools to cope with challenging life situations.

Social prescribing

Women were keen to be offered group activities within mental health support. Often their desired activities were outdoors, and included cycling, hiking, construction courses, and outdoor crafts. However, ensuring that there were options for those with physical limitations was seen as important.

“All the activities we did for outdoors. But they would learn a skill or craft. They would go rock climbing, archery, kayaking, but basically it was a mindful distraction where it was a safe space”.

Royal Air Force Veteran served 1983 to 2007

Peer support

Women discussed the benefits of spending time with people who understand service life, and who may be navigating similar challenges. However, several women shared their negative experiences in male-dominated group settings and wanted dedicated groups for women. Women veterans also discussed the benefit of peer mentorship to provide informal support and to pick up on signs of mental health challenges.

“We need a mentor, for at least six months after we leave, that person that we can speak to, that we end up building that relationship with, that trust with [...] And I’m not saying it necessarily has to be a woman. It doesn’t. But they have to understand women’s needs”.

Royal Air Force served 2005 to 2016

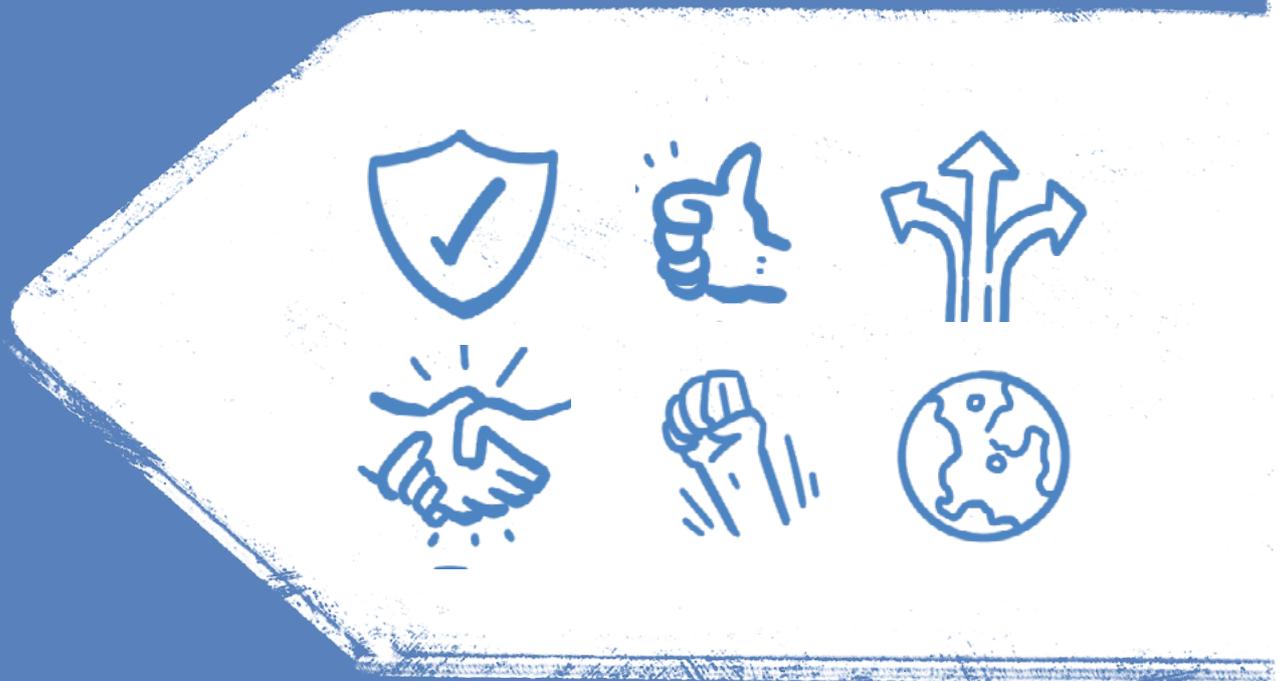
Improving the visibility of women veterans

Women highlighted the need to increase the visibility of women in support service branding and materials. They also felt that services should be clearer about what support is offered, to overcome the perception that support is only given for combat-related mental health challenges. Additionally, women felt there was a need to increase society’s general awareness of the role that women play in the Armed Forces and the challenges they may face, to improve their visibility in society.

“Certainly on the website, it does mention about sexual assault and abuse within the military, particularly for females. And I think that just acknowledging that has helped people see that [...] I’m not on my own”.

Mental Healthcare Professional NHS veteran specialist services





Guidance for mental healthcare professionals working with women veterans

Based on the project findings and consultation with our women veterans' co-design group, guidance was developed for mental healthcare professionals working with women veterans. This resource is intended for professionals working in mental healthcare to consider in the context of the services they provide to women veterans.

The purpose of this guidance is to support good practice in meeting the mental healthcare needs of this group, contextualised within the principles of Trauma Informed Practice¹⁵. The model recognises the impact of trauma exposure, and highlights **6 factors that should be considered to provide the best possible care**:



Safety (physical, psychological, and emotional),

Trustworthiness

Choice



Collaboration

Empowerment

Culture consideration

The final version of this guidance can be accessed at: www.centreformilitarywomensresearch.com/womenveterans/guidance. Or you can scan this QR code.



The resource is **not** intended to provide formal clinical direction for providing services or care to women veterans and should not be used in the place of formal clinical training and/or supervision. Rather it should be considered in addition to this, to enhance knowledge and understanding of women veterans' care needs, and to support clinical formulation¹⁶.

Preliminary evaluation of guidance

Once the co-design group had signed off on the draft guidance, a survey was developed to undertake a preliminary evaluation with 9 MHCPs working within NHS-England veteran mental health services (Op Courage). Professionals were not required to implement this guidance, rather the survey aimed to evaluate the perceived quality, benefits, and challenges of using the guidance. The survey sought participant's feedback on the utility and usability of the guidance (i.e., comprehension, perceived barriers of implementing suggestions with current service users), the practical utility of the recommendations for improving services (i.e., potential fit, ease of implementation of changes within current service model), and any suggestions for improvement.

¹⁵ Office for Health Improvement and Disparities (2022) Working definition of trauma-informed practice.

¹⁶ Defined as, 'A detailed statement of the diagnosis in multidimensional terms. It will contain a classification of the disorder and a specification of the factors, physical, constitutional and psychogenic, which have contributed to its appearance. It will also contain a short plan for further investigation and treatment'. Baird et al, (2017) Clinical formulation: where it came from, what it is and why it matters, BJPsych Advances, 23, pp. 95-103.

Conclusions

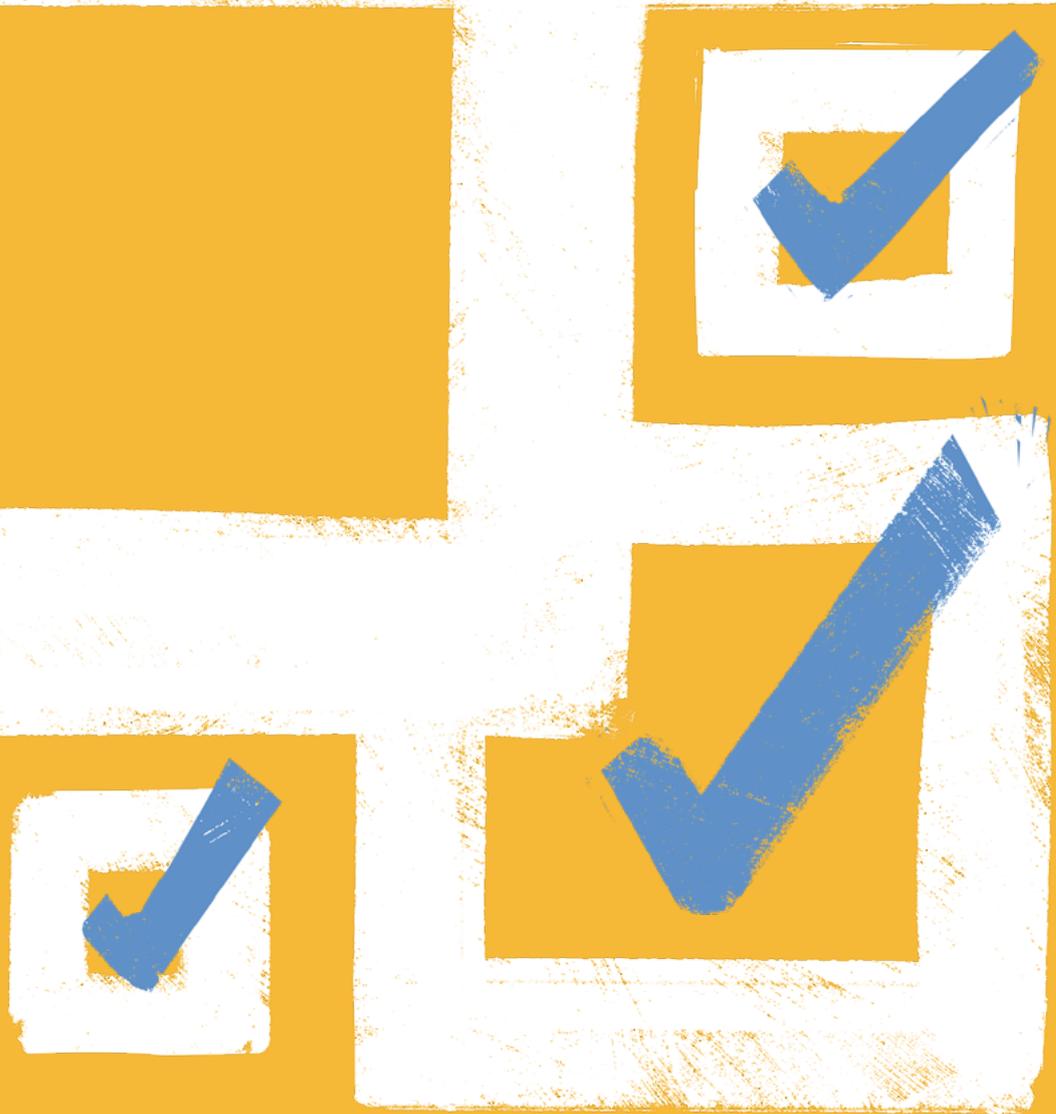
The findings outlined in this report suggest that women veterans have unique mental health needs that require mental healthcare services to consider their gendered experiences in the military and veteran world.

Many women veterans that we spoke to reported experiences of gender-related discrimination and violence during military service that had an enduring impact on their civilian life and mental health. Whilst women's gendered experiences in service may be viewed by some as historic issues (i.e., based on historic sexism or discriminatory bans on pregnancy and homosexuality), the impact of these experiences is current and enduring. Many women left service suddenly due to historic bans or via a medical discharge, leaving them no time to prepare for their transition. Women often felt as though they didn't fit with either the veteran or civilian communities, and experienced loneliness and isolation. Financial difficulties were common, exacerbated by the complexities of the UK benefits system and the Armed Forces Compensation Scheme.

Women veterans and mental healthcare professionals highlighted several gendered barriers that women veterans experience in accessing mental health services. Many women reported not identifying with the term 'Veteran' and so not feeling as though veteran mental health services were 'for them'. For those that considered accessing veteran-specific services, there was a perception that these services had been designed for men, and concerns were raised around the understanding of women's experiences during service and specific care needs. This extended to service branding, which was dominated by male veterans and combat-related language, again leading women to question whether these services could meet their needs.

Importantly, women veterans were clear about what they wanted from mental health services. To encourage women to approach services in the first place, improving the visibility of women in service branding and materials was seen as critical. Clinician understanding of both the military lifestyle and women's unique military experiences was very important, as was service user choice in clinician military background and gender, and the option for women-only treatment groups. Additionally, women veterans wanted the opportunity to access peer support from other women veterans, who could understand and relate to their experiences. Providing trauma-informed care was key for our participants, who spoke of the importance of feeling listened to, developing trust in the therapeutic relationship, and validating their often-traumatic experiences where they had previously been dismissed. Guidance for providing trauma-informed mental healthcare to women veterans can be accessed here: www.centreformilitarywomensresearch.com/womenveterans/guidance

To improve the engagement of women veterans in mental healthcare services in the UK, an ongoing commitment is needed to design, develop, and improve services in consultation with women veterans. We make a number of recommendations in the next section to support these endeavours.



Recommendations

The recommendations outlined in this report have been developed following a comprehensive analysis of the in-depth qualitative data collected and have been refined through workshops and engagement with women veterans and mental healthcare providers. Some of the recommendations could be applied to the general improvement of services for women, irrespective of their veteran status. However, some of these recommendations are veteran-specific and relate to the unique experiences and needs of women who have served in the military.

This project explored the experience of female veterans living in England only, due to the differences in the statutory veteran mental health services available in each devolved nation. As such, these recommendations are focused on services delivered in England. However, many will be applicable and useful to services based in the other devolved nations of the UK.



RECOMMENDATIONS FOR:

All veteran-specific mental health support providers in England, including NHS-England OP Courage services, and charitable and third-sector veteran organisations.

- 1 Encouraging professionals to utilise existing training and resources focused on providing trauma-informed care, including the guidance developed within this project, which embeds principles of trauma-informed care within the context of women veterans' needs.**

- 2 Veteran-specific mental health services should be responsive to the gendered nature of care needs and the care preferences of women veterans. This should include, but is not limited to:**
 - Providing mandatory training to staff that includes content on women's differing experiences during military service (e.g., gender discrimination, bullying and violence, gendered mental health stigma, military parenthood), how this may impact their mental health, and gendered barriers to accessing mental healthcare.
 - Providing women with the option to request the gender and military background of the mental healthcare professional supporting them. The availability of this option should be highlighted on the services' webpage and in all service materials.
 - Ensuring services offered are as flexible and accessible as possible, taking into consideration the additional caring responsibilities women often hold. This should include being understanding and responsive to "did not attend (DNA)" occurrences and late cancellations that may be because of caring responsibilities.
 - Integrating patient and public involvement (PPI) into service design and improvement as standard, with an over-representation of women veterans to ensure their needs are adequately voiced and considered.
 - Supporting the continued professional development of staff to undertake additional training to support best practice when working with women veterans.

- 3 Veteran-specific services should adapt their branding to:**
 - Ensure the visibility of women veterans in imagery.
 - Consider the appropriateness of military terminology and language related to combat used in service branding and information, so that it is clear that services are not just for combat-related trauma.
 - Consult with women veterans in any rebranding process.

4 Veteran-specific mental health support services should embed women veteran ambassadors within their services to promote visibility and engagement.

These ambassadors should be empowered and appropriately trained to:

- Share their stories of accessing mental health support on organisational websites and relevant materials as case studies, to provide more information to other women veterans who are potential service users.
- Act as a point of contact for women who wish to discuss concerns related to accessing the services.
- Represent women veterans' needs within organisations by attending meetings with service providers and commissioners of services.
- Be involved in the hiring of care staff within services.

5 Veteran-specific services should work together to develop a women veterans' peer support network, which is independent of the statutory sector. This should be co-designed with women veterans to meet their needs and should provide:

- Check-ins during the early transition delivered by veterans to periodically ask if they are experiencing any challenges and direct them to relevant support if needed.
- Mentoring from other veterans during transition.



RECOMMENDATIONS FOR:

NHS mental health services

- 6** The development of NHS-wide standards for the mental healthcare of women veterans that reflect research findings on how to best support their care needs.
- 7** Improvement needs to be made to the understanding and training amongst all NHS staff with regards to women veterans' mental healthcare needs. Including:
 - Developing training resources, which could include an e-learning module, focused on women's experiences in service and how this can impact their mental health.
 - Incorporating veteran awareness training into undergraduate pre-reg curriculum for all health and social care courses, with an element dedicated to women in the military.
- 8** Improvements need to be made to awareness of NHS veteran-specific services and the support they can provide for women. Ensuring that:
 - Advertising/marketing of services targets women veterans via social media, community organisations, and social groups that serving women and veterans are likely to attend (e.g., defence women's network, women's institutes, veteran breakfast clubs, local gyms, and parenting groups).
 - Websites and promotional material are clear that women are eligible to access support, and that support is offered for both non-combat and combat military-related challenges. This recommendation should be implemented alongside Recommendation 2.
- 9** Existing Armed Forces champions within NHS services should undertake professional development to understand the need of women veterans.
- 10** Services should ensure they are accurately recording women veterans, to enable tracking of this group's engagement with treatment. This should include:
 - Recording the numbers of women veterans accessing treatment within their services directly.
 - Recording forward referrals for women veterans, especially referrals into relevant veteran-specific physical and mental health pathways.



RECOMMENDATIONS FOR:

Ministry of Defence

- 11 Enhance education and training for service personnel to recognise and manage women's mental health challenges, including:**
- Training for the Chain of Command on women's different and unique experience of service, and their potentially differentiated mental health needs.
 - Training for Defence Medical Services staff to highlight the potential differences between servicewomen and servicemen's experiences of military service and the impact on their mental health.
 - Ensuring existing education for Service Personnel related to promoting well-being highlights gender differences where relevant.
 - Resources that challenge specific narratives associated with mental health help-seeking in the military, such as weakness and "service before self" narratives.
- 12 Improve signposting to appropriate mental health support services during transition for women service leavers, including:**
- Developing a resource specifically targeted towards signposting women veterans to appropriate mental health support services, designed with input from servicewomen and women veterans.
 - Providing information on the benefits of sharing veteran status with professionals when accessing mental health support.



RECOMMENDATIONS FOR:

Office for Veterans' Affairs (OVA)

- 13 Ensure current efforts to improve societies' recognition of veterans involve a specific focus on misconceptions around women in the military community and highlight women as part of the veteran community. This could include a national campaign specifically aimed at targeting stereotypes of veterans as older male combat veterans.**
- 14 Review how information is distributed and targeted to veterans to ensure current strategies are adequately reaching women veterans.**
- 15 We are aware of several ongoing research projects examining the needs of women veterans. The OVA must ensure that the findings of this and other UK research studies focused on the needs of women veterans are embedded in the development and execution of the proposed Veteran Women's Strategy.**



RECOMMENDATIONS FOR:

The research community

- 16** The current study should be replicated with full-time reservist women veterans, who may fall through the gaps of eligibility for current veteran mental healthcare provision.
- 17** Based on our research findings, we recommend that mixed methods research should be conducted, focused on the following issues:
 - The experience and impact of gender-based discrimination and bullying, sexual harassment, sexual assault, and rape during military service, on women veterans' mental health and support needs.
 - Female-specific health issues and care needs during and after military service (i.e., menopause, pregnancy, menstruation), and the impact of these on women's mental health and well-being.
 - The impact of motherhood on women's mental health and well-being during and after military service, including a focus on women who leave service for reasons related to motherhood.
- 18** Importantly, as veteran mental health services respond to the recommendations of this and other research with women veterans, independent service evaluations should be conducted to monitor the impact of implementing gender-sensitive care for women veterans on engagement and satisfaction with services and mental health outcomes.

Appendices

Appendix 1: Project Methodology

Project overview

An 18-month project was conducted, in collaboration with the East of England NHS Veteran's Transition, Intervention, and Liaison Service (TILS), and Salute Her, a charity that provides gender-specific mental health services for women veterans in the UK. We used an experience-based co-design approach, grounded in a qualitative exploration of the mental health support needs and experiences of women veterans in England, to co-design guidance and recommendations for meeting the needs of women in veteran mental health services.

Project aims

Considering emerging international and UK evidence of the gender-specific barriers to mental healthcare experienced by women veterans, this project aimed to:

- Identify the mental health support needs and experiences of women veterans in England.
- Co-design, produce, and carry out a preliminary evaluation of guidance for mental healthcare professionals (MHCPs) and recommendations for commissioners to enhance UK veteran-specific mental health services for women.

Why was a qualitative approach taken?

We used a qualitative research approach to achieve our first aim. Qualitative research explores and provides deeper insights into real-world problems¹⁷ by gathering participants' experiences, perceptions, and behaviours. It answers the 'how' and the 'why' instead of 'how many' or 'how much'.¹⁷ Thus it was appropriate to employ a qualitative approach as this project set out to understand in-depth women veterans' mental health needs, and the complexities of the barriers and facilitators to women veterans' access and positive experiences of mental health support. Our qualitative approach allowed us to explore women's nuanced discussion of their experiences, including their emotional experiences of accessing support, their perception of services, and their complex and varied veteran identities.

How did we collect and analyse our qualitative data?

Semi-structured interviews and focus groups were held with 48 women veterans and 12 mental healthcare professionals, depending on the participant's preference. All interviews and focus groups were held on Microsoft Teams, with the exception of one interview conducted in person.

Participant sample: The veteran sample was open to all those who identified as a woman, had served in the UK Armed Forces, had experienced a mental health challenge in the last 5 years, and were currently living in England. Women did not have to have a formal diagnosis, nor have sought treatment. The MHCP sample was open to all professionals who work with veterans in mental health services in England in their current role, or a previous role within in the last 5 years.

Data collection and analysis: All sessions were audio recorded and transcribed. Transcripts were reflexively thematically analysed following the framework outlined by Braun and Clarke¹⁸, using NVivo 12. Via a rigorous process, substantial themes are developed from the interview data. Thematic analysis is an established method for data analysis in the fields of social science, including in health research. It is often used to explore social phenomena, such as experiences, views, perceptions, representation, and social processes. Therefore, it suited this project's aim to understand women veterans' needs, experiences, and the factors that influenced their choices to access (or not) and experience of mental health support.

17 Moser A, Korstjens I. Series: Practical guidance to qualitative research. Part 1: Introduction. *Eur J Gen Pract.* 2017 Dec;23(1):271-273.

18 Braun, V., & Clarke, V. (2022). *Thematic analysis: A practical guide.* Sage

What is co-design and why is it important?

Co-design is a method that is used in research and service design in which decision-making is shared equally throughout the process¹⁹. This method involves people coming together with the relevant experience to create something – this can be anything from research tools to new services or policies. Individuals with lived experience are brought in to work in partnership with the project team to facilitate understanding of what this group needs and wants. Draft or design of the tool/service/policy etc. is then carried out between the project team and co-design group. Sign off is required from the co-design group before the work can be considered complete.

There are many reasons why it is important and beneficial to incorporate co-design. Informing our decision to embed co-design throughout this project was a desire to include the different perspectives and experiences of women veterans, design the 'right' project to ensure the aims and questions asked were meaningful, clear and sensitive, and embed women veterans' voices throughout the project outputs, including the guidance for MHCPs and project recommendations.

How did we use co-design in this project?

A co-design group of 14 women veterans was formed for the duration of this project. The co-design group met 3 times formally (twice via Microsoft Teams and once in person), with guidance sought via email throughout as needed. Members of the co-design group were selected to capture a range of service branches, eras, ranks, and service lengths. Members were involved in the design of interview protocols, interpretation of findings, and design of guidance for MHCPs and recommendations for improving services.

To develop the guidance and recommendations for working with women veterans in mental healthcare services, a formal in-person workshop was held. Interactive activities were undertaken in breakout groups, and then discussed as a group to begin to develop a consensus around draft guidance and potential recommendations. Following the formal workshop, this guidance was further developed and refined by the research team, with iterative feedback from the co-design group by email. A further co-design group meeting was dedicated to members feeding back on and refining the guidance.

Reception of guidance

Feedback was broadly positive, with useful suggestions for improvements. Most respondents agreed or strongly agreed that the guidance was easily understood (80%) and provided enough information to support the care of women veterans (88.9%). Additionally, the majority agreed or strongly agreed that the guidance improved their understanding of the potential mental health needs of women veterans (77.8%), and trauma-informed care (88.9%). Open-text answers highlighted that respondents particularly liked the summary sections, links to other resources, the use of quotes from women veterans to give insight into their perspective, and the use of the 6 principles of trauma-informed care. All suggestions for improvement were taken forward, and changes were made to the final version of the guidance published alongside this report.

A note on ethics

Prior to data collection, ethical approval for the project was received from both the Health Research Authority (REC reference: 21/SW/0181) and Anglia Ruskin University (Reference: HEMS/21/22/004). Special attention was paid to the potential needs of participants due to the sensitive subject matter. This included the development of a distress protocol, which detailed the steps that should be taken if a participant became distressed before, during, or after taking part in the project.

Appendix 2: Mental healthcare professional participant characteristics

| | | Frequency* |
|--|---|------------|
| Gender | Female | 8 |
| | Male | 2 |
| Previous service in the armed forces | Yes | 3 |
| | No | 7 |
| Last employed in a role supporting veterans' mental health | Current | 10 |
| | Within last year | 2 |
| Type of service | NHS specialist veteran mental health services | 8 |
| | Veteran/military specialist charity or 3rd sector | 3 |
| | Private treatment | 1 |

*Please note that in some cases totals will not reach 12 due to incomplete responses to the demographic survey

Appendix 3: Women Veteran Participant Characteristics

| | | Frequency* | |
|--|--|--|----|
| Nationality | UK | 44 | |
| Ethnicity | White Irish | 1 | |
| | White British | 43 | |
| Service branch | Army | 25 | |
| | Royal Navy | 7 | |
| | Royal Air Force | 12 | |
| | More than 1 branch | 3 | |
| Rank on discharge (NATO Ranks) | Other ranks (OR-1 to OR-9) | 15 | |
| | Officer ranks (OF-1 to OF-10) | 27 | |
| Accessed support post-service | Yes | In the last 4-5 years | 1 |
| | | In the last 1-3 years | 5 |
| | | Less than 1 year ago | 13 |
| | | Currently receiving support or treatment | 18 |
| | No | 6 | |
| Type of post-service mental health support | NHS mainstream | 21 | |
| | NHS veteran specialist | 11 | |
| | Veteran/ military specialist charity or 3rd Sector | 7 | |
| | Non-veteran/military specialist or 3rd sector | 6 | |
| | Private treatment | 19 | |
| Other | 4 | | |

*Please note that in some cases the total is not 48 due to incomplete responses to the demographic survey. In the case of types of post-service support, some women accessed support from multiple sources & some participants did not complete this survey item.

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