TRANSITION AND WELLBEING RESEARCH PROGRAMME

MENTAL HEALTH AND WELLBEING TRANSITION STUDY

Mental Health Prevalence and Pathways to Care

Summary Report

2018

978-0-6481608-4-7 (PDF)
978-0-6481608-5-4 (Print)

Suggested reference:

Van Hooff M, Forbes D, Lawrence-Wood E, Hodson S, Sadler N, Benassi H, Hansen C, Grace B, Avery J, Searle A, Iannos M, Abraham M, Baur J, Varker T, O'Donnell M, Phelps A, Frederickson J, Sharp M, McFarlane A, 2018, *Mental Health Prevalence and Pathways to Care Summary Report, Mental Health and Wellbeing Transition Study*, the Department of Defence and the Department of Veterans' Affairs, Canberra.

This report is available from:

The Department of Defence
http://www.defence.gov.au/Health/DMH/ResearchSurveillancePlan.asp

The Department of Veterans' Affairs
www.dva.gov.au/prevalence-pathways-summary-report

Published by the Department of Veterans' Affairs, Canberra

Publication no: P03435

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Other key organisations

Australia Post.

Context

In Australia, military service is held in high esteem with a recognition that it places high demands on those who serve, and can include exposure to extreme physical, psychological and mental stressors (Dobson et al., 2012; Forces in Mind Trust, 2013). Approximately 5,000 (9%) serving men and women transition out of the Regular Australian Defence Force (ADF) each year, either discharging completely (if involuntarily discharged, that is on medical or administrative grounds) or transferring into the Active or Inactive Reserves. This represents a significant number of Transitioned ADF members who are currently in the critical early stages of adjusting to civilian life and reintegrating into their community.

The period of transition from military to civilian life is quickly becoming recognised as one of the most significant and stressful transitions in the life course of military members world-wide owing to potential changes in identity, community and residence, social networks and status, family roles, occupation, finances, routines, responsibilities, supports and culture. Changes brought about by the transition process can lead to the development and/or exacerbation of existing service related mental and physical symptoms resulting in psycho-social adjustment issues ranging from employment difficulties and family/relationship conflict, to mental health and substance abuse problems.

Currently, there is very little systematic research about the mental health and wellbeing as well as the associated risk and protective factors and pathways to care in representative cohorts of transitioned military members. Most studies to date have focused on cohorts from specific deployments or those seeking treatment or compensation from the Department of Veterans' Affairs (DVA) or the international equivalent, as these are the populations suggested to be most at risk. While international literature estimates 60–75% of transitioned military members report an easy adjustment to civilian life, it is likely others, particularly those who developed mental health symptoms or disorder prior to discharge, may struggle upon transition. The types of symptoms experienced by those who struggle and the factors that facilitate or inhibit these individuals from accessing care are essential to understand in order to ensure they receive appropriate mental health care in the civilian sector.

In Australia, only one in 10 ADF members who have recently transitioned out of the Defence Force choose to (or are able to) access veteran healthcare services therefore, administrative data alone cannot provide an accurate snapshot of the health of the population in the Australian context. Consequently, a population or cohort based approach is essential to establish accurate prevalence estimates of mental disorder in Transitioned ADF members. It is only through this understanding that targeted policy and programs can be developed that will meet the needs of individuals in this stage of the military career cycle.

This study builds on the findings of the 2010 Mental Health Prevalence and Wellbeing Study (McFarlane et al., 2011) which previously established the prevalence of mental disorder in the Regular ADF in 2010. It also examines the mental health and wellbeing and patterns of health service seeking and usage among ADF members in the first five years following transition from Regular 'full-time' ADF Service (January 2010-December 2014). The five-year window immediately post transition was chosen as this is a critical period to target for early intervention. Importantly, investigation of the differences in the mental health and wellbeing in current serving Regular ADF members, with Transitioned ADF members who are now in the Active and Inactive/Standby Reserves as well as Transitioned ADF members who have discharged completely into the community, provides critical information on the risk and protective factors throughout each stage of transition. Protective factors such as healthy worker or 'healthy warrior' effect have been seen for full-time regular serving ADF members but can lose strength as members transition out of the ADF.

Furthermore, a comparison of the self-reported psychological distress and alcohol consumption of the Transitioned ADF in 2015 with the contemporaneous data collected by the Australian Bureau of Statistics (ABS) in 2014–2015 as part of the National Health Survey was performed. This comparison situates the Transitioned ADF in the context of the civilian population using the most contemporary (and temporally equivalent) Australian data available. Mental health issues and disorder are not confined within the ADF. Nor are stigmas and barriers to care such as access, cost locality and stigmas. An understanding of how Transitioned ADF compare to the Australian community in this context provides a more thorough understanding of the role that military service plays in the amelioration or exacerbation of mental health symptoms as well as the factors that assist or limit access to care within these two populations.

The Transition and Wellbeing Research Programme is the most comprehensive study undertaken in Australia of the impact of military service on the mental, physical and social health of Transitioned and 2015 Regular Australian Defence Force (ADF) members and their families (the study populations). Utilising a robust two-phase design, the internationally acclaimed gold standard structured interview for assessing ICD-10 and DSM-IV mental disorder (Composite International Diagnostic Interview [CIDI]) (Kessler and Ustun, 2004)), and a two-stage statistical weighting methodology to correct for differential non-response and systematic response biases, this study provides the most thorough assessment of the mental health and wellbeing and patterns of help seeking in the Transitioned ADF compared to the current serving Regular ADF conducted to date.

This Report summarises the Mental Health and Wellbeing Transition Study methodology, describes the study populations and presents the key findings from the first two reports of the Transition and Wellbeing Research Programme: *Mental Health Prevalence* and *Pathways to Care*.

Key findings

The Transition and Wellbeing Research Programme addresses key research priorities of both the DVA and the Department of Defence (Defence) over three studies: The Mental Health and Wellbeing Transition Study, the Impact of Combat Study and the Family Wellbeing Study. The findings from the first two reports form a fundamental component of the work under way by both DVA and Defence to enhance transition processes including enhancing mental health support services and suicide prevention initiatives (Commonwealth of Australia, 2017).

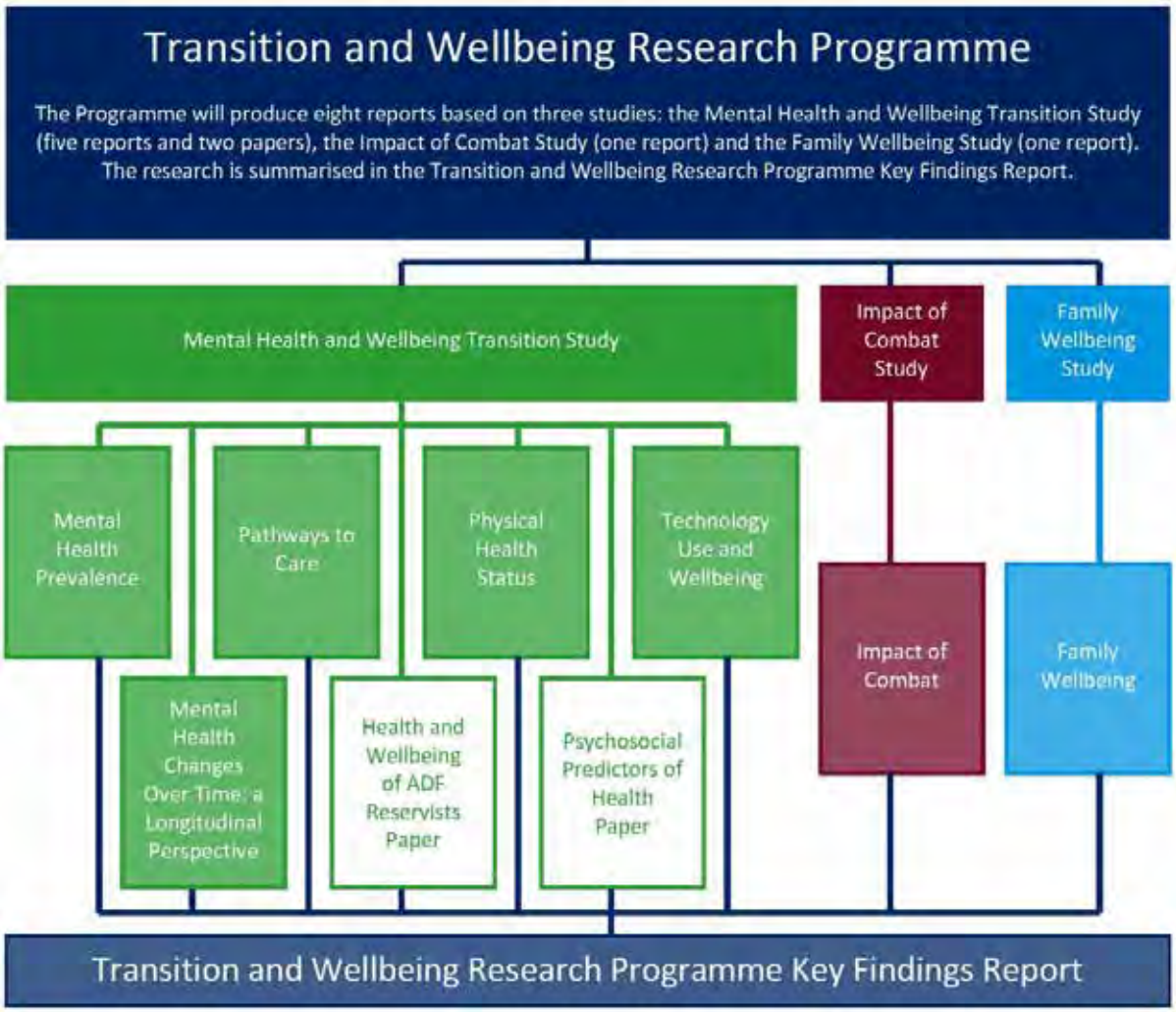
Results show ADF members transitioning from full-time military service represent a group at particular risk for mental disorder who would benefit from proactive strategies that aim to lessen the burden of mental illness and assist the transition process. An estimated 46% of ADF members who had transitioned from full-time service within the past five years, met 12-month diagnostic criteria for a mental disorder using a structured diagnostic interview. This level of 12-month disorder combined with the significantly greater severity of current self-reported symptoms of psychological distress, depression anxiety, anger, suicidality and alcohol use, particularly at subthreshold levels, in the Transitioned ADF compared to the 2015 Regular ADF places this population at significant risk of impairment and disability highlighting the challenges of transitioning out of full-time military service. Despite these levels of disorder, the levels of engagement in employment and socially connected roles among the Transitioned ADF is encouraging. For example, when the spectrum of roles, including studying, were taken into account, approximately 84% of the Transitioned ADF were either working or engaged in some purposeful activity, suggesting a degree of social engagement.

In regard to seeking care, the majority of the 2015 Regular ADF and Transitioned ADF populations with a mental health concern will take the initial steps in seeking care within the first 12 months, with a considerable number doing so within the first three months. This care is commonly provided not only by psychologists and General Practitioners (GPs) and Medical Officers (MOs), but also by psychiatrists and a range of other allied mental health providers. The majority of those with mental health concerns have engaged in care for these concerns, despite high rates of endorsement of stigma related beliefs.

While the rates of initial engagement and uptake of services are reasonably high, due to an accumulation of factors that occur at each phase of the help-seeking process, the findings suggest an under-engagement with evidence-based treatment for those with a current disorder. This is more evident in the Transitioned ADF than in the 2015 Regular ADF. Similarly, satisfaction with services is higher in the 2015 Regular ADF. Whilst effective treatment can and often should be episodic, these findings indicate that strategies need to be considered for improving engagement rates, retention and delivery of best practice care at each contact point.

The findings of the *Mental Health Prevalence Report* and the *Pathways to Care Report* and the subsequent reports will provide the foundation for evidence-based policy and programs to support those that have served our nation to successfully transition from full-time military service.

Background



The Transition and Wellbeing Research Programme (Programme) is the most comprehensive study undertaken in Australia that examines the impact of military service on the mental, physical and social health of:

- serving and ex-serving Australian Defence Force (ADF) members including those who have been deployed in contemporary conflicts, and
- their families.

This research further extends and builds on the findings of the world-leading research conducted with current serving members of the ADF in the 2010 Military Health Outcomes Program (MilHOP).

This research, conducted in 2015, arises from the collaborative partnership between the Department of Veterans' Affairs (DVA) and Department of Defence. It aims to implement the Government's goal of ensuring that current and future policy, programs and services are responsive to the current and emerging health and wellbeing needs of serving and ex-serving ADF members and their families before, during and after transition from military life.

Ten objectives were developed to guide the Programme. The objectives are being realised through three studies comprising eight reports: the Mental Health and Wellbeing Transition Study (five reports and two papers), the Impact of Combat Study (one report), the Family Wellbeing Study (one report) and the Transition and Wellbeing Research Programme Key Findings Report, which summarises the research, as the diagram above shows.

The table below shows which reports deliver on the objectives. This publication, the *Mental Health Prevalence and Pathways to Care Summary Report*, addresses the first three objectives of the Programme, which are to:

1. Determine the prevalence of mental disorders amongst ADF members who have transitioned from Regular ADF service between 2010 and 2014.
2. Examine the self-reported mental health status of Transitioned ADF and the 2015 Regular ADF.
3. Assess pathways to care for Transitioned ADF and the 2015 Regular ADF, including those with a probable 30-day mental disorder.

Two eminent Australian research institutions, one specialising in trauma and the other in families, are leading the research programme. The Centre for Traumatic Stress Studies at the University of Adelaide is conducting the Mental Health and Wellbeing Transition Study and the Impact of Combat Study, and the Australian Institute of Family Studies is conducting the Family and Wellbeing Study.

Their research depth and expertise is enhanced through partner institutions from Monash University, University of New South Wales, Phoenix Australia – Centre for Posttraumatic Mental Health and InnoWell Pty Ltd, formerly the Young and Well Cooperative Research Centre.

Table 1 Programme reports and objectives

Programme objectives	Corresponding reports and papers
1. Determine the prevalence of mental disorders among ADF members who have transitioned from Regular ADF service between 2010 and 2014. 2. Examine self-reported mental health status of Transitioned ADF and the 2015 Regular ADF.	*Mental Health Prevalence Report*
3. Assess pathways to care for Transitioned ADF and the 2015 Regular ADF, including those with a probable 30-day mental disorder.	*Pathways to Care Report*
4. Examine the physical health status of Transitioned ADF and the 2015 Regular ADF.	*Physical Health Status Report*
5. Investigate technology and its utility for health and mental health programmes including implications for future health service delivery.	*Technology Use and Wellbeing Report*
6. Conduct predictive modelling of the trajectory of mental health symptoms/disorder of Transitioned ADF and the 2015 Regular ADF, removing the need to rely on estimated rates.	*Mental Health Changes Over Time: A Longitudinal Perspective Report*
7. Investigate the mental health and wellbeing of currently serving 2015 Ab initio Reservists.	*The Health and Wellbeing of ADF Reservists paper*
8. Examine the factors that contribute to the wellbeing of Transitioned ADF and the 2015 Regular ADF.	*Psychosocial Predictors of Health paper*
9. Follow up on the mental, physical and neurocognitive health and wellbeing of participants who deployed to the Middle East Area of Operations between 2010 and 2012.	*Impact of Combat Report*
10. Investigate the impact of ADF service on the health and wellbeing of the families of Transitioned ADF and the 2015 Regular ADF.	*Family Wellbeing Report*
All objectives	*Transition and Wellbeing Research Programme Key Findings Report*

Through surveys and interviews, the researchers engaged with a range of ex-serving and current serving ADF members including:

- ADF members who transitioned from the Regular ADF between 2010 and 2014 (including Ex-Serving, Active and Inactive Reservists) known as Transitioned ADF
- a random sample of Regular ADF members serving in 2015 known as 2015 Regular ADF
- a sample of Ab initio Reservists serving in 2015 (who have never been full-time ADF members)
- 2015 Regular ADF and Transitioned ADF members who participated in MilHOP
- family members nominated by the above.

This report summarises the Mental Health and Wellbeing Transition Study methodology, describes the study populations, and presents the key findings from the first two reports of the Transition and Wellbeing Research Programme. This study is the first Australian study to establish the prevalence of mental disorder and pathways to care in a representative cohort of ADF members who have recently (2010–2014) transitioned out of Regular ADF service. It is also the first Australian study to map potential risk and protective factors associated with mental disorder in this Transitioned ADF population, and compare the self-reported mental health and wellbeing outcomes of this population with a contemporary sample of ADF members still in Regular military service in 2015, and the Australian community.

Methodology

Study design

Mental disorder prevalence estimates in the Transitioned ADF were obtained using a two-phase design. In the first phase, Transitioned ADF and 2015 Regular ADF members were screened for mental health problems, psychological distress, physical health problems, wellbeing factors, pathways to care and occupational exposures using a 60-minute self-report questionnaire which was tailored to their current ADF status. All analyses comparing the Transitioned ADF with the 2015 Regular ADF used the self-report data. The self-report measures of mental health were administered to *all* participants in the study and therefore allow comparisons between the mental health of the Transitioned ADF and a contemporary cohort of Regular ADF members to be made. Examination of self-reported symptoms has gained increasing consideration in mapping the emerging risks of mental disorder at a population level over time.

In the second phase, a sub-sample of Transitioned ADF members surveyed in Phase 1 were interviewed over the telephone using the World Health Organisation's Composite International Diagnostic Interview (WMH-CIDI 3.0), with selection for this interview based on strata derived from rank, sex, Service and scores on measures of posttraumatic stress (PCL) and alco4hol consumption (AUDIT). Priority was given to Transitioned ADF members who were identified as being more likely to have a mental health problem based on their Phase 1 screening questionnaire, as well as groups accounting for the smallest proportion of the actual population (i.e. females). The CIDI was also used in the 2010 Mental Health Prevalence and Wellbeing Study (MHPWS) (McFarlane et al., 2011)

As the demographic and service characteristics of the Transitioned ADF and 2015 Regular ADF are known (i.e. sex, Service branch, rank and medical fitness, a dichotomous variable derived from Medical Employment Classification Status) it was possible to compare members who responded to the survey with members who did not. This allowed weighting of the data to provide estimates of mental disorder that are representative of the Transitioned ADF and self-reported mental health symptoms that are representative of each of the study populations: Transitioned ADF and 2015 Regular ADF.

Study population

In this report, Transitioned ADF refers to the population of ADF members who transitioned from full-time ADF service between 2010 and 2014, including those who transitioned into the Active and Inactive Reserves and those who had discharged completely (Ex-Serving). The 2015 Regular ADF refers to ADF members who were serving full-time in the ADF in 2015.

This Report summarises findings on the Transitioned ADF and the 2015 Regular ADF, and provides self-report comparisons with the Australian Community (2014–2015: Socio-demographically matched data drawn from the 2014–2015 ABS National Health Survey (NHS) data) wherever possible (Australian Bureau of Statistics, 2015).

The limited comparison of the mental health of the Transitioned ADF with an Australian community sample from the ABS, matched on age, sex and employment status, was included in this study, to situate the Transitioned ADF in the context of the civilian population. Two mental health outcomes were available to be compared between these groups: psychological distress and self-reported alcohol consumption.

Response rates

Of the Transitioned ADF population of 24,932, 96% (N = 23,974) were invited to participate in Phase 1 of the study. Those not invited represented those individuals who may have opted out of the study or did not have any usable contact information. Thirty-eight per cent (N = 20,031) of the 2015 Regular ADF population (N = 52,500) were invited to participate in Phase 1 of the study. The sample of 2015 Regular ADF invited to participate included a stratified random sample of 5040 regular ADF members in 2015 as well as those who had participated in the MilHOP between 2010 and 2012, and who were still serving in 2015.

Phase 1 responders

Of those invited, 18% (N = 4326) of the Transitioned ADF population and 42.3% (N = 8480) of the 2015 ADF population completed the Phase 1 survey. Figure 1 shows the overall response rates for each sample.

Phase 1 responders in both the Transitioned and 2015 Regular ADF were predominantly Army (followed by Air Force and Navy), male and higher in rank (see Table 2), with the mean age of responders in both groups being approximately 41 years old. Transitioned females were more likely to respond than Transitioned males, while 2015 Regular ADF females were less likely to respond than their male counterparts. Not unexpectedly, Transitioned ADF were more likely to be unfit on transition from Regular ADF (31.1%) compared to the 2015 Regular ADF population (16.1%).

Figure 1 **Survey response rates for the Transitioned ADF and the 2015 Regular ADF**

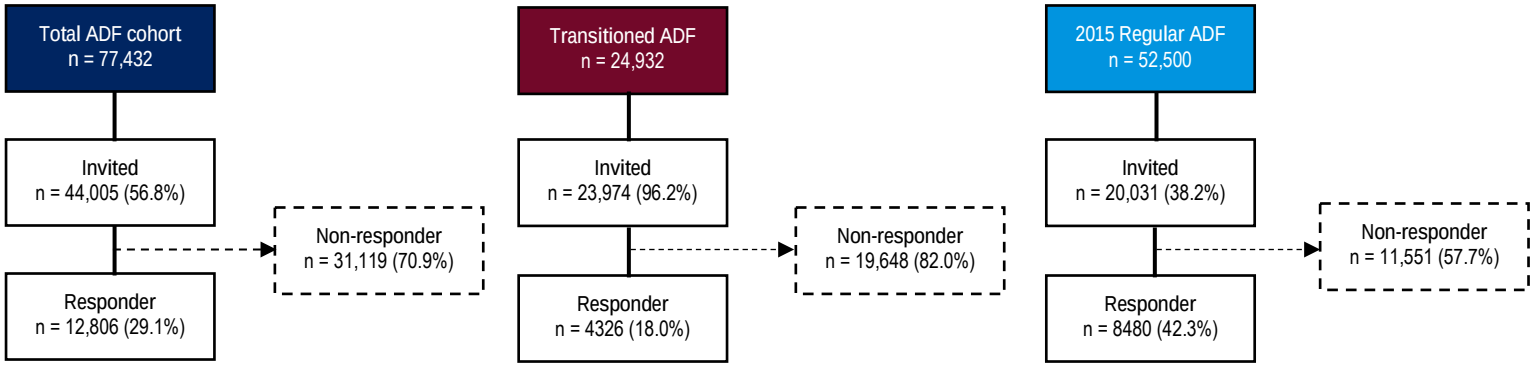


Table 2 Survey response rates by Service for the Transitioned ADF and the 2015 Regular ADF

	Transitioned ADF N = 24,932				2015 Regular ADF N = 52,500			
	Population	Invited	Responders	Response rate (%)	Population	Invited	Responders	Response rate (%)
Service								
Navy	5671	5495	863	15.7	13,282	5113	2040	39.9
Army	15,038	14,465	2463	17.0	25,798	8067	3500	43.4
Air Force	4223	4014	1000	24.9	13,420	6851	2940	42.9
Sex								
Male	21,671	20,713	3646	17.6	47,645	15,176	6693	44.1
Female	3261	3261	380	20.9	4855	4855	1787	36.8
Rank								
OFFR	4063	3939	1259	32.0	13,444	7847	3538	45.1
NCO	7866	7393	2097	28.4	17,491	9117	4336	47.6
Other Ranks	13,003	12,642	970	7.7	21,565	3067	606	19.7
Medical fitness								
Fit	18,273	17,525	2981	17.0	46,022	17,097	7116	41.6
Unfit	6659	6449	1345	20.9	6478	2934	1364	46.5
Total	24,932	23,974	4326	18.0	52,500	20,031	8480	42.3

Notes:
Unweighted data
95%CI: 95% Confidence Interval
Response rates presented in the table above are calculated as the proportion of those invited to participate in the study
OFFR: Officer, NCO: Non-Commissioned Officer

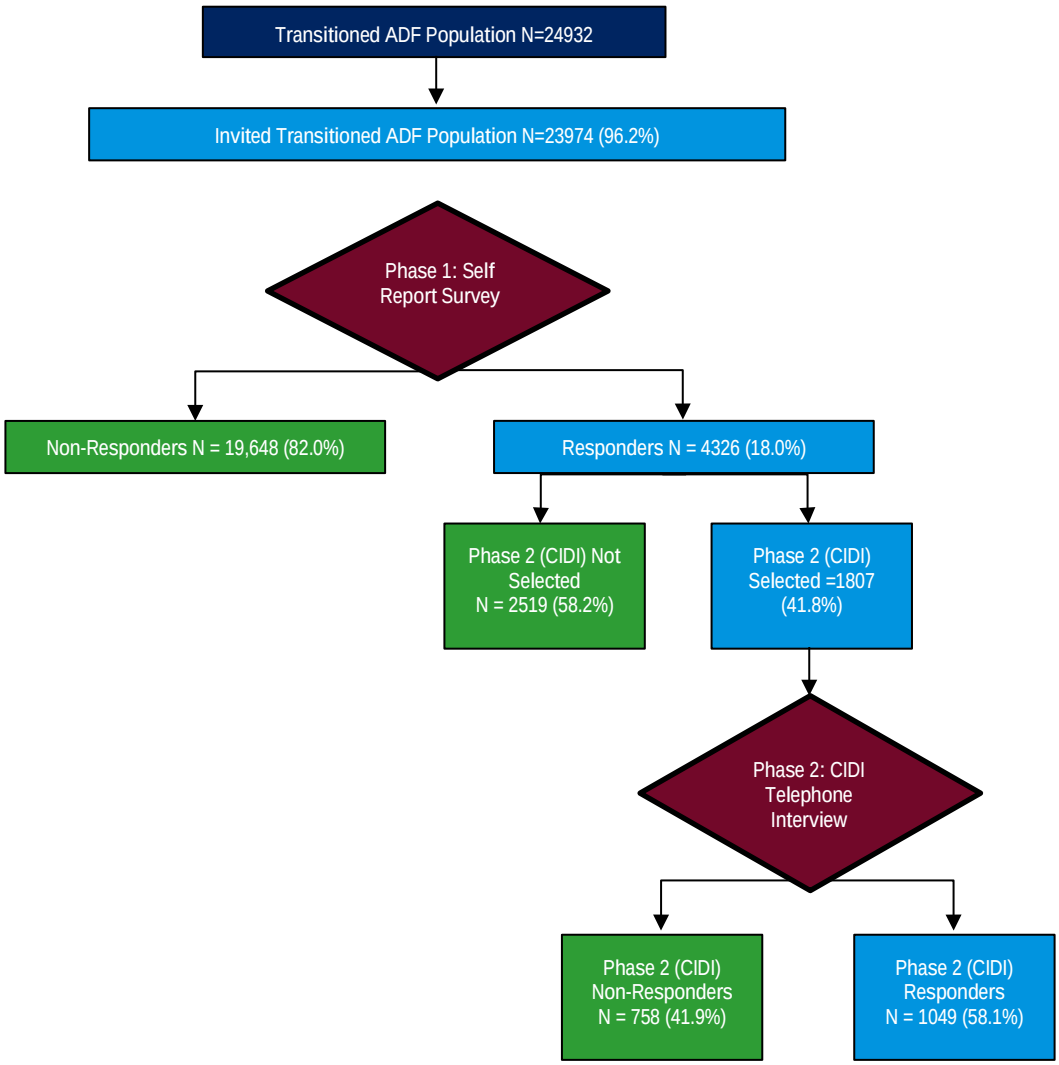
Phase 2 responders

In Phase 2, 1807 Transitioned ADF members were selected for a CIDI diagnostic interview, and 1049 completed the interview.

Ethics

The study protocol was approved by the DVA Human Research Ethics Committee (E014/018) and was recognised under expedited review processes by Defence and the University of Adelaide Human Research Ethics Committee. The study protocol was also submitted to AIHW Ethics Committee, which granted approval (EO 2015/1/163). This study was conducted in accordance with the Australian Code for the Responsible Conduct of Research (https://www.nhmrc.gov.au/guidelines-publications/r39).

Figure 2 **Flowchart of participation in Phase 2 of the Mental Health Prevalence and Transition Study for Transitioned ADF members**



How to interpret and discuss the findings in this report

Prevalence estimates

- Where the report refers to prevalence estimates of mental disorder and symptoms, these are the *estimated* rates of a particular outcome within an entire population (i.e. entire Transitioned ADF, entire 2015 Regular ADF or Transitioned ADF with Probable Disorder, 2015 Regular ADF with Probable Disorder). It is important to understand that these are estimates. These estimates represent the proportion of cases we would predict to observe in the entire population, based on the proportion of actual cases detected in the subpopulation who completed the outcome measure (the CIDI interview for mental disorder estimates, the self-report survey for estimates of mental health symptoms).
- When considering prevalence estimates, the estimated proportions are more informative than the estimated numbers.
- While results in this report were weighted to be representative of the total population, this weighting was performed on the basis of four key variables: **sex, rank, Service (Navy, Army or Air Force)** and **medical fitness**. This assumes a general consistency across individuals with each combination of these characteristics (strata), and does not account for individual differences, or other factors that may influence the outcomes of interest.
- Weighted estimates of mental health outcomes for the Australian community were standardised on the basis of sex, employment status and age. These standardised rates are not the true rates in the Australian Bureau of Statistics (ABS) population, but hypothetical rates that would have been observed if the Australian community population had the same age, sex and employment distribution as the ADF Transition population. This standardised rate takes into account any differences in the age, sex and employment structure of the two populations. Thus, when comparing the two populations using standardised rates, any remaining differences between them cannot be attributed to confounding by these three demographic factors.
- The relatively low response rates observed in the study mean that the weighted estimates presented may have a lower level of accuracy, with estimates more highly dependent on the characteristics used for weighting.
- The estimates for subpopulations (strata) with higher response rates can be considered more accurately representative of those subpopulations than those with lower response rates.
- In the case of diagnosable mental disorder:
  - In this report, all lifetime and 12-month mental disorder prevalence rates were calculated using diagnostic criteria obtained from the World Health Organization International Classification of Diseases (10th revision) (World Health Organisation, 1994) and as such provide a more inclusive measure of mental disorder than the Diagnostic and Statistical Manual of Mental Disorder (DSM 5) (American Psychiatric Association, 2013).
  - Where mental disorder cases were detected among a proportion of study participants who completed the CIDI, the characteristics of this subpopulation were used as a basis for estimating the likelihood of disorder caseness in the broader study population who share those characteristics (through statistical weighting).
  - A two-phase weighting process was used to derive the prevalence estimates of diagnosable mental disorder. Stage 1 weighting accounted for the non-representativeness of the sample invited to

complete a diagnostic interview, while Stage 2 weighting adjusted the weights to be representative of the characteristics of the total population.

- To interpret the precision or imprecision of a given estimate, readers might consider additional information supplied with the estimates, such as confidence intervals.

Confidence intervals: confidence intervals represent the possible range of values within which the presented estimate falls. Where the value of interest is a prevalence estimate, the confidence intervals show the range of error of the estimate. In general, confidence intervals that are very close to the estimate value reflect the precision of the estimate, while confidence intervals that are very wide reflect estimate imprecision. Where there are wide confidence intervals, associated estimates should be interpreted cautiously, with the upper and lower limits considered the top and bottom range of possible precise values.

Significance: Where a between group difference is discussed as significant in the text, this means that the difference between groups was statistically tested, adjusting for sex, age and Service, and the associated confidence intervals had no overlap between groups.

Populations used in this report: The primary populations of interest used in this report were ADF members who transitioned from the Regular ADF between 2010 and 2014 (Transitioned ADF) and the 2015 Regular ADF population. Of note: the ***Pathways to Care Report*** focused on three specific sub-populations of Transitioned and Regular ADF members: (1) those who reported ever having a concern about their mental health (2) those who reported having had assistance for their mental health, (3) those who scored above (probable 30-day mental disorder) and below (no probable 30-day mental disorder) the epidemiological cut-off on the screens for anxiety and depression (K10) and posttraumatic stress (PCL).

Caveats: (1) The overall response rate was low, particularly for the Transitioned ADF, with a rate of 18% (n = 4326). This was largely due to the limited contact information available for this group which may not have been updated for several years; (2) Consistent with previous research (Dobson et al., 2012; McFarlane et al., 2011), responders in this study were more likely to be females, Officers, Non-Commissioned Officers and Air Force members. Individuals classified as medically unfit were also more likely to respond. The current study addressed this response bias by statistically weighting the results based on four key variables – sex, rank, Service (Navy, Army or Air Force) – known to impact response rates and the prevalence of mental disorder more broadly, and medical fitness. The lower the number of responders, the less accurate the resulting weighted population estimates are likely to be. This is highly relevant to rank, with Officers and Non-Commissioned Officers over-represented among responders, while Other Ranks were highly under-represented, despite Other Ranks accounting for the largest proportion of the total population. As such, estimates stratified by rank should be interpreted with caution; (3) A large proportion of this study is based on self-report measures, which are subject to potential biases, including recall bias and other response biases. This response bias must be acknowledged in the interpretation of the findings presented; (4) This study reported ICD-10 rates of mental disorder which is likely to affect prevalence estimates for PTSD because ICD-10 PTSD has a lower threshold for severity of symptoms to achieve a diagnosis (Peters et al., 2006) than the DSM diagnostic system. However, given the literature regarding the morbidity associated with sub-syndromal DSM PTSD, the population defined in this study is clinically relevant (McFarlane, 2010); (5) All data used to examine help-seeking and pathways to care (for example categories of providers accessed, the types of services they received from these providers and the sources of funding for each) are based on participant self-report. Although descriptors were included in the survey to help participants discriminate between types of mental health services provided, in reality this can be quite difficult for veterans and the lay community to identify; (6) Finally, this study only investigates the initial stages of transition (the first five years), and only includes ADF members who transitioned from ADF service between 2010 and 2014. Further study of this cohort should be an important priority to map the ongoing course of mental disorder following ADF service. This is particularly important in light of evidence about the emergence of disorders among veterans many years after active service in conflicts such as Vietnam (Johnston et al., 2016).

Socio-demographic characteristics

In order to fully understand how Transitioned ADF members are functioning in their civilian lives it is important to consider their current socio-demographic profile, as well as the circumstances surrounding their transition. There are known risk factors for social disadvantage in the literature that can contribute to mental health issues (Australian Bureau of Statistics, 2010) including unemployment, incarceration, housing instability including homelessness, and being in receipt of disability payments. Understanding the extent to which Transitioned ADF members are exposed to these factors can provide valuable insight into the overall mental, physical and social health of this population.

Overall, approximately 84% of the Transitioned ADF were either working or engaged in some purposeful activity (62.8% employed) with the most commonly reported areas of employment being government administration and Defence (16.8%), mining (9.9%), construction (8.8%) and transport and storage (8.6%). Just over 5.5% of the Transitioned ADF had retired.

Similar to the 2015 Regular ADF, the majority of the Transitioned ADF were aged 28–47 years (56.2%), were male (86.9%), were in a significant relationship (74.7%), were of lower rank (52.2%) and were Army (60.3%). Just over one third of Transitioned ADF had served 4–7.9 years in the Regular ADF (36.2%), followed by 23.2% who had served for 20+ years. Compared to the 2015 Regular ADF, Transitioned ADF were *more likely* to be: aged over 58 years, female, lower in rank, from the Army, classified as medically unfit, and to have under eight years of service with the ADF. In contrast, Transitioned ADF were *less likely* than 2015 Regular ADF to be in a relationship where they are not living with their partner.

Just under half (43.3%) of the Transitioned ADF were Ex-Serving (discharged) at the time of survey completion and therefore no longer remained engaged with Defence in a Reservist role. A quarter of the Transitioned ADF had remained in an Active Reservist role (25.7%) and therefore continued to be engaged in service for a specified number of days per year; 30.1% were Inactive Reservists and therefore their contact with Defence would be variable and for some there would be no ongoing contact.

The most common type of discharge/resignation reported was 'own request' (53.7%) with over 60% of these voluntarily discharging or discharging due to the end of a fixed period of service. Just over 20% of the Transitioned ADF were estimated to have been medically discharged, with their employment terminated by the ADF on the grounds of being permanently or at least in the long-term not fit to serve, or not fit for deployment to operational (warlike) service. The most common reasons for transition were 'impact of service life on family' (10.2%), 'better employment prospects in civilian life' (7.2%), 'mental health problems' (6.5%) and 'physical health problems' (4.3%).

In relation to the Transitioned ADF, potentially at greatest risk were a small subset (5.2%) who reported being unemployed at the time of the survey. In addition, just under half of Transitioned ADF members reported being unemployed for a period of three months or more after transitioning from Regular ADF service. There were also a very small proportion who reported having been arrested, convicted or incarcerated since transition (an estimated 5.1%), and approximately 3.4% who reported that they had not been living in stable housing in the two months prior to completing the survey.

One final group of particular interest, and who may be at significant risk due to the fact they have a known/diagnosed physical or mental health conditions, were the 8.9% who were on some form of disability support pension, as well as those discharged from the ADF on a medical discharge but who have not yet engaged with DVA. While over 43% of the Transitioned ADF reported currently accessing DVA funded treatment, there is likely a proportion of those who had medically discharged who were not.

Mental Health Prevalence Report findings

Key findings

Definitions of key terms used in this report

Transitioned ADF members -Population of ADF members who transitioned from full-time ADF service between 2010 and 2014, including those who transitioned into the Active and Inactive Reserves and those who had discharged completely (Ex-Serving).

2015 Regular ADF – ADF members who were serving full-time in the ADF in 2015

Lifetime prevalence – A prevalence that meets diagnostic criteria for a mental disorder at any point in the respondent's lifetime.

12-month prevalence – Meeting the diagnostic criteria for a lifetime ICD-10 mental disorder and having reported symptoms in the 12 months before the interview.

Refer to the Glossary of terms for definitions of other key terms in this section.

Demographics

- More than half of Transitioned ADF members remained in the ADF as Reservists (55.8%). Of these, 25.7% were Active Reservists.
- Approximately, 84% of the Transitioned ADF were either working or engaged in some purposeful activity with 62.8% being employed. Just over 5.5% of the Transitioned ADF had retired.
- More than 43% of Transitioned ADF members reported accessing DVA-funded treatment through either a DVA White Card (39.4%) or DVA Gold Card (4.2%).
- Just over one-fifth of the Transitioned ADF were estimated to have been medically discharged.
- The most commonly reported reasons for transition were 'impact of service life on family' (10.2%), 'better employment prospects in civilian life' (7.2%), 'mental health problems' (6.5%) and 'physical health problems' (4.3%).
- There were no significant differences in housing stability between the Transitioned ADF and the 2015 Regular ADF, with more than 93% estimated to have been in stable housing in the previous two months.
- Just over 40% of the Transitioned ADF and 36% of the 2015 Regular ADF reported having a diploma or university qualification.
- Twice as many members of the Transitioned ADF were classified as medically unfit compared to the 2015 Regular ADF.

Estimated prevalence of lifetime mental disorder in Transitioned ADF

- Almost three in four Transitioned ADF members are estimated to have met criteria for a mental disorder at some stage in their lifetime that is either, prior to, during or after their military career.
- Anxiety and (46.1%) Alcohol disorders (47.5%) were the most common classes of lifetime disorder.
- One quarter of Transitioned ADF members were estimated to have met criteria for posttraumatic stress disorder (PTSD) in their lifetime (24.9%).

Estimated prevalence of 12-month mental disorder in Transitioned ADF

- Just over half of the Transitioned ADF had not experienced a mental disorder in the previous 12 months.
- 46.4% of Transitioned ADF members are estimated to have experienced a mental disorder in the previous 12 months.

Anxiety disorders

- Anxiety disorders were the most common type of 12-month mental disorder among the Transitioned ADF with over one in three (37.0%) experiencing an anxiety disorder in the last 12 months.
- PTSD (17.7%), panic attacks (17.0%), agoraphobia (11.9%) and social phobia (11.0%) were the most common types of anxiety disorders in the Transitioned ADF.

Affective disorders

- One in five (23.1%) Transitioned ADF are estimated to have experienced an affective disorder in the last 12 months.
- The most common affective disorder type in Transitioned ADF was depressive episodes (11.2%).

Alcohol disorders

- 12.9% of the Transitioned ADF met criteria for an alcohol disorder in the last 12 months.

Occurrence of more than one disorder at the same time (comorbidity) in Transitioned ADF

- Of the Transitioned ADF with a 12-month mental disorder more than half (55.2%) had at least one comorbid or co-existing mental disorder.

Estimated prevalence of suicidality (ideation, planning, attempting) in Transitioned ADF

- Just over 20 per cent of Transitioned ADF experienced suicidal ideation, plans or attempts in the last 12 months.
- 28.9% of Transitioned ADF had felt that their life was not worth living.
- 21.2% had felt so low that they thought about taking their own life.
- 7.9% of Transitioned ADF had made a suicide plan.
- 2.0% of Transitioned ADF reported having attempted suicide.

Transition factors associated with 12-month mental disorder and suicidality in Transitioned ADF

Transition status

- Transitioned ADF, who were Ex-Serving, had significantly greater rates of anxiety disorders, affective disorders, alcohol disorders and suicidality compared to both Inactive and Active Reservists indicating poorer mental health outcomes for those who are most disengaged with Defence.

Years since transition

- The estimated rates of 12-month mental disorder were lowest in Transitioned ADF who had transitioned less than one year ago, increasing at one year or more post-transition. This may inform the timing of possible mental health surveillance activities.

Reason for discharge

- Transitioned ADF who had been medically discharged had significantly higher rates of affective, anxiety and alcohol disorders and suicidality than those who discharged for other reasons.

DVA Status

- Affective, anxiety and alcohol disorders and suicidality were more commonly observed in those Transitioned ADF who were in contact with or receiving services from DVA. This is expected given DVA is the primary conduit to care and assistance for ex-serving members.

Self-reported mental health in Transitioned ADF compared to the 2015 Regular ADF

- Compared to 2015 Regular ADF, the Transitioned ADF reported significantly higher current mental health symptoms across all domains measured.

Psychological distress

- Compared to 2015 Regular ADF, nearly twice as many Transitioned ADF had high to very high psychological distress (33.1% vs 18.7%).

Posttraumatic stress symptoms

- Compared to 2015 Regular ADF, nearly three times as many Transitioned ADF had high to very high posttraumatic stress symptoms (24.3% vs 8.7%).

Alcohol use

- Compared to 2015 Regular ADF, nearly four times as many Transitioned ADF reported alcohol use at levels which suggest the need for further assessment.
- Compared to the 2015 Regular ADF, the Transitioned ADF were significantly more likely to report higher alcohol consumption and problems with drinking.

Depressive symptoms

- Compared to 2015 Regular ADF, nearly three times as many Transitioned ADF had moderately severe to severe depressive symptoms (19.5% vs 7.4%).

Anxiety symptoms

- Compared to 2015 Regular ADF, more than twice as many Transitioned ADF had moderate to severe general anxiety disorder symptoms (22.3% vs 9.6%).

Suicidality

- The Transitioned ADF had significantly higher rates of suicidal ideation, plans and attempts compared to 2015 Regular ADF.

Anger

- Transitioned ADF members experienced significantly greater levels of anger than the 2015 Regular ADF.

Self-reported trauma exposure

- An estimated 85% or more of the entire Transitioned ADF and 2015 Regular ADF have experienced a potentially adverse deployment exposure.
- Exposure to toxins were the most common deployment exposure type with over 50% of Transitioned ADF and 2015 Regular ADF reporting potentially toxic/environmental exposures (smoke, fumes, chemicals, and local food and water).

Self-reported mental health in the Transitioned ADF compared to the Australian Community

Psychological distress

- Levels of psychological distress in the Transitioned ADF were significantly higher than the Australian Community, with almost three times more Transitioned ADF reporting high to very high psychological distress (33.1%) compared to the Australian Community (12.8%).
- Patterns of psychological distress were similar in the Australian community and the Transitioned ADF for males and females and consistent across all age bands.

Alcohol use

- Overall, the Australian Community drank more standard drinks on a single occasion in the last 12 months than the Transitioned ADF.
- Frequency of alcohol consumption in the last 12 months was similar for the Transitioned ADF compared to the Australian Community, but results varied by age and sex.
- A significantly higher proportion of Transitioned ADF females reported drinking daily, weekly and monthly compared to Australian Community females.
- There were no differences between the Transitioned ADF and the Australian Community in the frequency of alcohol consumed in the last 12 months in the 18–27-year age group.

Prevalence of mental disorder in Transitioned ADF

The key objective of the Mental Health and Wellbeing Transition Study, Mental Health Prevalence Report was to document the mental health and wellbeing of 24,932 ADF members who had recently (between 2010–2014) transitioned from Regular military service. Providing this evidence base is a fundamental component of the work under way within both DVA and Defence to enhance transition processes in addition to describing the characteristics of the population.

International research suggests that there are a number of distinct risk and protective factors that may influence the likelihood of mental health problems during and following transition from military service. These include factors specific to transition such as whether someone is still in reserve service or has left the military

completely, the length of time that has passed since transition, whether someone was medically discharged or left for another reason, and whether someone is engaged with services such as DVA. Service specific factors such as Service branch, rank, whether someone has deployed or not, and how long someone has served for are also important. Finally, there is evidence that demographic factors like sex and age may also be relevant. In addition to presenting the lifetime and 12- month prevalence of a range of common mental disorders in Transitioned ADF, the Mental Health Prevalence Report also examined them in relation to each of these factors.

Estimated lifetime prevalence of mental disorder in Transitioned ADF

Consistent with the 2010 MHPWS report, this study examined three classes of common mental disorder anxiety, affective and alcohol disorder. Almost three quarters of the Transitioned ADF were estimated to have met ICD-10 criteria for any lifetime mental disorder, with the most common of these being alcohol disorders (Table 3). Forty-six per cent of the Transitioned ADF were estimated to have met criteria for a lifetime anxiety disorder, and one quarter were estimated to have met criteria for PTSD specifically in their lifetime. Just under 40% were estimated to have met criteria for a lifetime affective disorder.

Table 3 Estimated prevalence of lifetime ICD-10 anxiety, affective, alcohol and any disorders in Transitioned ADF

	Transitioned ADF (n = 24,932)		
Lifetime ICD-10 Disorder	Weighted n	%	95% CI
Anxiety disorder (including PTSD)	11,378	46.1	41.4, 50.9
Anxiety disorder (excluding PTSD)	7976	31.9	27.7,36.6
Anxiety disorder (ABS)	10,421	41.8	37.1,46.6
Affective disorder	9769	39.6	35.0, 44.4
Alcohol disorder	11,714	47.5	42.8, 52.2
PTSD	6134	24.9	20.9, 29.3
Any disorder	18,435	74.7	70.5, 78.5

Note: 95%CI: 95% Confidence Interval

Estimated 12-month prevalence of mental disorder, comorbidity and suicidality in the Transitioned ADF

12-month ICD-10 mental disorder

In the past 12 months, it is estimated that nearly half of the Transitioned ADF met criteria for an ICD-10 mental disorder (Table 4). The most common class of 12-month mental disorder among the Transitioned ADF was anxiety, with more than one in three estimated to have met criteria for an anxiety disorder in the past 12 months. Posttraumatic stress disorder, panic attacks, agoraphobia and social phobia were the most common individual disorders, with 17.7% of the Transitioned ADF estimated to have met criteria for PTSD in the previous 12 months. An estimated 19.3% met criteria for an anxiety disorder other than PTSD. One in five Transitioned ADF members were estimated to have experienced an affective disorder in the past 12 months, with the most common type being depressive episodes. Alcohol disorders were the least prevalent 12-month mental disorders among the Transitioned ADF with an estimated 12.9% meeting ICD-10 criteria for a 12-month diagnosis.

Table 4 Estimated prevalence of 12-month ICD-10 anxiety, affective, alcohol, any disorder in Transitioned ADF

12-month ICD-10 Disorder	Transitioned ADF (n = 24,932)		
	Weighted n	%	95% CI
Any anxiety disorder	9232	37.0	32.6, 41.7
Panic attack	4244	17.0	13.8, 20.8
Panic disorder	1344	5.4	3.6, 8.0
Agoraphobia	2975	11.9	9.1, 15.5
Social phobia	2738	11.0	8.4, 14.3
Specific phobia	1936	7.8	5.8, 10.3
Generalised anxiety disorder	917	3.7	2.2, 6.0
Obsessive compulsive disorder	1029	4.1	2.6, 6.6
Posttraumatic stress disorder	4408	17.7	14.5, 21.3
Any affective disorder	5755	23.1	19.2, 27.5
Depressive episodes	2783	11.2	8.6, 14.3
Dysthymia	1140	4.6	3.1, 6.7
Bipolar affective disorder	2443	9.8	7.0, 13.5
Any alcohol disorder	3219	12.9	9.8, 16.9
Alcohol harmful use	948	3.8	2.3, 6.3
Alcohol dependence	2271	9.1	6.4, 12.8
Any disorder	11,558	46.4	41.7, 51.1

Note: 95%CI: 95% Confidence Interval

12-month ICD-10 mental disorder comorbidity

The issue of mental disorder comorbidity is important as it is a marker of the severity of disorder and associated impairment in functioning and presents a significant challenge in obtaining optimal treatment outcomes (Hruska et al., 2014).

Mental disorder comorbidity among the Transitioned ADF was high. In the Transitioned ADF, just over half of those with a mental disorder had a least one comorbid disorder, with one in four Transitioned ADF meeting criteria for two or more mental disorder classes (Table 5: two classes:15.1%, three classes:8.2%, four classes: 1.9%). Alcohol disorders were the most common comorbid condition, with approximately 95% of those meeting 12-month criteria for an alcohol disorder also having another mental disorder. In relation to PTSD specifically, over 80% meeting 12-month criteria had another comorbid mental disorder.

Table 5 Estimated prevalence n (%) of single and co-morbid affective, anxiety (excluding PTSD), PTSD and alcohol use disorders in the Transitioned ADF in the previous 12-months using ICD-10 criteria

ICD-10 mental disorder group	Total (n = 24,932)		
	Weighted n	%	95% CI
No mental disorder	13,374	54.2	49.5, 58.9
Any alcohol disorder only	501	2.0	1.0, 3.9
Any anxiety disorder only (excl. PTSD)	2084	8.4	6.5, 10.9
PTSD only	873	3.5	2.3, 5.4
Any affective disorder only	1601	6.5	4.4, 9.4
One mental disorder class	5059	20.4	17.1, 24.3
Any anxiety disorder (excl. PTSD) and any alcohol disorder	596	2.4	1.2, 4.8
Any affective disorder and any alcohol disorder	224	0.9	0.3, 2.7
PTSD and any alcohol disorder	317	1.3	0.5, 3.4
Any anxiety disorder (excl. PTSD) and any affective disorder	1412	5.7	3.8, 8.6
Any anxiety disorder (excl. PTSD) and PTSD	814	3.3	2.1, 5.1
Any affective disorder and PTSD	381	1.5	0.7, 3.3
Two mental disorder classes	3744	15.1	12.0, 19.1
Any anxiety disorder (excl. PTSD) and any alcohol disorder and PTSD	356	1.4	0.6, 3.7
Any anxiety disorder (excl. PTSD) and any alcohol disorder and any affective disorder	731	3.0	1.5, 5.7
Any alcohol disorder and PTSD and any affective disorder	26	0.1	0.0, 0.4
Any anxiety disorder (excl. PTSD) and PTSD and any affective disorder	912	3.7	2.3, 5.9
Three mental disorder classes	2025	8.2	5.7, 11.6
Four mental disorder classes	468	1.9	0.9, 4.0

Note: 95%CI: 95% Confidence Interval

12-month suicidality

Suicide and suicidality are issues of major concern in military populations. In this study, 21.7% of the Transitioned ADF reported some form of suicidal ideation, plans or attempts in the last 12 months with more than one quarter reporting they felt their life was not worth living and an estimated 21.2% reporting they had felt so low that they thought about death by suicide (Table 6). Overall, an estimated 7.9% of the Transitioned ADF reported making a suicide plan and 2.0% had attempted suicide.

Table 6 Self-reported suicidal ideation, plans and attempts in the Transitioned ADF

Suicide n (%) represent those answering yes to these items			
	Transitioned ADF 2015 (n = 24,935)		
	Weighted n	%	95% CI
Felt life not worth living	7208	28.9	(27.3, 30.6)
Felt so low thought about committing suicide	5294	21.2	(19.8, 22.8)
Made a suicide plan	1965	7.9	(7.0, 8.9)
Attempted suicide	505	2.0	(1.6, 2.6)
Any suicidality*	5342	21.7	20.2, 23.3

* Calculated as yes to either felt so low thought about committing suicide, made a suicide plan, or attempted suicide
Note: 95%CI: 95% Confidence Interval
Note: This terminology in this table reflects the standardized survey item used in this study, however it should be noted that this is no longer considered an appropriate description, and the term 'committing suicide' should be replaced with 'thought about taking their own life'

Transition factors and 12-month mental disorder and suicidality in Transitioned ADF

It was the transition specific factors including the type of transition, years since transition, reason for discharge that were most associated with mental disorder and suicidality prevalence. DVA status and 12-month mental disorder were also strongly associated.

Transitioned status

Overall, mental health outcomes were poorer for those Transitioned ADF who were most disengaged with Defence. Specifically, those who had fully discharged at the time of completing the study (Ex-Serving) recorded

the highest rates of 12-month mental disorder across the various disorder categories (Table 7), and had significantly higher estimated rates of suicidality. This is also consistent with the finding of the 2017 Australian Institute of Health and Welfare (AIHW) suicide study (Australian Institute of Health and Welfare, 2017). In contrast, those Transitioned ADF who were Inactive and Active Reservists had substantially lower rates of 12-month mental disorder and suicidality, however rates of diagnosable disorder, representing one in three, still remain a concern within this group.

Years Since Transition

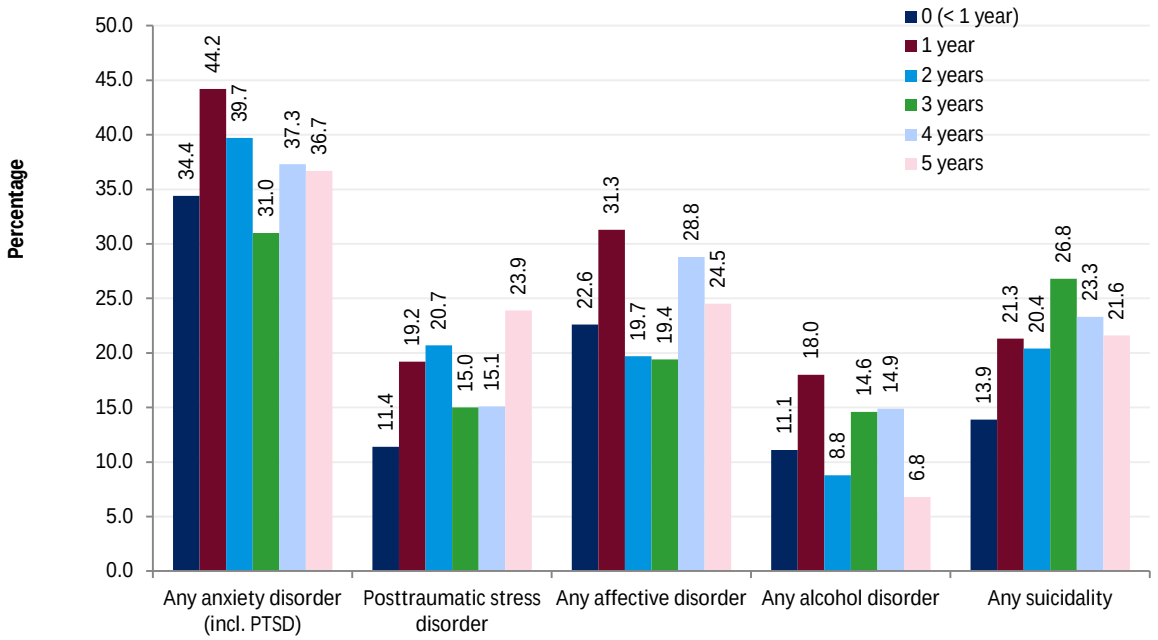
Length of time since transition was also associated with various mental health outcomes. Overall, estimated rates of 12-month mental disorder were lowest in those who had transitioned less than one year ago, increasing at one year or more post-transition. This was not a linear association, and varied according to mental health outcome. This is a particularly important finding as it suggests that the most critical time for mental health surveillance may occur a significant time after transition from Regular ADF service. Furthermore, it may be indicative of the first 12 months following transition being a critical risk period for future disorder emergence.

Table 7 **Estimated prevalence of 12-month ICD-10 disorders and suicidality in Transitioned ADF members, by transition status (Ex-Serving, Inactive Reservists and Active Reservists)**

12-month ICD-10 Disorder and Suicidality	Transition status								
	Ex-serving (n = 11,440)			Inactive Reservists (n = 6447)			Active Reservists (n = 6968)		
	Weighted n	%	95% CI	Weighted n	%	95% CI	Weighted n	%	95% CI
Any anxiety disorder (incl. PTSD)	5102	44.6	37.2, 52.2	1902	29.5	22.5, 37.5	2223	31.9	24.9, 39.9
Posttraumatic stress disorder	2437	21.3	16.0, 27.8	1006	15.6	11.1, 21.5	948	13.6	8.7, 20.6
Any affective disorder	3764	32.9	26.0, 40.5	1096	17.0	11.2, 24.9	871	12.5	7.9, 19.2
Any alcohol disorder	2139	18.7	13.2, 25.9	561	8.7	4.8, 15.4	509	7.3	3.4, 15.0
Any suicidality*	3598	31.5	28.8, 34.2	1010	15.7	13.3, 18.4	866	12.4	10.3, 14.9

* Calculated as yes to either felt so low thought about committing suicide, made a suicide plan, or attempted suicide

Figure 3 **Estimated prevalence of 12-month ICD-10 disorders and suicidality in Transitioned ADF members, by years since transition**



Reason for discharge

Those with a medical discharge had significantly greater estimated rates of affective, anxiety, and alcohol disorder, and greater suicidality than those who transitioned for another reason (Table 8). These findings are not unexpected, as individuals with a medical versus other type of discharge would be expected to have greater rates of mental (and other) disorders.

Table 8 Estimated prevalence of 12-month ICD-10 disorders and suicidality in Transitioned ADF members, by reason for discharge

	Reason for discharge					
	Medical (n = 5082)			Other (n = 19,154)		
12-month ICD-10 Disorder and Suicidality	Weighted n	%	95% CI	Weighted n	%	95% CI
Any anxiety disorder (incl. PTSD)	2608	51.3	41.4, 61.2	5800	30.3	25.4, 35.7
Posttraumatic stress disorder	1171	23.0	16.3, 31.6	2800	14.6	11.1, 19.0
Any affective disorder	2008	39.5	30.2, 49.6	3324	17.4	13.2, 22.3
Any alcohol disorder	1030	20.3	13.0, 30.2	1997	10.4	7.1, 15.0
Any suicidality*	2165	42.6	38.9, 46.4	3065	16.0	14.4, 17.7

* Calculated as yes to either felt so low thought about committing suicide, made a suicide plan, or attempted suicide

DVA Status

Among the Transitioned ADF, those who were a DVA client had significantly greater estimated rates of affective, anxiety, and alcohol disorder, and greater suicidality than those who were not a DVA client (Table 9). Similar to the results for medical discharge these findings are not unexpected. As DVA is the primary conduit to care and assistance for ex-serving members, higher rates of mental disorder among DVA clients suggests that many of those Transitioned ADF who require assistance are already seeking it through DVA.

Of concern, however is the remaining, relatively large proportion (i.e. 40% of those with 12-month PTSD, 51% of those with a 12-month Affective Disorder) of Transitioned ADF who met criteria for a 12-month ICD-10 mental disorder but are not recorded as a DVA client. This highlights that many transitioned members who have a mental disorder in the first five years following discharge from military service are *not DVA clients*, and therefore are *not* receiving support through DVA.

Table 9 Estimated prevalence of 12-month ICD-10 disorders and suicidality in Transitioned ADF members, by DVA status

	DVA Client					
	No (n = 15,605)			Yes (n = 8774)		
12-month ICD-10 Disorder and Suicidality	Weighted n	%	95% CI	Weighted n	%	95% CI
Any anxiety disorder (incl. PTSD)	3480	22.3	16.4, 29.5	3975	45.3	39.4, 51.3
Posttraumatic stress disorder	1326	8.5	5.0, 14.1	1983	22.6	18.0, 28.0
Any affective disorder	2590	16.6	11.1, 24.0	2492	28.4	23.1, 24.4
Any alcohol disorder	1248	8.0	4.5, 13.9	1395	15.9	11.5, 21.6
Any suicidality*	2497	16	13.8, 18.5	2393	27.3	25.1, 29.6

* Calculated as yes to either felt so low thought about committing suicide, made a suicide plan, or attempted suicide

ADF service factors and 12-month mental disorder and suicidality In Transitioned ADF

Service specific factors such as Service branch, rank, deployment, and years of service had mixed associations with mental disorder and suicidality prevalence among the Transitioned ADF. Service branch at time of transition had some association with rates of PTSD, alcohol disorder and suicidality, and rank at time of transition from Regular service had some association with 12-month mental disorder more generally. Transitioned ADF who had ever deployed were more likely to meet criteria for an anxiety disorder than those who had not, and overall, years of Regular ADF service was negatively associated with estimated rates of 12-month ICD-10 mental disorders, though this was not a linear relationship, and varied by disorder category.

Service

The estimated prevalence of 12-month PTSD was greater in the Army and Air Force compared to Navy; Army and Navy had higher estimated alcohol disorder prevalence compared to Air Force; and estimated suicidality was highest amongst Transitioned ADF from the Army (Table 10).

Table 10 Estimated prevalence of 12-month ICD-10 Disorder and suicidality in Transitioned ADF by Service at time of transition from Regular Service

12-month ICD-10 Disorder and Suicidality	Service at Transition								
	Navy (n = 5671)			Army (n = 15,038)			Air Force (n = 4223)		
	Weighted n	%	95% CI	Weighted n	%	95% CI	Weighted n	%	95% CI
Any anxiety disorder (incl. PTSD)	1856	32.7	24.3, 42.5	5755	38.3	32.1, 44.8	1621	38.4	31.3, 46.0
Posttraumatic stress disorder	532	9.4	6.6, 13.1	3022	20.1	15.3, 25.9	854	20.2	15.3, 26.3
Any affective disorder	1309	23.1	15.5, 32.9	3577	23.8	18.5, 30.0	869	20.6	14.4, 28.6
Any alcohol disorder	760	13.4	7.5, 22.8	2173	14.4	10.2, 20.1	286	6.8	3.0, 14.8
Any suicidality*	1207	21.7	18.5, 25.3	3367	22.7	20.7, 24.8	768	18.4	15.8, 21.5

* Calculated as yes to either felt so low thought about committing suicide, made a suicide plan, or attempted suicide

Rank

Estimated rates of 12-month ICD-10 affective disorders, alcohol disorders, and rates of self-reported suicidality were higher among Other Ranks, while anxiety disorders were higher among Non-Commissioned Officers compared to Officers (Table 11).

Table 11 Estimated prevalence of 12-month ICD-10 Disorders and suicidality in Transitioned ADF by rank at time of transition from Regular Service

12-month ICD-10 Disorder and Suicidality	Rank at Transition								
	OFFR (n = 4063)			NCO (n = 7866)			Other Ranks (n = 13,003)		
	Weighted n	%	95% CI	Weighted n	%	95% CI	Weighted n	%	95% CI
Any anxiety disorder (incl. PTSD)	1203	29.6	25.0, 34.6	3181	40.5	36.3, 44.8	4848	37.3	29.5,45.8
Posttraumatic stress disorder	608	15.0	11.6, 19.1	1559	19.8	16.6, 23.5	2242	17.2	12.0,24.2
Any affective disorder	531	13.1	9.9, 17.1	1582	20.1	16.8, 23.9	3642	28.0	21.1, 36.2
Any alcohol disorder	263	6.5	4.3, 9.7	571	7.3	5.3, 9.8	2385	18.3	12.6, 25.9
Any suicidality*	533	13.2	11.7, 14.8	1687	21.8	0.3, 23.4	3122	24.4	21.7, 27.2

*Calculated as yes to either felt so low thought about committing suicide, made a suicide plan, or attempted suicide

Deployment

Transitioned ADF who had been on an operational deployment were more likely to meet criteria for an anxiety disorder (in particular Obsessive-Compulsive Disorder and PTSD) compared to those who had never deployed (Table 12). This is in direct contrast with the findings from the 2010 MHPWS report, and suggests that those ADF members who have been on an operational deployment and who have a mental disorder may be more inclined to transition out of Defence. Notably, an estimated 1 in 4 Transitioned ADF members who have never deployed still meet criteria for a 12-month disorder, despite never having been on an operational deployment.

Table 12 Estimated prevalence of 12-month ICD-10 Disorders and suicidality in Transitioned ADF, by deployment status

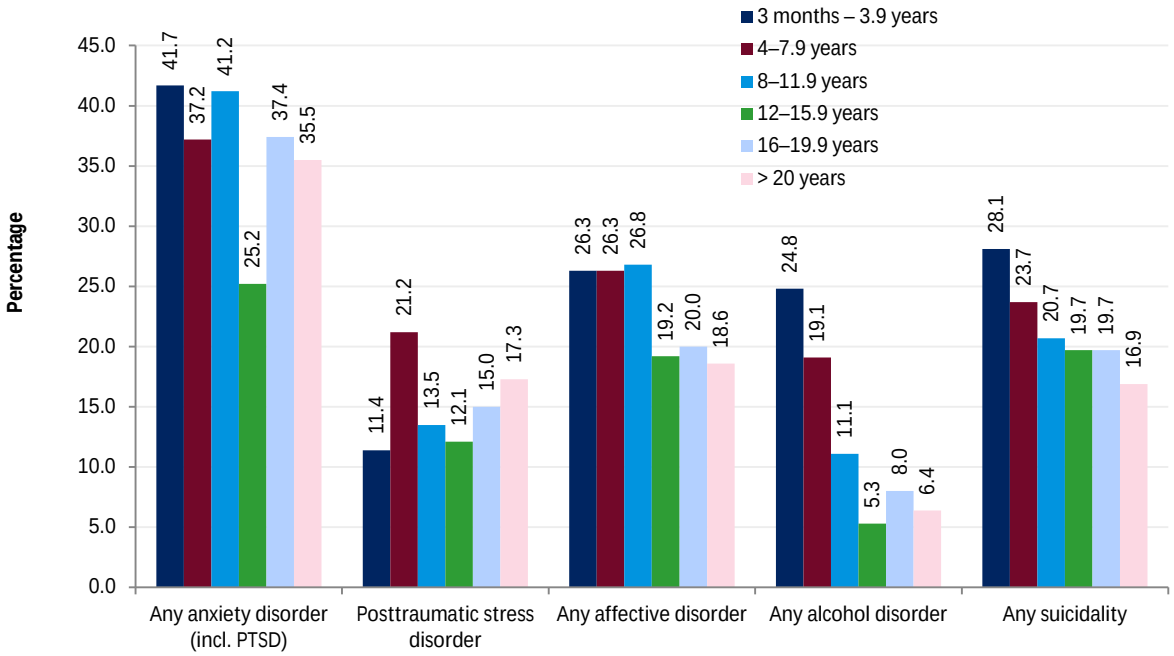
12-month ICD-10 Disorder and Suicidality	Deployment Status					
	Ever Deployed (N = 20,087)			Never Deployed (N = 4885)		
	Weighted n	%	95% CI	Weighted n	%	95% CI
Any anxiety disorder (incl. PTSD)	7370	39.1	34.2, 44.3	1405	25.1	15.7, 37.7
Posttraumatic stress disorder	3782	20.1	16.2, 24.5	196	3.5	1.3, 9.0
Any affective disorder	4436	23.6	19.3, 28.5	1251	22.4	13.2, 35.3
Any alcohol disorder	2560	13.6	10.0, 18.2	602	10.8	4.7, 22.6
Any suicidality*	4301	22.3	20.7, 24.0	1041	18.5	15.4, 22.0

* Calculated as yes to either felt so low thought about committing suicide, made a suicide plan, or attempted suicide

Years of service

In general, rates of affective disorder were highest among those serving between 1 and 12 years in the ADF. Alcohol disorders and suicidality showed a general decrease with increasing years of service. Anxiety disorders overall were highest in those serving 3 months – 3.9 years and 8–11.9 years and lowest in those serving 12–15.9 years. Finally, for PTSD specifically, while estimated 12-month prevalence was reasonably evenly distributed among the different lengths of service (as can be seen in Figure 4) it was highest among those who had served between 4 and 7.9 years (21.2%, 95% CI 14.2, 30.4).

Figure 4 Estimated prevalence of 12-month ICD-10 Disorders and suicidality by years of Regular Service



Demographic factors and 12-month mental disorder and suicidality in Transitioned ADF

Overall, sex and age had little association with estimated rates of 12-month ICD-10 mental disorder among the Transitioned ADF.

Sex

There were no significant sex related differences in affective, anxiety or alcohol disorders, or self-reported suicidality (Table 13).

Table 13 Estimated prevalence of 12-month ICD-10 disorders and suicidality in Transitioned ADF by sex

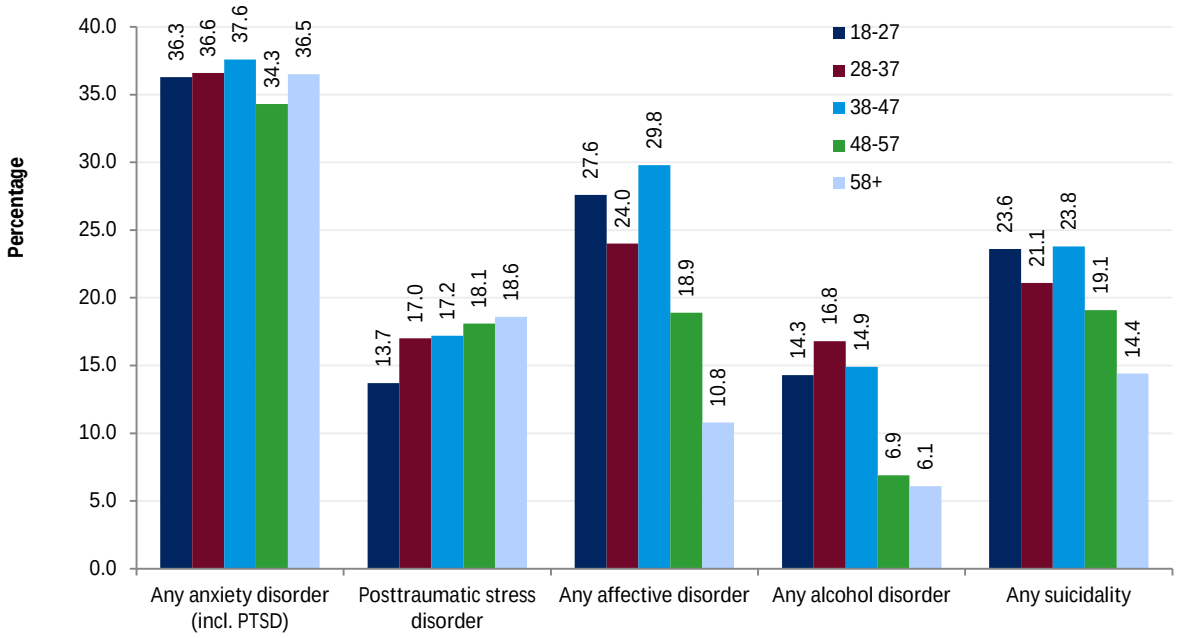
	Sex					
	Male (n = 21,671)			Female (n = 3261)		
12-month ICD-10 Disorder and Suicidality	Weighted N	%	95% CI	Weighted N	%	95% CI
Any anxiety disorder (incl. PTSD)	7865	36.3	31.5, 41.4	1367	41.9	32.3, 52.2
Posttraumatic stress disorder	3598	16.6	13.2, 20.7	810	24.8	18.2, 32.8
Any affective disorder	5005	23.1	18.8, 28.0	750	23.0	14.7, 34.1
Any alcohol disorder	2848	13.1	9.7, 17.5	371	11.4	5.3, 22.7
Any suicidality*	4643	21.7	20.1, 23.4	699	21.7	18.4, 25.4

*Calculated as yes to either felt so low thought about committing suicide, made a suicide plan, or attempted suicide

Age

There were some age-related trends, with 12-month affective disorders and suicidality showing a similar pattern of prevalence across age groups and lowest in Transitioned ADF aged 58+ (Figure 5). Alcohol disorders were most commonly observed among the younger Transitioned ADF, aged 18–47. Anxiety disorder was relatively stable across age groups.

Figure 5 Estimated prevalence of 12-month ICD-10 disorders and suicidality in Transitioned ADF members, by age



Transitioned ADF compared to 2015 Regular ADF

Current self-reported mental health

Currently, little is known about the similarities and differences in the mental health of recently transitioned and current serving Regular ADF members, and how symptoms change and develop in ADF members once they transition. Self-report measures of mental health can provide valuable additional information on the severity and nature of current symptomatology and in this report, mental health symptoms were compared between the Transitioned ADF and the 2015 Regular ADF. A range of symptoms were compared: psychological distress, posttraumatic stress, alcohol use, depression, anger, suicidality, and anxiety, and self-reported lifetime and service related trauma exposures, and these are reported in Table 14.

Psychological distress (measured by K10)

Psychological distress was higher among the Transitioned ADF than in the 2015 Regular ADF with 33.0% scoring in the high to very high band compared to 18.7% of the 2015 Regular ADF. In general, the level of psychological distress was high among the Transitioned ADF and over 40.6% scored equal to or above the screening cut-off of 19. Importantly, a further 17.8% of the Transitioned ADF had a moderate level of symptomatology reflecting subthreshold anxiety or depressive disorders: these are a group at risk of developing a diagnosable disorder in the future.

Posttraumatic stress symptoms (measured by PCL)

Similar to findings for psychological distress, the severity of posttraumatic stress symptoms was significantly greater in the Transitioned ADF compared to the 2015 Regular ADF, highlighting the strength of the relationship between poor mental health and transition. Approximately 38% of the Transitioned ADF had moderate to very high posttraumatic stress symptoms and almost one quarter scored in the high to very high-risk categories. This compared to 20.2% and 8.7% of the Regular ADF respectively. Almost 40% of the Transitioned ADF scored equal to or above the ADF screening cut-off of 29 (McFarlane et al., 2011). Importantly, these individuals represent the group who could be considered to have subthreshold PTSD symptoms and should be a target for early intervention.

Alcohol use (measured by AUDIT)

Overall, self-reported alcohol use and problem drinking were significantly greater in the Transitioned ADF compared to the 2015 Regular ADF. Compared to the 2015 Regular ADF, the Transitioned ADF reported significantly higher AUDIT total scores, more frequent drinking, and drinking more standard drinks on a typical day. They were also more likely to report a problem with drinking and to anticipate problems cutting down or stopping drinking if they tried, a pattern of drinking consistent with psychological dependence. Just over 11% of the Transitioned ADF scored in Band 3 or above in the Transitioned ADF, indicating a need for referral and/or brief counselling, compared to 3.3% of the 2015 Regular ADF.

Depressive symptoms (measured by PHQ)

The severity of self-reported depressive symptoms was significantly higher in the Transitioned ADF compared to the Regular ADF, with 19.5% of the Transitioned ADF reporting moderately severe (scoring range 15–19) to severe depressive symptoms (scoring range 20–27), compared to 7.4% of the Regular ADF. A further 11.1% of the Transitioned ADF had symptoms of depression in the moderate range (scoring range 10–14), highlighting the prevalence of subthreshold depression which is a significant risk in terms of future morbidity (Pine et al., 1999). As with posttraumatic stress symptoms and symptoms of psychological distress, the higher rates of self-reported depressive symptoms in the Transitioned ADF further underscores the role that symptoms may play in influencing the decision to leave the military, as well as the impact of transition on mood more generally.

Anxiety symptoms (measured by GAD-7)

The severity of self-reported symptoms of generalised anxiety in the Transitioned ADF was high with 22.3% reporting moderate to severe symptoms. In contrast, a significantly lower proportion of the 2015 Regular ADF (9.6%) reported moderate to severe symptoms.

Suicidal ideation and behaviour

The Transitioned ADF were significantly more likely to report suicidal ideation, plans and attempts than the 2015 Regular ADF. This is consistent with the recent AIHW report into the incidence of suicide among serving and Ex-Serving ADF members (Australian Institute of Health and Welfare, 2017) which found rates of completed suicide were lower than the general population among those still serving in the ADF (Regular and Reserve) but higher in those who were Ex-Serving. The consistency of the self-reported suicidality observed in the current study with data regarding completed suicide is of high importance, as it strongly indicates that the Ex-Serving Transitioned ADF are at increased risk of suicidal ideation escalating to suicidal behaviour.

Anger (measured by DAR-5)

Self-reported anger was measured in this study for a range of reasons, notably because it is an important symptom of PTSD. In particular, as reported in the scientific literature, the associated impairments and impacts on interpersonal relationships and social functioning in relation to anger are significant. Overall, self-reported anger followed the same patterns as for other psychological symptoms and for diagnosable mental disorder with Transitioned ADF members reported significantly greater levels of anger than the 2015 Regular ADF.

Table 14 Estimated proportions of Transitioned ADF and 2015 Regular ADF in each scoring band for the K10, PCL, AUDIT, PHQ-9, GAD-7 and the DAR-5

	Transitioned ADF 2015 (n = 24,932)			2015 Regular ADF (n = 52,500)		
	Weighted N	%	95% CI	Weighted N	%	95% CI
Psychological Distress (K10)						
Low (10–15)	11,904	47.7	45.9, 49.6	33,015	62.9	59.3, 66.4
Moderate (16–21)	4438	17.8	16.4, 19.3	8278	15.8	13.5, 18.4
High (22–29)	3371	13.5	12.3, 14.8	4179	7.9	6.4, 9.9
Very High (30-50)	4884	19.6	18.2, 21.1	5644	10.8	8.4, 13.7
Posttraumatic Stress (PCL)						
Low (17–29)	14,879	59.7	57.9, 61.5	41,432	78.9	75.6, 81.9
Moderate (30–39)	3426	13.7	12.5, 15.1	6013	11.5	9.3, 14.1
High (40–49)	2032	8.2	7.2, 9.2	2605	5.0	3.4, 7.3
Very High (50–85)	4003	16.1	14.8, 17.5	1957	3.7	2.6, 5.4
Alcohol Use (AUDIT)						
Band I (0–7)	16,236	65.1	63.2, 66.9	41,430	78.9	75.6, 81.9
Band 2 (8–15)	5574	22.4	20.8, 24.1	9151	17.4	14.7, 20.5
Band 3 (16–19)	1169	4.7	3.9, 5.6	988	1.9	1.1, 3.3
Band 4 (20 to 40)	1616	6.5	5.6, 7.5	726	1.4	0.6, 3.1
Depression (PHQ-9)						
Minimal (0–4)	11,342	45.5	43.7, 47.3	29,505	56.2	52.6, 59.7
Mild (5–9)	5788	23.2	21.7, 24.8	13,391	25.5	22.4, 28.9
Moderate (10–14)	2764	11.1	9.9, 12.3	5228	9.9	7.9, 12.5
Moderately Severe (15–19)	2250	9.0	8.0, 10.2	2374	4.5	3.1, 6.5
Severe (20–27)	2622	10.5	9.5, 11.7	1562	2.9	1.7, 5.1
General Anxiety (GAD-7)						
Minimal (0–4)	13,545	54.3	52.5, 56.1	36,907	70.3	66.8, 73.6
Mild (5–9)	5523	22.2	20.7, 23.7	10,049	19.1	16.4, 22.2
Moderate (10–14)	2734	10.9	9.9, 12.2	2671	5.1	3.7, 6.94
Severe (15–21)	2850	11.4	10.3, 12.6	2384	4.5	2.9, 6.9
Suicidality						
Felt life not worth living	7208	28.9	27.3, 30.6	6927	13.2	10.7, 16.2
Felt so low thought about committing suicide	5294	21.2	19.8, 22.8	4493	8.6	6.4, 11.3
Made a suicide plan	1965	7.9	6.9, 8.9	950	1.8	1.0, 3.3
Attempted suicide	505	2.0	1.6, 2.6	311	0.6	0.2, 1.6
Any suicidality†	5342	21.7	20.2, 23.3	4533	8.8	6.7, 11.6
	M	SE	95% CI	M	SE	95% CI
Anger (DAR-5)						
Anger frequency	2.4	0.02	2.4, 2.5	2.2	0.04	2.1, 2.2
Anger intensity	2.0	0.02	1.9, 2.0	1.7	0.04	1.6, 1.7
Anger duration	1.9	0.02	1.8,1.9	1.5	0.04	1.5, 1.6
Antagonism towards others	1.7	0.02	1.7, 1.8	1.4	0.04	1.3, 1.5
Social relations	1.8	0.02	1.8, 1.8	1.5	0.04	1.4, 1.6
DAR-5 total	9.8	0.1	9.6, 10.0	8.2	0.5	7.9 8.5

Deployment exposures and lifetime trauma exposure

The consistent findings of elevated rates of psychological symptoms and mental disorder among the Transitioned ADF need to be considered in the context of the reported deployment and non-deployment traumatic stress exposures experienced by this population.

Results of this study suggest that those who have transitioned from the ADF have had substantially higher levels of deployment related traumas in contrast to those who remain within the ADF in 2015. For example, in the Transitioned ADF, 38.3% reported they had gone on combat patrols in contrast to 29.9% of the 2015 Regular ADF. Similarly, among the Transitioned ADF, 37.4% had either handled or seen dead bodies in contrast to 30.2% of the 2015 Regular ADF.

Additionally, Transitioned ADF reported significantly higher rates of lifetime trauma (including both military and non-military trauma) compared to the 2015 Regular ADF with 77.0% of the Transitioned ADF and 69.3% of the 2015 Regular ADF reporting being exposed to a traumatic event in their lifetime. Transitioned ADF also reported being exposed to a greater number of different lifetime traumatic events compared to 2015 Regular ADF.

While it is important not to minimise the significant exposures of those who remain within Regular ADF service, these findings suggest that those who transition have on average endured a slightly greater history of a range of traumatic exposures both on deployment and in their lifetime compared to the 2015 Regular ADF.

An Australian Community comparison: psychological distress and alcohol use in Transitioned ADF compared to the Australian community

Psychological distress (measured by K10)

National and International research has demonstrated that military service places high demands on those who serve. The 2010 MHPWS showed that ADF members experienced a significantly higher prevalence of lifetime trauma (both deployment related and pre-enlistment trauma) compared with a socio-demographically matched Australian community (ABS). The 2010 MHPWS study also showed that the 2010 Regular ADF had a significantly higher prevalence of 12-month depressive episodes and posttraumatic stress compared to the Australian community. The increased risk of lifetime trauma exposure and mental disorder in ADF members, combined with transition related stressors places Transitioned ADF members at particular risk as they assimilate back into civilian society which has clear implications for service provision and support.

In this section key measures of mental health are compared between Transitioned ADF members and a stratified sample of the general Australian community, in order to place the mental health of Transitioned members within the civilian context (please see methodology section for details on how estimates from the Australian community were calculated). Comparisons between the Transitioned ADF and the Australian community were made using contemporaneous data obtained from the 2014–2015 ABS National Health Survey (NHS): in particular the K10 and number of Alcohol Use questions taken from the NHS.

In general, psychological distress was higher among the Transitioned ADF compared to the Australian community (Table 15). Almost three times more Transitioned ADF scored in the high to very high psychological distress bands (33.1%) compared to the Australian community (12.8%). Further analyses comparing the two populations by age and sex (not listed in table) showed that the largest difference between the Transitioned ADF and the Australian community, across the various sex and age groups, was in the very high scoring band on the K10 for psychological distress where nearly one in five Transitioned ADF scored in this band compared with just under 5% of the Australian community. Psychological distress was also found to decrease overall with age in the Transitioned ADF, while in the Australian community it remained relatively stable across age groups.

Table 15 Estimated prevalence in the Transitioned ADF compared to the Australian community K10 scoring bands for psychological distress

	Transitioned ADF (n = 24,932)			Australian Community			Difference		
	%	SE	95% CI	%	SE	95% CI	%	SE	95% CI
Low (10–15)	47.7	0.9	45.9, 49.6	66.3	0.9	64.5, 68.2	-18.6	1.3	-21.2, -15.9
Moderate (16–21)	17.8	0.7	16.4, 19.3	20.1	0.8	18.6 21.6	-2.3	1.0	-4.3, -0.2
High (22–29)	13.5	0.7	12.3, 14.8	8.3	0.6	7.1, 9.4	5.3	0.9	3.5, 6.9
Very High (30–50)	19.6	0.7	18.2, 21.1	4.5	0.5	3.5, 5.5	15.1	0.9	13.3, 16.9

Note: 95%CI: 95% Confidence Interval

Alcohol use

A quite different pattern of results was found when comparing patterns of alcohol use between the Transitioned ADF and the Australian community. Overall, the Australian community drank more standard drinks on a single occasion in the last 12 months than the Transitioned ADF, with a significantly higher proportion of the Australian community (48.3%) drinking more than seven or more standard drinks on a single occasion compared to the Transitioned ADF (33.2%), this pattern was particularly salient in Australian community males (Table 16). Overall, however, there were fewer observed differences in the rates of alcohol consumption between the two samples, particularly in the lower age groups (not presented in Table 16).

The majority of Transitioned ADF and the Australian community consumed alcohol weekly (approximately 45% – 48%), followed by monthly and less than monthly. A significantly higher proportion of the Transitioned ADF than the Australian Community reported drinking monthly. (Table 17). This pattern was mostly accounted for by ADF males. There were female specific differences in rates of problem drinking between the Transitioned ADF and the community (not presented in Table 17), with a significantly higher proportion of Transitioned ADF females reporting drinking daily, weekly and monthly compared to Australian community females.

Table 16 Estimated proportions of maximum number of standard drinks on a single occasion in the last 12 months in Transitioned ADF compared to the Australian community

	Transitioned ADF (n = 24,932)			Australian Community			Difference		
	%	SE	95% CI	%	SE	95% CI	%	SE	95% CI
11 +	21.6	0.9	19.9, 23.3	34.2	1.0	32.3, 36.1	-12.6	1.3	-15.2, -10.1
7–10	11.6	0.6	10.4, 12.9	14.1	0.7	12.7, 15.4	-2.4	0.9	-4.3, -0.6
5 or 6	12.8	0.6	11.6, 14.7	10.5	0.6	9.4, 11.6	2.3	0.8	0.6, 3.9
3 or 4	11.3	0.6	10.2, 12.5	12.0	0.7	10.6, 12.5	-0.7	0.9	-2.6, 1.1
1 or 2	10.7	0.6	9.7, 11.8	13.7	0.6	12.5, 14.9	-3.0	0.8	-4.7, -1.4

Note: 95%CI: 95% Confidence Interval

Table 17 Estimated proportions of the Frequency of Alcohol Consumption in Transitioned ADF compared to the Australian community in the last 12 months

	Transitioned ADF (n = 24,932)			Australian Community			Difference		
	%	SE	95% CI	%	SE	95% CI	%	SE	95% CI
Daily	4.3	0.4	3.6, 5.0	5.1	0.4	4.4, 5.8	-0.8	0.5	-1.8, 0.23
Weekly	47.6	0.1	45.6, 49.5	45.4	1.0	43.5, 47.3	2.2	1.4	-0.5, 4.8
Monthly	26.1	0.9	24.4, 27.9	20.1	0.9	18.4, 21.8	6.0	1.3	3.5, 8.5
Less than monthly	14.1	0.7	12.8, 15.6	13.0	0.6	11.8, 14.3	1.1	0.9	-0.8, 2.9

Note: 95%CI: 95% Confidence Interval

Implications and future directions: Mental Health Prevalence

The rates of mental disorder identified in ADF members in the first five years following transition in this study is a matter of concern that warrants attention with nearly half estimated to have a 12-month mental disorder. This level of 12-month disorder combined with the significantly greater severity of current self-reported symptoms of psychological distress, depression anxiety, anger, suicidality and alcohol use in the Transitioned ADF compared to the 2015 Regular ADF highlights the challenges of transitioning out of full-time military service.

Consistent with the findings of the 2017 AIHW report on suicide incidence among serving and ex-serving members, those discharging medically are one of the most high-risk groups identified in this report and should be a priority for further evaluation and follow-up (Australian Institute of Health and Welfare, 2017). Importantly however, there is also a large proportion of Transitioned ADF who were not medically discharged but who met criteria for a mental disorder in the last 12 months (i.e. 62.3% of those with a 12-month affective disorder – 70.5% of those with 12-month PTSD). Thus, many of these individuals may not have been referred to the appropriate mental health providers at the point of transition. This raises important questions as to whether these disorders emerged following discharge or failed to be declared or identified during the discharge medical. It also raises questions as to whether there should be a more systematic mental health assessment during military service and/or the discharge process using structured diagnostic interviews. Furthermore, as has been planned by Defence, referral of discharging members to a primary health care provider should increasingly become a priority as this is likely to significantly assist in both the diagnosis of emerging disorders as well as referral to treatment networks.

Similarly, a large proportion of Transitioned ADF who met criteria for a 12-month mental disorder, were not recorded as a DVA client (i.e. 40% of those with 12-month PTSD, 51% of those with a 12-month Affective Disorder). Taken together these findings suggest a need to address how ADF members are screened, assessed and monitored for mental health conditions both pre-and post-transition. The data also reinforces the importance of a range of initiatives currently being implemented by DVA and Defence to enhance early identification and intervention, including through the transition process.

One example highlighted in the 2017 Government response to the National Mental Health Commission Review is the Early Engagement Model. The goal is for DVA to establish a relationship with serving members as early in their career as practical. This will include Defence notifying DVA at agreed events during a member's career including events such as enlistment, involvement in a serious incident, medical discharge or retirement (Commonwealth of Australia, 2017). Defence is also reforming the ADF Transition Support Service to offer coaching and mentoring with a focus on developing an individual post separation plan, including employment support. This new model is aimed at all ADF members who are transitioning. This new model will also see Transition Officers contacting each member one month after separation to check on the success of the post separation plan and whether any new issues have arisen.

Over recent years, Defence has been trialling and implementing an enhanced mental health screening program which builds upon the comprehensive program of screening which already occurs post-deployment and post-exposure to critical incidents. Key components include standardising mental health screening measures across screening events, introducing periodic mental health screening for all ADF members (regardless of whether they have deployed) within primary health care settings, Command requested screening for high-risk groups, and updates to the health examination conducted as part of the discharge process (O'Donnell et al., 2014). This Mental Health Screening Continuum also includes the development of an online self-assessment website which will allow ADF members to anonymously assess their own mental health.

Meanwhile, the Veterans and Veterans Counselling Service (VVCS) is working towards development of a VVCS online system to increase help-seeking, early intervention and self-management. Through participatory design, VVCS intends to establish a range of digital options for care, including a Mental Health eClinic that offers immediate online assessment resulting in a dashboard of results as well as support via apps and eTools where

real-time data (i.e. physical activity, mood, sleep) can be displayed progressively. This initiative will see a wide variety of information, co-designed with members and their families that enhances awareness of the challenges experienced by transitioning members and offers information and tools to manage these experiences. Increased tailoring of online tools will not mitigate the need for some members of the community to access more direct clinical support, but will increase the likelihood that all discharging ADF members and their families are aware of, and understand the services available to them through the VVCS. As part of this offering VVCS would seek to make available a self-administered, online mental health check that connects the client to appropriate tools, resources and supports depending on individual need. In addition to these initiatives, it is suggested Defence and DVA consider the integration of screening processes pre-and post-transition and online resources to enable continuity throughout the transition process.

The findings in this report also strongly support an important DVA initiative to increase access to care: the DVA non-liability health care program. This program pays for mental health treatment for serving and ex-serving ADF members without needing to establish that the condition was caused by their ADF service. This treatment is delivered through the provision of a DVA White Card and allows ex-serving ADF members to access GPs, psychologists, psychiatrists, medication, public or private hospital care, and VVCS counselling services. Originally this was just for five common mental health conditions: PTSD, depressive disorder, anxiety disorder, and alcohol and substance use disorders with a set period of service. This has been now extended to anyone who has ever served at least one day in the full-time ADF and all mental health conditions.

The data in the report also highlights the importance of ensuring that whenever individuals access care they obtain a comprehensive assessment by military aware clinicians who are cognisant of the need for effective differential diagnosis when developing treatment plans. In the Transitioned ADF, just over half of those with a mental disorder had a least one comorbid disorder, with one in four Transitioned ADF meeting criteria for two or more mental disorder classes. The issue of mental disorder comorbidity is important as it is a marker of the severity of disorder and presents a significant challenge in obtaining optimal treatment outcomes, particularly when the co-morbid disorder(s) are not clearly defined from the outset (Hruska et al., 2014). These findings have important implications from a clinical perspective including the need to upskill both military and civilian clinicians on the specific criteria of a broad range of disorders beyond depression and PTSD. The relatively high rates of some individual disorders such as bipolar disorder in Transitioned ADF members found in this study, are matters of considerable concern, particularly due to the behavioural disinhibition, including greater suicidal risk, associated with bipolar disorder (Raja and Azzoni, 2004). Further longitudinal research should be conducted to examine the potential risk factors for this disorder and other high prevalence disorders in military populations, such as epigenetic consequences of PTSD and related stress exposures, in order to clearly identify subpopulations who maybe at particular risk.

A qualitative study of Transitioned ADF members who have been identified as having particular mental disorders would assist in better understanding the issues which cannot be captured by the structured diagnostic interview and questionnaires used in this study. This strategy would assist in better understanding the nuances and difficulties experienced by ADF members as they navigate the civilian healthcare system upon transition for the first time. This would also build on the quantitative information in the *Pathways to Care Report* including the nature of the interventions that have been offered once contact is made with the mental health system. It needs to be recognised that there are many limitations within the civilian health care sector and these are potentially impacting on Transitioned ADF members who do not have DVA entitlements.

The Mental Health Prevalence report examined both diagnosable mental disorders as well as self-reported subthreshold mental health symptoms. This latter group represent those at significant risk of the later emergence of disorder: a predictable outcome given the international evidence which has shown an association between increasing age/time and increasing rates of some disorders such as PTSD (Mota et al., 2016; Smid et al., 2013). This is in keeping with the importance of the introduction in Australia of the ability for GPs to conduct a comprehensive ADF Post Discharge Health Assessment (Reed et al., 2016) and further

supports the Departments considering further options for ongoing surveillance of this population including those who have transitioned to the Active and Inactive Reserves.

The current study focuses on ADF members who transitioned from Regular ADF service between 2010 and 2014. This includes ADF members who transitioned into the Active and Inactive Reserves. What this study does not address is the mental health of Reservists who have never served in the Regular ADF (Ab Initio Reservists). Given data was collected on a sample of Ab Initio Reservists as part of this Programme, future planned analyses will compare the impacts of military service in these three Reservist groups.

More generally this study highlights the value of ongoing health surveillance of longitudinal cohorts. In the case of longitudinal surveillance, it is possible to make causal associations particularly where exposures have been measured in close proximity to their occurrence. Two planned future reports: *Impact of Combat Report and Mental Health Changes Over Time: a Longitudinal Perspective Report* will provide some examples of the power of these prospective cohort studies to assist with the identification of risk and protective factors for good and poor health outcomes over time, and how these can directly inform risk mitigation and resilience building strategies to protect future cohorts.

Finally, the relationship between deployment exposures and the levels of psychological symptoms and mental disorder in both the Transitioned and Regular ADF require further exploration. This is particularly important longitudinally given recent research highlighting the role of sensitisation following deployment as a risk factor for the development of delayed onset PTSD and other mental disorders (McEwen, 2003; Smid et al., 2013).

Areas for future research

This study examined the prevalence of mental disorder in Transitioned ADF members and compared self-reported mental health symptoms among Transitioned and 2015 Regular ADF members. Substantially more information exists within the dataset collected however and is yet to be analysed. It is critical that the value of this information is understood and that ongoing strategies for further analyses are developed in the light of the findings that emerge. Following are a number of suggested areas for further examination of this data that emerge from the findings of the first report:

- Examination of the relationship between aspects of social disadvantage (i.e. homelessness, unemployment) and mental health in Transitioned ADF.
- Examination of the association between mental disorder and functioning, social integration and impairment and how this differ between those with a co-morbid alcohol disorder and those without.
- Examination of the impact of alcohol use without problem drinking on the severity of disorder and functioning.
- Examination of the predictors of comorbid mental disorder and the impacts of comorbidity on functioning and impairment.
- Examination of the predictors (in relation to mental disorder and the difficulties associated with transition into civilian roles) of the increasing suicidality since transition.
- Examination of the impact of deployment location and deployment exposures on the mental health of those who have transitioned. What are the patterns of social integration, help seeking and treatment efficacy in these populations?
- Examination of the nature and prevalence of the physical comorbidities in Transitioned ADF with mental disorders. How does the presence of physical comorbidities impact on the help-seeking and treatment effectiveness for mental disorders?

- Examination of the risk factors for PTSD in deployed and non-deployed ADF members who have transitioned compared to those who remain in Regular ADF service.
- Examination of the predictors of who becomes a DVA client versus who does not and the effect this has on employment and other domains of social adjustment in those with a mental disorder.
- Examination of the relationship between anger and mental disorder in Transitioned and 2015 Regular ADF and the impact of anger on levels of impairment and current levels of distress.
- Examination of the impact of anger with and without mental disorder on criminal acts and related social integration.
- Examination of predictors of suicidal ideation and behaviour of transitioned ADF members compared with the civilian community.

Pathways to Care among Transitioned ADF and 2015 Regular ADF

Key findings

Definitions of key terms used in this report

Transitioned ADF members -population of ADF members who transitioned from full-time ADF service between 2010 and 2014, including those who transitioned into the Active and Inactive Reserves and those who had discharged completely (Ex-Serving).

2015 Regular ADF – ADF members who were serving full-time in the ADF in 2015

Mental health concern – having ever had any level of concern about their mental health.

Probable mental disorder – Where probable rates of mental disorder are presented, these are based on self-reported epidemiological cut-offs.

Refer to the Glossary of terms for definitions of other key terms in this section.

Demographics

- More than half of Transitioned ADF members remained in the ADF as Reservists (55.8%). Of these, 25.7% were Active Reservists.
- Approximately, 84% of the Transitioned ADF were either working or engaged in some purposeful activity with 62.8% being employed. Just over 5.5% of the Transitioned ADF had retired.
- More than 43% of Transitioned ADF members reported accessing DVA-funded treatment through either a DVA White Card (39.4%) or DVA Gold Card (4.2%).
- Just over one-fifth of the Transitioned ADF were estimated to have been medically discharged.
- The most commonly reported reasons for transition were 'impact of service life on family' (10.2%), 'better employment prospects in civilian life' (7.2%), 'mental health problems' (6.5%) and 'physical health problems' (4.3%).
- There were no significant differences in housing stability between the Transitioned ADF and the 2015 Regular ADF, with more than 93% estimated to have been in stable housing in the previous two months.
- Just over 40% of the Transitioned ADF and 36% of the 2015 Regular ADF reported having a diploma or university qualification.
- Twice as many members of the Transitioned ADF were classified as medically unfit compared to the 2015 Regular ADF.

Self-reported concerns for mental health

- Over half the Transitioned ADF (64.4%) and 2015 Regular ADF (52.1%) have been concerned about their mental health during their lifetime.
- Prevalence of mental health concerns were significantly higher for the Ex-Serving group (70.9%) compared with the Inactive (61.0%) and the Active (57.6%) Reserve groups.

Help-seeking in the Transitioned ADF and 2015 Regular ADF

- Approximately, 3 in 4 Transitioned ADF and 2015 Regular ADF have received assistance for their mental health in their lifetime. Of these, about 41% of Transitioned ADF and 46% of 2015 Regular ADF report receiving assistance currently or within the last 12 months.
- Approximately, half of Transitioned ADF and 2015 Regular ADF sought help for their mental health within three months of becoming concerned about it.

Support from others in seeking care

- For around 60% of Transitioned ADF and 2015 Regular ADF, who were concerned about their mental health and sought assistance, someone else had suggested they seek care for their mental health, usually a partner or friend.
- Only about 30% received assistance in engaging with mental health care. For Transitioned ADF this was most commonly a doctor (either a General Practitioner or Medical Officer), partners or supervisors and, for Regular 2015 ADF, this was most commonly supervisors, General Practitioners or Medical Officers.

Primary reasons for seeking care

- In both the Transitioned and Regular ADF the most common reasons for seeking assistance were depression, anxiety, relationship problems and anger.

Help-seeking among Transitioned ADF and 2015 Regular ADF with a probable current mental disorder

- Of the Transitioned ADF and 2015 Regular ADF with a probable current mental disorder, who have expressed a concern about their mental health and sought care, 75% had done so currently or within the last 12 months.
- Of those with probable disorder, 2015 Regular ADF were more likely than Transitioned ADF to seek care within the first three months.

Attrition in help seeking

- Self-reported rates of help seeking for a mental health problem are reasonably high, but due to attrition at each help seeking stage and variability in the treatment services delivered, approximately a quarter of those with a probable current mental disorder were estimated to have received evidence-based care in the last 12 months.

Mental health service use

In Transitioned ADF and 2015 Regular ADF with a mental health concern

- Transitioned ADF and 2015 Regular ADF with a mental health concern reported very high rates of consulting a General Practitioner/Medical Officer, psychologist and/or a psychiatrist at some stage in their lifetime.
- There were high rates of satisfaction with the services delivered by these health professionals.

In Transitioned ADF and 2015 Regular ADF with a probable current mental disorder

- While the majority of Transitioned ADF and 2015 Regular ADF with a probable current mental disorder had reported consulting a psychologist in the self-report survey, only half of these had done so in the last 12 months.
- Approximately 60% of Transitioned ADF and 2015 Regular ADF with a probable current mental disorder reported consulting a psychiatrist in the self-report survey, and over half of these had done so in the last 12 months.

Satisfaction with health service factors

- 2015 Regular ADF were more likely to be satisfied than Transitioned ADF in the accessibility, location, effectiveness, competence, friendliness, convenience and confidentiality of health services. Those with probable current mental disorders reported lower satisfaction across all health service factors.

Mental health services funding

- Defence was the main funder of mental health services for the 2015 Regular ADF, followed by DVA, including Veterans and Veterans Families Counselling Service (VVCS).
- DVA was the main funder of mental health services for Transitioned ADF, followed by Medicare and self-funding.

Methods used to inform or assess mental health among the Transitioned ADF and 2015 Regular ADF

Websites

- Around one quarter of Transitioned ADF and 2015 Regular ADF used websites to inform or assess their mental health, and were most likely to access websites designed by DVA or Defence. While satisfaction with the DVA and Defence websites were at reasonable levels, the proportion accessing them was low.

Smart phone apps

- Use of all smart apps were low in both Transitioned and 2015 Regular ADF members, but doubled in those with a probable current mental disorder.

Helplines

- About 10% of both Transitioned and 2015 Regular ADF members used a veteran or military helpline, and these rates doubled in those with a probable current mental disorder. VVCS Vetline was the most highly used helpline with very high satisfaction rates.

Ex-service organisations (ESOs)

- Less than 10% of Transitioned and 2015 Regular ADF members used ESOs to inform or assess their mental health. This doubled for those with a probable current mental disorder.
- Rates of satisfaction with ESO services were high.

Receiving health information

- Both Transitioned and 2015 Regular ADF members preferred receiving mental health information face-to-face rather than by the internet or by telephone. This effect was much stronger in those with a probable current disorder.

Stigma

- In both Transitioned 2015 and Regular ADF members, the highest rated stigmas were concerns others would lose confidence in them, that they would be seen as weak, that they would be treated differently, that they would feel worse due to being unable to solve their own problems, that they would feel embarrassed. Those with probable current mental disorder were more likely to endorse each stigma item.
- The most common reasons for not seeking assistance in both Transitioned and 2015 Regular ADF members were a perceived preference to self-manage, ability to function effectively and feeling afraid to ask.
- Over half the Transitioned ADF and around 40% of the 2015 Regular ADF with probable current mental disorder held four or more stigma-related beliefs. However, the vast majority of those with mental health concerns still engaged in care.

Barriers to seeking help

- The most common barriers to seeking help for 2015 Regular ADF were concerns about the impact on deployability or career and for Transitioned ADF were concerns about the impact on career and expense.

Pathways to Care Report objectives

The *Pathways to Care Report* investigated self-reported pathways to care in transitioned and currently serving ADF members with mental health care needs, to ensure they have access to and receive appropriate mental health care. It specifically sought to identify:

- What proportion of Transitioned ADF and 2015 Regular ADF sought professional care for their mental health concerns?
- What are the patterns of latency between onset of a mental health concern and seeking care?

- For those who sought care, what problems were driving their decision to seek care, did someone else suggest they seek care and if so, who was that and did someone else assist them in actually getting to care?
- What types of professionals did they consult, what type of services did they report the professionals provided and how satisfied were they with what was provided?
- What other self-management strategies did they use to address their mental health concerns and what were their levels of satisfaction with those strategies?
- What were common attitudes and beliefs about mental health and seeking care focusing initially on the entire cohort and then those with mental health concerns who did not seek care?

Self-reported patterns of service engagement were considered from both within the respective Transitioned ADF and 2015 Regular ADF populations and with comparisons between them, with further examination of the differences between the Transitioned ADF sub-groupings (Ex-Serving, Active Reservists, Inactive Reservists). The study also compared these patterns between those who did and did not meet criteria for current probable 30-day mental disorder, as defined by meeting the epidemiological cut-offs on the screens for anxiety and depression (K10) and posttraumatic stress (PCL).

Self-reported concern for mental health

Over half of the Transitioned ADF (64.4%) and the 2015 Regular ADF (52.1%) had experienced concerns about their mental health in their lifetime (Table 18). Within the Transitioned ADF, concerns about mental health were most prevalent in the Ex-Serving group (70.9%), and this was significantly different compared to both the Inactive (61.0%) and the Active (57.6%) Reserve groups.

Of note, a small but important minority of those with probable 30-day disorder (11.2% of the Transitioned ADF and 27.3% of the 2015 Regular ADF) *did not* express concern about their mental health.

Table 18 Estimated proportion of 2015 Regular ADF and Transitioned ADF who reported being concerned about their mental health in their lifetime, stratified by probable 30-day disorder

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
No	1294	8880	35.6 (33.7,37.6)	3362	25,128	47.9 (44.0, 51.8)
Yes	2485	16,052	64.4 (62.4,66.3)	4339	27,372	52.1 (48.3, 56.0)
Probable 30-day disorder (by concerned about mental health)						
No, Not Concerned	107	789	11.2 (9.0,14.0)	239	2069	27.3 (19.1, 37.5)
Yes, Concerned	920	6234	88.8 (86.0,91.0)	727	5506	72.7 (62.5, 90.0)
No probable 30-day disorder (by concerned about mental health)						
No, Not Concerned	1187	8091	45.2 (42.8,47.6)	3123	23,059	51.3 (47.2, 55.4)
Yes, Concerned	1565	9818	54.8 (52.4,57.2)	3612	21,866	48.7 (44.6, 52.8)

Denominator: Entire cohort
Notes:
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25.
95%CI: 95% Confidence Interval

Help-seeking among those with a mental health concern

Of those with a concern about their mental health, approximately three in four Transitioned ADF and 2015 Regular ADF reported having ever received assistance for their mental health (Table 19). Approximately 41% of Transitioned ADF and 46% of 2015 Regular ADF reported receiving assistance for their mental health *currently or within the last 12 months*.

Within the Transitioned groups, the Ex-Serving were more likely to seek assistance for their mental health concerns (82.2%) or currently be receiving treatment (38.2%), than the Inactive Reservists (68.3%, 18.4%), or Active Reservists (67.7%, 15.2%) (table/figure not shown in report).

Of those with a probable 30-day disorder, the majority of Transitioned ADF (84.0%) and 2015 Regular ADF (81.4%) reported receiving assistance for their mental health in their lifetime, with 75% of these reporting receiving care currently or within the last 12 months. This equates to approximately 63% of Transitioned ADF and 61% of 2015 Regular ADF with a probable 30-day disorder being currently or recently in care.

Table 19 Weighted estimate of 2015 Regular ADF and Transitioned ADF who reported being concerned about their mental health in their lifetime, and whether they ever had assistance for their mental health, stratified by probable 30-day disorder

	Transitioned ADF n = 16,052			2015 Regular ADF n = 27,372		
	n	Weighted n	% (95%CI)	n	Weighted n	% (95%CI)
All						
No, never received assistance	562	3922	24.4 (22.3,26.7)	965	6546	23.9 (19.6,28.9)
Yes, Currently	714	4374	27.3 (25.2,29.4)	972	6433	23.5 (19.0,28.7)
Yes, In the Last 12 months	342	2199	13.7 (12.1,15.5)	815	6183	22.6 (18.2,27.7)
Yes, more than 12 months ago	852	5449	33.9 (31.7,36.3)	1571	8124	29.7 (25.6,34.1)
Dichotomised grouping						
No, Never	562	3922	24.4 (22.3,26.7)	965	6546	23.9 (19.6,28.9)
Yes, Ever	1908	12,022	74.9 (72.6,77.0)	3358	20,740	75.8 (70.8,80.1)
Probable 30-day disorder	n = 6234			n = 5506		
No, never received assistance	119	960	15.4 (12.55,18.76)	94	1006	18.3 (9.7,31.8)
Yes, Currently	496	3141	50.4 (46.4,54.3)	359	2752	50.0 (37.1,62.8)
Yes, In the Last 12 months	114	760	12.2 (9.9,15.0)	112	599	10.9 (7.8,14.9)
Yes, more than 12 months ago	186	1334	21.4 (18.3,24.9)	159	1131	20.6 (11.8, 33.4)
Dichotomised grouping						
No, Never	119	960	15.4 (12.6,18.8)	94	1006	18.3 (9.7,31. 8)
Yes, Ever	796	5236	84.0 (80.6,86.9)	630	4482	81.4 (68.0,90.0)
No probable 30-day disorder	n = 9818			n = 21,866		
No, never received assistance	443	2962	30. 27 (27.3,33.2)	871	5540	25.3 (20.6,30.8)
Yes, Currently	218	1233	12.6 (10.7,14.6)	613	3682	16.8 (12.8,21.9)
Yes, In the Last 12 months	228	1438	14.7 (12.6,17.0)	703	5584	25.5 (20.4,31.5)
Yes, more than 12 months ago	666	4114	41.9 (38.9,45.0)	1412	6993	32.0 (27.6,36.8)
Dichotomised grouping						
No, Never	443	2962	30.2 (27.3,33.2)	871	5540	25.3 (20.6,30.8)
Yes, Ever	1112	6786	69.1 (66.1,72.0)	2728	16,258	74.4 (68.9,79.1)

Denominator: those who were concerned about their mental health
Notes:
194 (weighted) participants (2015 Regular ADF=86 (0.31%); Transitioned ADF=108 (0.67%)) had a missing value and are not included. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25.
95%CI: 95% Confidence Interval

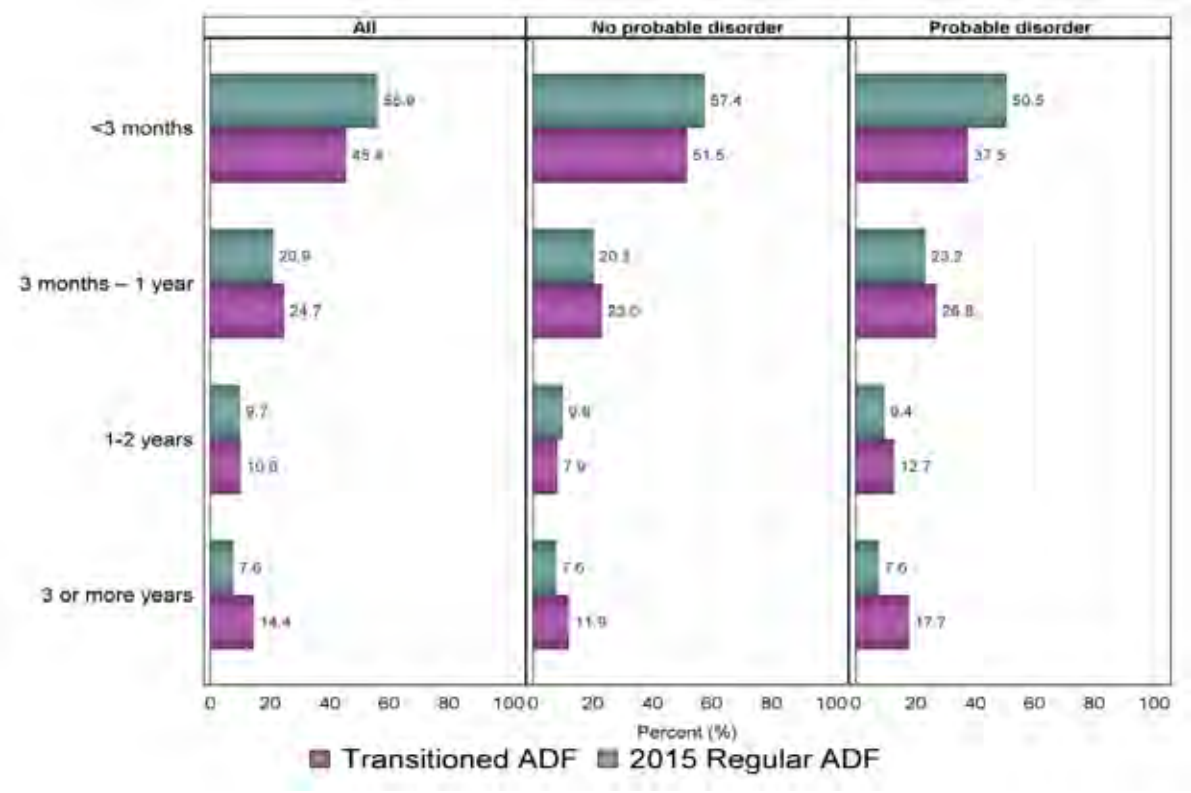
Help-seeking latency

Most Transitioned ADF members sought assistance for a mental health concern within one year of concern onset, with 45.4% of Transitioned ADF members seeking care within three months and another 24.7% between three months and a year (Figure 6). For those with a probable 30-day disorder, only 37.5% sought care within three months of being concerned and 17.7% waited three or more years.

Rates of early treatment seeking were significantly higher in the 2015 Regular ADF, with 55.9% seeking care within the first three months of concern onset, including 50.5% of those with a probable 30-day disorder.

Of note, is the significant minority of Transitioned ADF (14.4%) and 2015 Regular ADF (7.6%) who waited more than three years to seek care.

Figure 6 **Estimated length of time between having a mental health concern and help-seeking among Transitioned ADF and 2015 Regular ADF stratified by probable 30-day disorder**



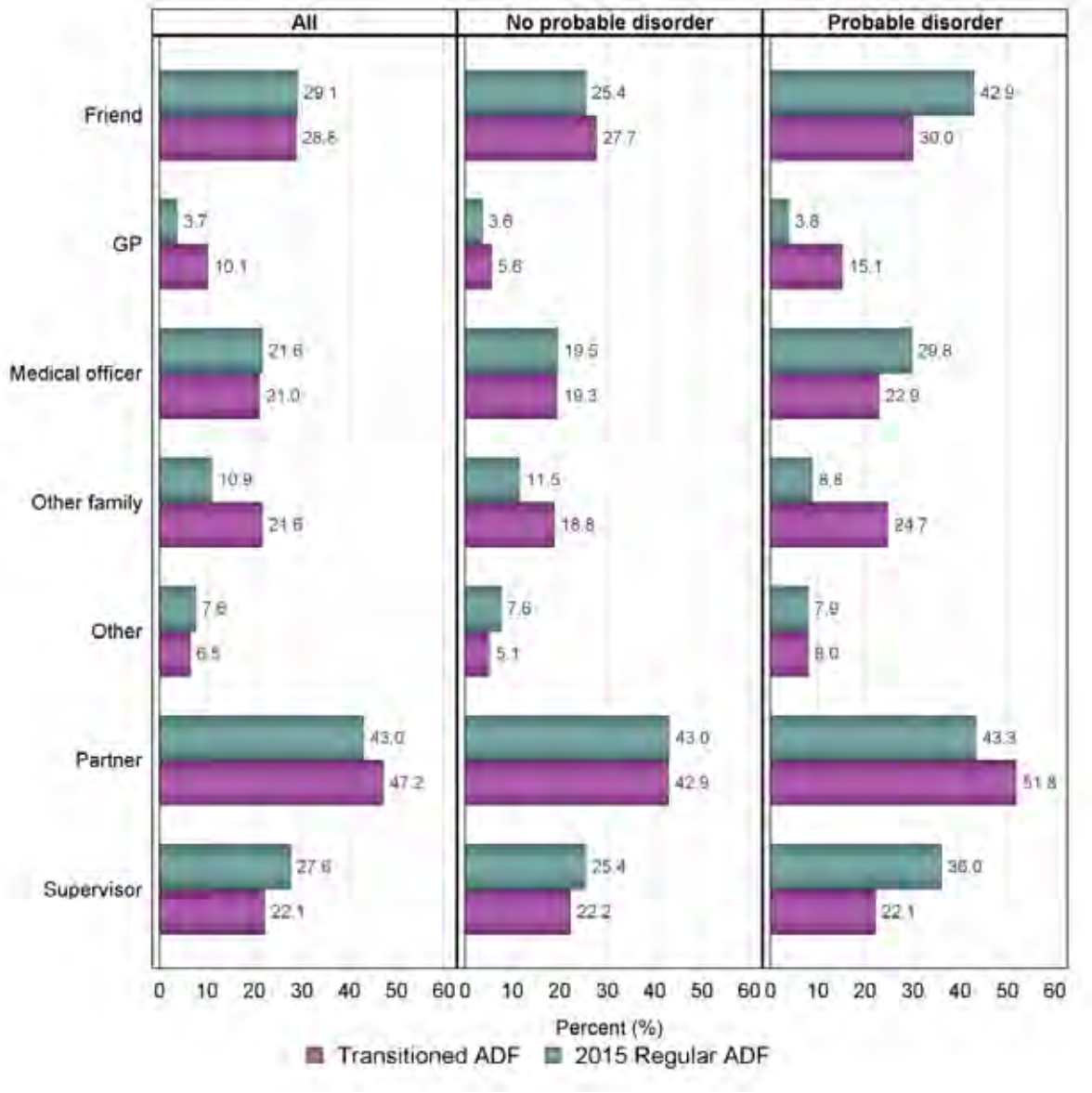
Support from others in seeking care

Who suggested they seek help?

In order to better understand patterns of service engagement, it is important to identify the most common pathways into care. For the majority of Transitioned ADF (62.5%) and 2015 Regular ADF (57.5%) who were concerned about their mental health and had ever sought assistance, engagement with professional care was suggested by another. These rates were similar for those with a probable 30-day disorder (68.6% and 55.5% respectively) (Figure 7).

Partners were most likely to suggest Transitioned ADF (47.2%) and 2015 Regular ADF (43.0%) seek assistance for their mental health, followed by friends (28.8% and 29.1%), supervisors (22.1% and 27.6%) and General Practitioners (GPs)/Medical Officers (MOs) (combined 31.1% and 25.3%).

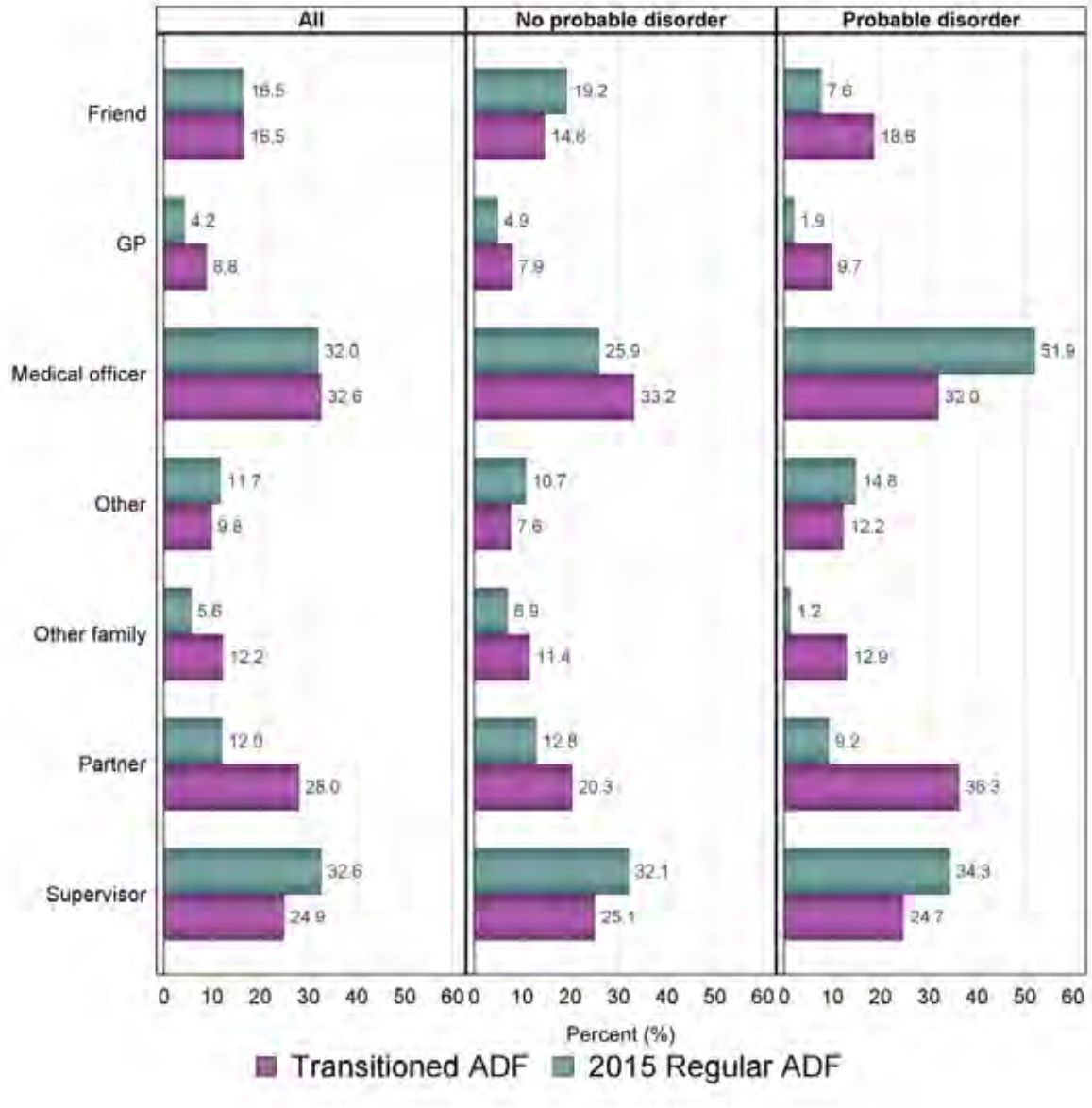
Figure 7 **Who suggested help-seeking in Transitioned ADF and 2015 Regular ADF stratified by probable 30-day disorder (Note: all proportions are estimated)**



Who assisted them to seek help?

While the majority of Transitioned ADF and 2015 Regular ADF who sought care had it suggested by someone else, only a minority of those were actively assisted in accessing this care. For 32.6% of Transitioned ADF, someone else assisted them to engage with care, and this was most commonly a GP/MO (combined 41.4%), partner (28.0%), or supervisor (24.9%) (Figure 8). For the 28.5% of 2015 Regular ADF who received assistance with engaging with care, this was most commonly provided by supervisors (32.6%), then GP/MOs (combined 36.2%), friends (16.5%), and partners (12.0%).

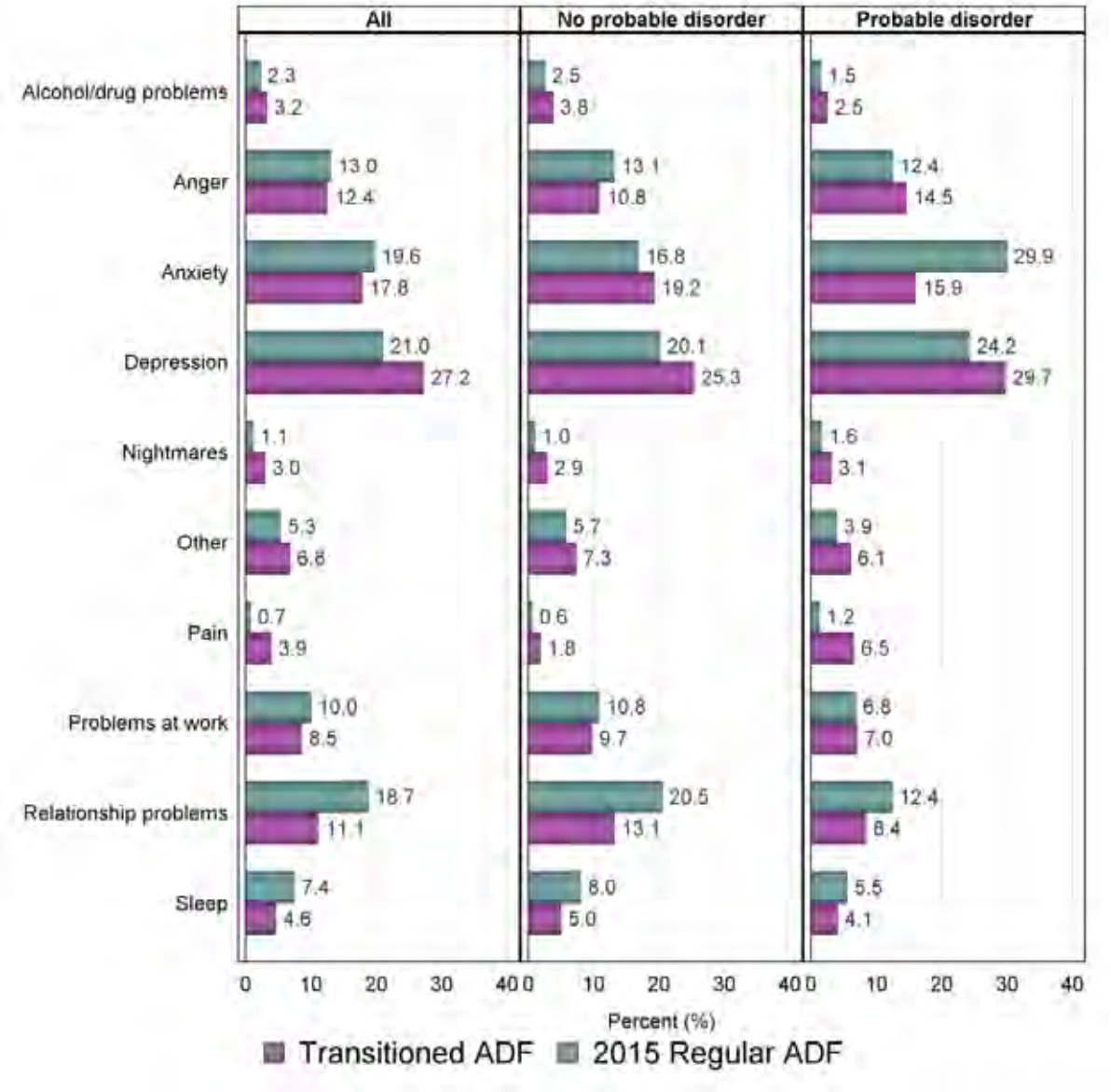
Figure 8 **Who assisted help-seeking in Transitioned ADF and 2015 Regular ADF stratified by probable 30-day disorder**



Primary reasons for seeking care

There was considerable consistency in the Transitioned ADF and 2015 Regular ADF in the primary reasons for seeking mental health care, with the most common reasons being depression (27.2% and 21.0%), anxiety (17.8% and 19.6%), relationship problems (11.1% and 18.7%), and anger (12.4% and 13.0%) (Figure 9). This pattern of primacy of depression, anxiety and anger was consistent for those with and without probable 30-day disorder, however Transitioned ADF with a probable disorder were most likely to seek care for depression whereas 2015 Regular ADF with a probable disorder were most likely to seek help for anxiety.

Figure 9 **Primary reason for seeking assistance for mental health among the Transitioned ADF and 2015 Regular ADF stratified by probable 30-day disorder**



Mental health service use

Who was consulted?

The Transitioned ADF and 2015 Regular ADF with a mental health concern reported high rates of engagement with health and mental health professionals for mental health care during their lifetime, with most reporting consulting a GP/MO (80.9% and 77.6%), a psychologist (81.3% and 87.6%) and/or a psychiatrist (49.9% and 38.9%) (Table 20).

Table 20 Estimated proportion of the Transitioned ADF and 2015 Regular ADF consulting each type of health professional, stratified by probable 30-day disorder

	Transitioned ADF n = 12,022			2015 Regular ADF n = 20,740		
	n	Weighted n	% (95%CI)	n	Weighted n	% (95%CI)
General Practitioner/Medical Officer						
Ever	1550	9720	80.9 (78.5,83.0)	2524	16,103	77.6 (72.8,81.8)
< 12 months ago	729	4616	38.4 (35.6,41.1)	1182	7868	37.9 (32.0,44.2)
> 12 months ago	1009	6330	52.7 (49.9,55.4)	1605	9474	45.7 (39.7,51.8)
Probable 30-day disorder						
Ever	707	4574	87.4 (84.1,90.1)	533	4051	90.4 (86.5,93.3)
< 12 months ago	462	2987	57.1 (52.8,61.2)	377	2483	55.4 (40.9,69.0)
> 12 months ago	363	2402	45.9 (41.7,50.1)	244	1917	42. 8 (29.3,57. 5)
No probable 30-day disorder						
Ever	843	5146	75.8 (72.5,78.9)	1991	12,052	74.1 (68.3,79.2)
< 12 months ago	267	1629	24.0 (21.0,27.3)	805	5385	33.1 (26.7,40.2)
> 12 months ago	646	3929	57.9 (54.2,61.5)	1361	7557	46.5 (39.9,53.2)
Psychologist						
Ever	1604	9772	81.3 (78.8,83.5)	2902	18,171	87.6 (83.7,90.7)
< 12 months ago	646	3878	32.3 (29.8,34.9)	1327	9148	44.1 (38.0,50.4)
> 12 months ago	1109	6864	57.1 (54.3,59.8)	1871	10,796	52.1 (45.9,58.2)
Probable 30-day disorder						
Ever	703	4413	84.3 (80.4,87.5)	576	4189	93.5 (90.1,95.7)
< 12 months ago	390	2342	44.7 (40.6,48.9)	381	2464	55.0 (40.6,68.6)
> 12 months ago	396	2596	49.6 (45.4,53.8)	280	2336	52.1 (38.2,65.7)
No probable 30-day disorder						
Ever	901	5360	79.0 (75.6,82.0)	2326	13,982	86.0 (81.2,89.8)
< 12 months ago	256	1536	22.6 (19.7,25.9)	946	6684	41.1 (34.4,48.2)
> 12 months ago	713	4267	62.9 (59.2,66.4)	1591	8460	52.0 (45.3,58.7)
Psychiatrist						
Ever	989	6003	49.9 (47.2,52.6)	1160	8068	38.9 (33.0,45.2)
< 12 months ago	477	2818	23.4 (21.3,25.7)	470	3201	15.4 (11.3,20.8)
> 12 months ago	613	3840	31.9 (29. 5,34.5)	761	5137	24.8 (19.5,30.9)
Probable 30-day disorder						
Ever	574	3485	66.5 (62.3,70.6)	342	2696	60.2 (46.4,72.4)
< 12 months ago	364	2123	40.6 (36.6,44.6)	212	1426	31.8 (20.2,46.2)
> 12 months ago	287	1847	35.3 (31.4,39.3)	602	3744	23.0 (17.5,29.6)
No probable 30-day disorder						
Ever	415	2518	37.1 (33.6,40.7)	818	5372	33.0 (26.7,40.0)
< 12 months ago	113	694	10.2 (8.2,12.7)	258	1775	10.9 (7.0,16.6)
> 12 months ago	326	1993	29.4 (26.1,32.8)	159	1393	31.1 (18.9,46.7)
Other mental health professional						
Ever	567	3662	30.5 (28.0,33.1)	1010	6945	33.5 (27.7,39.9)
< 12 months ago	196	1177	9.8 (8.3,11.5)	369	2058	9.9 (7.2,13.6)
> 12 months ago	414	2785	23.2 (20.9,25.7)	689	5050	24.4 (17.0,30.7)
Probable 30-day disorder						
Ever	274	1745	33.3 (29.6,37.3)	218	1474	32.9 (21.2,47.2)
< 12 months ago	136	786	15.0 (12.4,18.0)	132	743	16.6 (9.8,26.7)
> 12 months ago	166	1173	22.4 (19.0,26.2)	102	788	17.6 (8.6,32.7)
No probable 30-day disorder						
Ever	293	1917	28.3 (25.0,31.8)	792	5470	33.7 (27.2,40.8)
< 12 months ago	60	391	5.8 (4.2,7.8)	237	1315	8.1 (5.3,12.2)
> 12 months ago	248	1612	23.8 (20.7,27.1)	587	4262	26.2 (20.1,33.4)

Denominator: Those who were concerned about their mental health and sought assistance.
Notes:
95%CI: 95% Confidence Interval
These are not mutually exclusive groups and therefore do not sum to 100%.
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25.

For those with a probable 30-day disorder who had sought assistance, 84.3% and 93.5% of Transitioned ADF and 2015 Regular ADF respectively had consulted a psychologist. Of those, 55.5% of Transitioned ADF and 66.1% of 2015 Regular ADF had done so in the last 12 months. Approximately 60% of both the Transitioned ADF and the 2015 Regular ADF with a probable 30-day disorder had consulted a psychiatrist.

What services were provided and what were the levels of satisfaction with these services?

Among the Transitioned ADF, overall satisfaction ratings for core services for each of GP/MOs, psychologists, psychiatrists, and other mental health professionals were in the 60% to70% range. Satisfaction reported by 2015 Regular ADF was considerably higher across MOs, psychologists and psychiatrists, with rates of between 70% and 90%.

GPs/MOs

The services most commonly provided by GPs/MOs to Transitioned ADF (73.4%) and 2015 Regular ADF (83.9%) was referral to another service. Other services provided, included information (50.2% and 46.7%), prescribing medicine (68.5% and 35.2%) and support (42.7% and 38.9%).

The GP/MO services with which Transitioned ADF were most satisfied included referrals (74.7%), information (66.1%), medicine (66.9%) and support (61.6%). The GP/MO services with which the 2015 Regular ADF were most satisfied included trauma-focused cognitive behavioural therapy (CBT) and CBT (87.4% and 81.2%), referral (82.3%), and psychotherapy (78.3%).

Psychologists

The service most commonly provided by psychologists to Transitioned ADF (80.6%) and 2015 Regular ADF (85.7%) was supportive counselling. Other services included CBT (63.7% and 63.9%) and information (55.9% and 51.9%).

The psychology services with which Transitioned ADF were most satisfied included referrals (72.6%), information (68.6%), supportive counselling (62.5%) and CBT (59.9% including trauma-focused CBT 59.9%). The psychology services 2015 Regular ADF were most satisfied with included CBT (83.9%, including trauma focused CBT 85.5%), information (82.0%) and referrals (84.7%).

Of note, within this study the use of CBT is the best proxy for the delivery of evidence-based psychological treatment for the most common veteran and military mental health problems, and both the Transitioned ADF and the 2015 Regular ADF are reporting high rates of psychologists delivering CBT (63%).

Psychiatrists

The services most commonly provided by psychiatrists to Transitioned ADF (77.9%) and 2015 Regular ADF (54.5%) were prescribing medicine, followed by supportive counselling (63.4% and 45.0%) and information (60.1% and 53.8%).

The psychiatry services the Transitioned ADF were most satisfied with included information (69.5%), medicine (66.7%) and CBT (63.0%). The psychiatry services the 2015 Regular ADF were most satisfied with included information (85.2%), medicine (78.3%), supportive counselling (66.8%) and CBT (61.5%).

Other mental health providers

The services sought from other mental health professionals such as social workers, occupational therapists and mental health nurses to address mental health concerns were also examined. The most commonly delivered services reported by the Transitioned ADF and 2015 Regular ADF were supportive counselling (69% and 63%) followed by information provision (60% and 39%).

Attrition in help seeking

While the findings indicate high rates of engagement with mental health care, the attrition at each stage of engagement must also be taken into consideration.

Using the Transitioned ADF as an example:

- 84% of those with a lifetime mental health concern and who had a probable 30-day disorder sought care in their lifetime.
- Of these, 81% had consulted a psychologist for these concerns.
- This equates to 68% of those with a mental health concern at some stage in their lives and who had probable 30-day disorder having sought care from a psychologist. Of this 68%, 55% have seen their psychologist in the last 12 months, i.e., 38% of the total of those with a lifetime mental health concern and current probable 30-day disorder.
- Of the 38% of Transitioned ADF with a probable 30-day disorder seeing a psychologist in the last 12 months, 63% of these received CBT (the best proxy for receiving evidence-based care), (i.e. approximately 24% with a mental health concern and probable 30-day disorder received CBT from a psychologist in the past 12 months).

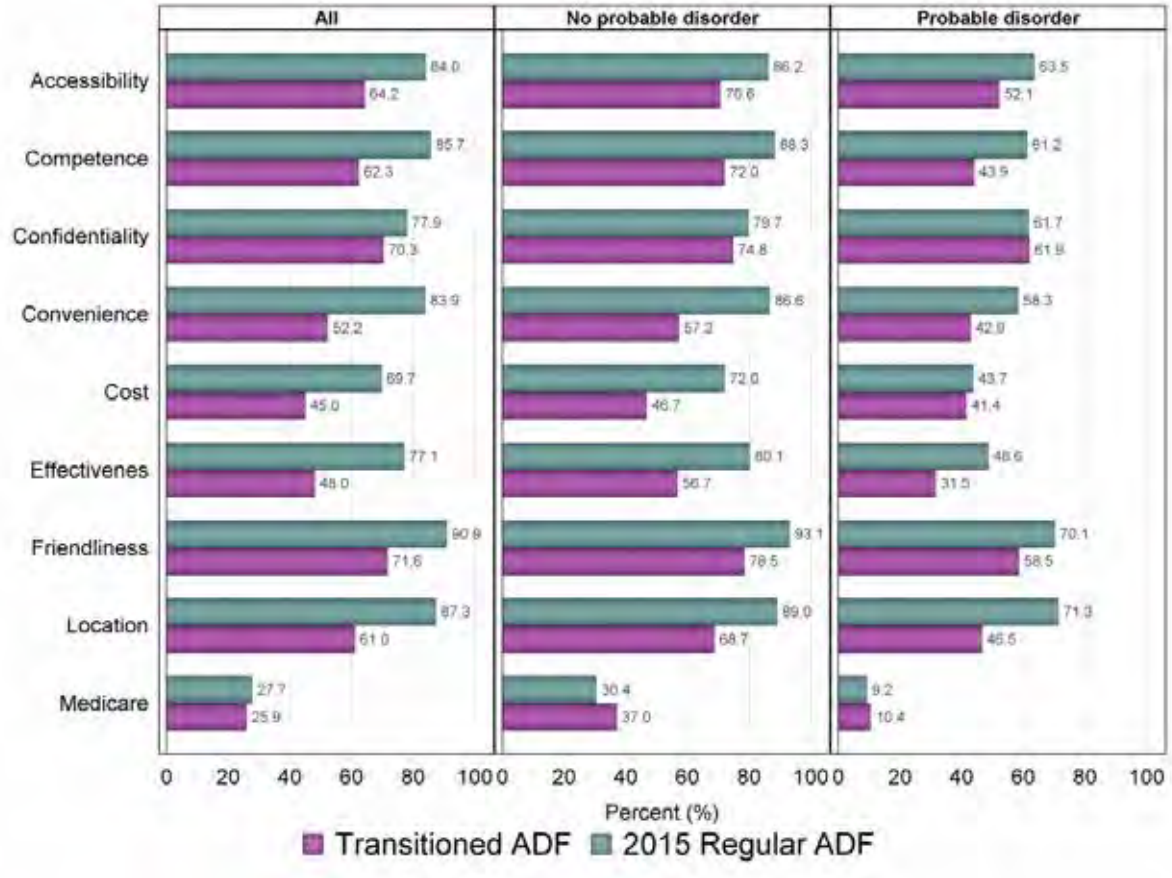
Therefore, whilst the rates of engagement and uptake at each time point are reasonably high, and exceed community and international standards in veteran and military mental health, a minority of Transitioned ADF with a probable 30-day disorder reported receiving CBT (24%), which would be considered the most evidence-supported treatment for the most prevalent conditions in this population.

Satisfaction with health service factors

Satisfaction with the accessibility, cost, location, effectiveness, competence, friendliness, convenience and confidentiality of health services are presented in Figure 10. 2015 Regular ADF were more likely to be satisfied than Transitioned ADF in all service factors, with the exception of cost, where there was no significant difference. In both Transitioned ADF and 2015 Regular ADF, those with probable 30-day disorders reported lower satisfaction in all service factors.

Of the key health service factors, Transitioned ADF were most satisfied with friendliness (71.6%), and confidentiality (70.3%) and 2015 Regular ADF were most satisfied with friendliness (90.9%), location (87.3%), and competence (85.7%).

Figure 10 **Aspects of service satisfaction in Transitioned ADF and 2015 Regular ADF, stratified by probable 30-day disorder**



Who is funding the treatment?

As would be expected, Defence was reported to be the dominant funder of mental health related care for the 2015 Regular ADF, and DVA was reported to be the dominant funder of care for the Transitioned ADF (table/figure not shown in report).

For the Transitioned ADF, 57.1% reported receiving GP/MO services funded by DVA, followed by Medicare (40.6%), self-funded (22.1%), and Defence funded (14.9%). With respect to psychology services, 47.4% reported receiving services funded by DVA, followed by VVCS self-referral (25.8% with an additional 5.9% of Defence funded VVCS services), and Medicare (20.8%).

Within the 2015 Regular ADF, 93.0% reported receiving MO/GP services funded by Defence and 10.8% reported receiving these services funded through DVA. Approximately 85% reported receiving psychology services funded by Defence, followed by VVCS self-referral (17.1% with an additional 5.1% of Defence funded VVCS services).

Self-help strategies for informing and assessing mental health

Websites

Overall, 30.3% of Transitioned ADF and 25.0% of the 2015 Regular ADF reporting using a website to inform or assess their mental health (Table 21). In the Transitioned ADF, 18.6% reported using the DVA website with an additional 10.0% using the ADF website. For 2015 Regular ADF, 14.5% reported using the ADF website followed by 10.5% using the DVA website. The Beyondblue website was the next most common website utilised by both groups (8.0% Transitioned ADF, 6.4% 2015 Regular ADF). Less than 2% reported using the At Ease website.

While satisfaction with the DVA and ADF websites are at reasonable levels, and both the Transitioned ADF and 2015 Regular ADF populations were most likely to access websites designed specifically for serving and ex-serving ADF members by either DVA or Defence, the proportion accessing them is low.

Table 21 Estimated proportion of Transitioned ADF and 2015 Regular ADF who used websites in the last 12 months to inform/assess mental health, stratified by probable 30-day disorder

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95%CI)	n	Weighted n	% (95%CI)
ADF website	401	2505	10.0 (8.9,11.3)	1285	7577	14.4 (12.1,17.2)
Helpful?	234	1407	56.2 (50.1,62.1)	948	5320	70.2 (60.9,78.1)
With probable 30-day disorder	143	838	11.9 (9.9,14.4)	227	1540	20.3 (13.7,29.2)
Helpful?	58	325	38.8 (29.8,48.7)	132	755	49.0 (29.9,68.5)
DVA website	815	4644	18.6 (17.3,20.1)	1005	5535	10.5 (8.8,12.6)
Helpful?	510	2694	58.0 (53.8,62.1)	795	3863	69.8 (59.8,78.2)
With probable 30-day disorder	386	2190	31.2 (28.1,34.5)	232	1374	18.1 (12.3,25.9)
Helpful?	206	1071	48.9 (43.1,54.8)	168	679	49.4 (31.4,67.6)
At Ease website	84	437	1.8 (1.4,2.3)	107	818	1.6 (0.8,2.9)
Helpful?	39	187	42.8 (31.1,55.5)	58	196	23.9 (11.6,42.9)
With probable 30-day disorder	40	225	3.2 (2.2,4.6)	23	270	3.6 (0.9,12.7)
Helpful?	16	93	41.2 (24.4,60.4)	11	30	11.3 (2.5,38.5)
Beyond Blue	302	1998	8.0 (7.0,9.2)	531	3381	6.4 (4.7,8.8)
Helpful?	208	1292	64.7 (57.4,71.3)	444	2647	78.3 (61.9,88.9)
With probable 30-day disorder	160	1109	15.8 (13.2,18.8)	129	1043	13.8 (7.3,24.6)
Helpful?	101	658	59.4 (49.5,68.5)	105	791	75.9 (38.2,94.1)
Any Health websites	1230	7549	30.3 (28.6,32.1)	2126	13,113	25.0 (21.8,28.5)
With probable 30-day disorder	535	3294	46.9 (43.2,50.6)	419	3021	40.0 (29.8,50.9)

Denominator: Entire cohort
Notes:
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25.
95%CI: 95% Confidence Interval
These are not mutually exclusive groups and therefore do not sum to 100%.

Internet treatments

Internet treatments such as MoodGYM, and e-couch were only used by approximately 2% of both the Transitioned ADF and 2015 Regular ADF. This rate was slightly higher for those with probable 30-day disorder.

Smartphone apps

Similarly, rates of uptake of smartphone applications remained quite low with only approximately 6% of Transitioned ADF and 2015 Regular ADF using these applications, although these rates doubled to 14% in both groups in those with a probable 30-day disorder. The most commonly used app was PTSD Coach used by 9.1% and 9.8% in the Transitioned ADF and the 2015 Regular ADF respectively.

Other internet

Approximately 20% of the Transitioned and 10% of 2015 Regular ADF reported using some form of additional internet usage to inform or assess their mental health. Of these, the most common form of additional internet use was social media, with 18.1% and 9.9% of Transitioned ADF and 2015 Regular ADF respectively using social media to inform or assess their mental health and approximately 55% of those finding it helpful. Considering this across the transitioned groups, the Ex-Serving group reported considerably higher social media usage of 22% compared with 17% and 13% in Inactive and Active Reservists respectively.

Telephone helplines

Approximately 9% of Transitioned ADF and 12% of 2015 Regular ADF used a veteran or military helpline, with rates of 17% and 19% respectively in those with a probable 30-day disorder. The VVCS Vetline was the most highly used helpline in both groups (approximately 8%) followed by 1800 IMSick in the 2015 Regular ADF (4.3%). Approximately 16% of Transitioned ADF and the 2015 Regular ADF with a probable 30-day disorder

reported using VVCS Vetline, with very high satisfaction rates of 75–85% in all users and 75% in those with a probable 30-day disorder.

Other telephone helplines which were not military specific, i.e., Lifeline, Mensline, Sane Australia were barely utilised across all groups (less than 2%), with the exception of 2015 Regular ADF members with a probable 30-day disorder, where 6% of this group reported use of the Relationships Australia helpline.

Ex-Service Organisations

Contact with ex-service organisations (ESOs) to inform or assess their mental health was reported by 9.2% of Transitioned ADF and 2.9% of 2015 Regular ADF. This figure doubled (18%) for those with a probable 30-day disorder. Rates of satisfaction with ESO services were also high, reinforcing the important role of these organisations within the broader veterans' service framework.

Preference for receiving mental health information

With respect to receiving health information, for both the Transitioned ADF and the 2015 Regular ADF there was a stronger preference for receiving this information face-to-face rather than by the internet or by telephone, which was the least preferred of the three options (Table 22). This effect was much stronger in those with a probable 30-day disorder, where 59.7% of Transitioned ADF and 52.2% of 2015 Regular ADF preferred to receive information face-to-face compared to the internet (26.8% and 29.5% respectively).

Table 22 Preferred method for receiving health information in the Transitioned ADF and 2015 Regular ADF, stratified by probable 30-day disorder

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95%CI)	n	Weighted n	% (95%CI)
All						
Face-to-face	1902	12,325	49.4 (47.4,51.4)	4484	29,335	55.9 (52.0,59.7)
Telephone	151	1219	4.9 (4.0,5.6)	178	1106	2.1 (1.2,3.6)
Internet	1182	7825	31.4 (29.6,33.3)	2199	14,975	28.5 (25.2,32.2)
Probable 30-day disorder	n = 7023			n = 7575		
Face-to-face	637	4191	59.7 (55.9,63.3)	630	3952	52.2 (41.3,62.8)
Telephone	45	350	5.0 (3.5,7.1)	33	429	5.7 (1.6,17.8)
Internet	261	1881	26.8 (23.6,30.3)	209	2235	29.5 (20.0,41.2)
No probable 30-day disorder	n = 17,909			n = 44,925		
Face-to-face	1265	8135	45.4 (43.1,47.8)	3854	25,383	56.5 (52.4,60.6)
Telephone	106	869	4.9 (3.8,6.1)	145	677	1.5 (1.0,2.2)
Internet	921	5944	33.2 (31.0,35.5)	1990	12,740	28.4 (24.8,32.9)

Denominator: Entire cohort
Notes:
Based on weighted counts, 7085 (13.49%) of 2015 Regular ADF, and 3562 (14.29%) Transitioned ADF had missing values for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25.
95%CI: 95% Confidence Interval

Stigma and barriers to care

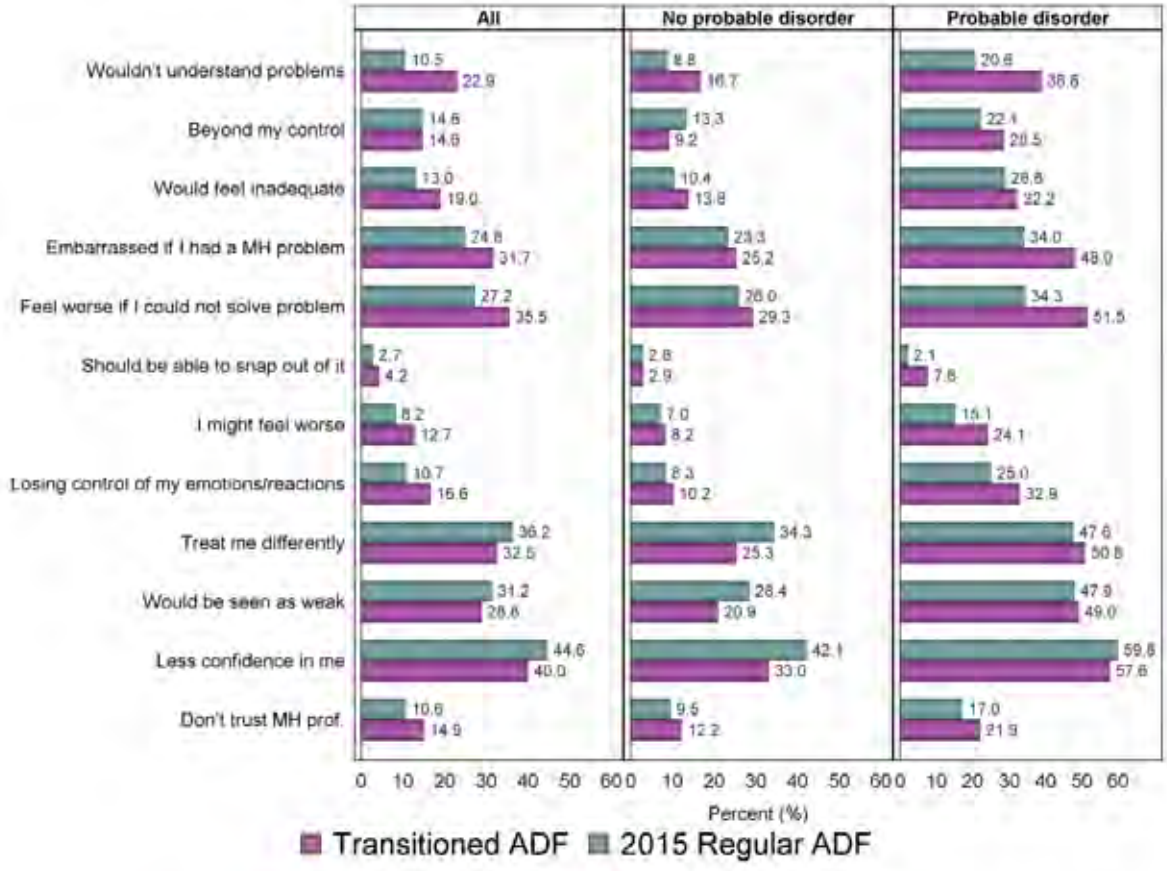
Stigma

This study examined the degree to which negative beliefs and attitudes to seeking care were evident amongst the Transitioned ADF and 2015 Regular ADF (Figure 11). This included the prevalence of negative beliefs relating to what help-seeking would mean about them and their expectation of themselves and how others would perceive them (self-stigma and anticipated public stigma), as well as beliefs about barriers to accessing care.

The most common negative attitudes and beliefs about help-seeking were consistent across both the Transitioned ADF and the 2015 Regular ADF, and included perceptions that others would lose confidence in them (40.0% and 44.6%), they would be seen as weak (28.8% and 31.3%), be treated differently (32.5% and

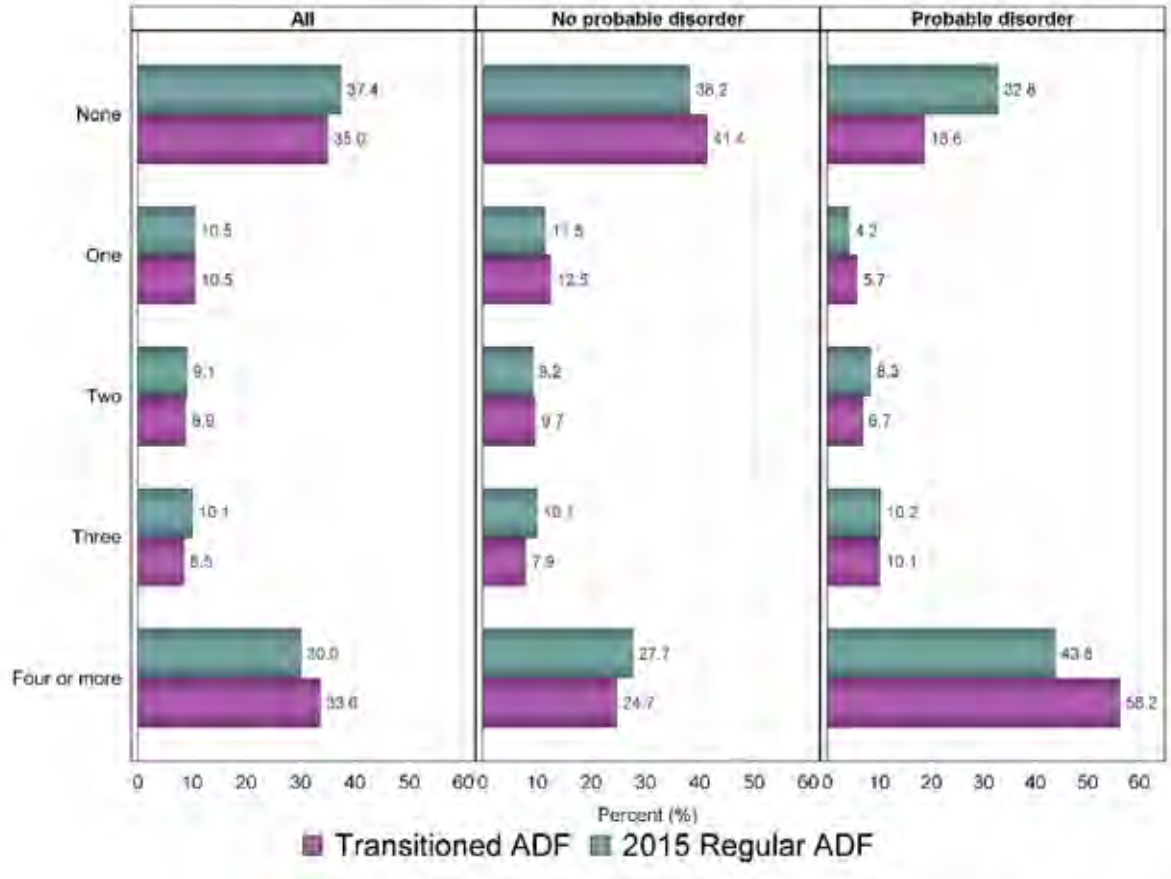
36.3%), feel worse due to being unable to solve their own problems (35.5% and 27.2%) and feel embarrassed (31.7% and 24.8%). Both the Transitioned ADF and the 2015 Regular ADF with probable 30-day disorder were more likely to endorse most stigma items.

Figure 11 Estimated proportion of Transitioned ADF and 2015 Regular ADF endorsing each stigma item stratified by probable 30-day disorder



While 35.0% of the Transitioned ADF and 37.4% of the 2015 Regular ADF groups did not report any stigmas, 33.6% and 30.0% respectively held four or more (Figure 12). In Transitioned ADF and 2015 Regular ADF with probable 30-day disorder, 56.2% and 43.8% respectively held four or more stigma related beliefs. Closer examination of this data indicated that care-seeking remained largely proportional to group size in the five stigma endorsement groupings, including for the group who endorsed four or more stigma-related beliefs.

Figure 12 **Number of stigmas endorsed in Transitioned ADF and 2015 Regular ADF stratified by probable 30-day disorder**



Barriers

The most common self-reported barrier to seeking care for a mental health problem in the Transitioned ADF was 'harm my career/career prospects' (30.3%), and for the 2015 Regular ADF was 'stop me from being deployed' (47.4%) (Figure 13). The next most commonly cited barriers for Transitioned ADF were 'too expensive' (30.0%) and 'difficulty getting time off work' (20.6%). For 2015 Regular ADF these were 'harm my career/career prospects' (38.7%) and 'difficulty getting time off work' (19.9%).

Similar results were found in those respondents with a probable 30-day disorder. For Transitioned ADF, the most commonly held barrier was 'too expensive' (42.2%), 'harm my career/career prospects' (41.9%) and 'difficulty getting time off work' (29.7%). For 2015 Regular ADF, these were 'stop me from being deployed' (47.2%), 'harm my career/career prospects' (46.0%) and 'difficulty getting time off work' (26.9%).

Reasons for not seeking assistance

The most common reasons for not seeking assistance for a mental health concern among the Transitioned ADF and 2015 Regular ADF were 'I can still function' (80.6% and 82.4%), 'prefer to manage myself' (76.7% and 80.1%), and 'afraid to ask' (42.6% and 44.9%) (Figure 14).

Figure 13 **Estimated proportion of Transitioned ADF and 2015 Regular ADF endorsing each barrier item stratified by probable 30-day disorder**

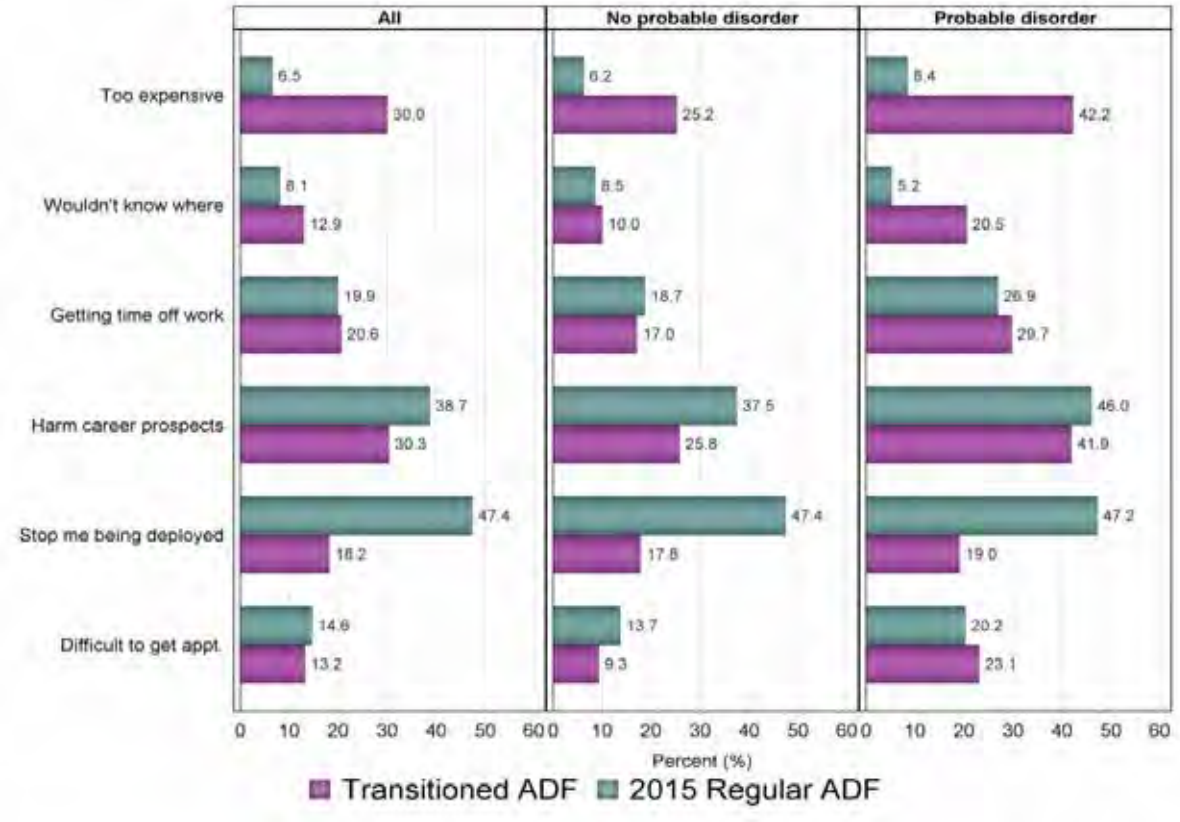


Figure 14 **Weighted estimate of reasons why help was not sought among those concerned with their mental health in the 2015 Regular ADF and Transitioned ADF, stratified by probable 30-day disorder**

Implications and future directions: Pathways to Care

The majority of the 2015 Regular ADF and the Transitioned ADF populations with a mental health concern will take the initial steps in seeking care within the first 12 months, with a considerable number doing so within the first three months. This care is commonly provided not only by psychologists, General Practitioners (GPs) and Medical Officers (MOs), but also by psychiatrists and a range of other allied mental health providers.

While the rates of initial engagement and uptake of services are reasonably high, due to an accumulation of factors that occur at each phase of the help-seeking process, the findings also suggest an under-engagement with evidence-based treatment for those with a current disorder. This is more evident in the Transitioned ADF than in the 2015 Regular ADF. Similarly, satisfaction with services is higher in the 2015 Regular ADF. Whilst effective treatment can and often should be episodic, these findings indicate that strategies need to be considered for improving engagement rates, retention and delivery of best practice care at each contact point.

Integration and coordination of services

There is currently a disparity between the available health service systems for Transitioned ADF and Regular ADF. One of the points of difference is the inherently more interconnected nature of the Defence health services for Regular ADF compared with the broader and more disparate range of services and service providers operating for Transitioned ADF. Currently there is little systematic coordination between the levels of care and providers of care for the Transitioned ADF, and therefore the risks of individuals falling out of care or into the gaps between services is considerable. Improving the organisation and coordination of health services across levels and types of care, and better supporting veterans in their navigation of services, will not only increase the potential for care to be delivered at the right level and intensity according to veterans' need, but will also place the veteran at the centre of the process and aid the ease with which they can assume agency in facilitating their own care. Aiding this coordination would be the future development and integration of a more proactive, outreach-focused and responsive health and non-health service capability.

Expertise in military culture and clinical presentations

With the exception of VVCS and the facilities providing accredited PTSD programs for veterans, services for Transitioned ADF are largely provided by a broad array of community practitioners and hospital-based services (National Mental Health Commission, 2017), many of which may not have sufficient exposure to military mental health issues. As such the military cultural competence and knowledge and skills in the treatment of veterans' common mental health problems may be quite variable. When satisfaction is examined more closely for specialised services such as the PTSD programs, satisfaction ratings are high and very high in currently serving ADF members. These systems have clear specifications to guide services delivered and identified quality assurance and evaluation processes around them specifically. In bolstering engagement and the satisfaction ratings for the competence and effectiveness domains identified in the *Pathways to Care Report* consideration needs to be given to the above features and factors in redressing these issues. One possibility to improve the quality and relevance of the services is to consider establishing networks of excellence (National Mental Health Commission, 2017) whereby services and practitioners with a cultural understanding of veterans and the experience, skill and competence in addressing veterans' mental health problems are identified and utilised. The network would also promote high levels of connectedness between services within the network, enabling closer communication between practitioners and allowing veterans to make informed decisions in the navigation of their own care.

While the focus is frequently on addressing more serious mental disorder, high quality services must also be provided for a broad range of presenting concerns in those without disorder. Such services serve a critical role of not only ameliorating current subclinical or broader psychosocial issues of concern but also in the prevention of further deterioration in mental health and the maintenance of wellbeing and functioning.

Bolstering effectiveness of treatment

Beyond the engagement in care, an issue for consideration is the degree to which Transitioned ADF and 2015 Regular ADF experience evidence-based treatments and an 'adequate dose' of such treatments (Rosen et al., 2011). The low reported rates of receiving CBT, the best proxy for evidence-based treatment within this study for common mental health problems, indicates the requirement for strategies to improve the extent to which evidence-based care is delivered and also the degree to which individuals remain in this care long enough to receive an effective intervention.

It is acknowledged that even the most evidence-based best practice interventions have limited effectiveness for a considerable proportion of veterans. Therefore, there is also a current DVA commitment reflected in the newly established DVA funded Centenary of Anzac Centre to continue to explore new and innovative biological, medical, social and psychological interventions to improve clinical outcomes for those who fail to benefit currently and adjunctive interventions in order to further enhance quality of life more broadly.

Bolstering support networks

For the majority of Transitioned and Regular ADF members in 2015, care had been suggested by others, particularly partners and friends. This reinforces the benefit of targeting mental health awareness and treatment information initiatives to the broader support network of Transitioned and Regular ADF members, including partners, family, peers, and commanders or supervisors. This has the potential to not only enhance treatment seeking rates but also direct current and ex-serving ADF members to the most appropriate source of mental health care.

Although the reported rates of contact with ESOs for mental health information and assistance were relatively low, rates of satisfaction with ESO services were high. This highlights the importance of DVA and Defence continuing to collaborate with the ESO community as they have the potential to act as a referral and access point to the evidence-based care provided by the broader veteran and ADF mental health care systems.

Bolstering the use of self-help strategies

While satisfaction with the DVA and ADF websites are at reasonable levels, and both the Transitioned ADF and 2015 Regular ADF populations were most likely to access websites designed specifically for ADF members by either DVA or Defence, the proportion accessing them is low. The reported use of mobile phone applications was even lower. Currently considerable effort and resources are being dedicated to the use of e-health options. There is much promise in these technologies, however, a better understanding of the reasons for the low uptake rates for current available resources is required. The awareness of and preferences for use of these technologies across information provision and e-interventions will be considered in more detail in the *Technology Use and Wellbeing Report*.

The overall use of social media was not high, but a quarter of Transitioned ADF with a probable 30-day disorder reported using social media as a resource for assessing or informing their mental health, with about half of those reporting it to be useful. Therefore, the potential use of social media in the promotion and dissemination of important health related information should be considered, and this could include consideration of online support groups to promote recovery. It will be however, important to better understand the manner in which social media is being used to leverage off this finding.

Both the 2015 Regular ADF and the Transitioned ADF were most likely to utilise a veteran or military helpline to inform or assess their mental health. The VVCS Vetline service, in particular, had a strong market presence and perceived satisfaction with this service was high. It appears to be a strong brand that can be built upon and integrated further into the service offerings of the health system.

As there was a stronger preference for receiving health information face-to-face than by internet or by telephone, particularly in those with a probable 30-day disorder, consideration should be given to delivery of health-related information face-to-face where possible. One of the most likely and frequent points of face-to-face contact in the 2015 Regular ADF or Transitioned ADF members' mental health is the GP/MO. Hence,

continuing to focus on building the capacity of GP/MOs to deliver clear and targeted mental health awareness, self-management and treatment information is important. These findings also support the current ADF approach of conducting face-to-face mental health screening at high risk points in the service member's career, including the post deployment mental health screening which includes a significant face-to-face psycho-educational component.

Stigma, beliefs about mental health treatment and barriers to care

There is evidence of significant self-stigma and anticipated public stigma in up to 50% of Transitioned and 2015 Regular ADF with probable 30-day disorders. While many of this group still sought care, these beliefs do impose a significant stress and emotional burden.

For those with mental health concerns who elected not to seek care, being afraid to ask was the most commonly cited reason for not accessing care. Furthermore, those with a probable 30-day disorder were more negative about the perceived trustworthiness of mental health professionals and the effectiveness of mental health treatment. Serious attention therefore needs to be paid by all agencies, departments and researchers to deliver clear and accurate public messaging regarding the potential availability and benefits of existing treatments, aligned with the evidence. Messaging that understates the availability of care and the effectiveness of this care can have significant impact on confidence and engagement (Rosen et al., 2011). Similarly, it is important that messages about the effectiveness of treatment be realistic and not overstated.

The prominence of the desire to help oneself was also evident in those with mental health concerns who did not seek care. Although a sense of agency, self-reliance and self-efficacy in solving one's problems is a highly valuable feature of resilience (Britt et al., 2016), a number of considerations emerge where this belief becomes a barrier to seeking care, where professional care is needed. Strategies to make self-help options more available, prominent, acceptable, non-threatening and effective ought to be considered. These may include digital options and greater examination and promulgation of self-management strategies both in terms of prevention and staying well, addressing subclinical problems and in the addressing of probable 30-day mental disorders (Commonweatlh of Australia Department of Health, 2013). There also needs to be further consideration of the messaging to a military population trained in the value of being able to solve their own problems and high levels of self-reliance. This messaging needs to consider how to effectively convey to this population that self-care, and when required, professional care-seeking for mental health concerns, can still be consistent with these values.

Finally, concerns that help-seeking will harm career need to be addressed through evidence. This is a complicated issue as declaration of mental health problems may, for reasons of overall duty of care to the organisation and the individuals (rather than public stigma), influence career outcomes in the short or longer term. However, it is critical that for those who seek care for mental health concerns, there is an ongoing focus on maximising their vocational engagement and career aspirations. For the purposes of changing culture, along with a strong policy and practice commitment to vocational rehabilitation and retention, it is critical that information about ADF members who have self-identified, sought care, and returned to meaningful and valued work be raised to greater attention and indeed be more commonplace. These examples should also represent a range of mental health problems. Current and ex-serving ADF members will understandably need to see examples of the successful application of vocational rehabilitation and retention to have the confidence that the practice matches the communications.

Areas for future research

The *Pathways to Care Report* examined the overall patterns of help-seeking and pathways into care among Transitioned ADF and 2015 Regular ADF members. There are however, a number of suggested areas for further examination of this data that emerge from these findings. The key ones include:

- Examination of the influence of gender, symptom severity, age, functioning and Service on help-seeking and perceived service satisfaction.

- Examination of the 15% of Transitioned ADF and 25% of 2015 Regular ADF who met criteria for a probable 30-day disorder but did not identify as having a concern about their mental health.
- Examination of the subgroup of Transitioned ADF with a probable 30-day disorder who endorsed four or more beliefs relating to stigma and barriers to care.
- Integration of the data from the *Pathways to Care Report* with the CIDI and suicidality data from the Mental Health Prevalence Report, to examine the patterns of help-seeking among those with specific diagnosed mental disorders and levels of suicidality.
- Examination of the patterns of service engagement in Transitioned ADF members based on their reported reasons for leaving the ADF, including a more detailed analysis of those who were medically or administratively discharged.

Glossary of terms

12-month prevalence – Meeting the diagnostic criteria for a lifetime ICD-10 mental disorder and having reported symptoms in the 12 months before the interview.

Affective disorders – A class of mental disorder. The Mental Health and Wellbeing Transition Study examined three types of affective disorders: depressive episodes, dysthymia and bipolar disorder. A key feature of these mental disorders is mood disturbance.

Agoraphobia – The marked fear or avoidance of situations such as crowds, public places, travelling alone or travelling away from home, which is accompanied by palpitations, sweating, shaking or dry mouth, as well as other anxiety symptoms such as chest pain, choking sensation, dizziness and sometimes feelings of unreality, fear of dying, losing control or going mad.

Alcohol dependence – A cluster of cognitive, behavioural and physiological characteristics indicating that the patient continues to use alcohol despite significant alcohol-related problems. A diagnosis was given if the person reported three or more of the following symptoms in the previous 12 months:

- a strong and irresistible urge to consume alcohol
- a tolerance to the effects of alcohol
- an inability to stop or reduce alcohol consumption
- withdrawal symptoms upon cessation or reduction of alcohol intake
- continuing to drink despite it causing emotional or physical problems
- reduction in important activities because of drinking or to drink.

Alcohol harmful use – A pattern of heavy drinking that is damaging to health. The damage may be physical or mental (in the absence of a diagnosis of dependence syndrome). Each participant was initially asked if they consumed 12 or more standard alcoholic drinks in a 12-month period. If so, they were then asked a series of questions about their level of consumption. A diagnosis of alcohol harmful use was applied if the alcohol interfered with work or other responsibilities; caused arguments with family or friends; was consumed in a situation where injury could occur; or resulted in the person being stopped or arrested by police; or if the participant continued drinking alcohol despite experiencing social or interpersonal problems as a result of their drinking during the previous 12 months. A person could not meet the criteria for alcohol harmful use if they met criteria for alcohol dependence.

Alcohol Use Disorders Identification Test (AUDIT) – Alcohol consumption and problem drinking was examined using the Alcohol Use Disorders Identification Test (Saunders et al., 1993), a brief self-report screening instrument developed by the World Health Organization. This instrument consists of 10 questions to examine the quantity and frequency of alcohol consumption, possible symptoms of dependence, and reactions or problems related to alcohol. The AUDIT is widely used in epidemiological and clinical practice for defining at-risk patterns of drinking.

Anxiety disorders – A class of mental disorder that involves experiencing intense and debilitating anxiety. Anxiety disorders covered in the survey were panic attacks, panic disorder, social phobia, specific phobia, agoraphobia, generalised anxiety disorder, posttraumatic stress disorder and obsessive-compulsive disorder.

Australian Bureau of Statistics (ABS) – Australia's national statistical agency, providing trusted official statistics on a wide range of economic, social, population and environmental matters of importance to Australia. To

enable comparison of estimates in the Transitioned ADF with an Australian Community population, direct standardisation was applied to estimates in the 2014–15 ABS National Health Survey (NHS) data. The NHS is the most recent in a series of Australia-wide ABS health surveys, assessing various aspects of the health of Australians, including long-term health conditions, health risk factors and health service use.

Australian Defence Force (ADF) – The ADF are members of the Permanent Navy, the Regular Army or the Permanent Air Force. This includes reserves that render continuous full-time service, or are on duty or in uniform. The Programme aims to examine the mental, physical and social health of serving and ex-serving ADF members and their families. It builds on previous research to inform effective and evidence-based health service provision for contemporary service members and veterans.

Australian Institute of Family Studies (AIFS) – The Australian Government's key research body focusing on family wellbeing. AIFS conducts original research to increase the understanding of Australian families and the issues that affect them. The research detailed in this report was conducted by a consortium of Australia's leading research institutions led by the Centre for Traumatic Stress Studies at the University of Adelaide, and AIFS.

Australian Institute of Health and Welfare (AIHW) – Australia's national agency for health and welfare statistics and information. It was used in this Programme to develop a Military and Veteran Research Study Roll by integrating contact information from various sources and databases.

Bipolar affective disorder – A class of mental disorder associated with significant mood fluctuations. These fluctuations are markedly elevated on some occasions (hypomania or mania) and markedly lowered on others (depressive episodes). A diagnosis of bipolar affective disorder was applied in this study if the individual met criteria for mania or hypomania in the previous 12 months.

Centre for Traumatic Stress Studies (CTSS) – This centre at the University of Adelaide seeks to improve evidence-based practice by informing and applying scientific knowledge in the field of trauma, mental disorder and wellbeing in at-risk populations. The Programme was conducted by a consortium of Australia's leading research institutions, led by the CTSS and the Australian Institute of Family Studies.

Chain of command – A line of authority and responsibility along which orders are passed within a military unit and between different units.

Class of mental disorder – A group of mental disorders that share common features. The survey included three classes of mental disorders: affective disorders, anxiety disorders and alcohol disorders.

Comorbidity – The occurrence of more than one disorder at the same time. Comorbidity was defined by grouping any alcohol, affective or anxiety disorder (excluding posttraumatic stress disorder – PTSD) and PTSD, according to their co-occurrence. In addition to breaking down the individual patterns of co-occurrence, five categories were defined, representing those with no mental disorder, and those with one, two, three or four disorders.

Confidence interval (CI) – This measurement gives an estimated range of values that is likely to include an unknown population parameter: the estimated range being calculated from a given set of sample data.

Department of Defence (Defence) – The Department is constituted under the *Defence Act 1903* (Cth). Its mission is to defend Australia and its national interests. In fulfilling this mission, Defence serves the government of the day and is accountable to the Commonwealth Parliament, which represents the Australian people.

Department of Veterans' Affairs (DVA) – The Department delivers government programs for war veterans, and members of the ADF and the Australian Federal Police and their dependants. In 2014, DVA, in

collaboration with the Department of Defence, commissioned the Transition and Wellbeing Research Programme, one of the largest and most comprehensive military research projects undertaken in Australia.

Deployment status – The Mental Health and Wellbeing Transition Study defined deployment status, based on survey responses, as:

- **Never deployed:** Individuals who did not endorse any deployments listed in the self-report survey (Your Military Career: Deployments) and did not endorse any deployment exposures (Your Military Career: Deployment Exposure)
- **Deployed:** Individuals who endorsed one or more of the listed deployments (Your Military Career: Deployments) or endorsed one or more of the deployment exposures (Your Military Career: Deployment Exposure).

Depressive episodes – Characteristic of a major depressive disorder, an episode requires that an individual has suffered from depressed mood lasting a minimum of two weeks, with associated symptoms or feelings of worthlessness, lack of appetite, difficulty with memory, reduction in energy, low self-esteem, concentration problems and suicidal thoughts. Depressive episodes can be mild, moderate or severe. All three are included under the same heading. Hierarchy rules were applied to depressive episodes, such that a person could not have met criteria for either a hypomanic or manic episode.

Diagnostic criteria – The survey was designed to estimate the prevalence of common mental disorders defined according to clinical diagnostic criteria under the International Statistical Classification of Diseases and Related Health Problems – 10th Revision (ICD-10). Diagnostic criteria for a disorder usually involves:

- the nature, number and combination of symptoms
- the time period over which the symptoms have been continuously experienced
- the level of distress or impairment experienced
- the circumstances for exclusion of a diagnosis, such as it being due to a general medical condition or the symptoms being associated with another mental disorder.

Dimensions of Anger Reactions Scale (DAR-5) – A concise measure of anger consisting of five items that address anger frequency, intensity, duration, aggression and interference with social functioning. Items are scored on a five-point Likert scale, generating a severity score ranging from 5 to 25, with higher scores indicating worse symptomatology. This scale has been used previously to assess Australian Vietnam veterans, as well as US Afghanistan and Iraq veterans, and shows strong unidimensionality, and high levels of internal consistency and criterion validity.

DVA client – A term used when referring to a DVA client during analyses. During construction of the DVA dataset for the Study Roll, DVA created an indicator for each veteran that assigned the degree of confidence in the accuracy of the data. This was based on the level of each veteran's interaction with DVA.

Each of the following were considered to signify whether someone was a DVA client:

- **High level of contact:** When a veteran received a fortnightly payment (such as income support or compensation pension) from DVA, which was a sign of regular ongoing contact with the client, so DVA was very confident that their address was up to date and correct
- **Medium level of contact:** When a veteran only had a treatment card (that is, they didn't receive ongoing payments) so there was less ongoing contact with the Department, and DVA was less confident about the accuracy of the client's address

- **Low level of contact:** When a veteran's illness or injury liability claim was not accepted by DVA as service-related so they would not automatically receive a treatment card or pension payment, but would still be considered a DVA client.

For this report, any individual in the study population who met any of the criteria above was flagged as a 'DVA client'. Those with this flag were compared against those without this flag.

Dysthymia – Characterised as a chronic or pervasive mood disturbance lasting several years that is not sufficiently severe or the depressive episodes are not sufficiently prolonged to warrant a diagnosis of a recurrent depressive disorder. The hierarchy rules applied to dysthymia meant that to have this disorder, a person could not have met criteria for either a hypomanic or manic episode and could not have reported episodes of severe or moderate depression within the first two years of dysthymia.

Epigenetic– is the study of heritable changes in gene expression (active versus inactive genes) that does not involve changes to the underlying DNA sequence – a change in phenotype without a change in genotype – which in turn affects how cells read the genes.

Ex-service organisation (ESO) – Organisations that provide assistance to current and former ADF members. Services can include but are not necessarily limited to welfare support, help with DVA claims, and employment programs and social support.

Generalised anxiety disorder (GAD) – A generalised and persistent worry, anxiety or apprehension about everyday events and activities lasting a minimum of six months that is accompanied by anxiety symptoms as described in 'agoraphobia'. Other symptoms may include muscle tension, inability to relax, irritability and difficulty concentrating. Using International Statistical Classification of Diseases and Related Health Problems – 10th Revision (ICD-10) criteria, generalised anxiety disorder cannot be diagnosed if symptoms can be better explained by another disorder, such as panic disorder, social phobia, obsessive-compulsive disorder or hypochondriacal disorder.

Generalised Anxiety Disorder 7-item Scale (GAD-7) – A brief seven-item screening measure based on the *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition* (DSM-IV) criteria for generalised anxiety disorder. Originally validated for use in primary care, the GAD-7 performs well in detecting probable cases of the disorder, with a sensitivity of 89% and a specificity of 82%.

Gold Card – A DVA health card for all conditions. Gold Card holders are entitled to DVA funding for services for all clinically necessary healthcare needs and all health conditions, whether or not they are related to war service. The card holder may be a veteran or the widow/widower or dependant of a veteran. Only the person named on the card is covered.

Help-seeking latency – The delay in time between first becoming concerned about a health problem and first seeking help for that problem. To assess help-seeking latency in the study, participants were asked to indicate when they first sought help for their own mental health. Options included 'within three months of becoming concerned' or 'within one year of becoming concerned'. Alternatively, participants were able to specify the number of years since becoming concerned. This item was developed by researchers for use in the study.

Hypomanic episodes – Episodes that last at least four consecutive days and are considered abnormal to the individual. These episodes are characterised by increased activity, talkativeness, elevated mood, disrupted concentration, decreased need for sleep and disrupted judgment, manifesting as risk-taking (for example, mild spending sprees). In a subgroup of people, these disorders are particularly characterised by irritability. To meet criteria for the 'with hierarchy' version, the person cannot have met criteria for an episode of mania.

Kessler Psychological Distress Scale (K10) – A short 10-item screening questionnaire that yields a global measure of psychological distress based on symptoms of anxiety and depression experienced in the most recent four-week period. Items are scored from 1 to 5 and are added up to give a total score between 10 and

50. Various methods have been used to stratify the scores of the K10. The categories of low (10–15), moderate (16–21), high (22–29) and very high (30–50) used in this report are derived from the cut-offs of the K10 that were used in the 2007 Australian Bureau of Statistics National Survey of Mental Health and Wellbeing (Slade et al., 2009).

Lifetime prevalence – A prevalence that meets diagnostic criteria for a mental disorder at any point in the respondent's lifetime.

Lifetime trauma – Exposure questions used in this study were drawn from the posttraumatic stress disorder module of the CIDI (Haro et al., 2006). Participants were asked to indicate whether or not they had experienced the following traumatic events: combat (military or organised non-military group); being a peacekeeper in a war zone or a place of ongoing terror; being an unarmed civilian in a place of war, revolution, military coup or invasion; living as a civilian in a place of ongoing terror for political, ethnic, religious or other reasons; being a refugee; being kidnapped or held captive; being exposed to a toxic chemical that could cause serious harm; being in a life-threatening motor vehicle accident; being in any other life-threatening accident; being in a major natural disaster; being in a man-made disaster; having a life-threatening illness; being beaten by a spouse or romantic partner; being badly beaten by anyone else; being mugged, held up or threatened with a weapon; being raped; being sexually assaulted; being stalked; having someone close to you die; having a child with a life-threatening illness or injury; witnessing serious physical fights at home as a child; having someone close experience a traumatic event; witnessing someone badly injured or killed or unexpectedly seeing a dead body; accidentally injuring or killing someone; purposefully injuring, torturing or killing someone; seeing atrocities or carnage such as mutilated bodies or mass killings; experiencing any other traumatic event.

Mania – Similar to hypomania but more severe in nature. Lasting slightly longer (a minimum of a week), these episodes often lead to severe interference with personal functioning. In addition to the symptoms outlined under 'hypomania', mania is often associated with feelings of grandiosity, marked sexual indiscretions and racing thoughts.

Medical Employment Classification (MEC) – An administrative system designed to monitor physical fitness and medical standards in the ADF. It is divided into four levels for members who are current or on discharge from the Regular ADF.

- **MEC 1:** Members who are medically fit for employment in a deployed or seagoing environment without restriction.
- **MEC 2:** Members with medical conditions that require access to various levels of medical support or employment restrictions. However, they remain medically fit for duty in their occupation in a deployed or seagoing environment. In allocating sub-classifications of MEC 2, access to the level of medical support will always take precedence over specified employment restrictions.
- **MEC 3:** Members who are medically unfit for duty in their occupation in a deployed or seagoing environment. The member should be medically managed towards recovery and receiving active medical management with the intention of regaining MEC 1 or 2 status within 12 months of an allocation of MEC 3 being made. The MEC is reviewed after a maximum of 12 months. If the person is still medically unfit for military duties in any operational environment, they are downgraded to MEC 4 or, if appropriate, referred to a Medical Employment Classification Review Board (MECRB) for consideration of an extension to remain at MEC 3.
- **MEC 4:** Members who are medically unfit for deployment or seagoing service in the long term. Members who are classified as MEC 4 for their military occupation are reviewed and the MECRB confirms their classification.

Medical fitness – A status defined as:

- **Fit:** Those who are categorised as fully employable and deployable, or deployable with restrictions. Participants are classified as 'fit' if they fall into MEC 1 or 2 as described above, or are assigned a perturbed MEC value of 'fit'.
- **Unfit:** Those not fit for deployment, their original occupation and/or further service. This can include people who are undergoing rehabilitation, transitioning to alternative return-to-work arrangements or who are in the process of being medically discharged from the ADF. Participants are classified as 'unfit' if they fall into MEC 3 or 4 as described above, or are assigned a perturbed MEC value of 'unfit'.

Medical discharge – The involuntary termination of the client's employment by the ADF on the grounds of permanent or long-term unfitness to serve, or unfitness for deployment to operational (war-like) service.

Mental disorders – Defined according to the detailed diagnostic criteria within the International Statistical Classification of Diseases and Related Health Problems – 10th Revision (ICD-10). This publication reports data for ICD-10 criteria.

Mental Health Prevalence and Wellbeing Study (MHPWS) – The 2010 study is part of the Military Health Outcomes Program (MilHOP), the first comprehensive investigation of the mental health of serving ADF members.

Middle East Area of Operations (MEAO) – Australia's military involvement in Afghanistan and Iraq is often referred to as the Middle East Area of Operations. Thousands of members have deployed to the MEAO since 2001, with many completing multiple tours of duty. The Transition and Wellbeing Research Programme will build upon the Military Health Outcomes Program, which detailed the prevalence of mental disorders among serving ADF members in 2010 as well as deployment-related health issues for those deployed to the MEAO.

Military Health Outcomes Program (MilHOP) – MilHOP detailed the prevalence of mental disorders among serving ADF members in 2010 as well as deployment-related health issues for those deployed to the Middle East Area of Operations. The Transition and Wellbeing Research Programme will address a number of gaps identified following MilHOP, including the mental health of Reservists, Ex-Serving members and ADF members in high-risk roles, as well as the trajectory of disorders and pathways to care for individuals identified with a mental disorder in 2010.

National Death Index (NDI) – A Commonwealth database that contains records of deaths registered in Australia since 1980. Data comes from the Registry of Births, Deaths and Marriages in each jurisdiction, the National Coronial Information System and the Australian Bureau of Statistics. Before contacting participants, the Study Roll was cross-checked against the NDI to ensure we did not attempt to approach deceased members.

National Health and Medical Research Council (NHMRC) – Australia's peak funding body for medical research. The NHMRC has funded previous investigations undertaken by the Centre for Traumatic Stress Studies.

National Health Survey (NHS) – The 2014–15 National Health Survey is the most recent in a series of Australia-wide ABS health surveys, assessing various aspects of the health of Australians, including long-term health conditions, health risk factors, and health service use.

Obsessive compulsive disorder (OCD) – A disorder characterised by obsessional thoughts (ideas, images, impulses) or compulsive acts (ritualised behaviour). These thoughts and acts are often distressing and typically cannot be avoided, despite the sufferer recognising their ineffectiveness.

Optimal epidemiological cut-off – The value that brings the number of false positives (mistaken identifications of a disorder) and false negatives (missed identifications of a disorder) closest together, thereby counterbalancing these sources of error most accurately. Therefore, this cut-off would give the closest

estimate to the true prevalence of a 30-day ICD-10 disorder as measured by the CIDI and should be used to monitor disorder trends.

Optimal screening cut-off – The value that maximises the sum of the sensitivity and specificity (the proportion of those with and without a disease who are correctly classified). This cut-off can be used to identify individuals who might need further evaluation.

Panic attack – Sudden onset of extreme fear or anxiety, often accompanied by palpitations, chest pain, choking sensations, dizziness, and sometimes feelings of unreality, fear of dying, losing control or going mad.

Panic disorder – Recurrent panic attacks that are unpredictable in nature.

Patient Health Questionnaire-9 (PHQ-9) – Self-reported depression was examined using the nine-item questionnaire. The items are scored from 0 to 3 and added up to give a total score between 0 and 27. Higher scores indicate higher levels of depression symptoms.

Pharmaceutical Benefits Scheme (PBS) – The PBS began as a limited scheme in 1948, offering free medicines for pensioners and a list of 139 'life-saving and disease-preventing' medicines free to other members of the community. Today, the PBS provides timely, reliable and affordable access to necessary medicines for all Australians. The PBS is part of the Australian Government's broader National Medicines Policy. Data on healthcare use and costs, and PBS and Repatriation Pharmaceutical Benefits Scheme data was obtained for consenting serving and Ex-Serving ADF members as part of the research programme.

Posttraumatic stress disorder (PTSD) – A stress reaction to an exceptionally threatening or traumatic event that would cause pervasive distress in almost anyone. Symptoms are categorised into three groups: re-experiencing memories or flashbacks, avoidance symptoms and either hyperarousal symptoms (increased arousal and sensitivity to cues) or inability to recall important parts of the experience.

The Posttraumatic Stress Disorder Checklist – civilian version (PCL-C) – A 17-item self-report measure designed to assess the symptomatic criteria of PTSD according to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). The answers are scored from 1 to 5 and added up to give a total symptom severity score of between 17 and 85. An additional four items from the newly released PCL-5 (in the DSM-5) were included, giving researchers flexibility to also measure PTSD symptoms according to the most recent definitional criteria.

Personnel Management Key System (PMKeyS) – An integrated human resource management system that provides the ADF with a single source of personnel management information about the entire Defence workforce – Royal Australian Navy, Australian Army and Royal Australian Air Force.

Prevalence of mental disorders – The proportion of people in a given population who meet diagnostic criteria for any mental disorder in a given time frame. (See also '12-month prevalence' and 'lifetime prevalence'.)

Probable mental disorder – Where probable rates of mental disorder are presented, these are based on self-reported epidemiological cut-offs.

Psychopathology – The scientific study of mental disorders.

Rank status – Three levels of rank were used in the Mental Health and Wellbeing Transition Study:

- **Commissioned Officer (OFFR):** Senior Commissioned Officers (Commander (CMDR), Lieutenant Colonel (LTCOL), Wing Commander (WGCDR) and above) and Commissioned Officers (Lieutenant Commander (LCDR), Major (MAJ), Squadron Leader (SQNLDR) and more junior ranks)

- **Non-Commissioned Officer (NCO):** Senior Non-Commissioned Officers (Petty Officer (PO), Sergeant (SGT) and more senior ranks), and Junior Non-Commissioned Officers (Leading Seaman (LS), Corporal (CPL) and more junior ranks)
- **Other Ranks:** Able Seaman (AB), Seaman (SMN), Private (PTE), Leading Aircraftman (LAC), Aircraftman (AC) or equivalent.

Reason for discharge – The reason for transitioning out of the ADF. In the Programme, the reason for discharge was derived from responses on the self-report survey, and classified accordingly:

- **Medical discharge:** Involuntary termination of the client's employment by the ADF on the grounds of permanent or at least long-term unfitness to serve, or unfitness for deployment to operational (war-like) service
- **Other:** All other types of discharge including compulsory age retirement, resignation at own request, assessed as unsuitable for further training, end of fixed-period engagement, end of initial enlistment period or return of service obligation, end of limited-tenure appointment, not offered re-engagement, accepted voluntary redundancy, compassionate grounds, and non-voluntary administrative discharge.

Repatriation Pharmaceutical Benefits Scheme (RPBS) – The benefits listed in the RPBS can only be prescribed for Department of Veterans' Affairs beneficiaries who hold a Gold, White or Orange card. Data on healthcare use and costs, and Pharmaceutical Benefits Scheme and RPBS data was obtained for consenting serving and Ex-Serving ADF members as part of the Programme.

Service status – The ADF is comprised of:

- **Australian Army:** The military land force, a potent, versatile and modern army that contributes to the security of Australia, protecting its interests and people
- **Royal Australian Navy:** A maritime force that contributes to regional security, supports global interests, shapes the strategic environment and protects national interests
- **Royal Australian Air Force:** An air force that provides immediate and responsive military options across the spectrum of operations as part of a whole-of-government joint or coalition response, either from Australia or deployment overseas. It does this through its key air power roles – control of the air; precision strikes; intelligence, surveillance and responses; and air mobility – enabled by combat and operational support.

Social phobia – The marked fear or avoidance of being the centre of attention or in situations where it is possible to behave in a humiliating or embarrassing way, accompanied by anxiety symptoms, and possibly blushing and fear of vomiting, defecating or urinating.

Specific phobia – The marked fear or avoidance of a specific object or situation such as animals, birds, insects, heights, thunder, flying, small enclosed spaces, sight of blood or injury, injections, dentists or hospitals, and accompanied by anxiety symptoms as described in 'agoraphobia'.

Stratification – Grouping outcomes by variables of interest. In Report 1, 12-month diagnosable mental disorder and self-reported suicidality were stratified by age, sex, rank, service, years of service in the Regular ADF, deployment status, transition status, years since transition, reason for transition and DVA client status.

Study Roll – Participants' contact details and demographic information were obtained via the creation of a study roll by the Australian Institute of Health and Welfare. This process involved integrating contact information from the following sources:

- Defence Personnel Management Key Solution database

- DVA client databases
- National Death Index
- ComSuper member database
- Military Health Outcomes Program (MilHOP) dataset.

Suicidal ideation – Serious thoughts about taking one's own life.

Suicidality – Suicidal ideation (serious thoughts about taking one's own life), suicide plans and attempts.

Subsyndromal disorder – Characterised by or exhibiting symptoms that are not severe enough for diagnosis as a clinically recognised syndrome.

Transitioned ADF/ADF members – ADF members who have left military service. For the study, this included all ADF members who transitioned from the Regular ADF between 2010 and 2014, including those who transitioned into the Active Reserve and Inactive Reserve.

Transitioned status – Transitioned ADF members were categorised into one of three groups, which broadly represented their level of continued association and contact with Defence and their potential access to support services provided by Defence:

- **Ex-serving:** A person who was a Regular ADF member before 2010, has since transitioned out of the ADF and is no longer engaged with Defence in a Reservist role. The individual is classified as discharged from Defence
- **Inactive Reservist:** A person who was a Regular ADF member before 2010, but has since transitioned into an Inactive Reservist role
- **Active Reservist:** A person who was a Regular ADF member before 2010, but has since transitioned into an Active Reservist role.

Two-phase design – A well-accepted epidemiological approach to investigating the prevalence of mental disorders. In the first phase, participants completed a screening questionnaire, which was generally economical in terms of time and resources. Based on the results of this screening and the demographic information provided, certain participants were selected for a more accurate but costly formal diagnostic interview.

Veterans' health cards – DVA, on behalf of the Australian Government, uses the health cards as a convenient method for veterans, war widows and their eligible dependants to access health and other care services. Arrangements are based on providing access to clinically appropriate treatment that is evidence-based. There are Gold, White and Orange health cards.

Weighting – Allowing for the inference of results for the entire population. Weighting involved allocating a representative value or 'weight' to the data for each responder, based on key variables. The weight indicated how many individuals in the entire population were represented by each responder. Weighting was applied to:

- correct for differential non-response
- adjust for any systematic biases in the responders (for example, oversampling of high scorers for the CIDI).

White Card – A DVA health card for specific conditions. A White Card entitles the holder to care and treatment for:

- injuries or conditions that are accepted as being caused by war or service-related

- malignant cancer, pulmonary tuberculosis, posttraumatic stress disorder, anxiety and/or depression, whether or not it was caused by war
- symptoms of unidentifiable conditions that arise within 15 years of service (other than peacetime service).

Services covered by a White Card are the same as those for a Gold Card, but must be for treatment of conditions that are accepted as being caused by war or service-related.

World Mental Health Survey Initiative Version of the World Health Organization Composite International Diagnostic Interview – version 3 (CIDI) – The CIDI (Kessler and Ustun, 2004) provides an assessment of mental disorders based on the definitions and criteria of two classification systems: the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) and the International Statistical Classification of Diseases and Related Health Problems – 10th Revision (ICD-10) (World Health Organisation, 1994). This instrument was used in phase 2 of the Programme.

Years since transition – To ascertain the number of years since transition from Regular Service, participants were asked to indicate what year they transitioned to Active Reserves, Inactive Reserves or were discharged out of the Service (Ex-Serving). Options included: zero, one, two, three, four or five years.

Years of Regular Service – The following categories were used in the Mental Health and Wellbeing Transition Study to define the number of years of Regular Service: 3 months – 3.9 years, 4–7.9 years, 8–11.9 years, 12–15.9 years, 16–19.9 years and 20+ years.

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TRANSITION AND WELLBEING RESEARCH PROGRAMME

MENTAL HEALTH AND WELLBEING TRANSITION STUDY

Pathways to Care

2018

ISBN 978-0-6481608-2-3 (PDF)
ISBN 978-0-6481608-3-0 (Print)

Suggested reference:

Forbes D, Van Hooff M, Lawrence-Wood E, Sadler N, Hodson S, Benassi H, Hansen C, Avery J, Varker T, O'Donnell M, Phelps A, Frederickson J, Sharp M, Searle A, McFarlane A, 2018, *Pathways to Care, Mental Health and Wellbeing Transition Study*, the Department of Defence and the Department of Veterans' Affairs, Canberra.

This report is available from:

The Department of Defence
http://www.defence.gov.au/Health/DMH/ResearchSurveillancePlan.asp

The Department of Veterans' Affairs
www.dva.gov.au/pathways-care-report

Published by the Department of Veterans' Affairs, Canberra

Publication no: P03383

Key findings

This *Pathways to Care Report* is the second of eight reports and two papers that comprise the Transition and Wellbeing Research Programme (the Programme). The Programme is the most comprehensive study undertaken in Australia on the impact of military service on the mental, physical and social health of Transitioned and 2015 Regular Australian Defence Force (ADF) members and their families (the study populations).

This report complements the first report, *Mental Health Prevalence,* which explored the prevalence of 12-month and lifetime mental disorder in the Transitioned ADF and compared self-reported symptoms in Transitioned ADF with 2015 Regular ADF members.

Pathways to Care investigates how Transitioned and 2015 Regular ADF access, use and value mental health services. This includes the proportion who received care, the type of care received, reasons for seeking care, pathways into care, satisfaction with services, funding of services and their attitudes and beliefs about mental health and seeking care.

Study populations for both reports are:

- ADF members who transitioned from the Regular ADF between 2010 and 2014 (including Ex-Serving, Active and Inactive Reservists)
- a random sample of Regular ADF members serving in 2015
- 2015 Regular ADF and Transitioned ADF members who participated in the 2010 Military Health Outcomes Program or MilHOP.

In regard to seeking care, the majority of the serving and Ex-Serving ADF populations with a mental health concern will take the initial steps in seeking care within the first 12 months, with a significant number doing so within the first three months. This care is commonly provided not only by General Practitioners (GPs) (non-Defence) and Medical Officers (MOs) (Defence), but by mental health professionals including psychologists, psychiatrists and a range of other allied mental health providers. The majority of those with mental health concerns have engaged in care for these concerns, despite high rates of endorsement of stigma-related beliefs.

While the rates of initial engagement and uptake of services are reasonably high due to an accumulation of factors that occur at each phase of the help-seeking process, the findings suggest an under-engagement with evidence-based treatment for those with a current disorder. This is more evident in the Transitioned ADF than in the 2015 Regular ADF.

Similarly, satisfaction with services is higher in the 2015 Regular ADF. While effective treatment can and often should be episodic, these findings indicate that strategies need to be considered for improving engagement rates, retention and delivery of best-practice care at each contact point.

We suggest reading the *Mental Health Prevalence* and *Pathways to Care Reports* chronologically to obtain a full understanding of the status of Transitioned and Regular ADF mental health. While reading the findings below, it is important to remember that references to the "… last 12 months …" is referring to the 12 months prior to the date of participation in the study with all data collection undertaken between 1 June and 31 December, 2015.

Definitions of key terms used in this report

Transitioned ADF members -population of ADF members who transitioned from full-time ADF service between 2010 and 2014, including those who transitioned into the Active and Inactive Reserves and those who had discharged completely (Ex-Serving).

2015 Regular ADF – ADF members who were serving full-time in the ADF in 2015

Mental health concern – having ever had any level of concern about their mental health.

Probable mental disorder – Where probable rates of mental disorder are presented, these are based on self-reported epidemiological cut-offs.

Refer to the Glossary of terms for definitions of other key terms in this section.

Demographics

- More than half of Transitioned ADF members remained in the ADF as Reservists (55.8%). Of these, 25.7% were Active Reservists.
- Approximately, 84% of the Transitioned ADF were either working or engaged in some purposeful activity with 62.8% being employed. Just over 5.5% of the Transitioned ADF had retired.
- More than 43% of Transitioned ADF members reported accessing DVA-funded treatment through either a DVA White Card (39.4%) or DVA Gold Card (4.2%).
- Just over one-fifth of the Transitioned ADF were estimated to have been medically discharged.
- The most commonly reported reasons for transition were 'impact of service life on family' (10.2%), 'better employment prospects in civilian life' (7.2%), 'mental health problems' (6.5%) and 'physical health problems' (4.3%).
- There were no significant differences in housing stability between the Transitioned ADF and the 2015 Regular ADF, with more than 93% estimated to have been in stable housing in the previous two months.
- Just over 40% of the Transitioned ADF and 36% of the 2015 Regular ADF reported having a diploma or university qualification.
- Twice as many members of the Transitioned ADF were classified as medically unfit compared to the 2015 Regular ADF.

Self-reported concerns for mental health

- Over half the Transitioned ADF (64.4%) and 2015 Regular ADF (52.1%) have been concerned about their mental health during their lifetime.
- Prevalence of mental health concerns were significantly higher for the Ex-Serving group (70.9%) compared with the Inactive (61.0%) and the Active (57.6%) Reserve groups.

Help-seeking in the Transitioned ADF and 2015 Regular ADF

- Approximately, 3 in 4 Transitioned ADF and 2015 Regular ADF have received assistance for their mental health in their lifetime. Of these, about 41% of Transitioned ADF and 46% of 2015 Regular ADF report receiving assistance currently or within the last 12 months.
- Approximately, half of Transitioned ADF and 2015 Regular ADF sought help for their mental health within three months of becoming concerned about it.

Support from others in seeking care

- For around 60% of Transitioned ADF and 2015 Regular ADF, who were concerned about their mental health and sought assistance, someone else had suggested they seek care for their mental health, usually a partner or friend.
- Only about 30% received assistance in engaging with mental health care. For Transitioned ADF this was most commonly a doctor (either a General Practitioner or Medical Officer), partners or supervisors and, for Regular 2015 ADF, this was most commonly supervisors, General Practitioners or Medical Officers.

Primary reasons for seeking care

- In both the Transitioned and Regular ADF the most common reasons for seeking assistance were depression, anxiety, relationship problems and anger.

Help-seeking among Transitioned ADF and 2015 Regular ADF with a probable current mental disorder

- Of the Transitioned ADF and 2015 Regular ADF with a probable current mental disorder, who have expressed a concern about their mental health and sought care, 75% had done so currently or within the last 12 months.
- Of those with probable disorder, 2015 Regular ADF were more likely than Transitioned ADF to seek care within the first three months.

Attrition in help seeking

- Self-reported rates of help seeking for a mental health problem are reasonably high, but due to attrition at each help seeking stage and variability in the treatment services delivered, approximately a quarter of those with a probable current mental disorder were estimated to have received evidence-based care in the last 12 months.

Mental health service use

In Transitioned ADF and 2015 Regular ADF with a mental health concern

- Transitioned ADF and 2015 Regular ADF with a mental health concern reported very high rates of consulting a General Practitioner/Medical Officer, psychologist and/or a psychiatrist at some stage in their lifetime.
- There were high rates of satisfaction with the services delivered by these health professionals.

In Transitioned ADF and 2015 Regular ADF with a probable current mental disorder

- While the majority of Transitioned ADF and 2015 Regular ADF with a probable current mental disorder had reported consulting a psychologist in the self-report survey, only half of these had done so in the last 12 months.
- Approximately 60% of Transitioned ADF and 2015 Regular ADF with a probable current mental disorder reported consulting a psychiatrist in the self-report survey, and over half of these had done so in the last 12 months.

Satisfaction with health service factors

- 2015 Regular ADF were more likely to be satisfied than Transitioned ADF in the accessibility, location, effectiveness, competence, friendliness, convenience and confidentiality of health services. Those with probable current mental disorders reported lower satisfaction across all health service factors.

Mental health services funding

- Defence was the main funder of mental health services for the 2015 Regular ADF, followed by DVA, including Veterans and Veterans Families Counselling Service (VVCS).
- DVA was the main funder of mental health services for Transitioned ADF, followed by Medicare and self-funding.

Methods used to inform or assess mental health among the Transitioned ADF and 2015 Regular ADF

Websites

- Around one quarter of Transitioned ADF and 2015 Regular ADF used websites to inform or assess their mental health, and were most likely to access websites designed by DVA or Defence. While satisfaction with the DVA and Defence websites were at reasonable levels, the proportion accessing them was low.

Smart phone apps

- Use of all smart apps were low in both Transitioned and 2015 Regular ADF members, but doubled in those with a probable current mental disorder.

Helplines

- About 10% of both Transitioned and 2015 Regular ADF members used a veteran or military helpline, and these rates doubled in those with a probable current mental disorder. VVCS Vetline was the most highly used helpline with very high satisfaction rates.

Ex-service organisations (ESOs)

- Less than 10% of Transitioned and 2015 Regular ADF members used ESOs to inform or assess their mental health. This doubled for those with a probable current mental disorder.
- Rates of satisfaction with ESO services were high.

Receiving health information

- Both Transitioned and 2015 Regular ADF members preferred receiving mental health information face-to-face rather than by the internet or by telephone. This effect was much stronger in those with a probable current disorder.

Stigma

- In both Transitioned 2015 and Regular ADF members, the highest rated stigmas were concerns others would lose confidence in them, that they would be seen as weak, that they would be treated differently, that they would feel worse due to being unable to solve their own problems, that they would feel embarrassed. Those with probable current mental disorder were more likely to endorse each stigma item.
- The most common reasons for not seeking assistance in both Transitioned and 2015 Regular ADF members were a perceived preference to self-manage, ability to function effectively and feeling afraid to ask.
- Over half the Transitioned ADF and around 40% of the 2015 Regular ADF with probable current mental disorder held four or more stigma-related beliefs. However, the vast majority of those with mental health concerns still engaged in care.

Barriers to seeking help

- The most common barriers to seeking help for 2015 Regular ADF were concerns about the impact on deployability or career and for Transitioned ADF were concerns about the impact on career and expense.

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Acknowledgments

Study participants

First and foremost, we acknowledge all current and ex-serving ADF personnel who generously gave their time to complete the study. This research was only made possible by their efforts and commitment to the study. Other key individuals include:

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Phoenix Australia, Centre for Posttraumatic Mental Health, University of Melbourne

Dr Tracey Varker, Professor Meaghan O'Donnell, Associate Professor Andrea Phelps, Dr Julia Frederickson, Dr Richard Cash, Dr John Cooper, Associate Professor Darryl Wade, Ms Loretta Watson.

Hunter Valley Foundation

Ms Shanti Ramanathan, Mr David Shellard, Dr Clare Hogue, Ms Phyllis Hartung, Mr Russ Redford and the team of CIDI interviewers.

Nexview Systems

Mr Trevor Moyle, Ms Hong Yan.

Australian Institute of Family Studies

Dr Galina Daraganova, Dr Jacquie Harvey.

Australian Institute of Health and Welfare

Mr Phil Anderson, Mr Nick Von Sanden, Mr Richard Solon, Mr Tenniel Guiver.

Australian Bureau of Statistics

Mr David Haynes, Ms Beatrix Forrest, Ms Michelle Ducat and staff from the Health and Disability Branch, Mr Barry Tynan and staff from the Communications and Dissemination Branch.

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Ms Kyleigh Heggie, Ms Karen Barker, Dr Loretta Poerio, Ms Melissa Preston, Dr Carmel Anderson, Mr Tim Cummins, Ms Olivia Mahn, Ms Rachel McNab, Mr Christian Callisen, Department of Veterans' Affairs.

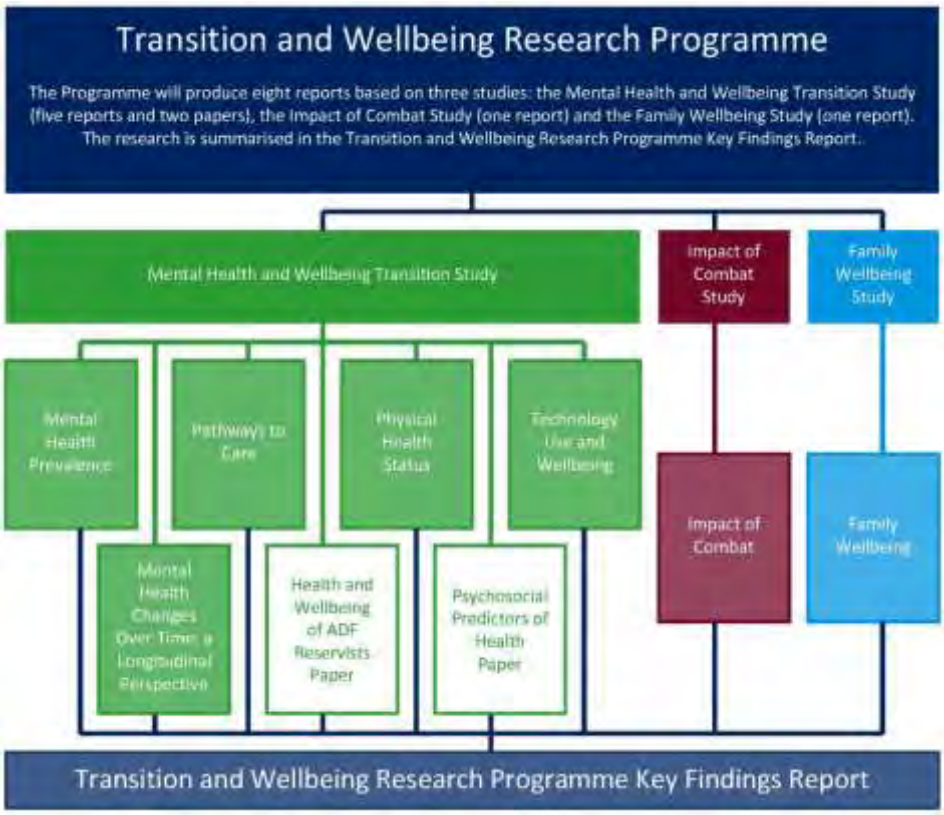
COL Laura Sinclair, Ms Jess Styles, Ms Kanny Tait, Department of Defence.

For their assistance in developing the Study Roll: Mr Mark Watson and Ms Megan MacDonald, Department of Veterans' Affairs, and Ms Carolina Casetta and Warrant Officer Class One Iain Lewington, Joint Health Command, Department of Defence.

Other key organisations

Australia Post.

Transition and Wellbeing Research Programme – an overview



The Transition and Wellbeing Research Programme (Programme) is the most comprehensive study undertaken in Australia that examines the impact of military service on the mental, physical and social health of:

- serving and ex-serving Australian Defence Force (ADF) members, including those who have been deployed in contemporary conflicts, and
- their families.

This research further extends and builds on the findings of the world-leading research conducted with current serving members of the ADF in the 2010 Military Health Outcomes Program (MilHOP).

This current research, conducted in 2015, arises from the collaborative partnership between the Department of Veterans' Affairs (DVA) and Department of Defence (Defence). It aims to implement the Government's goal of ensuring that current and future policy, programs and services are responsive to the current and emerging health and wellbeing needs of serving and ex-serving ADF members and their families before, during and after transition from military life.

Ten objectives were developed to guide the Programme. The objectives are being realised through three studies comprising eight reports: the Mental Health and Wellbeing Transition Study (five reports and two papers), the Impact of Combat Study (one report), the Family Wellbeing Study (one report) and the Transition and Wellbeing Research Programme Key Findings Report, which summarises the research, as the diagram above shows. The table below shows which reports deliver on the objectives. This report, *Pathways to Care*, addresses the objective:

3. Assess pathways to care for Transitioned ADF and the 2015 Regular ADF, including those with a probable 30-day mental disorder.

Programme objectives	Corresponding reports and papers
1. Determine the prevalence of mental disorders among ADF members who have transitioned from Regular ADF service between 2010 and 2014. 2. Examine self-reported mental health status of Transitioned ADF and the 2015 Regular ADF.	*Mental Health Prevalence Report*
3. Assess pathways to care for Transitioned ADF and the 2015 Regular ADF, including those with a probable 30-day mental disorder.	*Pathways to Care Report*
4. Examine the physical health status of Transitioned ADF and the 2015 Regular ADF.	*Physical Health Status Report*
5. Investigate technology and its utility for health and mental health programmes including implications for future health service delivery.	*Technology Use and Wellbeing Report*
6. Conduct predictive modelling of the trajectory of mental health symptoms/disorder of Transitioned ADF and the 2015 Regular ADF, removing the need to rely on estimated rates.	*Mental Health Changes Over Time: a Longitudinal Perspective Report*
7. Investigate the mental health and wellbeing of currently serving 2015 Ab initio Reservists.	*The Health and Wellbeing of ADF Reservists Paper*
8. Examine the factors that contribute to the wellbeing of Transitioned ADF and the 2015 Regular ADF.	*Psychosocial Predictors of Health Paper*
9. Follow up on the mental, physical and neurocognitive health and wellbeing of participants who deployed to the Middle East Area of Operations between 2010 and 2012.	*Impact of Combat Report*
10. Investigate the impact of ADF service on the health and wellbeing of the families of Transitioned ADF and the 2015 Regular ADF.	*Family Wellbeing Report*
All objectives	*Transition and Wellbeing Research Programme Key Findings Report*

Two eminent Australian research institutions, one specialising in trauma and the other in families, are leading the research programme. The Centre for Traumatic Stress Studies at the University of Adelaide is conducting the Mental Health and Wellbeing

Transition Study and the Impact of Combat Study, and the Australian Institute of Family Studies is conducting the Family and Wellbeing Study.

Their research expertise is enhanced through partner institutions from Monash University, the University of New South Wales, Phoenix Australia – Centre for Posttraumatic Mental Health and, until June 2016, the Young and Well Cooperative Research Centre, the work of which is being continued through Innowell.

Through surveys and interviews, the researchers engaged with a range of DVA clients and ADF members including:

- ADF members who transitioned from the Regular ADF between 2010 and 2014 (including Ex-Serving, Active and Inactive Reservists)
- a random sample of Regular ADF members serving in 2015
- a sample of Ab initio Reservists serving in 2015 (who have never been full-time ADF members)
- 2015 Regular ADF and Transitioned ADF members who participated in MilHOP
- family members nominated by the above.

DVA and Defence thank the current and ex-serving ADF members and their families who participated in this research for sharing your experiences and insights. Your efforts will help inform and assist the ways you, your colleagues, friends and families – as well as those who come after you – can best be supported during and after a military career.

1 Introduction

1.1 Background to the current report

The 2010 ADF Mental Health Prevalence and Wellbeing Study (2010 MHPWS) found that ADF members are generally literate on matters of mental health and aware of the mental health services available to them, but that a range of factors – including mental health status, attitudes, beliefs and barriers – influence how they access that care (McFarlane, Hodson, Van Hooff, Verhagen & Davies, 2011). Under-utilisation of mental health services may lead to individuals experiencing unnecessarily prolonged or exacerbated psychological distress (Clement et al., 2014), potentially worsening the impact on their relationships, their ability to maintain employment and their physical health.

The first report from the current Mental Health and Wellbeing Transition Study, *Mental Health Prevalence*, details the prevalence of mental disorders in Transitioned ADF and 2015 Regular ADF members. It is worth noting that there was high mental disorder comorbidity among Transitioned ADF members; more than 40% of Transitioned ADF members were estimated to have a 12-month mental disorder and more than half had at least one mental disorder comorbidity. This current report investigates the patterns of Transitioned ADF and 2015 Regular ADF members seeking and using health services due to concerns about their mental health. For detailed descriptions of service member types, see Annex B, section B.3. The following section outlines what is known to date about the patterns of Australian and international current and transitioned military members seeking help and services due to mental health concerns.

1.1.1 The DVA and Defence healthcare contexts

Current serving ADF members have access to health (including mental health) treatment and occupational rehabilitation across operational and non-operational activities, regardless of the source or cause of their mental health problems. These services are provided by a mix of military, Australian Public Service and contracted mental health professionals, which includes referral to the Veterans and Veterans Families Counselling Service (VVCS). Where appropriate, this care is provided with the support of various Defence welfare support agencies, including the Defence Community Organisation (DCO) and Defence Chaplaincy. Similar to the Australian community, primary Garrison healthcare services are provided according to a general practitioner (GP) model of care. Full-time ADF members seeking inpatient admission to external treatment facilities must access these services either as an emergency

admission through an Accident and Emergency tertiary facility, or by a Defence medical officer referring them to a psychiatrist who has admission rights to a facility (Department of Defence, 2011; Department of Defence, 2015).

Individuals requiring treatment for mental disorders are managed on a case-by-case basis. According to policy, they continue to be employed during their treatment and rehabilitation, then receive the support and opportunity to recover and return to their previous or new work within the ADF. If this is not possible, Defence policy is to oversee the transfer of health care and rehabilitation to DVA or specialist providers. Defence works closely with DVA to develop mental health awareness initiatives, and research, rehabilitation and transition processes, to improve early recognition of mental health problems and strengthen the continuity of any necessary health and rehabilitation care.

Defence also maintains three 24-hour telephone helplines. The 1800 IMSICK service provides triage and health support for all ADF members within Australia. The All-hours Support Line is a triage service that directs ADF members and their families to appropriate ADF or civilian mental health services. Finally, the Defence Family Helpline provides support, information and connection to the community for ADF members and their families.

When transitioning from full-time service, ADF members can transfer to the Active or Inactive Reserves or be completely discharged. Discharge from the ADF may be for medical or administrative reasons, or the individual may be separating from the ADF. ADF members in the Active or Inactive Reserves primarily access their health care, including mental health care, through the Australian healthcare system. However, if their mental health condition is attributable to their military service, they may be eligible to access care funded by Defence or DVA, including through VVCS.

DVA is responsible for the needs of those who serve or have served in defence of Australia. The Department discharges this responsibility by offering compensation and other financial entitlements, but also by providing health treatment to eligible individuals, including rehabilitation and treatment for physical and mental health conditions. The DVA website (www.dva.gov.au) provides comprehensive information about what care is available and how to access it. More specifically, the DVA At Ease website (at-ease.dva.gov.au/veterans/) provides information about mental health, together with a range of resources including the High Res or high-resilience webpage and app (at-ease.dva.gov.au/veterans/resources/mobile-apps/high-res-app/), which provide guided self-help for mental health problems.

Eligible veterans within the DVA system are provided with either a DVA White Card, for treatment of service-related accepted disabilities, or a DVA Gold Card, which entitles the holder to funding for all clinically necessary healthcare needs and the treatment of

all health conditions, regardless of whether they are related to war service. The system covers Transitioned ADF members who have not applied for, or are not eligible to receive, health care through either private health insurance or the national Medicare system. Furthermore, in the case of mental health, through 'non-liability health care', DVA could pay for treatment of five mental health conditions, whether or not they are service-related, including posttraumatic stress disorder (PTSD), anxiety, depression, and alcohol and substance misuse for individuals with three years' service. In 2014, this was expanded to anyone who has served at least one day in the full-time ADF, and in the 2016–17 budget expanded to any mental health condition.

Similar to Defence and the community, specialist, allied mental health or inpatient services for Transitioned ADF members are accessed through referral by a GP or through VVCS. Services include psychologist and social work services, psychiatric services, pharmaceuticals, trauma recovery programs for PTSD, and in-patient and out-patient hospital treatment. Funding for this mental health treatment is demand-driven, and is not capped.

VVCS is an accredited community mental health service that provides free, confidential, nation-wide counselling and support for war- and service-related mental health conditions. VVCS provides individual military-aware counselling, group programs, complex case coordination and suicide prevention training, as well as the 24-hour VVCS Veterans Line support service for veterans. VVCS provides these services for serving and ex-serving ADF members and their families.

The VVCS clinical service delivery model recognises that military trauma rarely affects an individual in isolation. Eligibility for VVCS programs is generally extended to include the families of deployed ADF members and those in high-risk employment areas. In 2014 it was expanded to cover everyone who had completed at least one day of full-time service, including current or former ADF members' partners and children. In the case of some client cohorts (for example, when a member has died by suicide or suspected suicide, or been killed in a service-related incident), eligibility extends beyond the immediate family to include siblings and parents. Since family issues and events often act as a catalyst for veterans to access care, it is hoped that this inclusive approach to service delivery will help reduce barriers to veterans seeking care.

Data from international studies on military populations referenced in this report examining the issue of help-seeking is primarily derived from the United States (US), United Kingdom (UK) and Canadian military and veteran communities. It is beyond the scope of this report to outline the nature of these healthcare systems, but it is worth noting that while the US and Canada have government-operated departments to address the healthcare needs of discharged veterans, there is no such department in the UK, where veterans must access public health care through the National Health

Service (NHS), along with the wider community. Because of this, charities such as The Royal British Legion and Combat Stress have arisen to provide more specialised support for veterans with mental health problems in the UK. More recently, NHS Wales, NHS Scotland and NHS England commissioned networks of veteran-specific services to assess, signpost and treat service-related mental health problems and psychological injuries.

1.1.2 Help-seeking rates for currently serving members

There is strong evidence indicating a gap between the identification of mental health conditions and patterns of help-seeking in other military populations, and under-use of mental health services (Kulesza, Pedersen, Corrigan & Marshall, 2015). US data estimate that less than half of current military members and veterans who would benefit from mental health services actually engage in treatment (Hoge et al., 2004; Kehle et al., 2010; Ramchand, Rudavsky, Grant, Tanielian & Jaycox, 2015). Similarly, studies in the UK found low rates of help-seeking. In these UK studies, Sharp et al. (2015) reported that 40% of military personnel who experienced mental health problems sought help, while Hines et al. (2014) found that of military personnel who reported a stress or emotional problem as a result of deployment, only 42% sought any help and only 29% sought formal or professional help. Consistent with this, a Canadian study of active military members found that only four in 10 military members with mental health difficulties had accessed mental health services in the past year (Fikretoglu, Guay, Pedlar & Brunet, 2008).

The most significant Australian study to date on help-seeking for currently serving members was the 2010 MHPWS (McFarlane et al., 2011). This study found rates of help-seeking varied by mental disorder ranging from 12% (simple phobia) to 76% (generalised anxiety disorder), with help-seeking for PTSD in the middle at 50%.

1.1.3 Help-seeking rates in veteran and transitioned populations

With respect to the transitioning from full-time service or veteran population, there is significant variation in accessing mental health services across countries and demographics. A study of UK ex-service personnel indicated that although 44% of the sample had a psychiatric diagnosis, only half of those were currently seeking help (Iversen et al., 2005).

Internationally, some studies indicate that the use of mental health services among veterans is improving. A study of 6,287 US female veterans found that approximately half of those surveyed perceived a need for mental health care (Kimerling et al., 2015). Encouragingly, 84% of those who were in need of care, accessed care. This rate was considerably higher than the general US population (50–60%). Another cross-sectional study of female US veterans found that the majority of veterans who experienced a

sexual assault had engaged in mental health counselling in the past 12 months, though only a minority received care immediately after the incident (Kintzle et al., 2015).

There is evidence that some individuals are more prepared to access mental health services following their transition from the military. A study of traumatically injured US soldiers returning from deployment reported that following their transition from the Department of Defense healthcare system, 81% of veterans used psychiatric services within the Veterans Health Administration (Copeland et al., 2011). The authors suggested that this occurred because veterans were freed from stigmatising beliefs within the military and the potential threat to their military career. In addition, their psychological distress may have worsened over time, or they may have taken longer to recognise the need to seek care. A 2012 study indicated that access to mental health services within the Veterans Health Administration was relatively high among veterans with PTSD: 58% of the population had accessed treatment for PTSD (Shiner, Drake, Watts, Desai & Schnurr, 2012). The authors noted that this was a much higher rate than that reported in the general community.

Unfortunately, there is concern that once veterans have sought assistance for mental health problems, many do not receive adequate treatment (Seal et al., 2010). For example, a US population study of 49,425 Iraq and Afghanistan veterans with newly diagnosed PTSD found only 9.5% received a recommended number of mental health treatment sessions within the first year of diagnosis (Seal et al., 2010). Similarly, a study of US veterans found that of those who began psychotherapy for PTSD within a year of diagnosis, only one-third completed eight or more sessions (Rosen et al., 2011). Another study of veterans who had initiated contact with US veteran mental health services indicated that 48% received minimal adequate care within the first year (Hebenstreit, Madden, Koo & Maguen, 2015). These findings suggest that a high proportion of veterans with PTSD are not receiving adequate treatment despite being diagnosed and having contact with mental health services.

In contrast, a study of Australian peacekeepers (Hawthorne, Korn & Creamer, 2014) found that 83% who had a mental health condition had seen a clinician or a therapist (80% a consulting GP, 32% a psychiatrist and 20% a psychologist) about their mental health concern in the preceding three months. These figures compare favourably with treatment-seeking rates reported in the international veteran literature. These rates also compare very favourably with the 2007 Australian National Survey of Mental Health and Wellbeing (NSMHW) which found that 35% of Australians (28% of men and 40% of women) with a diagnosed mental disorder had accessed care (Slade, Johnston, Oakley Browne, Andrews & Whiteford, 2009). Interestingly, an analysis of the veteran data within the NSMHW study found that male veterans did not use mental health services any more than other men, despite reporting poorer mental health throughout their lifetimes (McGuire et al., 2015). Based on demographics however, the majority of

veterans in the NMHWB study were more likely to be veterans of World War II and hence this result may have been influenced by this factor.

1.1.4 Comparison of help-seeking between serving and ex-serving members

A number of studies have reported on service utilisation rates for veterans or current serving personnel, but there is little research comparing service utilisation rates for ex-serving members against those of their current serving counterparts in the same study. Preliminary research indicates that under-use is a problem for both groups.

The 2010 MHPWS indicated that 50% of current serving ADF members who met the criteria for a mental disorder diagnosis had sought care in the previous 12 months. From the limited data available, rates appear higher in veterans, as reflected in the findings of the peacekeeper study (Hawthorne et al., 2014), where up to 83% had sought care in the previous three months.

Iversen et al. (2010) reported that depending on the type of problem, only 18.5–54.3% of UK recruits with perceived mental health problems had accessed any health services, and these help-seeking rates did not differ between currently serving members and veterans. A study comparing US Active Duty soldiers with Reservists (National Guard soldiers) suggested that both groups under-used services: only 27% of National Guard and 13% of Active Duty soldiers with a mental health problem had accessed mental health care (Kim, Thomas, Wilk, Castro & Hoge, 2010). Both groups had low rates of help-seeking, but it was particularly low for Active Duty soldiers. In a study of US military personnel who had previously been hospitalised with depression, bipolar or schizophrenia, just over half had used veteran health services once they had transitioned out of the military (Mojtabai, Rosenheck, Wyatt & Susser, 2003). This is a lower rate than in general populations, suggesting that some US veterans may have difficulty accessing mental health treatment after their separation from the military.

Overall, despite some variations, international literature focusing on serving and ex-serving military personnel with mental health problems indicates that approximately 40–50% have sought care for these concerns in the past 12 months. These rates appear slightly higher among discharged veterans than active serving personnel, possibly due to stigma and perceived impact on military career.

1.1.5 When transitioned and serving members first seek help

Delays in military personnel seeking help may be an important issue; delayed access to mental health care is associated with poorer outcomes (Boulos & Zamorski, 2015). The 2010 MHPWS found that current serving ADF members retrospectively reported a mean delay in help-seeking of between four years for lifetime depression and seven years for lifetime alcohol abuse (Searle, Lawrence-Wood, Saccone & McFarlane, 2013).

Evidence suggests there are differences between transitioned and current serving ADF members in terms of when they seek help. A study of US military personnel returning from deployment indicated that only 23–40% of those with mental disorders sought help within the first year of diagnosis (Hoge et al., 2004). By comparison, studies of US veterans have reported higher rates, 58% (Rosen et al., 2011) and 66.9% (Seal et al., 2010) of contact with mental health services within the first year of diagnosis.

In a retrospective study of personnel who developed PTSD while serving within the UK armed forces, the median time between onset and contacting a mental health service was one month (Brewin, Andrews & Hejdenberg, 2012). To help understand this high rate of seeking early treatment, further UK research has highlighted that concealing some mental health problems within active service may be difficult due to close health supervision, so individuals may be compelled by the chain of command to seek help when behavioural or psychological disturbances are present (Jones, Twardzicki, Fertout, Jackson & Greenberg, 2013). However, as noted above, the 2010 MHWPS (McFarlane et al., 2011) found that current serving ADF members in Australia retrospectively reported a mean delay of four years for lifetime depression and seven years for lifetime alcohol abuse. The UK and Australia have different approaches to mental health supervision, and at the time of the study, mental health screening in the ADF focused on deployed personnel. The 2010 MHPWS included all full-time serving members, regardless of their deployment history.

Therefore, while concerns for career and other attitudinal factors, discussed in more detail below, may retard treatment-seeking on the one hand, the high scrutiny within the Defence environment may aid early detection and referral for some members.

There may also be differences between Reservists and current serving members of the military. A US study of personnel returning from combat indicated that a large proportion were screened and found to have mental health problems in the months following their return home (Milliken, Auchterlonie & Hoge, 2007). Soldiers reported more mental health concerns and were referred at higher rates several months after their return compared to when they immediately returned, which may reflect a delay in the development of symptoms, or a delay in seeking treatment. This study found that Reservists who returned to civilian status following their deployment had more mental health concerns and were referred at higher rates than current serving members. The authors suggested that this may be due to Reservists wanting to take advantage of the veteran health services that are only available for 24 months after their return to civilian status.

Other predictors of earlier service utilisation have been suggested. Kehle and colleagues (2010) noted that seeking treatment within six months of returning home from deployment to Iraq was more likely for US veterans who sustained injury, held

positive attitudes regarding therapy, received therapy while in theatre, and had higher levels of PTSD and depressive symptoms. Delayed care-seeking may also be related to accessibility, so it is possible that programs designed to improve ease of access will shorten the time it takes for individuals to seek care. One study of a telepsychiatry transition clinic indicated that the majority (89%) of soldiers who took part in the program were within six months of being discharged from the Army (Detweiler et al., 2011). This reflects a need for earlier identification and treatment.

Overall, data on the latency of serving and ex-serving military personnel seeking mental health services is still emerging and inconsistent. While the general pattern suggests there is shorter latency among ex-serving personnel, there is variability in the influence of attitudinal factors; service eligibility, availability and accessibility; the extent of internal surveillance within Defence environments; and accessibility and entitlements across Reservist categories.

1.2 Stigma, and barriers to and facilitators of help-seeking

The above research indicates that there is considerable unmet need for support among serving and ex-serving military personnel with mental health problems. There are various explanations for this unmet need. One factor is the particular social, psychological and practical barriers that serving and ex-serving members experience in seeking help for mental health treatment (Batt, Geerlings, & Fetherston, 2016; Hodson & McFarlane, 2016; McGuire et al., 2015). Particular research assessing the barriers to, and facilitators of, current and ex-serving personnel accessing mental health care are discussed below.

1.2.1 Stigma

Stigma is a complex construct. For the purposes of this report we define it as a belief relating to an '*attribute that is deeply discrediting*', which reduces the target – either the self or another – *'from a whole and usual person to a tainted, discounted one*' (Goffman, 1963). Stigma can exist at the public or societal, interpersonal and individual levels (Chaudoir, Earnshaw & Andel, 2013). The process of stigmatisation follows when groups with power, stereotype, hold prejudice about and discriminate against a group they have labelled as different (Link & Phelan, 2001; Rüsch, Angermeyer & Corrigan, 2005; Thornicroft, 2008). In the case of mental illness, stigmatisation is related to shared cultural beliefs held by the public – or in this case a military organisation – about the attributes of those with mental illness. This may include ideas that people with mental health illness are dangerous, unpredictable or incompetent (Angermeyer & Dietrich, 2006; H. J. Forbes et al., 2013; Rüsch et al., 2005).

Stigma at the societal level is known as 'public stigma' – for example, the views and reactions the general population has in relation to people with mental illness (P. W.

Corrigan, Watson & Barr, 2006). At the interpersonal and individual levels, 'anticipated public stigma' is the extent to which people believe they will be viewed or treated in a negative way if their mental health problem or related help-seeking becomes known (Britt et al., 2016; Clement et al., 2014; Earnshaw & Chaudoir, 2009). 'Self-stigma' refers to an individual self-labelling themself as inferior or weak for needing help, and may reflect internalisation of actual or perceived public stigma (Vogel, Wade & Haake, 2006).

Military organisations can engender certain stigmatising beliefs in relation to help-seeking for mental health problems that may persist into civilian life (Langston, Gould & Greenberg, 2007; Vogt, 2011). Specifically, the cultural values of self-sufficiency and masculine identity, and the need for good occupational health for operational deployments, may work against an individual who may need to disclose mental health problems across their service and civilian lifetime (Gibbs, Olmsted, Brown & Clinton-Sherrod, 2011; Greene-Shortridge, Britt & Castro, 2007; Simmons & Yoder, 2013).

In the military literature, the most commonly explored stigma construct is anticipated public stigma.

1.2.2 Anticipated public stigma – prevalence, and association with help-seeking

Among ADF members in 2010, the highest rated concern about seeking help for mental health treatment was a fear of reduced deployability (36.9%). The next highest rated concerns were all related to anticipated public stigma. These included concerns that others would treat them differently (27.6%), that seeking help would harm their careers (26.9%) and that they would be seen as weak (25.3%). Practical barriers such as difficulty getting time off work and not knowing where to get help were lesser concerns in the ADF (14.7% and 6.3% respectively) (McFarlane et al., 2011).

These findings were similar to high rates of concerns about anticipated public stigma found in a range of studies of military populations internationally. Sharp and colleagues (2015) reported that the highest concerns among UK military personnel in relation to mental health help-seeking personnel were that unit leaders would treat them differently, others would see them as weak and unit members would have less confidence in them. Across the literature, when considering mental health help-seeking from formal, professional or medical sources, anticipated public stigmatising beliefs are reported at consistently higher levels than practical or logistical barriers to care, irrespective of whether personnel are current serving military members, Reservists or veterans (Britt et al., 2008; Iversen et al., 2011; Osório, Jones, Fertout & Greenberg, 2013).

Research has also consistently found that personnel reporting more mental health symptoms perceive greater levels of anticipated public stigma and barriers to care than

those with subthreshold symptoms (Jones et al., 2013; Kim, Britt, Klocko, Riviere & Adler, 2011; Ouimette et al., 2011). This finding is particularly important, as it is the military population who are in most need of treatment that are the most likely to perceive or experience high stigma and barriers to accessing care.

Anticipated public stigma is not a fixed entity and may differ depending on:

- deployment status – with anticipated public stigma highest during deployment compared to homecoming (Osorio, Jones, Fertout, & Greenberg, 2013)
- mental health problems – those with probable PTSD or alcohol problems perceive higher anticipated stigma (Gibbs et al., 2011; Iversen et al., 2011)
- serving status – UK Ex-Service personnel and US National Guard samples reported lower anticipated public stigma compared to current serving personnel (Sharp et al., 2015)
- country of origin – anticipated public stigma is higher in the UK Armed Forces compared to Australian, Canadian and US military populations, although more research is needed to assess differences between countries (Sharp et al., 2015).

Fewer studies have assessed the association between stigma and barriers to care and actual service use, as most studies focus only on 'intentions' to seek help (Vogt, 2011). In the few studies that have been undertaken, the findings are inconsistent. A systematic review of studies found that there was no association between anticipated public stigma and actual help-seeking or service use in military populations (Sharp et al., 2015). However, recent studies have used different anticipated public stigma measures that do show a negative association between anticipated public stigma and help-seeking and service use (Blais, Tsai, Southwick, & Pietrzak, 2015; Kulesza et al., 2015). No Australian studies have investigated the relationship between anticipated public stigma concerns and help-seeking in military populations.

1.2.3 Self-stigma

Literature related to the general population has highlighted the incidence of self-stigma, as distinct from anticipated or public stigma (P. W. Corrigan et al., 2006). Self-stigmatisation can lead to feelings of shame and inadequacy, which may affect an individual's self-worth and confidence to seek help (P. W. Corrigan, Kerr & Knudsen, 2005; Vogel et al., 2006). Self-stigma has also been linked to negative attitudes towards mental health services, and to lower intentions to seek mental health care (Conner et al., 2010; Vogel, Wade & Hackler, 2007). Finally, a systematic review by Clement and colleagues (2014) assessed stigma and help-seeking in a mixture of different populations and found that self-stigma specifically had a small and consistently negative association with help-seeking.

In the military literature, Blais and Renshaw (2013) and Murphy and colleagues (2014) found that, in military samples, a negative relationship existed between self-stigma and help-seeking intentions. Self-stigma has also been found to fully mediate the relationship between public stigma and help-seeking in US Service personnel and National Guard samples (Blais & Renshaw, 2014; Wade et al., 2015). Hence, there is evidence that public stigma contributes to the experience of self-stigma, which in turn affects help-seeking attitudes and willingness to seek help in military samples. However, self-stigma is an under-researched barrier in military literature. In particular, no Australian studies have investigated self-stigma and its association with help-seeking intentions or service use in a military sample.

1.2.4 Poor recognition of the need for treatment

An important barrier to seeking help for mental health problems – one that is consistently found across military populations – is the lack of a perceived need to seek treatment or support. In a UK military sample (including Service personnel, Reserves and Ex-Service personnel), 44% of individuals with a probable diagnosis of depression or anxiety, alcohol misuse or PTSD did not consider that they were experiencing a stress, emotional, alcohol-related or family problem (Iversen et al., 2011). Similarly, in a recent US sample of Active Duty soldiers, 70% of those who had never received treatment perceived no need for treatment, despite having a probable mental health problem (Naifeh et al., 2016). Additionally, recognition of the need for treatment may differ across diagnoses. In both Canadian and UK military research, those with probable hazardous alcohol use or dependence had the lowest likelihood of reporting a perceived need for treatment (Hines, Goodwin, et al., 2014; Sareen et al., 2007). In an Australian Army sample, military personnel were unlikely to perceive a need for treatment even when a mental health concern was acknowledged. Batt and colleagues (2016) found that 87% of Army personnel who identified as having stress or mental health concerns and wanted to improve their mental health indicated that they did not want help to achieve this.

This barrier to help-seeking is not unique to military personnel. A World Health Organization study across 24 countries found the most common reason for not seeking help for a mental health problem was not recognising the need for treatment (Andrade et al., 2014). There may be additional barriers that military personnel face in recognising their need, including military conceptions of whether help is deserved. A US study found that combat and non-combat veterans were less accepting of non-combat veterans' help-seeking behaviour, as they were seen to be less deserving of treatment (Ashley & Brown, 2015). Research has also interrogated the media's and charities' images of the 'hero warrior' as a representative of injured service personnel, which has created the 'hero–victim' dichotomy (Hines, Gribble, Wessely, Dandeker & Fear, 2014; McCartney, 2011). There are very public, vivid examples of current and former service personnel who have obvious, severe, life-changing injuries. These

examples have possibly created points of comparison against which military personnel judge themselves and judge whether their help-seeking is valid (Kleykamp & Hipes, 2015).

1.2.5 Attitudes or beliefs about mental health treatment

There is some evidence for negative attitudes towards mental health care in Australian military samples (Dunt, 2009), but this has not been thoroughly researched in formal studies. However, there is consistent evidence from US and Canadian military literature that negative attitudes towards mental health care are associated with decreased intentions to seek help and less use of healthcare services (Johnson et al., 2016; Sudom, Zamorski, & Garber, 2012; Valenstein et al., 2014).

For example, a large-cohort study of US soldiers previously deployed to Iraq or Afghanistan found that those who reported negative attitudes towards mental health treatment – such as 'I do not trust mental health professionals', 'psychological problems tend to work themselves out without help' and 'getting mental health support should be seen as a last resort' – were almost 40% less likely to use any type of mental health care (Kim et al., 2011). Stecker and colleagues (2013) interviewed 143 US Service personnel who had PTSD but were not receiving treatment. The most commonly endorsed barriers to care were concerns or negative attitudes regarding treatment, such as the concern that treatment would involve prescription medication (26%). In a recent US study, 36% of veterans endorsed the view that 'medication for mental health problems has too many negative side effects', and this belief was associated with a lower likelihood of veterans who presented with depression using a mental health care service (Vogt, Fox & Di Leone, 2014).

These findings have not been replicated in UK military studies, which report that negative attitudes towards mental health care are a less-important barrier to seeking help across service and ex-service populations when compared to the barrier of anticipated stigma (Iversen et al., 2011; Jones et al., 2013).

1.2.6 Preference for self-management

In military populations, large percentages of individuals do not seek help because they wish to solve or manage their problems on their own (Jones et al., 2013; Momen, Strychacz & Viirre, 2012). Iversen and colleagues (2005) found that the most common reason for UK ex-service personnel not seeking help was a sense of resilience and stoicism – the idea that 'it's a problem I should be able to deal with by myself'. A recent longitudinal study by Adler and colleagues (2015) found that in a sample of US soldiers, the preference for managing problems alone correlated with personnel seeking less treatment over time. This finding was replicated by Britt and colleagues (2016), who found that US active-duty soldiers who endorsed measures of self-reliance – such as 'I prefer to handle problems myself as opposed to seeking mental health

treatment' – were 63% less likely to have received treatment. Britt and colleagues (2016) suggest it may be the organisational culture of the military and the expectation of resilience that negatively affect help-seeking behaviours. These beliefs may also persist once individuals have left military service (Vogt, 2011).

1.2.7 Logistical and practical barriers to care

Practical barriers to care such as difficulty getting time off work or not knowing where to seek help have been endorsed at low levels in the ADF and in international military literature. However, there may be more significant practical barriers depending on sex, rank or service branch in the ADF. For example, the 2010 MHPWS found that female ADF members were 21% more likely than males to know where to get help, and that compared to Non-Commissioned Officers and Officers, other ranks were less likely to know where to access help (McFarlane et al., 2011).

In a US study, active duty personnel were more likely to report difficulties getting time off work for treatment compared to National Guard members, although National Guard members were more likely to be concerned about the expense of treatment compared to active duty personnel (Kim et al., 2010). In the UK, Reserves were more likely than active serving personnel to endorse practical barriers such as difficulty getting time off work or scheduling appointments (Iversen et al., 2011). It seems practical barriers may be different depending on service status, and may be a result of the different healthcare structures and services in each country.

The cost of accessing mental health services is a barrier for some US veterans. In particular, a recent study found that National Guard members were more likely than US Army members to perceive cost as a barrier to care (Gorman, Blow, Ames & Reed, 2011). Another study in the US found that women veterans with depression or PTSD who reported an unmet need for help were likely to cite affordability as a reason for going without or delaying care. Many did not know if they were eligible for veterans' affairs benefits and did not have health insurance (Lehavot, Der-Martirosian, Simpson, Sadler & Washington, 2013). This indicated that although funding may be an issue with some veterans, there is an also an issue with veterans being aware of the type of care they are eligible for. In fact, Washington, Yano, Simon & Sun (2006) highlighted that the perception of cost was a factor in women veterans not accessing mental health services, and that in particular, younger women were more likely to lack knowledge about their eligibility for veterans affairs services. This may be an issue across the US healthcare system generally. A study that compared women veterans in the US to non-veterans found that they did not differ in terms of their perceived financial barriers to care, and that in both groups financial barriers to care were associated with a quality of life marked by poor health (as was veteran status) (Shen & Sambamoorthi, 2012).

Some recent studies have examined how increased funding to mental health services impacts the extent to which veterans and military personnel in the US use services and achieve outcomes. An examination of funding for treatments related to substance use revealed that as funding increased, so did access to care and the intensity of care (Frakt, Trafton & Pizer, 2015). Logistical causes of under-use of services may also be influenced by funding and resource-based solutions. A study of veterans' affairs databases comparing the use of psychotherapy among US veterans in rural and urban areas found that between 2007 and 2010, use for both groups had increased, and the gap between urban and rural use was shrinking (Mott, Grubbs, Sansgiry, Fortney & Cully, 2015). The authors suggested this was related to specific efforts to engage rural veterans, such as increasing the number of rural mental health clinics, the resources at these clinics and the availability of telehealth services. Although the abovementioned studies suggest a relationship between enriched mental health services and better mental health outcomes, it is important to note some limitations of the research. These studies were not longitudinal, so they did not provide evidence of causal relationships. In addition, the studies drew on secondary data from military healthcare administrative databases, so if veterans sought help outside those systems it would not have been captured within the data.

In summary, many factors in military populations may affect help-seeking behaviours. In the ADF, the most important factor that acts as a barrier to help-seeking for mental health problems is the concern that seeking help might affect their ability to be deployed. This concern may be intertwined with other anticipated stigma concerns, such as the concern that their supervisors or colleagues may treat them differently, or that they will be perceived as weak. Other factors such as negative attitudes towards care and barriers to access are also emerging as important influences.

1.3 Pathways to care

1.3.1 The role of social support in facilitating help-seeking

Smaller networks are associated with more use of mental health care (Albert, Becker, Mccrone & Thornicroft, 1998). However, while social support can encourage help-seeking when severe mental health problems occur, it can inhibit help-seeking when the problem is low in severity. Negative and positive attitudes within a social network also affect help-seeking outcomes (Kogstad, Mönness & Sörensen, 2013).

In the general US population, being prompted to seek help and knowing someone who has previously sought help were related to positive expectations about mental health services and positive attitudes about seeking help from a mental health professional (Vogel, Wade, Wester, Larson & Hackler, 2007). In relation to veterans, there is equivocal evidence for the role of social support in encouraging help-seeking. Research involving Australian Vietnam veterans indicated that those with a probable PTSD

diagnosis were less likely to have received DVA treatment if they had better social support or stronger marital relationships, suggesting that social support may have inhibited them from treatment-seeking (Marshall, Jorm, Grayson, Dobson & O'Toole, 1997). Similarly, Johnson and colleagues (2016) found that in a sample of US veterans, those with reduced social support and leisure functioning (which refers to the perception of how well one is functioning in one's leisure time and social world) were more than two times more likely to have used mental health care in the previous 12 months. However, in another study involving a sample of US veterans with PTSD, social encouragement from family members, friends or other veterans increased the odds of receiving mental health treatment (Spoont et al., 2014).

Other military studies, conducted in current serving members and reservists have found more positive effects of social support in encouraging treatment-seeking. In a US sample of active duty soldiers, Warner and colleagues (2008) found that one of the most influential factors in overcoming barriers to seeking care was having 'family and friends strongly encourage' soldiers to get help. A study of a returning National Guard sample from Iraq found that supportive intimate relationships facilitated soldiers with PTSD symptoms using mental health treatment services (Meis, Barry, Kehle, Erbes & Polusny, 2010). Qualitative research involving US Army personnel indicated that having specific encouragement to seek help from a 'family member or spouse' or 'peer or battle buddy', as well as having a trusted person to talk to, was a crucial factor in help-seeking (Zinzow et al., 2013). Further qualitative research found that having supportive friends and family members enabled people to stay in treatment, as they were able to discuss the issues that arose (Murphy, Hunt, Luzon & Greenberg, 2014). In addition, Pfeiffer et al. (2012) found that in a sample of National Guard soldiers, tightly connected and supportive peer networks had the potential to decrease stigma related to mental health problems and encourage treatment. They also found that soldiers in loosely connected peer networks or those in networks with competing cliques were much less likely to seek mental health treatment based on interaction with their peers. So although social networks may provide positive informal support, the effect of attitudes within the network will moderate whether this support lends itself to future positive help-seeking behaviour.

A qualitative study of US veterans indicated that encouragement from spouses, partners, family members, peers (veteran and non-veteran) and employers played a crucial role in how veterans engaged in treatment (Sayer et al., 2009). These groups helped veterans recognise their PTSD; seek assistance, resources and providers; and schedule and secure appointments.

Informal support may be an important step in getting professional support. Brown and colleagues (2014) found that in a UK community sample, three-quarters of those with a probable mental health problem and who sought formal help were also using informal

help. In UK military samples, Iversen et al. (2010) and Hines, Goodwin et al. (2014) found that the majority of those who said they were experiencing a problem had only used informal sources of support such as a spouse or friend, rather than seeking professional help.

Identification within service

Australian, UK, US, Canadian and Dutch militaries conduct mental health screening to identify whether individuals require mental health referral and treatment (Fertout et al., 2011). However, research suggests that these screening processes may not successfully identify those who need help because soldiers tend to under-report symptoms (Nevin, 2009). In a study of UK armed forces personnel, just over half of those who had contact with medical services during service were identified as needing mental health support by other service personnel – during the course of treatment for physical injuries, by being referred by a superior or following a suicide attempt (Brewin et al., 2012).

Model of care

A systematic review in the US (Kehle, Greer, Rutks & Wilt, 2011) examined interventions that improved access to health care for veterans and whether these interventions led to improved clinical outcomes. The review included 16 studies, comprising community-based outpatient clinics, primary care mental health services and telemedicine. The co-location of walk-in support with primary care mental health services was consistently found to improve access. Community-based outpatient clinics were found to increase the initiation of care and primary care visits, while primary care mental health led to more primary care visits and use of preventative care. All reviewed studies observed positive outcomes on measures of satisfaction and use, although the limited data reported suggest that improved access does not necessarily lead to improved outcomes.

1.3.2 Types of mental health professionals accessed

Both DVA and Defence monitor the mental health services provided to serving and ex-serving ADF members (Department of Veterans Affairs, 2016). However, there is a lack of research on the types of mental health professionals that transitioned and current serving ADF members may be accessing without Defence or DVA funding, and how frequently they are accessing these services.

Research involving the UK armed forces indicates that personnel may access different types of mental health professionals pre-and post-discharge. In a study of British ex-service personnel, of those who had a psychiatric diagnosis and sought treatment, 28.2% sought help from a service charity, 86.9% sought help from their GP, 28.7% saw a psychiatrist, 8.1% saw a psychologist and 6.6% received help from a community psychiatric nurse (Iversen et al., 2005). The authors expressed concern that so few

were receiving the best evidence-based care. In addition, those who reported seeking help while still in the military were more likely to have access to a psychiatrist than those who sought help after discharge (56.5% compared to 28.7%). The authors questioned whether having a system similar to that in the US and Australia – where separate healthcare systems exist for veterans – would improve access to specialist care for UK veterans.

Two studies of US military personnel indicated that the types of mental health services accessed were broadly similar between current and transitioned members. A study of active duty soldiers indicated that those who sought help for stress, emotional, alcohol or family problems tended to seek help from mental health professionals at military facilities (14%) but less frequently sought help from mental health professionals at civilian facilities (4.8%), general medical care from military (3.2%) and civilian facilities (0.7%), or support from chaplains and the clergy (3.6%) (Kim et al., 2011). Overall treatment levels were low; only 19% of soldiers accessed any type of mental health care. However, a study of US veterans (with and without mental disorders) indicated marginally higher rates of contact with mental health professionals: over a quarter (25.8%) had contact with any type of mental health professional, 18% saw a psychiatrist and 15% received medication for their mental health condition. Some people sought help from a chaplain and also received mental health treatment (7%), although a considerable number (10%) saw a chaplain but did not receive any mental health treatment (Elbogen et al., 2013). This indicates that while contact with mental health professionals was reasonably high, a considerable number of individuals relied solely on informal sources of mental health support.

A Canadian survey on the transition from military to civilian life investigated whether veterans access general medical care more or less than the general population. The survey found that the majority had a medical doctor (82%), consistent with the general population (80%) (Thompson et al., 2011). However, veterans with a serious mental illness may be less likely to access medical care than those without a psychiatric illness. Chwastiak, Rosenheck and Kazis (2008) reported that veterans with schizophrenia, bipolar disorder or a drug use disorder were less likely to use primary care than veterans without a psychiatric illness.

Experiences with mental health professionals may also influence whether individuals receive treatment from this source. A study of US Reservists who had returned from deployment indicated that those with a history of help-seeking were more likely to seek help from mental health professionals compared to those who had not sought help in the past (Blais & Renshaw, 2013).

1.3.3 Use of self-help strategies

Self-help strategies and self-management of distressing psychological symptoms can help serving and ex-serving military personnel overcome some of the barriers to accessing care. Self-help strategies can be accessed anonymously, which overcomes the problem of stigma, and they are often inexpensive and available in geographically remote locations.

Digital sources of self-help

Web-based delivery of mental health assistance has a number of potential advantages. It allows for creative delivery of information via video and audio-streamed presentations, which can enable the user to be more interactive (Whealin, Kuhn & Pietrzak, 2014). Accordingly, self-help programs may offer assistance to those who are not otherwise able to access standard care. Indeed, a study of US soldiers indicated that 33% of those who were unwilling to attend in-person therapy were open to trying web-based care (Wilson, Onorati, Mishkind, Reger & Gahm, 2008). Studies also indicate that the veteran population would be able to access self-help resources and strategies online. A study of women veterans in the US found that on average, this demographic has a high level of access to the internet (85%), markedly higher than the reported rate for the general US population (78%) (Lehavot et al., 2013). However, veterans with serious mental illness – particularly those who are older and less educated, and have an alcohol use disorders may be less likely to use the internet (Klee, Stacy, Rosenheck, Harkness & Tsai, 2016). These veterans were found to have lower rates of computer, internet and mobile phone use compared to the general population, suggesting that technology-based self-help may still present barriers for some veterans who require mental health treatment, particularly for those with severe mental illness.

Healthcare programs delivered via a smartphone or tablet (known as mHealth in the US, but e-mental health in Australia) are a promising way to provide digital self-help to veterans who already use these devices. A study of veterans referred for outpatient PTSD treatment in the US found that the vast majority (76%) of these veterans had access to mHealth-capable devices, although younger veterans were significantly more likely to own a device than older veterans. Despite this, less than 10% actually reported using existing mHealth programs. More promisingly, more than half the veterans studied said they would be interested in using mHealth applications for problems such as anger management, sleep hygiene or anxiety management (Erbes et al., 2014). This indicates that mHealth applications may have the potential to increase access to care – particularly among younger veterans who already use mobile phones and tablets – and that promoting awareness of these programs may improve their uptake among veterans. It is also worth noting that this mental health care delivery method is relatively new, so there are many considerations that need to be addressed in terms of

safety, privacy, evidence-based practice, ease of use and regulation – to name a few (Shore et al., 2014).

Various studies have found that internet-based self-management programs have some utility in treating mental health problems that arise in the military context. An example is the DE-STRESS program: an eight-week daily internet-based program that provides teaches psychoeducation, sleep hygiene, coping skills, cognitive reframing, self-guided in-vivo exposure, and trauma writing exercises (Litz, Engel, Bryant & Papa, 2007). A randomised control trial evaluating this program among US Department of Defense personnel and military personnel indicated that it was just as effective in reducing global depressive symptoms and the PTSD symptoms of avoidance and hyperarousal as web-based supportive counselling.

Vets Prevail is another US self-management program for veterans with mild to moderate PTSD and depression (Hobfoll, Blais, Stevens, Walt & Gengler, 2015). It is based on cognitive behavioural therapy, and a randomised control trial indicated that it was more effective at reducing PTSD and depression symptoms than the treatment as usual condition. The authors speculated that it was successful because it circumvented barriers of access and stigma. Other US digital self-management programs for veterans include VetChange for veterans with problem drinking and PTSD symptoms (Brief, Rubin, Enggasser, Roy & Keane, 2011); afterdeployment.org, which can help veterans transition from deployment (Ruzek et al., 2011); and Considering Professional Help, a web-based psychoeducational program for veterans, which addresses barriers to mental health care including problem recognition, stoicism, stigma and negative beliefs about mental health services (Whealin et al., 2014).

In Australia, DVA and Defence have collaboratively developed a range of digital self-help resources, including websites and mobile applications. Websites included DVA's At Ease; ADF's Health and Wellbeing Portal, Fighting Fit; and more recently, the High Res website (at-ease.dva.gov.au/veterans/resources/mobile-apps/high-res-app/), which presents evidence-informed tools to build resilience. There are also smartphone apps that can help manage PTSD, suicide ideation and alcohol misuse. There has been no research to date on the effectiveness or uptake of these resources.

Non-digital sources of self-help

More than 3000 Australian charities currently list serving or ex-serving ADF members as beneficiaries. Australian ex-service organisations provide services including self-help initiatives such as welfare and social connections, and programs that involve equine therapy, yoga and adventure activities. There has been no research to date on the effectiveness or acceptability of these organisations or programs.

There is less research about non-digital self-help. Collinge and colleagues (2012) investigated a self-directed program of integrative therapies consisting of guided meditation, relaxation exercises and simple massage techniques aimed at reducing stress and increasing interpersonal connectedness. The program was evaluated in its application to National Guard personnel who were reintegrating into civilian life following deployment in Iraq or Afghanistan. These veterans demonstrated improvements in symptoms of PTSD and depression, and their partners experienced reduced stress levels. However, the study involved a relatively small sample (n = 41) and there was no control group, so it is difficult to draw strong conclusions about the effectiveness of the intervention.

In a study of British military personnel, a large proportion reported seeking help from informal sources such as chaplains and other non-medical professional services (such as social workers) (Iversen et al., 2010). Others used informal sources of help including family members, spouses or friends. Veterans in particular were more likely than current serving members to use informal sources of help, but this difference was not significant when adjusted for age and deployment status. The authors suggested that this may be due to an emphasis on self-reliance and also not wanting to disclose information to a professional who may be required to pass it back up the chain of command. Similarly, another study of current serving members of the British Army indicated that a higher proportion of those who sought help did so from informal support sources rather than military medical sources (Jones et al., 2013). Participants were more willing to engage with friends or family members than with any other source of support; online therapists and the unit chain of command were the least preferred sources of support. In a study of US Active Duty soldiers, chaplains were the second most reported source of help for mental health concerns, behind military mental health professionals (Morgan, Hourani, Lane & Tueller, 2016). The authors surmised that the confidentiality of discussions with a chaplain may encourage individuals to disclose problems, especially as soldiers did not need to indicate religious affiliations to seek help from a chaplain. However, soldiers who personally fired on the enemy or lost unit colleagues were less likely to seek help from a chaplain, which the authors speculated was related to issues of moral injury or spiritual doubt.

1.4 Services used

Serving and ex-serving ADF members who access healthcare services to deal with mental health concerns may access various healthcare professionals during the course of their care, including, GPs, psychologists, psychiatrists and social workers. This is consistent with other militaries that also use a range of mental health professionals to deliver services ranging from psychoeducation and training with a focus on coping strategies; counselling and evidence-based therapies; group-based programs; medication; and inpatient acute treatment programs. A number of other health and

allied health professionals – including pharmacists (Finley, Crismon & Rush, 2003), chaplains (Nieuwsma et al., 2014), occupational therapists (Rogers, Mallinson & Peppers, 2014) and social workers (Amdur et al., 2011) – also deliver mental health treatment for serving and ex-serving members.

Defence and DVA both have care models that allow primary healthcare practitioners to refer to a range of other healthcare providers, depending on the clinical needs of the individual. Although DVA and Defence monitor data such as spending on referrals to different professionals, there is less information available on the specific mental health services or interventions these providers deliver.

A study of British military personnel with mental health problems stratified types of disorders by the type of treatment being received (Iversen et al., 2010). Of those with depressive or anxiety disorder, more than half received medication (55.8%) and/or some form of counselling or psychotherapy (50.6%), while only 12.9% received cognitive behavioural therapy (CBT). For those diagnosed with alcohol misuse or PTSD, there were higher rates of psychotherapy than medication, but only around 6% received CBT. There was no difference between current serving members and Reservists in terms of the treatment being received (Iversen et al., 2010).

1.4.1 Interdisciplinary programs

There is an increasing tendency to integrate mental health professionals into primary care settings, to help treat mental health problems. Integrated care tends to emphasise preventative medical care, patient education and close collaboration with mental health providers. A study of US veterans (Druss, Rohrbaugh, Levinson & Rosenheck, 2001) receiving primary medical care either through an integrated care initiative or through a general medicine clinic indicated that patients treated through the integrated clinic had a greater number of primary care visits and greater improvements in health than those in the 'treatment as usual' group. Another study examined the effectiveness of integrating general and specialist care for veterans with depression in Veterans Affairs Medical Centers, by integrating mental health clinical nurse specialists. The intervention group had a higher referral rate to mental health services (Swindle et al., 2003).

Increasingly, there have been calls for an interdisciplinary approach when treating veterans, because of the interconnected physical, psychological and psychosocial problems in this population (Spelman, Hunt, Seal & Burgo-Black, 2012). Veteran health services have already begun to shift towards this style of program, including those that help veterans transition to civilian life. A US study described a residential group-based program led by psychologists, counsellors and a physician (Westwood, McLean, Cave, Borgen & Slakov, 2010). A study examining an interdisciplinary program for individuals

with psychiatric and addiction comorbidity indicated that overall inpatient use and recidivism decreased after the implementation of this model (Lambert, 2002).

1.4.2 Satisfaction with services

Understanding the factors that lead to satisfaction with care among transitioned and current serving members of the military is important. Satisfaction with care can influence adherence to treatment and use of future mental health care services (Rosen et al., 2011). Research involving Australian peacekeeping veterans revealed satisfaction rates of approximately 60% (Hawthorne et al., 2014). Peacekeeping veterans with more extensive trauma histories, with a diagnosed mental disorder and of younger age were more likely to rate themselves as dissatisfied with health services accessed (Hawthorne et al., 2014). Studies of satisfaction levels with mental health services among US veterans reported that 42–49% of US veterans with mental disorders had a positive appraisal of the care they received (Burnett-Zeigler, Zivin, Ilgen & Bohnert, 2011).

There may be gender differences in terms of satisfaction with veteran health care. In a US study of veterans who accessed Department of Veterans Affairs (VA) health care, male veterans were more satisfied than female veterans with the care they received (Wright, Craig, Campbell, Schaefer & Humble, 2006). Less-favourable perceptions of VA healthcare have been associated with attrition from VA among women US veterans (Hamilton, Frayne, Cordasco & Washington, 2013). Another study found that despite relatively high use of VA mental health services among women veterans, only half of those surveyed reported that this support met their needs very well or completely. Those who reported that their needs were not met tended to be younger and non-white with 1 in 5 stated that they felt uncomfortable when receiving treatment because of their gender (Kimerling et al., 2015). Factors associated with greater satisfaction including having female providers and women-only treatment settings and groups.

1.4.3 Interactions with staff members

A number of studies investigating satisfaction with care among veterans have emphasised the role of staff members, in particular their ability to build relationships with healthcare users. A US study that examined perceptions of behavioural health care among veterans with substance use disorders found that satisfaction with care was associated with perceiving staff as supportive and empathic (Blonigen, Bui, Harris, Hepner & Kivlahan, 2014). Importantly, positive perceptions of care were associated with greater use of services. Perceived improvement was strongly linked to staff members' ability to help patients develop goals that went beyond symptom management, such as employment and education. Another study of US veterans found that friendly and caring staff members led to greater satisfaction with care (Fontana, Rosenheck, Ruzek & McFall, 2006). In addition, patients could distinguish between

satisfaction with care and satisfaction with the outcome of treatment. PTSD symptoms were more highly related to satisfaction with clinical outcomes than satisfaction with care, and the friendliness of staff members was more highly related to satisfaction with quality of care than satisfaction with clinical outcome. This indicates that although staff friendliness influences satisfaction with care, it does not necessarily influence the perception of treatment outcomes. Relationships between staff members may also be important to patient satisfaction. A US study indicated that satisfaction among psychiatric patients was related to the relationships between the staff members who treated them (Wells et al., 2006) – that is, patients' satisfaction improved in the presence of strong mutual respect between the staff members. The importance of patient–staff relationships has also been investigated. In a study of current serving US Army soldiers, mistrust in healthcare providers was associated with dissatisfaction with care (Moore, Hamilton, Pierre-Louis & Jennings, 2013). The authors linked mistrust in healthcare providers to a reduced likelihood that an individual will adhere to treatment and follow their recommendations, which resulted in worse treatment outcomes and overall poorer health status.

1.4.4 Psychiatric symptom severity

Many studies have highlighted the link between poorer mental health status and lower satisfaction with care, including the Australian peacekeeper study outlined above (Hawthorne et al., 2014). A study of US veterans indicated that patients receiving a psychiatric diagnosis were less satisfied with their inpatient care than those who had not received a psychiatric diagnosis, regardless of whether they were treated in a psychiatric treatment program or a medical unit (Hoff, Rosenheck, Meterko & Wilson, 1999). The authors suggested that this should be taken into consideration when evaluating patients' satisfaction with mental health programs compared to other health programs. Another study of US veterans who received psychiatric inpatient care indicated that patient satisfaction was associated with initial functioning – fewer symptoms, higher quality of life, higher level of functioning or employment at the time of admission – and treatment gains (Holcomb, Parker, Leong, Thiele & Higdon, 1998). Other studies have indicated that a diagnosis of PTSD is associated with lower satisfaction with health care (Burnett-Zeigler et al., 2011). One study of US veterans with serious mental illness identified a potential solution to this, in the sense that patients' desire to be involved in treatment decisions tended to predict lower levels of satisfaction with their treatment. The authors suggested that allowing individuals to be involved in decisions about their own treatment would build a stronger therapeutic relationship (Klingaman et al., 2015).

1.4.5 Access to care

Access to care is another factor in determining patient satisfaction. Among Australian veteran peacekeepers, satisfaction with health care could be related to ease of access, as individuals who held a DVA Gold Card (and were therefore eligible to have all their

health care funded by DVA) reported higher satisfaction than those with a DVA White Card (eligible for only specific conditions to be funded by DVA) or no DVA health card (Hawthorne et al., 2014). In a study of US Army soldiers and their families, better access to care was associated with improved patient satisfaction (Moore et al., 2013). In addition, for injured soldiers in the Warrior Transition Unit who were either transitioning back to the Army or into civilian life, barriers to accessing behavioural health services alongside social support, and barriers to coordination of care were perceived to be areas for improvement (Gallaway et al., 2015).

VVCS is currently working to broaden access to health care through its research program, which will assess whether online counselling achieves the same results for clients as in-person counselling. This randomised control study seeks to examine the impacts of making online counselling more available to clients, especially in rural or remote settings. However, while technologies such as telepsychiatry may improve access to care, they may not be preferred methods of treatment delivery. Lindley and colleagues (2010) indicated that treatment acceptance was less likely when assessments were conducted by phone and by primary care physicians. However, clinic location also impacted acceptance and adherence. Aspects of treatment facilities and programs may also influence care.

1.5 The current study

Internationally, there is extensive literature on the multitude of factors related to pathways to care for serving and ex-serving members of the military. Much of the existing literature is based on US, UK and, to a lesser extent, Canadian studies. Given the need to ensure that Australian transitioned and current serving ADF members with mental healthcare needs have access to and receive appropriate mental health care, this study sought to investigate pathways to care for transitioned and currently serving ADF members, drawing on the above literature.

Building on the findings of the 2010 MHPWS, this study sought to investigate the patterns of seeking and using health services among ADF members who transitioned out of the ADF between 2010 to 2014 (Transitioned ADF) and a stratified random sample of current serving ADF members serving in 2015 (2015 Regular ADF). In doing so, this report sought to identify:

- What proportion of Transitioned ADF and 2015 Regular ADF sought professional care for their mental health concerns?
- What are the patterns of latency between onset of a mental health concern and seeking care?

- For those who sought care, what problems were driving their decision to seek care? Did someone else suggest they seek care? If so, who was it and did someone else assist them in actually getting to care?
- What types of professionals did they consult, what type of services did they report the professionals provided and how satisfied were they with what was provided?
- What other self-management strategies did they use to address their mental health concerns and what were their levels of satisfaction with those strategies?
- What were common attitudes and beliefs about mental health and seeking care focusing initially on the entire cohort and then those with mental health concerns who did not seek care?

The patterns of service engagement questions were considered from both within the respective Transitioned ADF and 2015 Regular ADF populations and in comparisons between them, with further examination of the differences between the Transitioned ADF subgroups (Ex-Serving, Active Reservists and Inactive Reservists). The study also compared the answers of those who did and did not meet the criteria for a current probable 30-day mental disorder, as defined by the epidemiological cut-off on the Posttraumatic Stress Disorder Checklist (PCL) and Kessler Psychological Distress Scale (K10).

Addressing the above questions will provide critical information to better understand access to, and use of, services, and the factors, strengths, gaps and preferences that guide current patterns of service use. The findings of this report will provide DVA and Defence with information to guide future service delivery and mental health initiatives, to help further improve outcomes for recently transitioned and current serving ADF communities.

How to interpret and discuss the findings in this report

Weighted prevalence estimates:

- Where the report talks about prevalence estimates, it is referring to the *estimated* rates of a particular outcome within the entire population or subpopulation. It is important to understand that these are estimates. These estimates represent the proportion of cases we would predict to observe in the total population, based on the proportion of actual cases detected in the subpopulation who completed the outcome measure.
- When considering prevalence estimates, estimated proportions are more informative than estimated numbers.
- While results in this report were weighted to represent the total population, this weighting was performed on the basis of four key variables: sex, rank, Service (Navy, Army or Air Force) and medical fitness. This assumes a general consistency across individuals with each combination of these characteristics (strata), and does not account for individual differences or other factors that may influence the outcomes of interest.
- The relatively low response rates observed in the study mean that the weighted estimates presented may have a lower level of accuracy, with estimates more highly dependent on the characteristics used for weighting.
- Estimates for subpopulations (strata) with higher response rates more accurately represent those subpopulations than those with lower response rates.
- The subpopulations (strata) used for weighting in this report are presented in Tables 12.4, 12.5 and 12.6. These tables show how many individuals within the population each responder represents for each stratum. The higher this number, the more caution should be applied in interpreting the associated estimates.
- Where an outcome is relatively rare and is detected at a high rate in individuals who share characteristics with a large proportion of the population (such as Other Ranks), the estimated proportion of the entire population predicted to have achieved that outcome should be greater than the proportion of cases detected.
- Where an outcome is relatively common and is detected at a high rate in those who share characteristics with a small proportion of the population, the estimated proportion of the total population predicted to have achieved that outcome should be lower than the proportion of cases detected.
- To interpret the precision or imprecision of a given estimate, readers might consider additional information supplied with the estimates, such as confidence intervals.

Confidence intervals: These represent the possible range of values within which the presented estimate falls. Where the value of interest is a prevalence estimate, confidence intervals show the range of error in the estimate. In general, confidence intervals that are very close to the estimate value indicate that the estimate is more precise, while very wide confidence intervals suggest that the estimate is imprecise. Where there are wide confidence intervals, associated

estimates should be interpreted cautiously, and the upper and lower limits should be considered the top and bottom range of possible precise values.

Standard errors: Like confidence intervals, standard errors indicate the range of error in an average score.

Between-group comparisons: Where comparing prevalence estimates between groups, the overlap in confidence intervals provides an indication of between-group differences. Where there is significant overlap, any apparent difference in estimates is more likely to reflect an error in measurement or estimate. In general, the smaller the subpopulation of interest the greater the error, so where a stratification variable has a very small number in some categories, estimates are likely to have large associated confidence intervals or standard errors.

Odds ratios (ORs): When estimating the prevalence of a particular health outcome there could be differences in the prevalence rates between two groups (for example, between 2015 Regular ADF and Transitioned ADF). This could be due to differences in factors other than transition status – such as sex, age, Service or rank – across the comparison groups, particularly if these other factors are associated with the health outcome. If this is true, these factors potentially confound the findings. One way to address this is to employ a logistic regression model that controls (adjusts for) these factors. The statistical output from a logistic regression model is an odds ratio (OR), which denotes the odds of a particular group (such as Transitioned ADF) having a particular health outcome compared to a reference group (such as 2015 Regular ADF).

An OR of greater than one indicates increased odds of having the outcome compared to the reference group, whereas an OR of less than one suggests less likelihood of having the particular health outcome compared to the reference group. For example, an OR of 1.7 for the Transitioned ADF (compared to 2015 Regular ADF) suggests that the Transitioned ADF members have 70% increased odds of having that particular health outcome. Conversely, an OR of 0.70 suggests that the Transitioned ADF members are 30% less likely to have the particular health outcome compared to the 2015 Regular ADF. When an OR is greater than two, we can then say that the Transitioned ADF are twice as likely to have the particular health outcome, compared to the 2015 Regular ADF. Similarly, if the OR is greater than three, they would be three times as likely to have the particular health outcome, and so forth.

Significance: Where the text describes a between-group difference as significant, this means that the difference between groups was statistically tested then adjusted for sex, age and Service, and there was no overlap in the associated confidence intervals between groups.

Further caveats to be considered when reading and discussing the findings from this study:

- The overall response rate for the study was low, particularly among Transitioned ADF. While responder data could be statistically weighted up to the total population, the lower the number of responders, the less accurate the resulting weighted population estimates.

- Response rate data show that some subpopulations had substantially lower response rates, which effects the accuracy of the associated estimates. In particular, Officers and Non-Commissioned Officers were over-represented among responders, while Other Ranks were highly under-represented, despite accounting for the largest proportion of the total population.[1] As such, any estimates stratified by rank should be interpreted with a degree of caution.
- A large proportion of this study relates to self-reporting measures, which are subject to potential biases, including recall bias. The collection of diagnostic mental disorder data allow for corroboration of findings, although these potential biases should be noted.

Glossary: refer to the Glossary of terms for definitions of key terms.

[1] An examination of the distribution of age, sex and Service characteristics for each rank category in the population, and among responders showed that for Officers, the two oldest age categories were over-represented, and the two youngest age groups were under-represented. There was a similar pattern for Non-Commissioned Officers. For Other Ranks, there was a slightly different pattern: while the youngest age category was under-represented, all other age categories were somewhat over-represented. The distribution of sex among the rank categories was similar for responders and the population, with a slightly inflated proportion of female responders. Similarly, the distribution of Service across the rank categories for responders was largely reflective of the population distribution. Therefore, while Other Ranks were under-represented, the characteristics of those who responded were broadly similar to the total Other Rank population.

2 Methodology

2.1 Study design

In Phase 1 of the Mental Health and Wellbeing Transition Study, Transitioned ADF and 2015 Regular ADF members were screened for mental health problems, psychological distress, physical health problems, wellbeing factors, pathways to care and occupational exposures. This screening was conducted using a 60-minute self-reporting questionnaire, which participants completed either online or in hard copy. Each participating sample received a slightly different questionnaire relevant to their current ADF status – Transitioned ADF member, 2015 Regular ADF member or Ab initio Reservist – and in regard to demographics, Service and deployment history. However, the core validated measures of psychological and physical health remained the same, and replicated where possible the measures previously administered as part of the 2010 Mental Health Prevalence and Wellbeing Study. This component of the design is critical to the longitudinal comparisons across time, and highlights the importance of a consistent approach to overseeing research design for military and veteran populations over time.

Further details of the self-reporting survey measures investigated in this report are provided in section 2.7.1.

2.2 Samples

This report uses two of the Programme's six overlapping samples. A detailed description of all six samples used in the broader Programme can be viewed in Annex B: Methodology.

Sample 1: Transitioned ADF – This sample comprised all ADF members who transitioned from Regular ADF between 2010 and 2014, and included those who transitioned into the Active Reserves and Inactive Reserves as well as those who were discharged completely from the Regular ADF (Ex-Serving members).

Sample 2: 2015 Regular ADF – This sample comprised three separate groups of Regular ADF members in 2015 who were invited to participate in the study: those who participated in the 2010 MHPWS and remained a Regular ADF member in 2015; those who participated in the Middle East Area of Operations Prospective Health Study between 2010 and 2012, and remained a Regular ADF member in 2015; and a stratified random sample of Regular ADF members from 2015 who were not part of the 2010

MHPWS or the MEAO Prospective Health Study. Combined results from these three groups were weighted to represent the entire Regular ADF in 2015.

Of the Transitioned ADF population of 24,932, 96% (23,974) were invited to participate. Those not invited were those who may have opted out of the study or did not have any usable contact information. Thirty-eight per cent (20,031) of the total 2015 Regular ADF population (52,500) were invited to participate.

The samples were taken from a Military and Veteran Research Study Roll (Study Roll) generated specifically for this Programme, and were held at the Australian Institute of Health and Welfare (AIHW). The Study Roll was generated from Defence personnel data, DVA contact data and ComSuper contact details, and cross-referenced against the National Death Index. For all individuals in the Transitioned ADF and the 2015 Regular ADF populations, basic demographic characteristics used for weighting were held by the AIHW until the conclusion of data collection, at which time it was provided to the researchers in an identified or de-identified form, depending on participation and consent status.

2.3 Response rates

2.3.1 Survey responders

Table 2.1 and Figure 2.1 show the total populations for the Transitioned ADF and the 2015 Regular ADF; the number from each population who were invited to participate in the study; and the proportion of those invited who responded.

Overall there was a response rate of 29.1% for the entire survey across Transitioned ADF and Regular ADF (total responders divided by the total number invited). As at 15 December 2015, 18.0% (4326) of the 23,974 Transitioned ADF members invited to participate had completed a survey. In contrast, the response rate among invited 2015 Regular ADF members (20,031) was much higher; 42.3% of the 2015 Regular ADF members who were invited to participate completing a survey. The breakdown of Transitioned ADF and 2015 Regular ADF members with enough data to be included in the survey is summarised in Figure 2.1.

Table 2.2 presents the unweighted demographic characteristics of Transitioned ADF and 2015 Regular ADF survey respondents.

Table 2.1 Mental Health and Wellbeing Transition Study survey response rates by Service, for Transitioned ADF and 2015 Regular ADF members

	Transitioned ADF n = 24,932				2015 Regular ADF n = 52,500			
	Population	Invited	Responders	Response rate (%)	Population	Invited	Responders	Response rate (%)
Service								
Navy	5671	5495	863	15.7	13,282	5113	2040	39.9
Army	15,038	14,465	2463	17.0	25,798	8067	3500	43.4
Air Force	4223	4014	1000	24.9	13,420	6851	2940	42.9
Sex								
Male	21,671	20,713	3646	17.6	47,645	15,176	6693	44.1
Female	3261	3261	380	20.9	4855	4855	1787	36.8
Rank								
OFFR	4063	3939	1259	32.0	13,444	7847	3538	45.1
NCO	7866	7393	2097	28.4	17,491	9117	4336	47.6
Other Ranks	13,003	12,642	970	7.7	21,565	3067	606	19.7
Medical fitness[2]								
Fit	18,273	17,525	2981	17.0	46,022	17,097	7116	41.6
Unfit	6659	6449	1345	20.9	6478	2934	1364	46.5
Total	24,932	23,974	4326	18.0	52,500	20,031	8480	42.3

Notes:
Unweighted data
95% CI: 95% confidence interval
Response rates presented in the table above are calculated as the proportion of those invited to participate in the study

[2] For details of the reclassification of Medical Employment Classification (MEC) as medical fitness, refer to Annex B.

Figure 2.1 **Survey response rates for the Transitioned ADF and the 2015 Regular ADF in the Mental Health Prevalence and Wellbeing Transition Study**

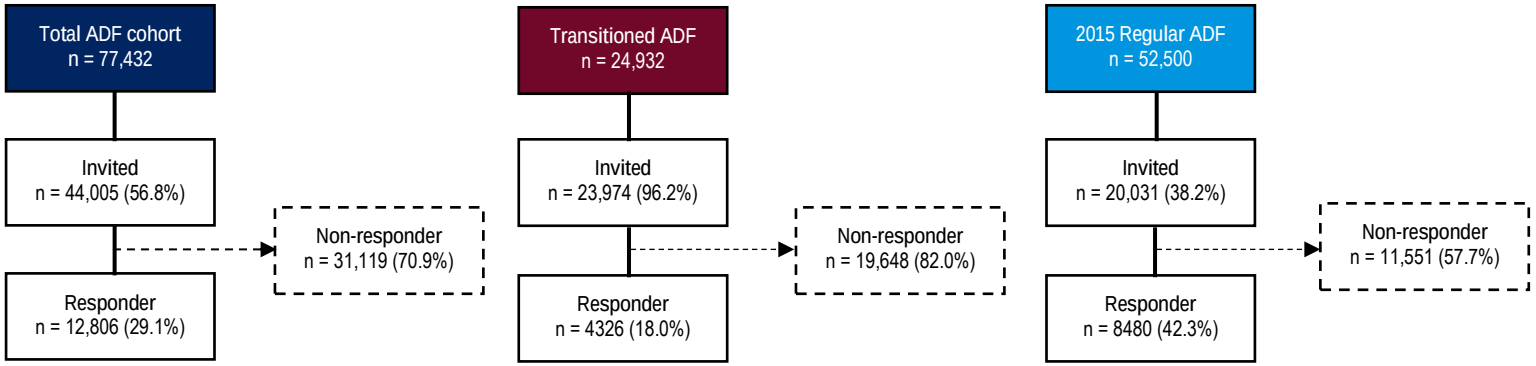


Table 2.2 Unweighted demographic characteristics of responders, by Transitioned ADF and 2015 Regular ADF

	Transitioned ADF n = 4326			2015 Regular ADF n = 8480		
	n	%	95% CI	n	%	95% CI
Age (M, SE)	41.9	0.18		41.1	0.11	
Age group						
18–27	471	10.9	(10.0, 11.9)	602	7.1	(6.6, 7.7)
28–37	1262	29.2	(27.8, 30.5)	2484	29.3	(28.3, 30.3)
38–47	1119	25.9	(24.6, 27.2)	2976	35.1	(34.1, 36.1)
48–57	871	20.1	(19.0, 1.4)	2069	24.4	(23.5, 25.3)
58+	548	12.7	(11.7, 13.7)	201	2.4	(2.1, 2.7)
Sex						
Male	3646	84.3	(83.2, 85.3)	6693	78.9	(78.0, 79.8)
Female	680	15.7	(14.7, 16.8)	1787	21.1	(20.2, 22.0)
Rank						
OFFR	1259	29.1	(27.8, 30.5)	3538	41.7	(40.7, 42.8)
NCO	2097	48.5	(47.0, 50.0)	4336	51.1	(50.1, 52.2)
Other Ranks	970	22.4	(21.2, 23.7)	606	7.15	(6.6, 7.7)
Service						
Navy	863	19.9	(18.8, 21.2)	2940	34.7	(33.7, 35.7)
Army	2463	56.9	(55.5, 58.4)	3500	41.3	(40.2, 42.3)
Air Force	1000	23.1	(21.9, 24.4)	2040	24.1	(23.2, 25.0)
Medical fitness						
Fit	2981	68.9	(67.5, 70.3)	7116	83.9	(83.1, 84.7)
Unfit	1345	31.1	(29.7, 32.5)	1364	16.1	(15.3, 16.9)

Response rate denominator: Those who were invited and responded to the survey
Note: Unweighted data
Note: 95% CI: 95% confidence interval

The characteristics of survey respondents were as follows:

Age: Transitioned ADF survey responders (mean age 41.9; SE 0.1) were of a similar age to the 2015 Regular ADF responders (mean age 41.1; SE 0.1).

Sex: Consistent with the Transitioned ADF population, the sample was predominantly male. Female Transitioned ADF members were significantly more likely to respond to the survey than male Transitioned ADF members. In the 2015 Regular ADF population, female members were less likely to respond than male members.

Rank: Survey responders from the Transitioned ADF comprised 29.1% Officers, 48.5% Non-Commissioned Officers and 22.4% Other Ranks. In the 2015 Regular ADF, there was a similar distribution of 41.7% Officers, 51.1% Non-Commissioned Officers and 7.2% Other Ranks. The Transitioned ADF population had significantly lower response rates for Officers and Non-Commissioned Officers, but significantly higher response

rates for Other Ranks compared to the 2015 Regular ADF. In both groups, the lower ranks were the poorest responders.

Service: In the Transitioned ADF, 19.9% of survey responders were from the Navy, 56.9% from the Army and 23.1% from the Air Force. For the 2015 Regular ADF, 24.1% of responders were from the Navy, 41.3% from the Army and 34.4% from the Air Force. When response rates in the different Services were compared, Transitioned Air Force members were most likely to respond, whereas Transitioned Navy and Transitioned Army members were least likely to respond. Among the 2015 Regular ADF, Army had the highest response rate at 43.4%.

Medical fitness: Not surprisingly, Transitioned ADF members were significantly more likely to be unfit when they transitioned from Regular ADF (31.1%) compared to the 2015 Regular ADF population (16.1%). Transitioned ADF members who were unfit had a response rate of 20.9% compared to 46.5% in the 2015 Regular ADF population.

2.4 Statistical analysis

Analyses were conducted in Stata version 13.1 or SAS version 9.2. All analyses were conducted using weighted estimates of totals, means and proportions, except where specified otherwise. Standard errors were estimated using linearisation, except where specified otherwise.

For the self-report measures, the proportion (n%) of ADF members in each subgroup is presented. Comparisons between the mean total scores among subgroups were also analysed where appropriate, using weighted multiple linear regressions. All regressions included the covariates of age, sex, Service and rank.

2.5 Weighting

The statistical weighting process used in the Mental Health and Wellbeing Transition Study replicated that used in the 2010 MHPWS, and allowed for the inference of results for the entire Transitioned ADF and 2015 Regular ADF populations.

Survey responder weights were used to correct for differential non-response to the survey by Transitioned ADF and 2015 Regular ADF. The weighting procedure involves allocating a representative value or 'weight' to the data for each responder, based on key variables that are known for the entire population (including responders and non-responders). This weight indicates how many individuals in the entire population each actual responder represents. Weighting data allows for the inference of results for an entire population – in this case, the Transitioned ADF – by assigning a representative value to each 'actual' case (responder) in the data. If a case has a weight of 4, it means that case counts in the data as four identical cases. By using known characteristics

about each individual within the population (in this case age, sex, rank and medical fitness), the weight assigned to responders indicates how many 'like' individuals in the entire population (based on those characteristics) each responder represents. Weighting is used to correct for differential non-response and to account for systematic biases that may be present in study responders. This methodology provides representative weights for the population to improve the accuracy of the estimated data, and requires that every individual within the population has actual data on the key variables that determine representativeness.

The Transitioned ADF weights were derived from the distinct strata of sex, Service, rank and medical fitness, a dichotomous variable derived from Medical Employment Classification (MEC) status. There were 313 (1.24%) of the total Transitioned ADF population with missing information on the strata variables and therefore the final weighted population for analyses was 24,932.

The 2015 Regular ADF weights were derived from the distinct strata of sex, Service, rank, medical fitness, and whether the individual completed a study as part of the Military Health Outcomes Program (MilHOP). The inclusion of this additional stratification variable was to account for the targeted sampling of the MilHOP cohort, who were then over-represented within the current serving responders. A MilHOP flag variable (yes/no = 1/0) was created and used in the weighting process in order to reduce this bias. There were 192 (0.36%) 2015 Regular ADF with missing information on the strata variables, which reduced the final weighted population for analysis to 52,500. Tables 12.4, 12.5 and 12.6 present the study population and responders within each stratum used for weighting, and show approximately how many individuals within each subpopulation each study responder represents.

2.5.1 Estimates from the survey

To maximise the actual data available for analysis, survey weights were calculated for each separate section of the survey. This addressed the issue of differential responses to various sections of the survey, where individuals potentially completed some but not all parts of the survey. A 'survey section responder' was defined as anyone who answered at least one question in that particular section of the survey. There was a total of 29 section responder weight variables. For the purpose of analysis, the weights used were always for the primary outcome variable of interest.

2.6 The scope of the current report

The current report will address the following research questions:

Chapter 4 examines and compares self-reported mental health concerns and help-seeking behaviours among Transitioned ADF and 2015 Regular ADF members. It addresses the following key questions:

- Are Transitioned ADF members more or less likely to have reported being concerned about their mental health compared to 2015 Regular ADF members?
- Are Transitioned ADF members more or less likely to report being concerned about their mental health prior to transition from current ADF service compared to 2015 Regular ADF members?
- Are Transitioned ADF members more or less likely to report having had assistance for their mental health compared to 2015 Regular ADF members?

Chapter 5 describes the pathways to care for Transitioned ADF and 2015 Regular ADF members who have had a concern about their mental health and who have sought care. It addresses the key question:

- Do Transitioned ADF and 2015 Regular ADF members differ in the length of time between becoming concerned about their mental health and seeking help?

In particular, this chapter explores:

- any differences in help-seeking latency (length of time between becoming concerned about their mental health and seeking help)
- support and assistance to seek help.

Chapter 6 describes the types of mental health professionals and services that Transitioned ADF and 2015 Regular ADF members sought or received help from for their mental health in the past 12 months. This chapter also examines the mental health professionals from whom the services were accessed, and how satisfactory those services were perceived to be. Chapter 6 addresses the following key questions:

- Do Transitioned ADF and 2015 Regular ADF members differ in the types of mental health services that they use?
- Do Transitioned ADF and 2015 Regular ADF members differ in their satisfaction with health services factors?

Chapter 7 describes the types of doctors or professionals that Transitioned ADF and 2015 Regular ADF members sought or received help from for their mental health in the past 12 months, and information on how these consultations were funded. It addresses the key question:

- Do Transitioned ADF and 2015 Regular ADF members differ in the mental health services that they reported receiving funding to use?

Chapter 8 examines:

- The self-help strategies that were most commonly utilised by Transitioned ADF and 2015 Regular ADF members to assess/inform their mental health in the last 12 months.
- Self-help strategies used by Transitioned ADF and 2015 Regular ADF members to maintain their mental health in the last 12 months.
- The preferred means of receiving mental health information in Transitioned ADF and 2015 Regular ADF members.
- Whether these strategies were found to be helpful.

Chapter 8 addresses the following key question:

- Do Transitioned ADF and 2015 Regular ADF members differ in the self-help strategies that they use?

Chapter 9 describes:

- The perceived stigmas and barriers to receiving care in Transitioned ADF and 2015 Regular ADF members
- The types of stigmas and perceived barriers endorsed by Transitioned ADF and 2015 Regular ADF members.
- The difference in type and number of stigmas and barriers reported by non-help-seekers (those who have never had assistance or sought help from a GP, psychologist, psychiatrist, other mental health professional) compared to help-seekers (those who have sought/received help) and if this pattern differs between Transitioned and 2015 Regular ADF members.
- The difference in the types of stigmas and barriers to care endorsed by those who score above (probable mental disorder) and below the epidemiological cut-off on the PCL, K10, (no probable mental disorder) in Transitioned ADF and 2015 Regular ADF members.
- Among those Transitioned ADF and 2015 Regular ADF members who have been concerned about their mental health but never sought assistance, the reasons why they did not seek help.

Chapter 9 addresses the following key questions:

- What are the perceived stigmas and barriers to receiving care in Transitioned ADF and Regular ADF members?
- Is there a significant difference in types of stigmas and perceived barriers endorsed by Transitioned ADF and 2015 Regular ADF members?
- Is there a significant difference in type and number of stigmas and perceived barriers reported by those who have never had assistance or sought help from a GP, psychologist, psychiatrist, other mental health professional (non-help-seekers), compared to those who have sought/received help, and is this pattern different in Transitioned ADF versus 2015 Regular ADF members (help seekers)?
- Is there a significant difference in the types of stigmas and barriers to care endorsed by those who score above (probable 30-day mental disorder) and below the epidemiological cut-off on the PCL, K10, AUDIT (no probable 30-day mental disorder) in Transitioned ADF and 2015 Regular ADF members?
- Among the Transitioned ADF and 2015 Regular ADF members, who have been concerned about their mental health but never sought assistance, what are the reasons why?

2.7 Measures used in the current report

2.7.1 Self-report survey

Concerns about mental health

Self-reported mental health concerns in the past 12 months and over participants' lifetime were examined by asking a single question: *Have you ever been concerned about your mental health? (Yes/No).* Participants indicated when they first became concerned about their mental health using a single item: *When did you become concerned about your mental health?* Participants were asked to indicate the date (month and year) when they first became concerned.

Assistance with mental health

Items addressing assistance sought for mental health were taken from the 2010 MHPWS (McFarlane et al., 2011). Lifetime and 12-month assistance sought for mental health problems was asked in one item: *Have you ever had assistance for your mental health?* Response options included:

- yes – currently
- yes – in the last 12 months

- yes – more than 12 months ago
- no.

Probable 30-day disorder

The presence of a probable 30-day disorder was determined based on scores from K10 (Kessler et al., 2002) and civilian PCL (PCL-C) audits (Weathers, 1993).

The K10 is a 10-item screening questionnaire that yields a global measure of psychological distress based on symptoms of anxiety and depression experienced in the most recent four-week period. Items are scored from 1 to 5 and summed to give a total score between 10 and 50. Response options were:

- all of the time
- most of the time
- some of the time
- a little of the time
- none of the time.

The PCL-C is a 17-item self-reporting measure designed to assess the symptomatic criteria of posttraumatic stress disorder (PTSD), set out in the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition* (DSM-IV). The 17 questions of the PCL-C are scored from 1 to 5, and summed to give a total symptom severity score of between 17 and 85. Participants were asked to indicate how much they were bothered by each symptom in the last month, from the following response options:

- not at all
- a little bit
- moderately
- quite a bit
- extremely.

Probable 30-day disorder-epidemiological cut-off scores

The use of an epidemiological mental disorder cut-off denotes whether symptoms are indicative of a probable 30-day mental disorder. In this case, the epidemiological rather than screening cut-off was used, as the interest was particularly on understanding the differences in pathways to care among people with and without a probable mental disorder. Participants were deemed to have a probable 30-day disorder if they scored above the optimal epidemiological cut-offs on the PCL or K10, where:

- probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25
- no probable 30-day disorder = PCL < 53 and K10 < 25.

Help-seeking latency

Participants indicated when they first became concerned about their mental health using a single item: *When did you become concerned about your mental health?* Participants were asked to indicate the date (month and year) when they first became concerned.

To assess help-seeking latency, participants indicated when they first sought help for their own mental health: *When did you first seek help for your own mental health?* Response options included:

- within three months of becoming concerned
- within one year of becoming concerned OR
- participants could specify the number of years after becoming concerned.

Who suggested seeking help?

Participants were asked to indicate if someone had suggested they seek help for their mental health: *Did someone else suggest you seek help for your mental health? (Yes/No)*. Options included:

- GP (non-Defence)
- medical officer (Defence)
- partner
- other family member
- friend or colleague
- supervisor, manager or commander
- other.

Assistance from others in seeking Care

Participants were asked to indicate if someone else assisted them in seeking mental health care: *Did someone else actually assist you (e.g., ring for an appointment, assist with transport) in seeking care for you? (Yes/No).* If yes, participants indicated who assisted them from the following seven options:

- GP (non-Defence)
- Medical Officer (Defence)
- partner
- other family member
- friend or colleague
- supervisor, manager or commander
- other.

Primary reason for seeking assistance for mental health concern

Participants' primary reason for seeking mental healthcare assistance was assessed by asking a single item: *What problem(s) led you to seeking care?* Participants specified the primary or main reason by choosing one of 11 response options, namely:

- anger
- anxiety
- relationship problems
- nightmares
- depression
- alcohol or other drug problems
- sleep
- pain
- problems at work
- gambling
- other.

Participants then indicated the secondary reason(s) for seeking care by marking all the options that applied from the list above.

Types of mental health professionals consulted in the past 12 months

Participants were asked whether they had ever sought or received help from the following list of doctors or professionals for their mental health in the previous 12 months and more than 12 months ago.

- GP or medical officer
- psychologist
- psychiatrist
- other mental health professional (social worker, occupational therapist or mental health nurse)
- other provider (counsellor, or complementary or alternative therapist)
- inpatient treatment or hospital admission
- hospital-based PTSD program
- residential alcohol or other drug program.

Types of services received

Participants were asked to indicate the types of service(s) they received from a GP, psychologist, psychiatrist or other mental health professional. Options included:

- information about mental illness, its treatment and available services
- medicine or tablets
- counselling – supportive, focusing on day-to-day stressors, problems and concerns
- counselling – psychotherapy, focusing on the impact of early-life experiences
- counselling – cognitive behavioural therapy (CBT), focusing on changing unhelpful thoughts and behaviours
- counselling – eye movement desensitisation and reprocessing (EMDR) with the main focus on addressing memories of traumatic experience, e.g., trauma-focused cognitive behavioural therapy (CBT).

Satisfaction with mental health services

Participants' satisfaction with each type of mental health service received was assessed in one item: *Were you satisfied with this service? (Yes/No)*. Participants rated their level of satisfaction with all the mental health services or care they had received in the past 12 months, based on the 10 factors of:

- accessibility
- cost
- location
- effectiveness
- health professional competence
- health professional friendliness
- convenience
- confidentiality
- Medicare cap
- other.

Participants rated their satisfaction with each of these factors on a 5-point Likert scale of:

- very dissatisfied
- dissatisfied
- neither satisfied or dissatisfied
- satisfied
- very satisfied
- N/A.

Types of doctors/professionals consulted

- GP or medical officer
- psychologist
- psychiatrist
- other mental health professional (social worker, occupational therapist or mental health nurse)
- inpatient treatment or hospital admission
- hospital-based PTSD program
- residential or other drug program.

Types of funding for mental health professional/service

Participants who sought or received help from a health professional or service in the last 12 months were asked how the service was paid for, with the following options:

- Medicare
- DVA
- Defence
- self-referral to the Veterans and Veterans Families Counselling Service (VVCS) – psychologist and other mental health professional only
- VVCS Defence referral – psychologist and other mental health professional only
- private health fund
- fully self-funded
- other (such as WorkCover)
- don't know.

Strategies for informing and assessing mental health

This section consisted of a single item with 32 specific help-seeking strategies participants used to inform or assess and maintain their mental health in the last 12 months, and whether or not participants found these strategies to be helpful. The 32 self-help strategies were grouped into the following seven categories:

- Websites:
  - ADF
  - DVA
  - At Ease
  - Black Dog Institute

  - Headspace
  - beyondblue
  - mindhealthconnect
  - Lifeline Australia
  - Kids Helpline
  - MensLine Australia
  - Other health website.

- Online treatment services:
  - MoodGYM
  - e-couch
  - Other online treatment service.

- Smartphone apps:
  - PTSD Coach
  - On Track
  - Other app.

- Other web-based sources:
  - Email subscription
  - Blogs
  - Social media.

- DVA or Defence telephone helplines:
  - Defence Family Helpline
  - ADF All-hours Support Line
  - 1800 IMSICK.

- Other telephone helplines:
  - Lifeline
  - MensLine
  - MindsSpot
  - Relationships Australia
  - SANE Australia
  - Other helpline.

- Ex-service organisations.

Self-help strategies used to maintain mental health

A single item asked participants to indicate the ways they have maintained their mental health in the past 12 months and if they found these strategies helpful: *Which of the following have you used in the last 12 months to maintain your mental health? Do/Did you find this helpful?* (Yes/No). Options included:

- communicating with a chaplain or church leader
- increased physical activity
- doing more of the things they enjoy
- seeking support from family or friends.

Preferred means of receiving mental health information

A single item asked participants to indicate their preferred means of receiving information about their mental health. Options included via telephone, the internet, or in person (face to face). This item was developed by researchers for use in the study.

Stigmas and barriers to care

To examine stigmas and barriers to care, participants were asked to rate the degree to which a list of 'concerns' might affect their decision to seek help: *Please indicate how each of these concerns <u>might</u> affect your decision to seek help.* Participants were asked to rate factors on a 5-point Likert scale.

Barriers:

- I wouldn't know where to get help.
- Help is too expensive.
- I have difficulty getting time off work.
- It would harm my career or career prospects.
- It would stop me from being deployed.
- It is difficult to get an appointment.

Stigmas:

- Wouldn't understand problems related to veteran/military experience.
- Outcome of seeking treatment would be beyond my control.
- Would feel inadequate.
- Would feel embarrassed.
- Would feel worse about self if I can't solve own problems.
- People with mental health problems can snap out of it if they want to.
- Might feel worse.
- Might lose control of emotions.

- People would treat me differently.
- Would be seen as weak.
- People might have less confidence in me.
- Don't trust mental health professionals.

Reasons why never sought assistance for mental health concerns

Participants were asked to indicate their reasons for not seeking help: *What are the reasons you did not seek help?* Participants indicated on a 5-point Likert scale how much they agreed or disagreed with the following reasons:

- I preferred to manage myself.
- I didn't think anything could help.
- I didn't know where to get help.
- I was afraid to ask for help, or of what others would think of me if I did.
- I couldn't afford the money.
- I can still function effectively.
- I got help from another source.

For the full methodology, including a comprehensive description of all the measures used in the survey, refer to Annex B.

3 Demographic characteristics of Transitioned ADF and 2015 Regular ADF

Transitioned ADF

- Over half of Transitioned ADF members remained in the ADF as Reservists (55.75%). Of these, 25.6% were Active Reservists.
- The majority of Transitioned ADF members had left full-time service between one and three years prior; the smallest proportion had left less than 12 months prior.
- The most commonly reported reason for leaving was 'own request', which was the case for over 60% of the Transitioned ADF.
- Just over one-fifth of the Transitioned ADF were estimated to have been medically discharged.
- The most commonly reported reasons for transition were 'impact of service life on family' (10.2%), 'better employment prospects in civilian life' (7.2%), 'mental health problems' (6.5%) and 'physical health problems' (4.3%).
- Almost two-thirds of Transitioned ADF members reported being engaged in civilian employment (62.8%). For those individuals, the most common industries of employment were government administration and Defence (16.8%), mining (9.9%), construction (8.8%), and transport and storage (8.6%).
- A considerable proportion of the Transitioned ADF reported a period of three months or longer in which they had been unemployed (43.7%) since transitioning from Regular ADF.
- More than 43% of Transitioned ADF members reported accessing DVA-funded treatment through a DVA White Card (39.4%) or DVA Gold Card (4.2%).
- Among Transitioned ADF members, approximately one in five reported joining an ex-service organisation.
- Among the Transitioned ADF, 3% reporting having been arrested (2.9%), convicted (2.1%) or imprisoned (0.07%) since their transition.

Transitioned ADF compared to 2015 Regular ADF

- Transitioned ADF and 2015 Regular ADF were equally likely to be aged 18–27, although compared to the 2015 Regular ADF, more Transitioned ADF members were over the age of 58.
- There were more females among Transitioned ADF members than among 2015 Regular ADF members.
- Transitioned ADF members were less likely than 2015 Regular ADF members to be 'in a relationship but not living together'.
- Just over 40% of Transitioned ADF members and 36% of 2015 Regular ADF members reported having a diploma or university education qualifications.
- There were no significant differences in housing stability between Transitioned ADF and 2015 Regular ADF members; it was estimated that more than 93% had been in stable housing in the previous two months.
- Transitioned ADF members were more likely than 2015 Regular ADF members to be in a lower rank.
- A greater proportion of Transitioned ADF members were from the Army compared to 2015 Regular ADF members.
- Twice as many Transitioned ADF members were classified as medically unfit compared to 2015 Regular ADF members.
- Transitioned ADF members were more likely to than 2015 Regular ADF members to report having less than eight years of service.

Glossary: refer to the Glossary of terms for definitions of key terms in this section.

Chapter 3 provides a detailed summary of the demographic characteristics of Transitioned ADF members, including an examination of the differences between Transitioned ADF and 2015 Regular ADF members. Outcomes are weighted up to the entire population using the technique described in Chapter 2 of this report, and so represent weighted estimates of these characteristics within the Transitioned ADF and 2015 Regular ADF cohorts.

3.1 Demographic characteristics of Transitioned ADF and 2015 Regular ADF members

Table 3.1 describes the demographic characteristics of Transitioned ADF and 2015 Regular ADF members.

Table 3.1 Weighted demographic characteristics of Transitioned ADF and 2015 Regular ADF members

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Age group[a]						
18–27	471	5195	20.8 (19.3, 22.5)	602	10,319	19.7 (16.4, 23.3)
28–37	1262	8808	35.3 (33.6, 37.1)	2484	17,472	33.3 (29.9, 36.9)
38–47	1119	5215	20.9 (19.7, 22.2)	2976	14,185	27.0 (24.5, 29.7)
48–57	871	3389	13.6 (12.8, 14.5)	2069	8019	15.3 (14.3, 16.4)
58+	548	1937	7.8 (7.2, 8.4)	201	721	1.4 (1.1, 1.7)
Sex*						
Male	3646	21,671	86.9	6693	47,645	90.8
Female	680	3261	13.1	1787	4855	9.2
Relationship status						
In a relationship and living together	3121	16,453	65.9 (64.2, 67.7)	5964	33,433	63.7 (60.1, 67.2)
In a relationship not living together	301	2182	8.8 (7.7, 9.9)	1100	8294	15.8 (13.1, 18.9)
Not in a relationship	821	5738	23.0 (21.5, 24.7)	1263	9847	18.8 (15.9, 22.0)
Education						
Primary or secondary school	1007	7062	28.3 (26.7, 30.0)	1996	15,269	29.08 (25.8, 32.6)
Certificate	975	7200	28.9 (27.2, 30.6)	1723	16,508	31.44 (28.1, 35.0)
Diploma	1063	5229	20.9 (19.7, 22.3)	1601	7787	14.8 (13.0, 16.9)
University	1221	5078	20.4 (19.3, 21.5)	3015	12,025	22.9 (21.6, 24.2)
Employment status						
Full- or part-time paid work	2909	17,063	68.4 (66.8, 70.0)	8480	52,500	100.0
Unpaid work	151	777	3.1 (2.6, 3.7)	–	–	–
Unemployed or looking for work	199	1289	5.2 (4.4, 6.1)	–	–	–
Unemployed – sickness allowance or disability support pension	412	2224	8.9 (8.1, 9.9)	–	–	–
Student	206	1728	6.9 (5.9, 8.1)	–	–	–
Retired	377	1373	5.5 (5.0, 6.0)	–	–	–
Main source of income						
Wage, salary, own business or partnership	2590	16,024	64.3 (62.7, 65.8)	8480	52,500	100.0
Age pension	263	911	3.7 (3.3,4.1)	–	–	–
Invalidity service pension	262	1322	5.3 (4.7, 6.0)	–	–	–

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
VEA, SRCA or MRCA compensation	195	1114	4.5 (3.8, 5.2)	–	–	–
Dividends, interest or investments	27	153	0.6 (0.4, 0.9)	–	–	–
Other pension, benefit or allowance	183	1342	5.4 (4.6, 6.4)	–	–	–
Superannuation	404	1590	6.4 (5.8, 7.0)	–	–	–
Other	301	1795	7.2 (6.3, 8.2)	–	–	–
Stable housing						
No	129	852	3.4 (2.8, 4.2)	233	2287	4.4 (2.9, 6.4)
Yes	4089	23,378	93.8 (92.8, 94.6)	8043	48,851	93.1 (90.7, 94.9)

Missing: 2015 Regular ADF: Age group: 148 (3.4%), Relationship status 153 (1.7%), Education 145 (1.7%), Stable housing 204 (2.6%); Transitioned ADF: Age group: 55 (1.6%), Relationship status 83 (2.2%), Education 60 (1.5%), Employment 72 (1.9%), Main income 101 (2.7%), Stable housing 108 (2.8%)
Note: 95% CI: 95% confidence interval
*No CIs are provided for sex, rank, Service and medical fitness as these variables were used to create strata for weighting

The age distribution across the two groups was significantly different. Transitioned ADF had more elderly (58+ age group) and fewer middle-aged (38–47 age group) members based on 95% confidence intervals, while the younger age groups were similar for Transitioned ADF and 2015 Regular ADF members. There were more female members in the Transitioned ADF group (13.1% vs 9.3% for the 2015 Regular ADF group). Based on 95% confidence intervals, there was no significant difference between the two groups for 'Not in a relationship' or 'In a relationship and living together', although Transitioned ADF members were significantly less likely to be 'In a relationship not living together'. There were differences in the highest education categories. Transitioned ADF members were significantly more likely to have a diploma (20.9% vs 14.8%) and significantly less likely to have a university qualification than the 2015 Regular ADF (20.4% vs 22.9%). There were no differences in whether the respondents reported having stable housing over the past two months.

Table 3.2 describes the service characteristics of Transitioned ADF and 2015 Regular ADF members. In the Transitioned ADF group there were fewer Officers (16.29% of Transitioned ADF vs 25.61% of 2015 Regular ADF) and more Other Ranks (52.15% Transitioned ADF vs 41.08% 2015 Regular ADF). The Service distribution also significantly varied between the two groups; there were more Army and fewer Air Force members in the Transitioned ADF group. Significantly more Transitioned ADF members (26.71%) were classified as being medically unfit compared to the 2015 Regular ADF group (12.34%).

Table 3.2 Weighted service characteristics in Transitioned ADF and 2015 Regular ADF members

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Rank[a]*						
OFFR	1259	4063	16.3	3538	13,444	25.6
NCO	2097	7866	31.6	4336	17,491	33.3
Other Ranks	970	13,003	52.2	606	21,565	41.1
Service[a]*						
Navy	863	5671	22.8 (22.8, 22.8)	2040	13,282	25.3
Army	2463	15,038	60.3 (60.3, 60.3)	3500	25,798	49.1
Air Force	1000	4223	16.9 (16.9, 16.9)	2940	13,420	25.6
Medical fitness*						
Fit	2981	18,273	73.29	7116	46,022	87.7
Unfit	1345	6659	26.71	1364	6478	12.3
Time in Regular ADF						
1 month – 3.9 years	316	2934	11.8 (10.5, 13.1)	263	6141	11.70 (8.9, 15.1)
4–7.9 years	966	9015	36.2 (34.5, 37.9)	840	9710	18.50 (15.4, 22.0)
8–11.9 years	613	3295	13.2 (12.1, 14.4)	1436	10,362	19.74 (16.9, 22.9)
12–15.9 years	478	2086	8.4 (7.6, 9.2)	1389	7568	14.42 (12.4, 16.8)
16–19.9 years	265	967	3.9 (3.5, 4.3)	994	4143	7.89 (7.1, 8.8)
20+ years	1580	5772	23.2 (22.4, 23.9)	3413	13,651	26.00 (24.4, 27.7)

[a] Either 2015 Regular ADF or on discharge from Regular ADF service
Note: 95% CI: 95% confidence interval
Missing: 2015 Regular ADF: Time in Regular ADF: 145 (1.7%)
Transitioned: Time in Regular ADF: 108 (3.4%)
*No CIs are provided for sex, rank, Service and medical fitness as these variables were used to create strata for weighting

3.2 Demographic characteristics of the Transitioned ADF

As seen in Table 3.3, more than half (55.8%) of Transitioned ADF members remained in the ADF as Reservists. Of these, just under a half were Active Reservists. Regardless of Reservist status, the majority reported transitioning between one and three years ago. The most common type of discharge or resignation reported was 'own request', which was the case for more than half (53.7%) of Transitioned ADF members, and this percentage increased to over 60% when including 'end of fixed period' (2.1%) and 'end of initial enlistment period' (5.2%). The second most common type of discharge was 'medical discharge'; approximately one-fifth (20.4%) of Transitioned ADF members reported this type of discharge. The most commonly reported reasons for transition were 'impact of service life on family' (10.2%), 'better employment prospects in civilian life' (7.2%), 'mental health problems' (6.5%) and 'physical health problems' (4.3%). A large proportion of Transitioned ADF members did not report their main reason for transition (39.5%).

Table 3.3 Weighted transition characteristics in the Transitioned ADF

Characteristic	Transitioned ADF n = 24,932		
	n	Weighted n	% (95% CI)
Serving status			
Ex-Serving	1675	10,902	43.3 (42.1, 45.4)
Reservist			
Active Reservist	1398	6398	25.7 (24.4, 26.9)
Inactive Reservist	1232	7502	30.1 (28.5, 31.8)
Years since transition			
0	376	1945	7.8 (6.9, 8.8)
1	852	4874	19.6 (18.2, 21.0)
2	810	4944	19.8 (18.4, 21.3)
3	876	5233	20.9 (19.5, 22.5)
4	663	3582	14.4 (13.2, 15.6)
5+	503	2785	11.2 (10.1, 12.3)
Type of discharge or resignation			
Compulsory age	177	612	2.5 (2.2, 2.8)
Own request	2408	13,383	53.7 (52.0, 55.3)
Unsuitable for further training	45	485	1.9 (1.4, 2.7)
End of fixed period	80	532	2.1 (1.6, 2.8)
End of initial enlistment period or return of service obligation	113	1293	5.2 (4.3, 6.3)
Limited tenured appointment (Officers)	22	85	0.3 (0.2, 0.6)
Not offered re-engagement	9	83	0.3 (0.2, 0.7)
Accepted voluntary redundancy	150	533	2.1 (1.9, 2.5)
Compassionate grounds	26	150	0.6 (0.4, 0.9)
Non-voluntary discharge – administrative	77	757	3.0 (2.4, 3.9)
Medical discharge	911	5082	20.4 (19.4, 21.4)
Other	208	1242	4.9 (4.2, 5.9)
Main reason for transition			
Better employment prospects in civilian life	285	1800	7.2 (6.3, 8.3)
Lack of promotion prospects	127	688	2.8 (2.2, 3.4)
Inability to plan life outside of work	82	646	2.6 (2.0, 3.3)
Impact of service life on family	457	2546	10.2 (9.2, 11.3)
Pressure from family	46	228	0.9 (0.7, 1.3)
Didn't want to be away from home	101	586	2.4 (1.9, 2.9)
Pregnancy	7	39	0.2 (0.1, 0.4)
Posting issues (unhappy with location or nature of postings)	224	1061	4.3 (3.7, 4.9)
Too many deployments	4	14	0.1 (0.0, 0.1)
Not enough deployments	41	341	1.4 (0.9, 1.9)
Because of my experiences on deployment	44	336	1.4 (0.9, 1.9)
Work not exciting or challenging enough	93	724	2.9 (2.3, 3.7)
Dissatisfaction with pay	31	168	0.7 (0.4, 1.0)
Personal experience of harassment, bullying or discrimination in the ADF	157	916	3.7 (3.1, 4.4)

Characteristic	Transitioned ADF n = 24,932		
	n	Weighted n	% (95% CI)
Personal experience of violence in the ADF	5	40	0.2 (0.1, 0.4)
Disciplinary action or criminal offence	8	74	0.3 (0.1, 0.7)
My service was terminated	106	677	2.7 (2.2, 3.4)
Physical health problems	178	1079	4.3 (3.6, 5.2)
Mental health problems	281	1616	6.5 (5.7, 7.4)
Other	178	1079	4.3 (3.6, 5.2)

Note: 95% CI: 95% confidence interval
Missing: Years since transition: 246 (6.3%), Type of discharge: 100 (2.8%), Main reason 1776 (39.5%)

Table 3.4 summarises employment and DVA support characteristics for Transitioned ADF members. Almost two-thirds (62.8%) of the Transitioned ADF group reported being engaged in civilian employment. For those individuals, the most common industries of employment were government administration and Defence (16.8%), mining (9.9%), construction (8.8%), and transport and storage (8.6%). Of those employed, 1.3% did not report which industry they were employed in. A considerable proportion of the Transitioned ADF (43.7%) reported a period of three months or longer in which they had been unemployed since transitioning from the Regular ADF. More than 43% of Transitioned ADF members reported accessing DVA-funded treatment using a DVA White Card (39.4%) or DVA Gold Card (4.2%).

As seen in Table 3.5, approximately 20% of the Transitioned ADF group reported joining an ex-service organisation or voluntary group. A small proportion of the Transitioned ADF group reported having been arrested (2.9%), convicted (2.1%) or imprisoned (0.1%) since transitioning from Regular ADF service.

Table 3.4 Weighted civilian employment and DVA support among Transitioned ADF members

Characteristic	Transitioned ADF n = 24,932		
	n	Weighted n	% (95% CI)
Civilian employment			
Employed	2516	15,664	62.8 (61.2, 64.4)
Not employed	1735	8771	35.2 (33.6, 36.8)
Hours worked in the past week [a]			
0–20	250	1652	10.6 (9.1, 12.2)
21–40	1199	7311	46.7 (44.3, 49.1)
41–60	790	4949	31.6 (29.4 ,33.9)
61–80	94	576	3.7 (2.9 ,4.7)
80+	112	790	5.0 (4.0, 6.3)
Civilian employment industry [a]			
Agriculture, forestry and fishing	53	380	2.4 (1.7, 3.4)
Mining	221	1557	9.9 (8.5, 11.6)
Manufacturing	92	751	4.8 (3.8, 6.1)
Electricity, gas and water supply	71	504	3.2 (2.4, 4.2)
Construction	162	1375	8.8 (7.4, 10.4)
Wholesale trade	23	188	1.2 (0.8, 1.9)
Retail trade	116	1058	6.8 (5.5, 8.3)
Accommodation, cafés and restaurants	54	420	2.7 (1.9, 3.7)
Transport and storage	230	1340	8.6 (7.3, 9.9)
Communication services	96	666	4.3 (3.4, 5.4)
Finance and insurance	35	216	1.4 (0.9, 2.1)
Property and business services	63	407	2.6 (1.9, 3.5)
Government administration and Defence	589	2637	16.8 (15.4, 18.4)
Education	119	598	3.8 (3.1, 4.8)
Health and community services	226	1210	7.7 (6.6, 9.0)
Cultural and recreational services	30	201	1.3 (0.8, 1.9)
Personal and other services	149	908	5.8 (4.8, 7.0)
Emergency services	153	1044	6.7 (5.5, 8.1)
Unemployment – at least a three-month period since transition			
Yes	1762	10,906	43.7 (42.0, 45.5)
No	2455	13,359	53.6 (51.8, 55.3)
DVA support since transition			
Treatment support (White Card or Gold Card)	1773	10,879	43.6 (41.8, 45.5)
White Card	1565	9834	39.4 (37.6, 41.3)
Gold Card	211	1057	4.2 (3.6, 4.9)

[a] Proportion of Employed Transition ADF only
Note: 95% CI: 95% confidence interval
Missing: Civilian employment: 75 (2.0%), Hours worked 71 (2.5%), Industry 34 (1.3%), Unemployment 109 (2.7%)

Table 3.5 Weighted ex-service organisation engagement and incarceration among Transitioned ADF members

Characteristic	Transitioned ADF n = 24,932		
	n	Weighted n	% (95% CI)
Ex-service organisations joined (n)			
None	2358	17,359	69.6(67.7, 71.5)
1	834	5060	20.3 (18.8, 21.9)
2	228	1347	5.4 (4.6, 6.3)
3	63	374	1.5 (1.1, 2.0)
4	17	82	0.3 (0.2, 0.6)
5+	11	47	0.2 (0.1, 0.3)
Other voluntary groups joined (n)			
None	2204	16,202	64.9 (63.0, 66.9)
1	732	4610	18.5 (17.0, 20.1)
2	345	1961	7.9 (6.9, 8.9)
3	133	854	3.4 (2.8, 4.3)
4	36	208	0.8 (0.6, 1.2)
5+	27	160	0.6 (0.4, 1.1)
Criminal behaviour since transition			
Arrested	72	746	2.9 (2.3,3.9)
Convicted	47	516	2.1 (1.5, 2.9)

Note: 95% CI: 95% confidence interval
Missing: Ex-service organisations: 60 (2.7%), Other organisations 94 (3.8%)

4 Lifetime self-reported mental health concerns and assistance sought

Key findings

Self-reported concern for mental health

- More than half of the Transitioned ADF (64.4%) and 2015 Regular ADF (52.1%) reported being concerned about their mental health during their lifetime.
- In Transitioned ADF, concerns about mental health was most prevalent in Ex-Serving ADF members (70.9%), which was significantly different from both Inactive Reservists (61.0%) and Active Reservists (57.6%).
- A small but important minority with a probable 30-day disorder (11.2% of Transitioned ADF and 27.3% of 2015 Regular ADF) did not express concern about their mental health.

Self-reported assistance for mental health in those with self-reported mental health concerns

- Approximately three in four Transitioned ADF and 2015 Regular ADF members reported having ever received assistance for their mental health.
- Approximately 41% of Transitioned ADF and 46% of 2015 Regular ADF members reported receiving assistance for their mental health currently or within the last 12 months.
- Of those with a probable 30-day disorder, the majority of Transitioned ADF (84.0%) and 2015 Regular ADF (81.4%) reported receiving assistance with their mental health in their lifetime.
- Of Transitioned ADF and 2015 Regular ADF members with a probable 30-day disorder who have sought care, 75% had done so currently or within the last 12 months.
- Ex-Serving ADF members were more likely to seek assistance for their mental health concerns (82.2%) than Inactive Reservists (68.3%) and Active Reservists (67.7%).

Glossary: refer to the Glossary of terms for definitions of key terms in this section.

4.1 Introduction

This chapter relates to mental health concerns among Transitioned ADF and 2015 Regular ADF members, as well as any help-seeking behaviours they exhibited. It compares Transitioned ADF and 2015 Regular ADF members on a number of different topics, for example, whether they had concerns about their mental health, and

whether they had received any assistance with their mental health. There are also comparisons between Transitioned ADF and 2015 Regular ADF members who meet the criteria for a probable 30-day affective or anxiety disorder (probable 30-day disorder is defined below). Transitioned ADF members are then broken down by the categories of transition status (Ex-Serving, Active Reservist and Inactive Reservist), and analysed by each topic.

4.1.1 Concerns about mental health

Items addressing participants' concerns about their mental health were developed specifically for the study by investigators. Self-reported mental health concerns in the past 12 months as well as in their lifetime were examined by a single item:

> Have you ever been concerned about your mental health? (Yes/No).

Participants were asked to indicate when they first became concerned about their mental health using a single item: *When did you become concerned about your mental health* also indicating the date (*month and year*) when they first became concerned.

4.1.2 Assistance with mental health

Items addressing assistance sought for mental health were taken from the 2010 MHPWS (McFarlane et al., 2011). Lifetime and 12-month assistance sought for mental health problems was asked in one item

> Have you ever had assistance for your mental health? The four response options were:
>
> - yes – currently
> - yes – in the last 12 months
> - yes – more than 12 months ago
> - no.

4.1.3 Probable 30-day disorder

The presence of a probable 30-day disorder was determined based on scores on the Kessler Psychological Distress Scale (K10) and Posttraumatic Stress Disorder Checklist (PCL). The K10 is a 10-item screening questionnaire for psychological distress that was developed for use in the United States National Health Interview Survey (US-NHIS) (Kessler et al., 2002). Originally designed as a short, easily administered screen for psychological distress, the K10 is typically used to inform and complement clinical interviews, and to quantify levels of distress in those who are in particular need of treatment.

The PCL is a 17-item measure used to measure symptoms of posttraumatic stress disorder (PTSD).

Participants were deemed to have a probable 30-day disorder if they scored above the optimal epidemiological cut-off (25 on the K10 or 53 on the PCL). Epidemiological cut-offs were derived from the 2010 MHPWS and give the closest estimate to the true prevalence of 30-day ICD-10 affective or anxiety disorders and PTSD, as measured by the World Mental Health Survey Initiative Version of the World Health Organization Composite International Diagnostic Interview – version 3 (CIDI).

A number of analyses include the presence of a probable 30-day disorder, so overall proportions of Transitioned ADF and 2105 Regular ADF members reporting a probable 30-day disorder have been calculated. Transitioned ADF members were significantly more likely than the 2015 Regular ADF members to report a probable 30-day disorder (28.17% at 95% CI: 26.47, 29.94 vs 14.43% at 95% CI: 11.75, 17.59).

4.1.4 Key questions addressed in this chapter

Chapter 4 examines the following key questions:

- Are Transitioned ADF members more or less likely than 2015 Regular ADF members to have reported being concerned about their mental health?
- Are Transitioned ADF members more or less likely than 2015 Regular ADF members to report being concerned about their mental health prior to their transition from full-time ADF service?
- Are Transitioned ADF members more or less likely than 2015 Regular ADF members to report having had assistance with their mental health?

4.2 Self-reported mental health concerns among Transitioned ADF and 2015 Regular ADF members

The self-reported prevalence of Transitioned ADF and 2015 Regular ADF members ever having had a mental health concern is reported in Table 4.1 and described in Figure 4.1. Ever having a mental health concern is also described in terms of whether or not the respondent had a probable 30-day disorder (that is, above the epidemiological cut-off of ≥ 53 PCL or ≥ 25 K10).

The majority of the Transitioned ADF reported ever having been concerned about their mental health (64.38%), where in the 2015 Regular ADF this prevalence was only slightly higher than those who were not concerned (52.14% vs 47.86%).

In the Transitioned ADF, the majority of those with a probable 30-day disorder reported having ever had a mental health concern (88.76%), whereas in the 2015 Regular ADF less of those with a probable 30-day disorder reported ever having had a mental health concern (72.68%).

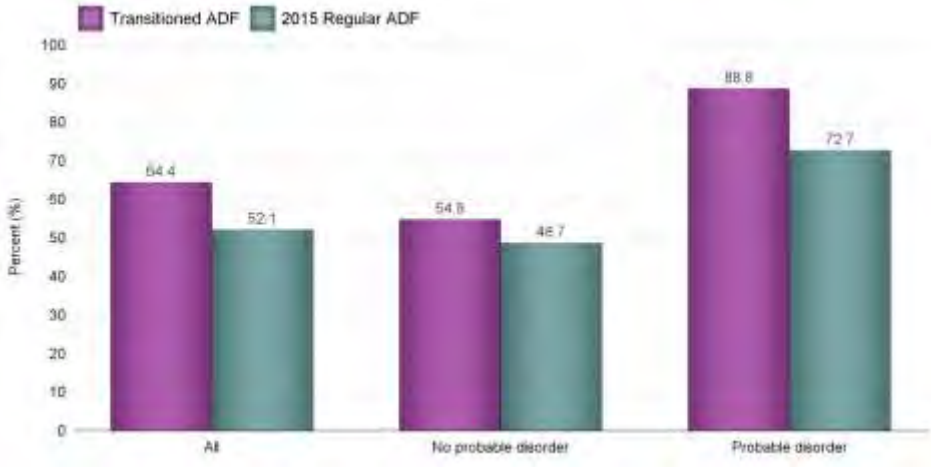
It is also interesting to note in the 2015 Regular ADF, of those who had a probable 30-day disorder, 27.32% were not concerned about their mental health, and in the Transitioned ADF this proportion was 11.24%. Of those with no probable 30-day disorder, approximately half of both the Transitioned ADF (54.82%) and the 2015 Regular ADF (48.67%) reported ever being concerned about their mental health.

Table 4.1 Weighted estimate of 2015 Regular ADF and Transitioned ADF members reporting concern about their mental health in their lifetime, stratified by probable 30-day disorder

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
No	1294	8880	35.62 (33.72, 37.57)	3362	25,128	47.86 (44.00, 51.75)
Yes	2485	16,052	64.38 (62.43, 66.28)	4339	27,372	52.14 (48.25, 56.00)
Probable 30-day disorder (concern about mental health)						
No, not concerned	107	789	11.24 (8.97, 13.99)	239	2069	27.32 (19.05, 37.51)
Yes, concerned	920	6234	88.76 (86.01, 91.03)	727	5506	72.68 (62.49, 80.95)
No probable 30-day disorder (concern about mental health)						
No, not concerned	1187	8091	45.18 (42.82, 47.56)	3123	23,059	51.33 (47.21, 55.42)
Yes, concerned	1565	9818	54.82 (52.44, 57.18)	3612	21,866	48.67 (44.58, 52.79)

Denominator: Entire cohort
Notes:
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval

Figure 4.1 **Weighted estimate of 2015 Regular ADF and Transitioned ADF members reporting concern about their mental health in their lifetime, stratified by probable 30-day disorder**



4.3 Self-reported mental health concerns among Transitioned ADF members

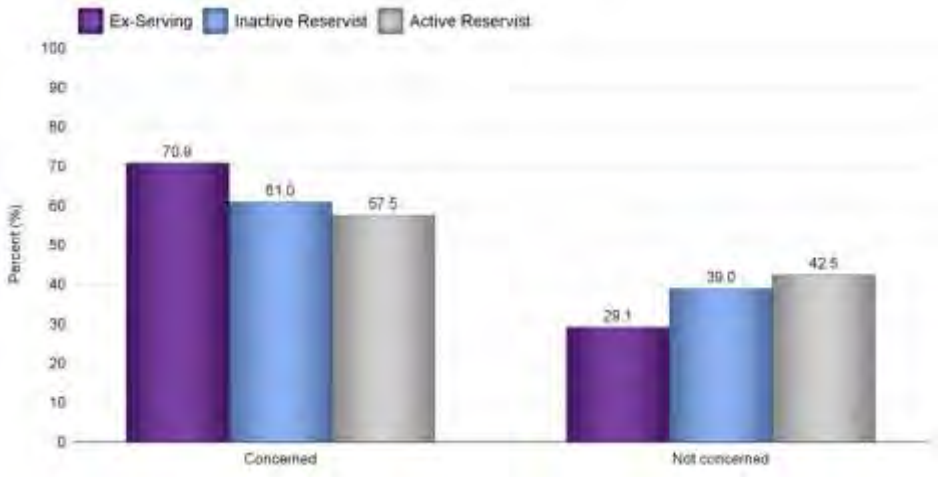
Table 4.2 and Figure 4.2 examine the breakdown by category for all respondents who have transitioned from full-time ADF service (Transitioned ADF). In each transition category, the majority of respondents reported that they had ever been concerned about their mental health. The group that reported the highest prevalence of concern about their mental health was the Ex-Serving Transitioned ADF group (70.9%).

Table 4.2 Weighted estimate of Transitioned ADF members who reported being concerned about their mental health in their lifetime

	Ex-Serving n = 10,876			Inactive Reservists n = 7513			Active Reservists n = 6426		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
No	357	3167	29.1 (26.2, 32.2)	404	2932	39.0 (35.2, 43.0)	528	2728	42.5 (39.0, 46.0)
Yes	1091	7709	70.9 (67.78, 73.8)	673	4581	61.0 (57.0, 64.8)	712	3698	57.6 (54.1, 61.0)
Total	1448	10,876	100.0	1077	7513	100.0	1240	6426	100.0

Denominator: Entire cohort. There are 117 (0.5%) Transitioned ADF where transition status is 'unknown', this group is not included.
Note: 95% CI: 95% confidence interval

Figure 4.2 Weighted estimated proportion of Transitioned ADF by reporting concerned about their mental health in their lifetime



4.4 Self-reported assistance for mental health among Transitioned ADF and 2015 Regular ADF members

A description of the proportion of Transitioned ADF and 2015 Regular ADF members based on whether they had ever had a concern about their mental health and whether they had received any assistance is reported in Table 4.3 and described in Figure 4.3.

Transitioned ADF and the 2015 Regular ADF members reported very similar prevalences of being concerned about their mental health and ever having received assistance with their mental health (74.89% vs 75.77%). There were also no significant differences between numbers of Transitioned ADF and 2015 Regular ADF members currently receiving assistance for their mental health problem (27.25% vs 23.5%).

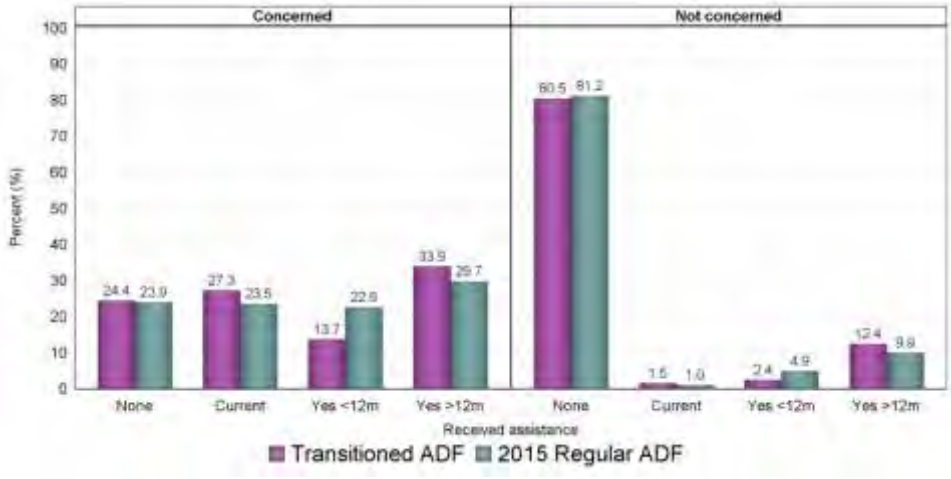
Just under one-quarter of Transitioned ADF (24.44%) and 2015 Regular ADF (23.92%) members reported never having received assistance despite being concerned about their mental health.

Table 4.3 Weighted estimate of 2015 Regular ADF and Transitioned ADF members concerned about their mental health in their lifetime, and whether they ever had assistance with their mental health

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Ever been concerned about mental health						
No, never received assistance	562	3922	24.44 (22.33, 26.67)	965	6546	23.92 (19.58, 28.86)
Yes, currently	714	4374	27.25 (25.22, 29.39)	972	6433	23.50 (19.03, 28.66)
Yes, in the last 12 months	342	2199	13.70 (12.09, 15.47)	815	6183	22.59 (18.21, 27.66)
Yes, more than 12 months ago	852	5449	33.94 (31.67, 36.29)	1571	8124	29.68 (25.64, 34.07)
Dichotomised grouping						
No, never	562	3922	24.44 (22.33, 26.67)	965	6546	23.92 (19.58, 28.86)
Yes, ever	1908	12,022	74.89 (72.64, 77.01)	3358	20,740	75.77 (70.83, 80.11)
Never been concerned about mental health						
No, never received assistance	1061	7146	80.47 (77.57, 83.08)	2805	20,402	81.19 (75.89, 85.55)
Yes, currently	13	135	1.52 (0.81, 2.82)	439	3653	14.54 (10.67, 19.50)
Yes, in the last 12 months	27	213	2.40 (1.52, 3.78)	104	1222	4.86 (2.53, 9.14)
Yes, more than 12 months ago	153	1100	12.39 (10.28, 14.85)	334	2490	9.91 (6.87, 14.09)
Dichotomised grouping						
No, never	1061	7146	80.47 (77.57, 83.08)	2805	20,402	81.19 (75.89, 85.55)
Yes, ever	193	1448	16.31 (13.88, 19.06)	478	3956	15.74 (11.73, 20.80)

Denominator: Entire cohort
Notes:
1250 (weighted) participants (2015 Regular ADF = 372 (3.53%); Transitioned ADF = 878 (3.74%)) had a missing value and are not included. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
95% CI: 95% confidence interval

Figure 4.3 Weighted estimate of 2015 Regular ADF and Transitioned ADF by concern about their mental health in their lifetime, and whether they ever had assistance for their mental health



4.5 Self-reported assistance for mental health among Transitioned ADF

Table 4.4 and Figure 4.4 describe whether Transitioned ADF members had ever been concerned about their mental health and whether they had received assistance, by transition category. Concerned respondents who were Ex-Serving ADF members were significantly more likely to have ever received treatment for their mental health problem (82.22%) or to currently be receiving treatment (38.16%), than Inactive Reservists (68.35% and 18.44%) or Active Reservists (67.70% and 15.22%). There were no differences in whether this assistance had been received in the last 12 months, by transition category.

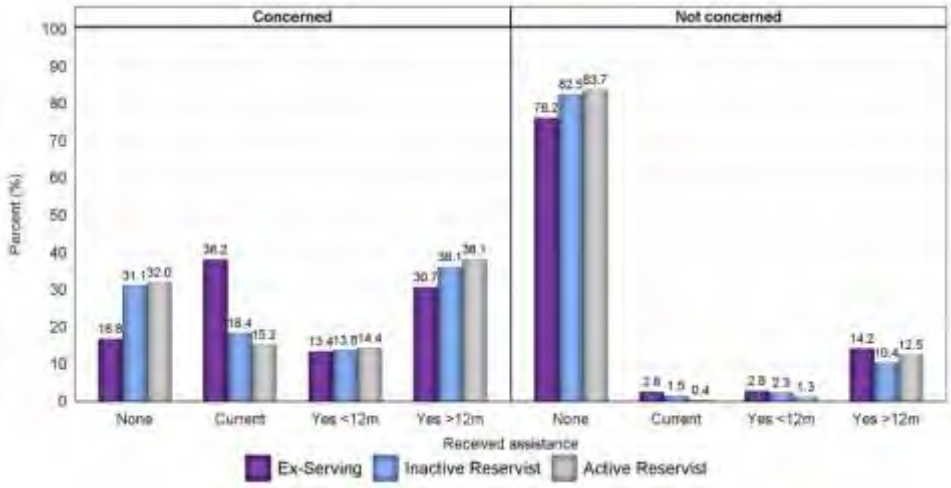
For respondents who were not concerned about their mental health, there was no difference between transition categories regarding the number of respondents who had ever received help for a mental health problem.

Table 4.4 Weighted estimate of Transitioned ADF members concerned about their mental health in their lifetime, and whether they ever had assistance with their mental health

	Ex-Serving n = 10,876			Inactive Reservists n = 7513			Active Reservists n = 6426		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Concerned about mental health									
No, never received assistance	157	1299	16.85 (14.07, 20.05)	195	1425	31.10 (26.60, 36.00)	209	1183	31.99 (27.76, 36.54)
Yes, currently	476	2942	38.16 (34.81, 41.62)	126	845	18.44 (14.96, 22.51)	108	563	15.22 (12.14, 18.91)
Yes, in the last 12 months	145	1033	13.40 (11.06, 16.15)	94	630	13.76 (10.71, 17.51)	102	531	14.37 (11.37, 17.99)
Yes, more than 12 months ago	302	2363	30.66 (27.29, 34.24)	256	1656	36.15 (31.48, 41.09)	291	1410	38.12 (34.09, 42.32)
Dichotomised grouping									
No, never	157	1299	16.85 (14.07, 20.05)	195	1425	31.10 (26.60, 36.00)	209	1183	31.99 (27.76, 36.54)
Yes, ever	923	6338	82.22 (78.98, 85.05)	476	3131	68.35 (63.43, 72.89)	501	2504	67.70 (63.15, 71.94)
Never been concerned about mental health									
No, never received assistance	274	2414	76.23 (70.49, 81.16)	337	2418	82.48 (76.87, 86.96)	447	2284	83.73 (79.43, 87.27)
Yes, currently	9	81	2.57 (1.21, 5.37)	2	43	1.46 (0.37, 5.57)	2	10	0.38 (0.10, 1.50)
Yes, in the last 12 months	8	90	2.83 (1.27, 6.18)	9	69	2.35 (1.05, 5.18)	9	35	1.29 (0.69, 2.40)
Yes, more than 12 months ago	48	449	14.18 (10.27, 19.25)	43	305	10.42 (7.04, 15.15)	61	341	12.51 (9.38, 16.49)
Dichotomised grouping									
No, never	274	2414	76.23 (70.49, 81.16)	337	2418	82.48 (76.87, 86.96)	447	2284	83.73 (79.43, 87.27)
Yes, ever	65	620	19.58 (15.00, 25.15)	54	417	14.23 (10.17, 19.56)	72	387	14.18 (10.93, 18.21)

Denominator: Entire cohort. There are 117 (0.5%) Transitioned ADF where transition status is 'unknown', this group is not included.
Note: 395 (weighted) participants (2015 Ex-Serving ADF = 205 (5.11%); Inactive Reservists = 122 (3.84%); Active Reservists= 68 (2.39%)) had a missing value and are not included.
However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
Note: 95% CI: 95% confidence interval

Figure 4.4 Weighted estimate of Transitioned ADF members concerned about their mental health in their lifetime, and whether they ever had assistance with their mental health



4.6 Self-reported assistance for mental health in Transitioned ADF and 2015 Regular ADF in those reporting a concern about their mental health

Table 4.5 and Figure 4.5 illustrate whether Transitioned ADF and 2015 Regular ADF members who had ever had a concern about their mental health received assistance. This has also been described by probable 30-day disorder (that is, above the epidemiological cut-off of ≥ 53 PCL or ≥ 25 K10).

Overall, in those that had a mental health concern, there was no difference between Transitioned and 2015 Regular ADF in those that were currently or had ever received help for a mental health problem.

Less than one in five Transitioned ADF (15.40%) and 2015 Regular ADF (18.27%) members reported never having received assistance despite reporting current symptoms indicative of a probable 30-day disorder

Of the Transitioned ADF and 2015 Regular ADF members who had ever had a mental health concern and who had a current probable 30-day disorder, 50.38% and 49.97% respectively reported that they were currently receiving assistance. A further 12.2% of Transitioned ADF and 10.88% of 2015 Regular ADF members reported receiving assistance within the last 12 months. For Transitioned ADF and 2015 Regular ADF members, 62.58% and 60.85% (respectively) who reported receiving care currently or

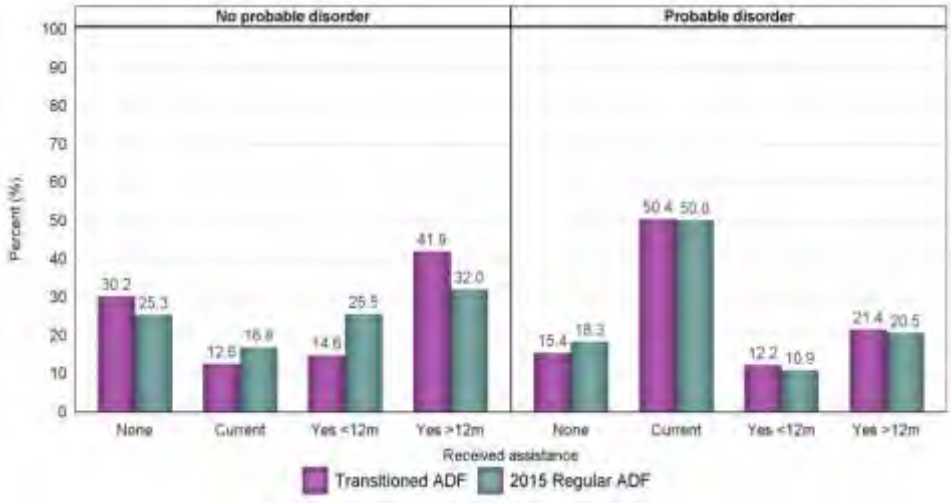
in the last 12 months represented 74.0% and 74.45% of those with a probable 30-day disorder who had ever received care for a mental health concern.

Table 4.5 Weighted estimate of 2015 Regular ADF and Transitioned ADF members who reported being concerned about their mental health in their lifetime, and whether they had ever received assistance with their mental health, stratified by probable 30-day disorder

	Transitioned ADF n = 16,052			2015 Regular ADF n = 27,372		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
All	n = 16,052			n = 27,372		
No, never received assistance	562	3922	24.44 (22.33, 26.67)	965	6546	23.92 (19.58, 28.86)
Yes, currently	714	4374	27.25 (25.22, 29.39)	972	6433	23.50 (19.03, 28.66)
Yes, in the last 12 months	342	2199	13.70 (12.09, 15.47)	815	6183	22.59 (18.21, 27.66)
Yes, more than 12 months ago	852	5449	33.94 (31.67, 36.29)	1571	8124	29.68 (25.64, 34.07)
Dichotomised grouping						
No, never	562	3922	24.44 (22.33, 26.67)	965	6546	23.92 (19.58, 28.86)
Yes, ever	1908	12,022	74.89 (72.64, 77.01)	3358	20,740	75.77 (70.83, 80.11)
Probable 30-day disorder	n = 6234			n = 5506		
No, never received assistance	119	960	15.40 (12.55, 18.76)	94	1006	18.27 (9.69, 31.78)
Yes, currently	496	3141	50.38 (46.44, 54.31)	359	2752	49.97 (37.14, 62.81)
Yes, in the last 12 months	114	760	12.20 (9.89, 14.95)	112	599	10.88 (7.84, 14.92)
Yes, more than 12 months ago	186	1334	21.40 (18.31, 24.86)	159	1131	20.55 (11.79, 33.35)
Dichotomised grouping						
No, never	119	960	15.40 (12.55, 18.76)	94	1006	18.27 (9.69, 31.78)
Yes, ever	796	5236	83.98 (80.59, 86.88)	630	4482	81.40 (67.97, 90.03)
No probable 30-day disorder	n = 9818			n = 21,866		
No, never received assistance	443	2962	30.17 (27.31, 33.19)	871	5540	25.34 (20.58, 30.77)
Yes, currently	218	1233	12.56 (10.74, 14.64)	613	3682	16.84 (12.75, 21.90)
Yes, in the last 12 months	228	1438	14.65 (12.55, 17.03)	703	5584	25.54 (20.35, 31.51)
Yes, more than 12 months ago	666	4114	41.91 (38.87, 45.01)	1412	6993	31.98 (27.55, 36.76)
Dichotomised grouping						
No, never	443	2962	30.17 (27.31, 33.19)	871	5540	25.34 (20.58, 30.77)
Yes, ever	1112	6786	69.12 (66.08, 72.00)	2728	16,258	74.35 (68.93, 79.12)

Denominator: Those who were concerned about their mental health
Notes:
194 (weighted) participants (2015 Regular ADF = 86 (0.31%); Transitioned ADF = 108 (0.67%)) had a missing value and are not included. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval

Figure 4.5 **Weighted estimate of 2015 Regular ADF and Transitioned ADF members who reported being concerned about their mental health in their lifetime, and whether they had ever received assistance with their mental health, stratified by probable 30-day disorder**



5 Pathways to care

Key findings

Latency of Care-Seeking

- Approximately half of Transitioned ADF (45.4%) and 2015 Regular ADF (55.9%) members sought assistance within three months of becoming concerned about their mental health.
- A small but notable group – 14.4% of Transitioned ADF and 7.6% of 2015 Regular ADF members – waited more than three years before seeking care.
- Of those with probable disorder, 2015 Regular ADF members were more likely (50.5%) than Transitioned ADF (37.5%) to seek care within the first three months.

Assistance from others when seeking care

- For 62.5% of Transitioned ADF and 57.5% of 2015 Regular ADF members, someone else had suggested that they seek assistance with their mental health. Similar rates were reported by those with a current probable disorder (68.6% and 55.5% respectively).
- Partners were mostly likely to suggest Transitioned ADF and 2015 Regular ADF (47.2% and 43.0%) seek assistance with their mental health. Others who suggested help-seeking included friends (28.8% and 29.1%), supervisors (22.1% and 27.6%), and General Practitioners (GPs) or Medical Officers (MOs) (31.1% and 25.3%).
- For 32.6% of Transitioned ADF, someone else helped them engage with care. This help was most commonly provided by a GP or MO (41.4%), a partner (28.0%) or a supervisor (24.9%).
- Of the 28.5% of 2015 Regular ADF members who received assistance with engaging in care, this assistance was most commonly provided by supervisors (32.6%), GPs and MOs (36.2%), friends (16.5%) and partners (12.0%).

Primary reasons for seeking assistance

- The most commonly reported reasons for seeking assistance were depression (27.2% and 21.0% for Transitioned ADF and 2015 Regular ADF respectively), anxiety (17.8% and 19.6%), relationship problems (11.1% and 18.7%) and anger (12.4% and 13.0%).

Glossary: refer to the Glossary of terms for definitions of key terms in this section.

5.1 Introduction

This chapter describes the pathways to care for Transitioned ADF and Regular ADF members who have had a concern about their mental health and have sought care. In particular, it explores any differences in help-seeking latency (the length of time between a person becoming concerned about their mental health and seeking help), and support received in seeking help, for Transitioned ADF and 2015 Regular ADF members with and without a probable 30-day mental disorder.

5.1.1 Help-seeking latency

Participants who indicated they were concerned about their mental health were asked to indicate when they first became concerned in one item (When did you become concerned about your mental health?), and indicate the date (month and year) when they first became concerned.

In order to assess help-seeking latency, participants were asked to indicate when they first sought help for their own mental health: *When did you first seek help for your mental health?* Options included 'within three months of becoming concerned' or 'within one year of becoming concerned'. Participants were also able to specify the number of years since they became concerned. This item was developed by researchers for use in the study.

5.1.2 Who suggested seeking help?

Participants were also asked in a single item to indicate if someone had suggested they seek help for their mental health. The response was a dichotomous yes/no response.

5.1.3 Key questions addressed in this chapter

This chapter explores answers to whether transitioned ADF and 2015 Regular ADF members differ in:

- Do Transitioned ADF and 2015 Regular ADF members differ in the length of time between becoming concerned about their mental health and seeking help?
- Do Transitioned ADF and 2015 Regular ADF differ in help-seeking latency (length of time between becoming concerned about their mental health and seeking help)?
- Do Transitioned ADF and 2015 Regular ADF differ in receiving support and assistance to seek help?

5.2 Help-seeking latency among Transitioned ADF and 2015 Regular ADF members

Table 5.1 and Figure 5.1 describe the proportion of Transitioned ADF and 2015 Regular ADF members who had ever had a concern regarding their mental health, and the time it took them to seek assistance. The largest proportion of Transitioned ADF members who had been concerned had sought assistance within the first three months (45.40%). However, around 10% of Transitioned ADF members waited more than one year between becoming concerned and seeking assistance, and an even greater proportion waited more than three years (14.42%). In the 2015 Regular ADF, 55.90% of those seeking assistance sought it in the first three months, 9.72% waited more than a year and 7.64% took more than three years to seek assistance.

Additionally, the latency for help-seeking in those with and without a probable 30-day disorder that is above and below the epi cut-off are described. Within the Transitioned ADF, 37.49% of those with a probable 30-day disorder took less than three months to obtain help, and this was a significantly higher rate of 50.46% in the 2015 Regular ADF.

A slightly greater proportion of those with no probable 30-day disorder sought assistance within three months of becoming concerned about their mental health (43%) compared to those with probable 30-day disorder (39%). This was significantly different. In those who took three or more years there was a significant difference between the Transitioned ADF (17.67%) and the 2015 Regular ADF (7.63%) in those with a probable 30-day disorder.

5.3 Help-seeking latency in the Transitioned ADF

Table 5.2 and Figure 5.2 describe, in those who had ever had a concern regarding their mental health, and the time it took for them to seek assistance with their mental health problem. The largest proportion of Transitioned ADF members who had ever been concerned and sought assistance within the first three months were Inactive Reservists (48.73%), followed by Active Reservists (45.41%) and Ex-Serving ADF members (44.61%).

Table 5.1 Weighted estimated length of time between mental health concern and seeking assistance among Transitioned ADF and 2015 Regular ADF members who were concerned about their mental health and had sought assistance, stratified by probable 30-day disorder

	Transitioned ADF n = 12,022			2015 Regular ADF n = 20,740		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
All	n = 12,022			n = 20,740		
< 3 months	847	5458	45.40 (42.64, 48.18)	1838	11,594	55.90 (49.82, 61.81)
3 months – 1 year	469	2964	24.65 (22.35, 27.11)	771	4325	20.85 (16.52, 25.96)
1–2 years	192	1206	10.03 (8.51, 11.79)	261	2015	9.72 (6.38, 14.53)
3 or more years	301	1733	14.42 (12.63, 16.41)	337	1585	7.64 (6.33, 9.20)
Probable 30-day disorder	n = 5236			n = 4482		
< 3 months	287	1963	37.49 (33.46, 41.70)	289	2261	50.46 (36.52, 64.32)
3 months – 1 year	205	1405	26.83 (23.25, 30.74)	154	1039	23.18 (12.88, 38.11)
1–2 years	107	667	12.74 (10.32, 15.63)	72	423	9.44 (5.90, 14.77)
3 or more years	153	925	17.67 (14.70, 21.10)	85	342	7.63 (5.32, 10.84)
No probable 30-day disorder	n = 6786			n = 16,258		
< 3 months	560	3495	51.50 (47.82, 55.17)	1549	9332	57.40 (50.73, 63.81)
3 months – 1 year	264	1559	22.97 (20.07, 26.16)	617	3286	20.21 (15.76, 25.54)
1–2 years	85	539	7.94 (6.11, 10.27)	189	1592	9.79 (5.84, 15.98)
3 or more years	148	808	11.91 (9.86, 14.31)	252	1243	7.64 (6.09, 9.55)

Denominator: Those who were concerned about their mental health and sought assistance
Note:
Based on weighted counts, 661 (5.50%) Transitioned ADF, and 1221 (5.89%) Regular ADF had a missing value for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
95% CI: 95% confidence interval

Figure 5.1 **Weighted estimated length of time between mental health concern and seeking assistance among Transitioned ADF and 2015 Regular ADF members who were concerned about their mental health and had sought assistance, stratified by probable 30-day disorder**

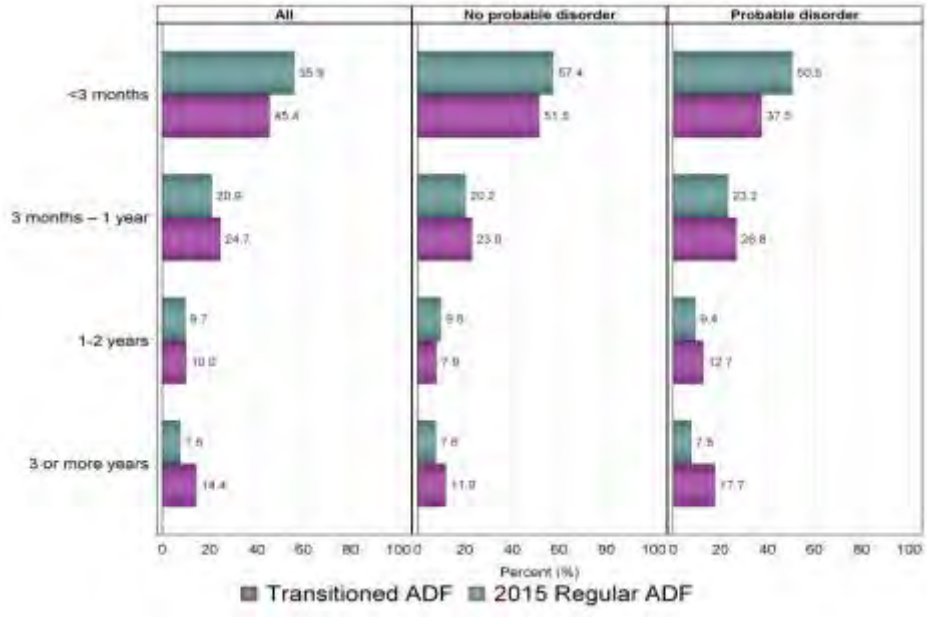
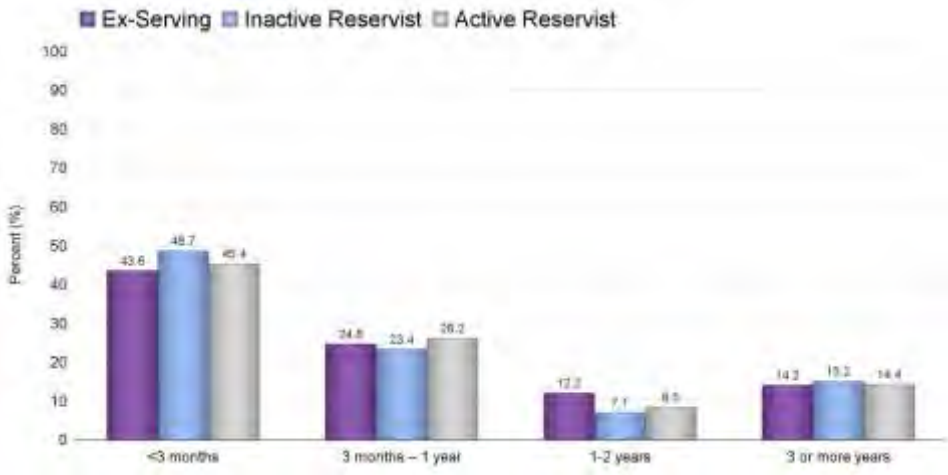


Table 5.2 Weighted estimated length of time between mental health concern and seeking assistance among Transitioned ADF who were concerned about their mental health and had sought assistance

	Ex-Serving n = 6338			Inactive Reservists n = 3131			Active Reservists n = 2504		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
< 3 months	402	2764	43.61 (39.67, 47.65)	214	1526	48.73 (42.93, 54.57)	225	1137	45.41 (40.09, 50.83)
3 months – 1 year	217	1569	24.76 (21.44, 28.41)	126	733	23.41 (19.13, 28.31)	125	657	26.24 (21.63, 31.45)
1–2 years	103	770	12.15 (9.72, 15.10)	40	223	7.12 (4.83, 10.37)	49	213	8.50 (6.24, 11.48)
3 or more years	151	898	14.17 (11.65, 17.13)	68	475	15.16 (11.28, 20.08)	82	361	14.40 (11.64, 17.68)

Denominator: Those who were concerned about their mental health and sought assistance
Notes:
Based on weighted counts, 336 (5.30%) Ex-Serving, 175 (5.58%) Inactive Reservists, and 136 (5.45%) Active Reservists had a missing value for this question.
However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
95% CI: 95% confidence interval

Figure 5.2 **Weighted estimated length of time between mental health concern and seeking assistance among Transitioned ADF who were concerned about their mental health and had sought assistance**



5.4 Suggestions by others that assistance may be helpful for a mental health problem among Transitioned ADF and 2015 Regular ADF members

The proportion of Transitioned ADF and 2015 Regular ADF members who were concerned about their mental health, had ever sought assistance and reported that someone else had suggested they seek assistance for their mental health is presented in Table 5.3 and Figure 5.3.

Just below two-thirds of Transitioned ADF (62.54%) and 2015 Regular ADF (57.49%) members reported that another person had suggested they seek assistance, and there were no differences between these two groups. This is further broken down by whether or not respondents had a probable 30-day disorder. Of Transitioned ADF members with a probable 30-day disorder, 68.61% reported that someone suggested they seek assistance, and this was significantly lower in the 2015 Regular ADF, at 55.46%.

The proportion of Transitioned ADF who were concerned about their mental health, had ever sought assistance and reported that someone else suggested they seek assistance with their mental health is described in Table 5.4 and Figure 5.4. Almost two-thirds of Ex-Serving (65.39%), 60.43% of Inactive Reservists and 58.36% of Active Reservists reported that another person had suggested they seek assistance. There were no differences between groups.

Table 5.3 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who had someone suggest they seek assistance with their mental health, stratified by probable 30-day disorder

	Transitioned ADF n = 12,022			2015 Regular ADF n = 20,740		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
All	n = 12,022			n = 20,740		
No one suggested seeking assistance	737	4303	35.80 (33.23, 38.44)	1581	8694	41.92 (36.42, 47.62)
Yes, someone suggested seeking assistance	1142	7518	62.54 (59.87, 65.14)	1747	11923	57.49 (51.78, 63.00)
Probable 30-day disorder	n = 5236			n = 4482		
No one suggested seeking assistance	247	1519	29.02 (25.43, 32.89)	250	1985	44.30 (31.10, 58.35)
Yes, someone suggested seeking assistance	531	3592	68.61 (64.67, 72.30)	376	2486	55.46 (41.42, 68.67)
No probable 30-day disorder	n = 6786			n = 16,258		
No one suggested seeking assistance	490	2784	41.03 (37.50, 44.65)	1331	6709	41.26 (35.34, 47.46)
Yes, someone suggested seeking assistance	611	3926	57.86 (54.22, 61.41)	1371	9437	58.05 (51.84, 64.01)

Denominator: Those who were concerned about their mental health and sought assistance
Notes:
Based on weighted counts, 123 (0.59%) 2015 Regular ADF and 200 (1.66%) Transitioned ADF had a missing value for this question and are not included above. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval

Figure 5.3 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who had someone suggest they seek assistance with their mental health, stratified by probable 30-day disorder

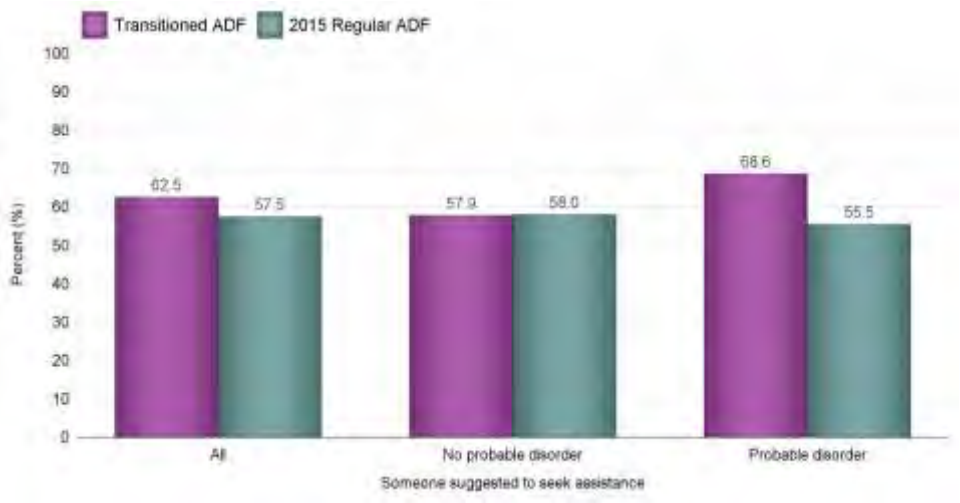


Table 5.4 Weighted estimate of Transitioned ADF members who had someone suggest they seek assistance with their mental health

	Ex-Serving n = 6338			Inactive Reservists n = 3131			Active Reservists n = 2504		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
No one suggested seeking assistance	323	2084	32.88 (29.25, 36.72)	192	1179	37.65 (32.16, 43.48)	217	1013	40.45 (35.48, 45.64)
Yes, someone suggested seeking assistance	584	4144	65.39 (61.50, 69.08)	276	1892	60.43 (54.58, 65.99)	279	1461	58.36 (53.15, 63.40)

Denominator: Those who were concerned with their mental health and sought assistance
Notes:
Based on weighted counts, 110 (1.74%) Ex-Serving, 60 (1.92%) Inactive Reservists, and 30 (1.18%) Active Reservists had a missing value for this question and are not included above.
However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
95% CI: 95% confidence interval

Figure 5.4 Weighted estimate of Transitioned ADF members who had someone suggest they seek assistance with their mental health

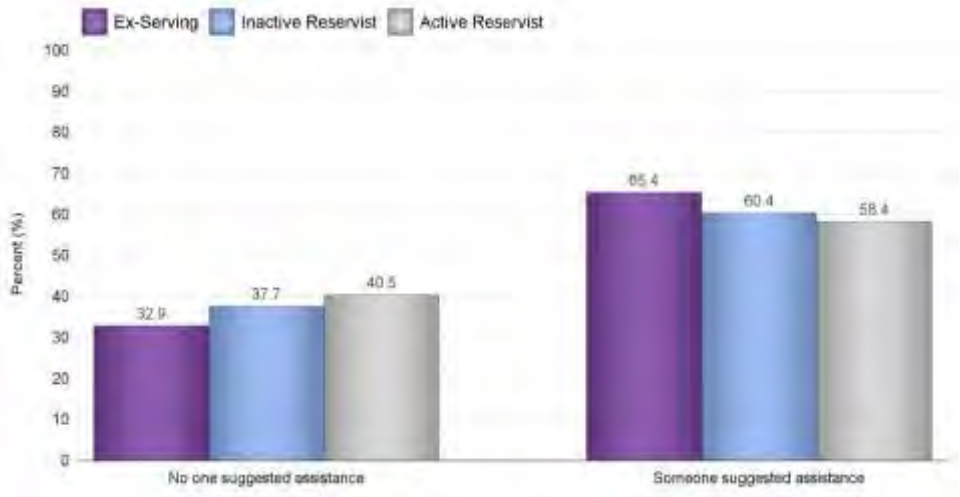


Table 5.5 and Figure 5.5 describe those who suggested seeking assistance among Transitioned ADF and 2015 Regular ADF who were concerned about their mental health and had ever sought assistance. Patterns were generally similar across Transitioned ADF and 2015 Regular ADF members. Seeking help was most commonly suggested by partners (47.16% for Transitioned ADF and 43.03% for 2015 Regular ADF) and friends (28.81% for Transitioned ADF and 29.07% for 2015 Regular ADF). Family members were more likely to make this suggestion for Transitioned ADF members (21.63%) than 2015 Regular ADF members (10.95%). This is further examined by whether the respondent had a probable 30-day disorder.

Table 5.6 and Figure 5.6 outline Transitioned ADF who were concerned about their mental health and had ever sought assistance, a description of who suggested that assistance should be sought. For Ex-Serving ADF members, seeking help was most often suggested by partners (42.82%), then friends (32.30%), MOs (25.59%) and family members (23.55%). For Inactive Reservists, seeking help was most often suggested by partners (49.69%) and friends (26.15%), then by supervisors (23.44%) and family members (20.70%). For Active Reservists, partners (56.29%) most often suggested seeking help, followed by friends (21.58%) and then supervisors (20.12%).

Table 5.5 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who had someone suggest they seek assistance with their mental health, and who suggested they seek assistance, stratified by probable 30-day disorder

	Transitioned ADF n = 7,518			2015 Regular ADF n = 11,923		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
All	n = 7,518			n=11,923		
Friend	307	2166	28.81 (25.65, 32.19)	473	3466	29.07 (21.26, 38.36)
GP	102	761	10.12 (8.15, 12.50)	55	435	3.65 (1.55, 8.33)
MO	257	1581	21.03 (18.31, 24.04)	370	2576	21.60 (15.40, 29.43)
Family	193	1626	21.63 (18.60, 25.01)	233	1305	10.95 (7.37, 15.96)
Other	71	486	6.46 (4.89, 8.49)	95	909	7.63 (3.87, 14.49)
Partner	593	3545	47.16 (43.63, 50.72)	876	5131	43.03 (34.86, 51.61)
Supervisor	212	1665	22.14 (19.13, 25.48)	396	3294	27.62 (19.76, 37.16)
Probable 30-day disorder	n = 3592			n = 2486		
Friend	158	1078	30.02 (25.59, 34.85)	123	1066	42.90 (24.56, 63.41)
GP	70	542	15.09 (11.77, 19.15)	18	94	3.80 (1.88, 7.55)
MO	135	822	22.87 (18.91, 27.38)	113	740	29.77 (14.98, 50.50)
Family	104	888	24.72 (20.25, 29.80)	51	219	8.80 (5.35, 14.13)
Other	38	286	7.95 (5.51, 11.35)	18	197	7.91 (2.25, 24.28)
Partner	289	1861	51.79 (46.58, 56.97)	194	1076	43.27 (26.04, 62.31)
Supervisor	101	793	22.08 (17.90, 26.93)	89	896	36.05 (18.18, 58.84)
No probable 30-day disorder	n = 3926			n = 9437		
Friend	149	1087	27.69 (23.30, 32.56)	350	2400	25.43 (17.47, 35.47)
GP	32	219	5.57 (3.63, 8.45)	37	341	3.61 (1.23, 10.13)
MO	122	760	19.35 (15.75, 23.53)	257	1836	19.45 (13.14, 27.82)
Family	89	738	18.81 (14.89, 23.47)	182	1087	11.51 (7.20, 17.90)
Other	33	200	5.10 (3.32, 7.75)	77	713	7.55 (3.42, 15.88)
Partner	304	1685	42.91 (38.21, 47.75)	682	4055	42.97 (33.88, 52.57)
Supervisor	111	872	22.20 (18.03, 27.01)	307	2398	25.41 (17.30, 35.67)

Denominator: Those who were concerned about their mental health, sought assistance, and had someone suggest they seek help
Notes:
The totals correspond to the 'Yes, someone suggested seeking assistance' categories in Table 5.3.
These are not mutually exclusive groups and therefore do not sum to 100%.
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval

Figure 5.5 **Weighted estimate of Transitioned ADF and 2015 Regular ADF who had someone suggest they seek assistance with their mental health, and who suggested they seek assistance, stratified by probable 30-day disorder**

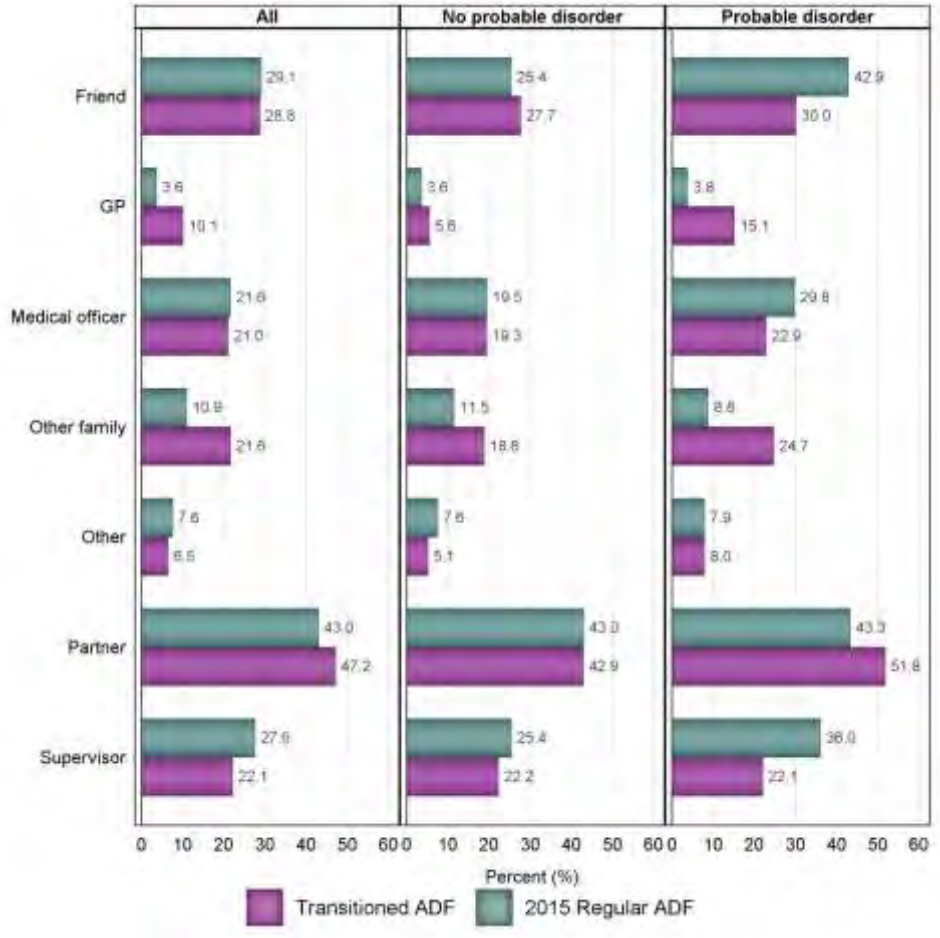
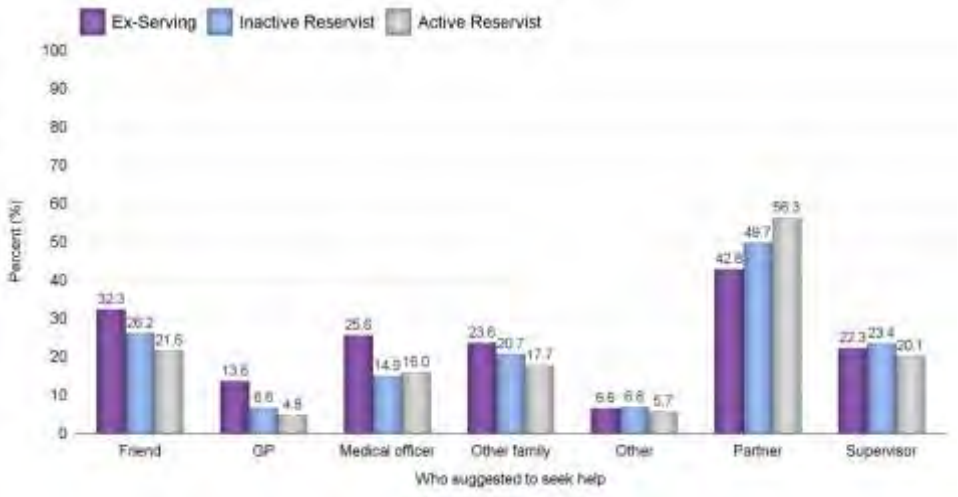


Table 5.6 Weighted estimate of Transitioned ADF members, by who suggested they seek assistance for a mental health concern

	Ex-Serving n = 4144			Inactive Reservists n = 1892			Active Reservists n = 1461		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Friend	179	1339	32.30 (27.81, 37.14)	69	495	26.15 (19.84, 33.63)	57	315	21.58 (15.93, 28.55)
GP	69	565	13.64 (10.56, 17.43)	17	125	6.62 (3.57, 11.95)	16	70	4.82 (2.84, 8.06)
MO	172	1061	25.59 (21.57, 30.07)	42	283	14.93 (10.23, 21.28)	42	234	15.99 (11.38, 22.00)
Family	109	976	23.55 (19.26, 28.46)	46	392	20.70 (14.91, 27.99)	38	259	17.70 (12.27, 24.85)
Other	38	273	6.59 (4.50, 9.57)	18	129	6.83 (3.81, 11.92)	15	83	5.71 (2.97, 10.70)
Partner	271	1775	42.82 (37.95, 47.83)	148	940	49.69 (42.08, 57.31)	172	823	56.29 (48.90, 63.40)
Supervisor	118	923	22.27 (18.26, 26.87)	46	444	23.44 (16.99, 31.41)	47	294	20.12 (14.63, 27.03)

Denominator: Those who were concerned with their mental health, sought assistance, and had someone suggest they seek help
Notes:
The totals correspond to the 'Yes, someone suggested seeking assistance' categories in Table 5.4.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 5.6 Weighted estimate of Transitioned ADF members based on who suggested they seek assistance with a mental health concern



5.5 Assistance from others in seeking help for a mental health concern among Transitioned ADF and 2015 Regular ADF

Table 5.7 and Figure 5.7 describe the proportion of Transitioned ADF and 2015 Regular ADF members who reported having had a concern about their mental health and received assistance when seeking help. Of these, similar proportions of Transitioned ADF (32.64%) and 2015 Regular ADF members (28.46%) reported receiving assistance in seeking help. This is further broken down by whether the respondent had a probable 30-day disorder. There was no difference in the proportion of Transitioned ADF and 2015 Regular ADF with a probable 30-day disorder who had someone assist them in seeking help (36.16% vs 30.72%).

Table 5.8 and Figure 5.8 describe the proportion of Transitioned ADF members who reported having had a concern about their mental health and who reported receiving assistance from someone in seeking assistance, by transition category. Of these, similar proportions of Inactive Reservists (26.61%) and Active Reservists (27.35%) reported receiving assistance in seeking help. However, there were significant differences between these groups and the Ex-Serving group, of which 37.47% received assistance in seeking help.

Table 5.7 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who had someone assist them in seeking help with their mental health, stratified by probable 30-day disorder

	Transitioned ADF n = 12,022			2015 Regular ADF n = 20,740		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
All	n = 12,022			n = 20,740		
No one assisted	1311	7900	65.71 (62.97, 68.35)	2598	14,626	70.52 (64.12, 76.20)
Yes, someone assisted	567	3924	32.64 (30.03, 35.36)	724	5903	28.46 (22.80, 34.89)
Probable 30-day disorder	n = 5236			n = 4482		
No one assisted	505	3227	61.63 (57.41, 65.68)	459	3087	68.87 (53.27, 81.10)
Yes, someone assisted	275	1893	36.16 (32.16, 40.36)	166	1377	30.72 (18.52, 46.39)
No probable 30-day disorder	n = 6786			n = 16,258		
No one assisted	806	4673	68.86 (65.21, 72.30)	2139	11,540	70.98 (63.80, 77.24)
Yes, someone assisted	292	2030	29.92 (26.52, 33.55)	558	4526	27.84 (21.60, 35.06)

Denominator: Those who were concerned about their mental health and sought assistance.
Notes:
Based on weighted counts, 211 (1.02%) 2015 Regular ADF and 198 (1.65%) Transitioned ADF had a missing value for this question and are not included above. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval

Figure 5.7 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who had someone assist them in seeking help with their mental health, stratified by probable 30-day disorder

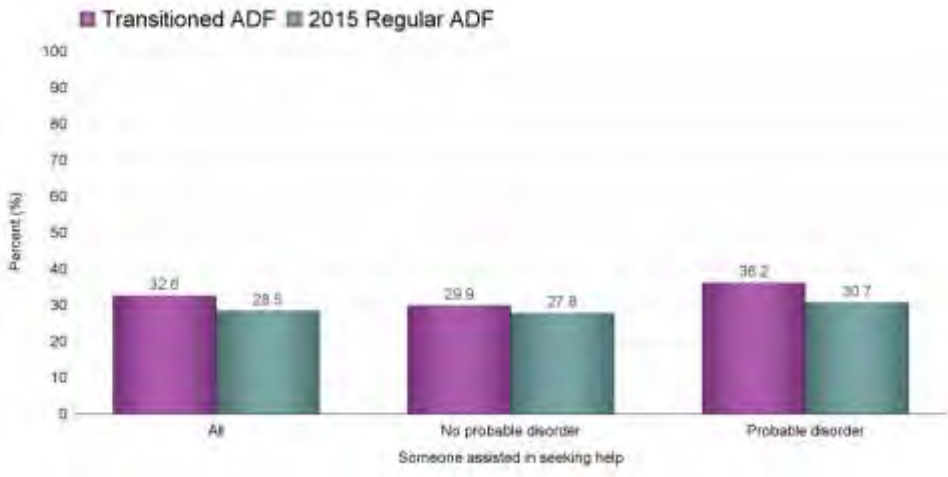


Table 5.8 Weighted estimate of Transitioned ADF members who had someone assist them in seeking help with their mental health

	Ex-Serving n = 6338			Inactive Reservists n = 3131			Active Reservists n = 2504		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
No	579	3848	60.72 (56.69, 64.61)	357	2244	71.67 (65.79, 76.89)	370	1789	71.46 (66.24, 76.17)
Yes	328	2375	37.47 (33.62, 41.48)	110	833	26.61 (21.49, 32.45)	126	685	27.35 (22.70, 32.56)

Denominator: Those who were concerned about their mental health and sought assistance
Notes:
Based on weighted counts, 115 (1.81%) Ex-Serving, 54 (1.72%) Inactive Reservists, and 30 (1.18%) Active Reservists had a missing value for this question and are not included above.
However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
95% CI: 95% confidence interval

Figure 5.8 Weighted estimate of Transitioned ADF members who had someone assist them in seeking help with their mental health

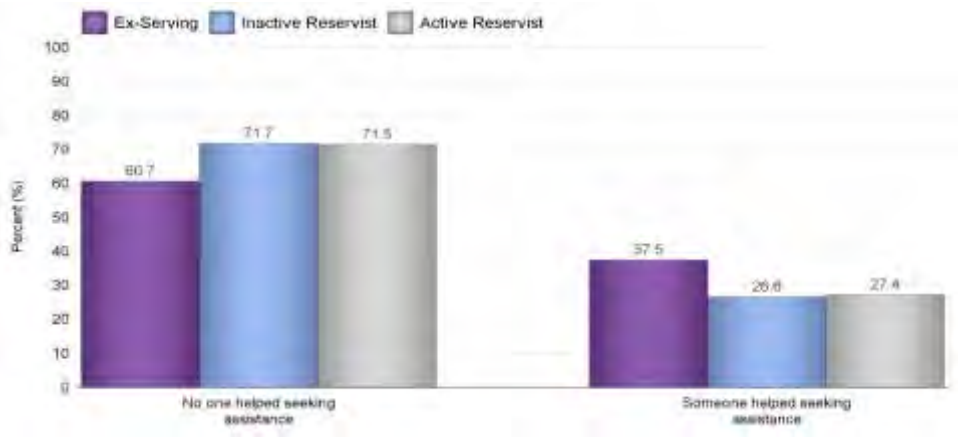


Table 5.9 and Figure 5.9 describe the different sources who provide assistance in seeking help in Transitioned ADF and 2015 Regular ADF members. For Transitioned ADF, help was most often provided by MOs or GPs (combined 41.40%), then partners (28.01%) and supervisors (24.91%). For 2015 Regular ADF members, help was most often provided by supervisors (32.59%) and MOs or GPs (combined 36.20%), then by friends (16.46%) and partners (11.98%). The data can be further broken down based on whether the respondent had a probable 30-day disorder. Those with a probable 30-day disorder in the Transitioned ADF group were most likely to have received help from a partner (36.29%), while those with a probable 30-day disorder in the 2015 Regular ADF group were most likely to have received assistance from an MO or GP (combined 53.81%).

Table 5.10 and Figure 5.10 describe different sources who provided assistance in seeking help in Transitioned ADF members who were concerned about their mental health and had sought assistance. The Ex-Serving group were most likely to have been assisted by an MO or GP (combined 46.49%), Inactive Reservists mostly received assistance from their partner (25.33%) and more Active Reservists reported receiving assistance from MOs (34.45%).

Table 5.9 Weighted estimate of Transitioned ADF and 2015 Regular ADF members based on who assisted them in seeking help with a mental health problem, stratified by probable 30-day disorder

	Transitioned ADF n = 3924			2015 Regular ADF n = 5903		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
All	n = 3924			n = 5903		
Friend	95	649	16.53 (13.10, 20.66)	119	972	16.46 (7.86, 31.28)
GP	43	345	8.80 (6.26, 12.23)	17	247	4.18 (0.96, 16.36)
MO	203	1279	32.60 (28.14, 37.39)	274	1887	31.98 (21.91, 44.05)
Other	51	386	9.83 (7.10, 13.44)	52	689	11.67 (4.90, 25.28)
Family	51	477	12.17 (8.92, 16.38)	33	328	5.55 (1.82, 15.69)
Partner	174	1099	28.01 (23.83, 32.61)	140	707	11.98 (7.78, 17.99)
Supervisor	113	977	24.91 (20.55, 29.84)	234	1924	32.59 (20.75, 47.18)
Probable 30-day disorder	n = 1893			n = 1377		
Friend	57	352	18.61 (13.92, 24.43)	26	105	7.62 (3.73, 14.94)
GP	25	184	9.73 (6.42, 14.49)	5	26	1.89 (0.59, 5.89)
MO	95	605	31.98 (25.90, 38.73)	80	715	51.92 (24.91, 77.85)
Other	27	231	12.22 (7.88, 18.48)	14	204	14.79 (4.12, 41.23)
Family	25	245	12.94 (8.39, 19.42)	6	16	1.20 (0.49, 2.88)
Partner	102	687	36.29 (29.82, 43.30)	30	126	9.15 (4.55, 17.55)
Supervisor	51	468	24.69 (18.70, 31.85)	53	472	34.31 (12.16, 66.34)
No probable 30-day disorder	n = 2030			n = 4526		
Friend	38	296	14.60 (9.97, 20.89)	93	867	19.15 (8.53, 37.57)
GP	18	161	7.93 (4.55, 13.46)	12	221	4.88 (0.95, 21.50)
MO	108	674	33.18 (26.89, 40.14)	194	1172	25.91 (17.54, 36.50)
Other	24	154	7.59 (4.75, 11.93)	38	485	10.72 (3.50, 28.43)
Family	26	232	11.45 (7.28, 17.54)	27	311	6.88 (2.13, 20.02)
Partner	72	412	20.29 (15.39, 26.28)	110	581	12.84 (7.74, 20.53)
Supervisor	62	510	25.11 (19.11, 32.24)	181	1451	32.07 (19.12, 48.54)

Denominator: Those who were concerned about their mental health, who sought assistance, and had assistance seeking help
Notes:
The totals correspond to the 'Yes' categories in Table 5.7.
These are not mutually exclusive groups and therefore do not sum to 100%.
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval

Figure 5.9 **Weighted estimate of Transitioned ADF and 2015 Regular ADF members based on who assisted them in seeking help with a mental health problem, stratified by probable 30-day disorder**

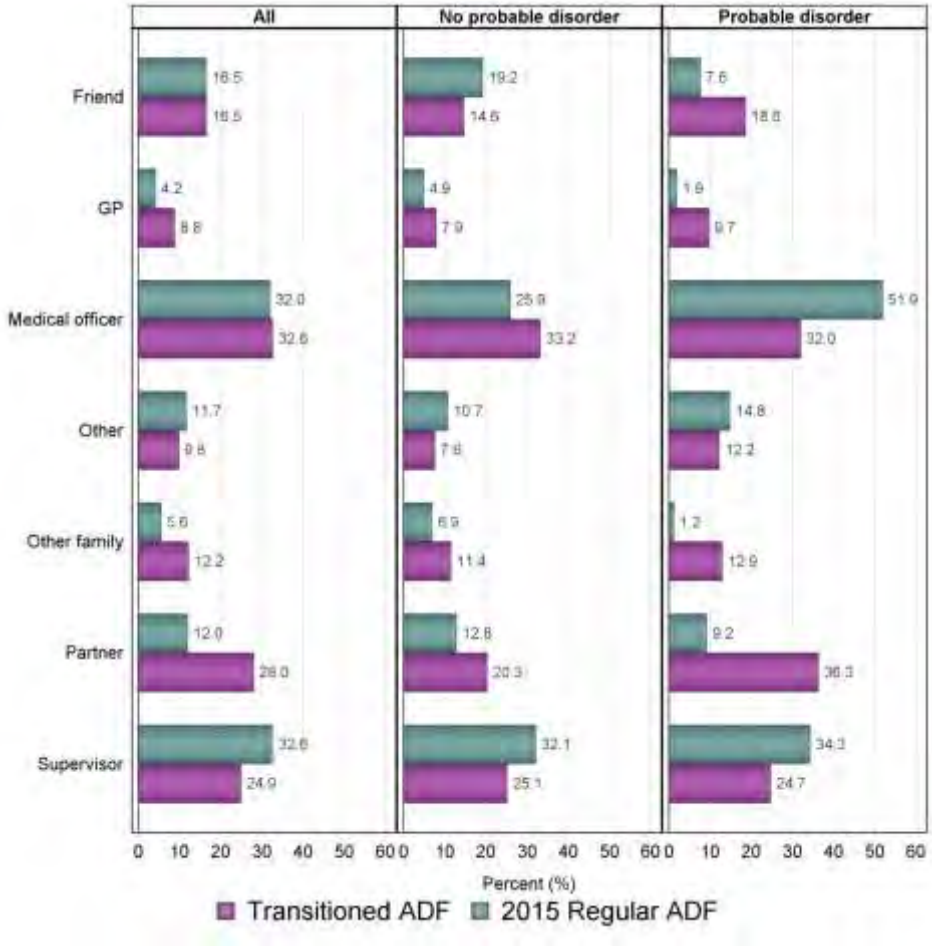
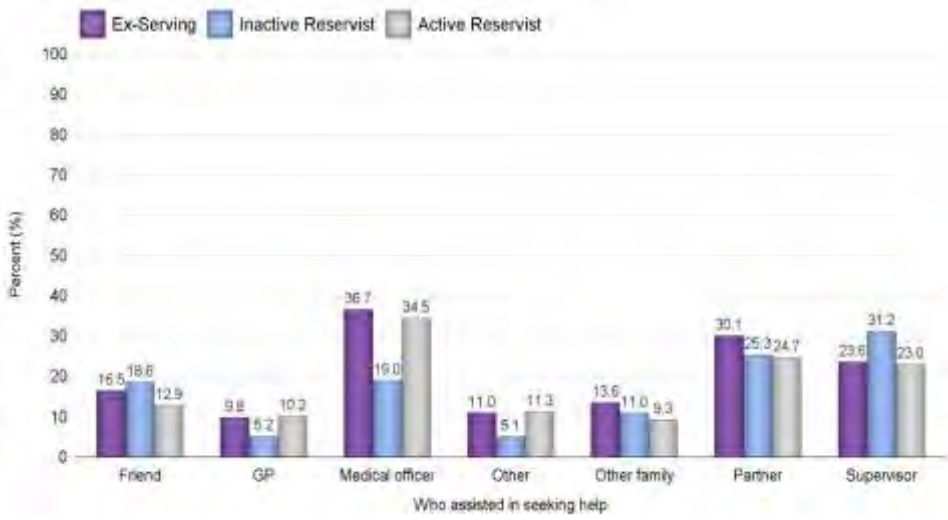


Table 5.10 Weighted estimate of Transitioned ADF members based on who assisted them in seeking help with their mental health

	Ex-Serving n = 2,375			Inactive Reservists n = 833			Active Reservists n = 685		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Friend	60	392	16.52 (12.23, 21.94)	15	155	18.59 (10.40, 31.01)	19	88	12.85 (7.89, 20.25)
GP	29	232	9.78 (6.49, 14.50)	6	43	5.17 (1.79, 14.07)	8	70	10.19 (4.44, 21.70)
MO	130	872	36.71 (30.57, 43.30)	28	159	19.04 (11.87, 29.13)	44	236	34.45 (25.25, 44.99)
Other	31	261	11.00 (7.23, 16.39)	6	43	5.11 (2.04, 12.21)	13	77	11.29 (5.68, 21.20)
Family	34	322	13.56 (9.21, 19.52)	9	91	10.98 (4.95, 22.59)	8	64	9.33 (4.27, 19.17)
Partner	98	715	30.09 (24.29, 36.60)	39	211	25.33 (16.99, 35.99)	36	169	24.69 (17.89, 33.03)
Supervisor	64	559	23.55 (18.15, 29.97)	26	260	31.23 (20.58, 44.32)	23	158	23.03 (15.05, 33.57)

Denominator: Those who were concerned with their mental health, who sought assistance, and had assistance seeking help
Notes:
The totals correspond to the 'Yes, someone suggested seeking assistance' categories in Table 5.8.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 5.10 Weighted estimate of Transitioned ADF by who assisted when seeking help



5.6 Primary reason for seeking assistance with a mental health concern

Table 5.11 and Figure 5.11 describe the primary reasons for seeking assistance for mental health among Transitioned ADF and 2015 Regular ADF members who were concerned about their mental health and had sought assistance.

The most commonly reported reasons for seeking assistance were depression (27.22% for Transitioned ADF and 21.01% for 2015 Regular ADF), followed by anxiety (17.80% for Transitioned ADF and 19.64% for 2015 Regular ADF), relationship problems (11.05% for Transitioned ADF and 18.72% for 2015 Regular ADF) and anger (12.43% for Transitioned ADF and 12.96% for 2015 Regular ADF). In general, reasons for seeking assistance showed similar patterns across Transitioned and 2015 Regular ADF members, although relationship problems were a more commonly cited reason for 2015 Regular ADF members. The data are further broken down by whether the respondent had a probable 30-day disorder.

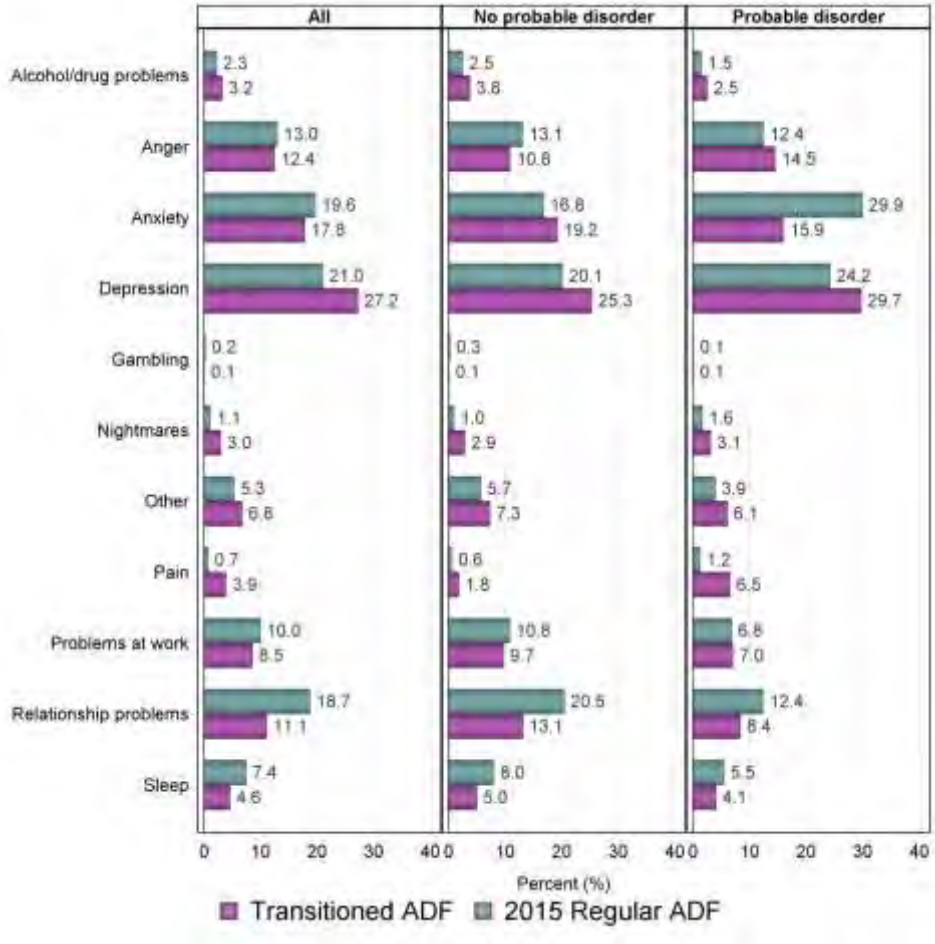
The primary reason for seeking assistance for a mental health concern for the three categories of Transitioned ADF, for those how had ever had a concern and had sought assistance, has not been reported here due to small cell sizes.

Table 5.11 Weighted estimate of primary reason for seeking assistance for mental health among the Transitioned ADF and 2015 Regular ADF, stratified by probable 30-day disorder

	Transitioned ADF n = 12,022			2015 Regular ADF n = 20,740		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
All	n = 12,022			n=20,740		
Alcohol or drug problems	45	387	3.22 (2.23, 4.63)	51	470	2.27 (0.95, 5.29)
Anger	220	1495	12.43 (10.65, 14.46)	315	2687	12.96 (8.80, 18.68)
Anxiety	346	2140	17.80 (15.76, 20.04)	607	4074	19.64 (14.90, 25.44)
Depression	527	3272	27.22 (24.86, 29.72)	748	4357	21.01 (16.58, 26.24)
Gambling	2	11	0.09 (0.03, 0.34)	10	44	0.21 (0.09, 0.49)
Nightmares	58	355	2.95 (2.14, 4.06)	57	228	1.10 (0.80, 1.51)
Other	121	813	6.77 (5.45, 8.37)	269	1104	5.33 (4.49, 6.30)
Pain	72	465	3.86 (2.98, 4.99)	40	148	0.71 (0.49, 1.05)
Problems at work	177	1027	8.55 (7.21, 10.10)	379	2064	9.95 (7.31, 13.40)
Relationship problems	222	1329	11.05 (9.46, 12.87)	647	3883	18.72 (14.64, 23.62)
Sleep	92	551	4.58 (3.58, 5.85)	204	1544	7.44 (4.48, 12.12)
Probable 30-day disorder	n = 5236			n = 4482		
Alcohol or drug problems	17	130	2.49 (1.37, 4.49)	15	65	1.46 (0.78, 2.73)
Anger	105	760	14.51 (11.69, 17.88)	70	557	12.42 (4.87, 28.22)
Anxiety	131	835	15.94 (13.04, 19.34)	120	1341	29.92 (17.15, 46.82)
Depression	237	1554	29.68 (25.99, 33.67)	181	1086	24.22 (14.59, 37.42)
Gambling	1	4	0.08 (0.01, 0.44)	1	3	0.07 (0.01, 0.33)
Nightmares	35	160	3.06 (2.18, 4.29)	14	73	1.62 (0.83, 3.16)
Other	46	318	6.07 (4.34, 8.43)	36	176	3.92 (2.40, 6.33)
Pain	48	342	6.53 (4.75, 8.91)	12	55	1.23 (0.56, 2.69)
Problems at work	64	369	7.04 (5.33, 9.25)	73	305	6.80 (4.70, 9.75)
Relationship problems	63	438	8.36 (6.20, 11.17)	79	555	12.39 (6.31, 22.90)
Sleep	33	212	4.06 (2.70, 6.06)	25	246	5.48 (1.96, 14.42)
No probable 30-day disorder	n = 6786			n = 16,258		
Alcohol or drug problems	28	256	3.78 (2.37, 5.98)	36	405	2.49 (0.92, 6.58)
Anger	115	735	10.83 (8.68, 13.44)	245	2131	13.11 (8.55, 19.57)
Anxiety	215	1305	19.23 (16.48, 22.31)	487	2733	16.81 (12.41, 22.36)
Depression	290	1718	25.32 (22.33, 28.56)	567	3271	20.12 (15.34, 25.94)
Gambling	1	7	0.10 (0.02, 0.61)	9	41	0.25 (0.10, 0.62)
Nightmares	23	194	2.87 (1.71, 4.76)	43	155	0.95 (0.67, 1.36)
Other	75	495	7.30 (5.50, 9.64)	233	929	5.71 (4.74, 6.87)
Pain	24	123	1.81 (1.19, 2.76)	28	93	0.57 (0.38, 0.86)
Problems at work	113	659	9.71 (7.83, 11.97)	306	1759	10.82 (7.59, 15.20)
Relationship problems	159	891	13.13 (10.96, 15.65)	568	3327	20.47 (15.76, 26.14)
Sleep	59	338	4.98 (3.64, 6.78)	179	1298	7.99 (4.53, 13.71)

Denominator: Those who were concerned with their mental health and sought assistance.
Notes:
Based on weighted counts, 178 (1.48%) Transitioned ADF and 137 (0.66%) 2015 Regular ADF had a missing value for this question and are not included above. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval

Figure 5.11 Weighted estimate of primary reason for seeking assistance for mental health among the Transitioned ADF and 2015 Regular ADF, stratified by probable 30-day disorder



6 Mental health professional use in last 12 months, by service and satisfaction

Key findings

Mental health service use

- Transitioned ADF and 2015 Regular ADF members reported very high rates of consulting a General Practitioner (GP) or Medical Officer (MO) (80.9% and 77.6%), a psychologist (81.3% and 87.6%) and/or a psychiatrist (50.0% and 38.9%) for help with a mental health concern at some stage in their lifetime.
- For those with a probable 30-day disorder who had sought assistance, 84.3% and 93.5% of Transitioned ADF and 2015 Regular ADF members respectively had consulted a psychologist. Of those, 55.5% of Transitioned ADF and 66.1% of 2015 Regular ADF members had done so in the last 12 months.
- For those with a probable 30-day disorder who had sought assistance, 66.6% and 60.2% of Transitioned ADF and 2015 Regular ADF members respectively had consulted a psychiatrist. Of those, 63.4% of Transitioned ADF and 61.2% of 2015 Regular ADF members had done so in the last 12 months.

MOs and GPs

- The most commonly provided service by GPs/MOs to Transitioned ADF (73.4%) and 2015 Regular ADF (83.9%) was referral to another service. Other commonly provided services were information (50.7% and 46.7%), medicine (68.5% and 35.2%) and support (42.7% and 38.9%).
- The GP and MO services with which Transitioned ADF members were most satisfied were referrals (74.7%), information (66.1%), medicine (66.9%) and support (61.6%). The services with which 2015 Regular ADF members were most satisfied were trauma-focused and general cognitive behavioural therapy (CBT) (87.4% and 81.2%), referral (82.3%) and psychotherapy (78.3%).

Psychologists

- Psychologists most commonly provided supportive counselling to Transitioned ADF (80.6%) and 2015 Regular ADF (85.7%) members. Other commonly provided services were CBT (63.7% and 63.9%) and information (55.9% and 51.9%).

- The psychology services Transitioned ADF members were most satisfied with were referrals (72.6%), information (68.6%), supportive counselling (62.5%) and CBT (59.9%, including trauma-focused CBT 59.9%). Psychology services that 2015 Regular ADF were most satisfied with included CBT (83.9%, including trauma-focused CBT 85.5%), information (82.0%) and referrals (84.7%).

Psychiatrists

- The most commonly provided services by psychiatrists to Transitioned ADF (77.9%) and 2015 Regular ADF (54.5%) was prescribing medicine, followed by supportive counselling (63.4% and 45.0%) and information (60.1% and 53.8%).
- Psychiatry services that Transitioned ADF were most satisfied with were information (69.5%), medicine (66.7%) and CBT (63.0%). Psychiatry services that 2015 Regular ADF members were most satisfied with were information (85.2%), medicine (78.3%), supportive counselling (66.8%) and CBT (61.5%).

Satisfaction with health service factors

- Participants reported satisfaction with the accessibility, cost, location, effectiveness, competence, friendliness, convenience and confidentiality of health services. 2015 Regular ADF members were more likely than Transitioned ADF members to be satisfied with all service factors except for cost, where there was no significant difference.
- Among both Transitioned ADF and 2015 Regular ADF members, those with probable 30-day disorders reported lower satisfaction with the health service factors assessed.
- Of the key service factors, Transitioned ADF members were most satisfied with friendliness (71.6%) and confidentiality (70.3%), and 2015 Regular ADF members were most satisfied with friendliness (90.9%), location (87.3%) and competence (85.7%).

Glossary: refer to the Glossary of terms for definitions of key terms in this section.

6.1 Introduction

This section describes the types of mental health professionals and services that Transitioned ADF and 2015 Regular ADF members sought or received help from, focusing on those who sought consultation in the past 12 months. The results reflect the services used by those who reported ever having received assistance with their mental health.

First, use of mental health services is examined for the Transitioned ADF and 2015 Regular ADF groups broadly, and for those who met the criteria for a probable 30-day affective or anxiety disorder. This section then analyses the specific mental health professionals and services used by the Transitioned ADF population based on the categories of transition status (Ex-Serving, Active Reservist and Inactive Reservist). There is a detailed examination of the professionals who delivered these services, and

how satisfactory those services were perceived to be. The study investigators developed the survey items used in this section with specific knowledge and experience in the field. Specific questions on the types of doctors or professionals consulted were derived from the 'Help-Seeking' section of the World Mental Health Survey Initiative Version of the World Health Organization Composite International Diagnostic Interview – version 3 (CIDI) (Haro et al., 2006), which was also used in the 2007 National Survey of Mental Health and Wellbeing.

6.1.1 Mental health service use

Participants were asked whether they had ever sought or received help with their mental health from the following list of doctors or professionals in the last 12 months and more than 12 months ago.

- GP or MO
- Psychologist
- Psychiatrist
- Other mental health professional (social worker, occupational therapist or mental health nurse)
- Other provider (counsellor, or complementary or alternative therapist)
- Inpatient treatment or hospital admission
- Hospital-based posttraumatic stress disorder (PTSD) program
- Residential alcohol or other drug program.

6.1.2 Types of mental health services provided

Participants were also asked to indicate the types of service(s) they received from a GP, psychologist, psychiatrist and other mental health professionals, including:

- information about mental illness, treatments and available services
- medicines or tablets
- counselling (supportive – focused on support for day-to-day stressors, problems and concerns)
- counselling (psychotherapy – focused on the impact of early-life experiences)
- counselling (CBT – focused on changing unhelpful thoughts and behaviours)
- counselling (focused on addressing memories of traumatic experiences, such as through trauma-focused CBT and eye movement desensitisation and reprocessing (EMDR)).

It is worth noting that this question relied on the individual respondent understanding the different types of therapy and the differences between providers – such as psychologist vs psychiatrist, or psychologist vs social worker. This may limit the reliability of the findings in this section.

Participants' satisfaction with each type of mental health professional and types of services received was assessed by asking one question: *Were you satisfied with this service?* The potential response was a simple yes/no answer.

Participants were also asked to rate their satisfaction with a range of factors regarding all mental health services/care they had received in the past 12 months. These factors included:

- accessibility
- cost
- location
- effectiveness
- the competence of the health professional
- the friendliness of the health professional
- convenience
- confidentiality
- Medicare cap
- other.

Satisfaction with each of these factors was assessed on a 5-point Likert scale, from very dissatisfied to very satisfied.

6.1.3 Key questions addressed in this chapter

This chapter asks whether Transitioned ADF and 2015 Regular ADF members differ in:

- the types of mental health services they use
- their satisfaction with health services factors.

6.2 Self-reported mental health service use and satisfaction among Transitioned ADF and 2015 Regular ADF members

6.2.1 Overview of services

Table 6.1 describes the types of health professional Transitioned ADF and 2015 Regular ADF members consulted within the last 12 months, more than 12 months ago or ever. For both Transitioned ADF (81.29%) and 2015 Regular ADF (87.61%), psychologists were the most commonly consulted health professional 'ever'. However, Transitioned ADF (38.40%) and 2015 Regular ADF (37.947%) members were more likely to have

seen a GP or MO in the last 12 months. For those who had a probable 30-day disorder and had sought assistance, 84.3% and 93.5% of Transitioned ADF and 2015 Regular ADF members respectively had consulted a psychologist. Of those, 55.5% of Transitioned ADF and 66.1% of 2015 Regular ADF had done so in the last 12 months. For those who had a probable 30-day disorder and had sought assistance, 66.6% and 60.2% of Transitioned ADF and 2015 Regular ADF members respectively had consulted a psychiatrist. Of those, 63.4% of Transitioned ADF and 61.2% of 2015 Regular ADF members had done so in the last 12 months.

Table 6.2 describes the specific health professionals consulted ever, more than 12 months ago or within the last 12 months, by Transitioned ADF and by category of transition. GPs and MOs were the most commonly consulted health professionals 'ever' by Transitioned ADF, whereas psychologists were the most commonly consulted 'ever' by Inactive (75.72%) and Active Reservists (80.76%). In the last 12 months, GPs and MOs were also the more commonly seen in Ex-Serving (45.21%), Inactive Reservists (34.19%) and Active Reservists (26.20%).

Rates of use of hospital-based PTSD programs and residential alcohol programs are not reported for the three groups due to very low cell sizes of fewer than five.

Table 6.1 Weighted estimate of health professionals Transitioned ADF and 2015 Regular ADF members consulted, stratified by probable 30-day disorder

	Transitioned ADF n = 12,022			2015 Regular ADF n = 20,740		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
GP or MO						
Ever	1550	9720	80.86 (78.54, 82.98)	2524	16,103	77.64 (72.84, 81.80)
< 12 months ago	729	4616	38.40 (35.75, 41.13)	1182	7868	37.94 (32.01, 44.24)
> 12 months ago	1009	6330	52.66 (49.88, 55.42)	1605	9474	45.68 (39.71, 51.78)
Probable 30-day disorder						
Ever	707	4574	87.37 (84.07, 90.07)	533	4051	90.37 (86.45, 93.25)
< 12 months ago	462	2987	57.06 (52.82, 61.20)	377	2483	55.39 (40.91, 69.01)
> 12 months ago	363	2402	45.87 (41.72, 50.09)	244	1917	42.78 (29.27, 57.45)
No probable 30-day disorder						
Ever	843	5146	75.83 (72.52, 78.86)	1991	12,052	74.13 (68.30, 79.22)
< 12 months ago	267	1629	24.01 (20.97, 27.34)	805	5385	33.12 (26.73, 40.21)
> 12 months ago	646	3929	57.89 (54.20, 61.50)	1361	7557	46.48 (39.94, 53.15)
Psychologist						
Ever	1604	9772	81.29 (78.84, 83.52)	2902	18171	87.61 (83.73, 90.68)
< 12 months ago	646	3878	32.26 (29.77, 34.85)	1327	9148	44.11 (38.02, 50.38)
> 12 months ago	1109	6864	57.10 (54.32, 59.83)	1871	10,796	52.05 (45.88, 58.16)
Probable 30-day disorder						
Ever	703	4413	84.29 (80.43, 87.50)	576	4189	93.46 (90.11, 95.74)
< 12 months ago	390	2342	44.72 (40.63, 48.89)	381	2464	54.99 (40.55, 68.63)
> 12 months ago	396	2596	49.59 (45.39, 53.80)	280	2336	52.12 (38.24, 65.67)
No probable 30-day disorder						
Ever	901	5360	78.98 (75.63, 81.98)	2326	13,982	86.00 (81.15, 89.76)
< 12 months ago	256	1536	22.64 (19.70, 25.87)	946	6684	41.11 (34.39, 48.18)
> 12 months ago	713	4267	62.89 (59.23, 66.40)	1591	8460	52.03 (45.27, 58.72)
Psychiatrist						
Ever	989	6003	49.94 (47.23, 52.64)	1160	8068	38.90 (32.97, 45.18)
< 12 months ago	477	2818	23.44 (21.29, 25.74)	470	3201	15.43 (11.26, 20.79)
> 12 months ago	613	3840	31.94 (29.45, 34.54)	761	5137	24.77 (19.53, 30.88)
Probable 30-day disorder						
Ever	574	3485	66.56 (62.29, 70.58)	342	2696	60.15 (46.44, 72.44)
< 12 months ago	364	2123	40.55 (36.62, 44.61)	212	1426	31.82 (20.22, 46.22)
> 12 months ago	287	1847	35.28 (31.44, 39.33)	602	3744	23.03 (17.54, 29.62)
No probable 30-day disorder						
Ever	415	2518	37.11 (33.64, 40.72)	818	5372	33.04 (26.72, 40.04)
< 12 months ago	113	694	10.23 (8.17, 12.74)	258	1775	10.92 (7.03, 16.57)
> 12 months ago	326	1993	29.36 (26.13, 32.82)	159	1393	31.08 (18.85, 46.68)
Other mental health professional						
Ever	567	3662	30.47 (27.96, 33.09)	1010	6945	33.48 (27.66, 39.85)
< 12 months ago	196	1177	9.79 (8.32, 11.49)	369	2058	9.92 (7.18, 13.55)
> 12 months ago	414	2785	23.16 (20.85, 25.65)	689	5050	24.35 (18.96, 30.69)

	Transitioned ADF n = 12,022			2015 Regular ADF n = 20,740		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Probable 30-day disorder						
Ever	274	1745	33.33 (29.55, 37.34)	218	1474	32.89 (21.17, 47.22)
< 12 months ago	136	786	15.01 (12.44, 18.01)	132	743	16.57 (9.78, 26.68)
> 12 months ago	166	1173	22.40 (19.04, 26.17)	102	788	17.58 (8.58, 32.65)
No probable 30-day disorder						
Ever	293	1917	28.25 (24.97, 31.78)	792	5470	33.65 (27.16, 40.82)
< 12 months ago	60	391	5.76 (4.21, 7.84)	237	1315	8.09 (5.27, 12.23)
> 12 months ago	248	1612	23.75 (20.67, 27.14)	587	4262	26.21 (20.08, 33.44)
Other provider (counsellor or alternative)						
Ever	441	2580	21.46 (19.33, 23.76)	709	3862	18.62 (14.44, 23.67)
< 12 months ago	134	740	6.16 (5.00, 7.56)	179	1030	4.97 (2.65, 9.12)
> 12 months ago	333	2014	16.75 (14.81, 18.88)	559	2944	14.19 (10.87, 18.33)
Inpatient treatment						
Ever	336	1999	16.63 (14.74, 18.71)	298	1657	7.99 (5.37, 11.73)
< 12 months ago	120	688	5.72 (4.65, 7.02)	118	641	3.09 (1.72, 5.49)
> 12 months ago	234	1407	11.70 (10.07, 13.56)	191	1046	5.04 (2.99, 8.38)
Hospital-based PTSD program						
Ever	152	759	6.31 (5.26, 7.56)	87	701	3.38 (1.46, 7.63)
< 12 months ago	50	264	2.19 (1.62, 2.97)	34	404	1.95 (0.52, 7.04)
> 12 months ago	108	528	4.39 (3.51, 5.48)	54	299	1.44 (0.62, 3.29)
Residential alcohol program						
Ever	107	794	6.60 (5.25, 8.27)	110	1221	5.89 (3.04, 11.10)
< 12 months ago	23	155	1.29 (0.78, 2.11)	28	127	0.61 (0.40, 0.95)
> 12 months ago	88	683	5.68 (4.41, 7.30)	84	1099	5.30 (2.54, 10.72)

Denominator: Those who were concerned about their mental health and sought assistance
Notes:
These are not mutually exclusive groups and therefore do not sum to 100%.
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval

Table 6.2 Weighted estimate of health professionals consulted within the Transitioned ADF

	Ex-Serving n = 6338			Inactive Reservists n = 3131			Active Reservists n = 2504		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
GP or MO									
Ever	799	5481	86.48 (83.49, 89.00)	362	2264	72.30 (66.48, 77.46)	382	1930	77.09 (72.38, 81.20)
< 12 months ago	440	2866	45.21 (41.27, 49.22)	161	1070	34.19 (28.86, 39.94)	124	656	26.20 (21.54, 31.45)
> 12 months ago	481	3446	54.37 (50.37, 58.32)	237	1416	45.22 (39.57, 51.00)	288	1448	57.82 (52.43, 63.04)
Psychologist									
Ever	804	5334	84.16 (80.72, 87.09)	379	2371	75.72 (69.95, 80.69)	414	2022	80.76 (75.67, 84.99)
< 12 months ago	389	2327	36.71 (33.06, 40.52)	133	907	28.96 (23.88, 34.63)	121	623	24.88 (20.52, 29.82)
> 12 months ago	518	3679	58.04 (54.05, 61.94)	273	1643	52.48 (46.57, 58.32)	313	1514	60.46 (55.05, 65.62)
Psychiatrist									
Ever	618	3898	61.50 (57.48, 65.38)	177	1104	35.25 (30.05, 40.83)	188	960	38.35 (33.32, 43.63)
< 12 months ago	357	2109	33.28 (29.82, 36.93)	69	456	14.55 (10.98, 19.04)	48	232	9.26 (6.58, 12.88)
> 12 months ago	344	2332	36.79 (33.04, 40.70)	119	714	22.81 (18.38, 27.93)	146	769	30.72 (25.98, 35.90)
Other mental health professional									
Ever	306	2080	32.82 (29.16, 36.70)	115	797	25.44 (20.54, 31.06)	145	781	31.21 (26.51, 36.33)
< 12 months ago	126	713	11.24 (9.17, 13.71)	35	267	8.52 (5.60, 12.75)	35	198	7.89 (5.35, 11.49)
> 12 months ago	207	1576	24.87 (21.45, 28.64)	88	577	18.43 (14.25, 23.49)	118	627	25.04 (20.69, 29.96)
Other provider (counsellor or alternative therapist)									
Ever	182	1103	17.41 (14.72, 20.46)	120	819	26.15 (21.22, 31.77)	136	647	25.82 (21.63, 30.50)
< 12 months ago	72	381	6.02 (4.50, 8.00)	26	185	5.91 (3.54, 9.70)	35	170	6.77 (4.69, 9.69)
> 12 months ago	129	857	13.53 (11.09, 16.40)	97	645	20.60 (16.17, 25.88)	105	504	20.13 (16.35, 24.52)

	Ex-Serving n = 6338			Inactive Reservists n = 3131			Active Reservists n = 2504		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Inpatient treatment									
Ever	258	1568	24.74 (21.56, 28.22)	29	200	6.39 (3.98, 10.11)	44	203	8.09 (5.91, 10.98)
< 12 months ago	100	586	9.24 (7.32, 11.61)	7	38	1.22 (0.52, 2.82)	10	51	2.05 (1.02, 4.07)
> 12 months ago	175	1073	16.93 (14.22, 20.04)	22	162	5.17 (2.98, 8.83)	35	155	6.21 (4.39, 8.70)
Hospital-based PTSD program									
Ever	126	636	10.04 (8.14, 12.31)	17	82	2.63 (1.56, 4.38)	9	40	1.60 (0.84, 3.04)
< 12 months ago	41	226	3.56 (2.51, 5.02)	7	30	0.97 (0.46, 2.02)	2	8	0.31 (0.08, 1.21)
> 12 months ago	90	440	6.94 (5.37, 8.92)	11	56	1.80 (0.93, 3.44)	7	32	1.29 (0.62, 2.68)
Residential alcohol program									
Ever	74	546	8.62 (6.52, 11.31)	13	113	3.62 (1.79, 7.20)	18	116	4.64 (2.66, 7.97)
< 12 months ago	18	126	1.98 (1.11, 3.52)	2	8	0.25 (0.07, 0.95)	2	8	0.31 (0.08, 1.16)
> 12 months ago	59	461	7.27 (5.30, 9.88)	12	110	3.51 (1.70, 7.11)	16	108	4.33 (2.40, 7.68)

Denominator: Those who were concerned with their mental health and sought assistance
Note: 95% CI: 95% confidence interval

6.3 Specific health professional services accessed in the previous 12 months

6.3.1 GPs or MOs

Table 6.3 and Figure 6.1 examine the proportions of Transitioned ADF and 2015 Regular ADF members who accessed a GP or MO for a mental health concern in the last 12 months. The majority of visits for both Transitioned ADF (73.37%) and 2015 Regular ADF (83.92%) members resulted in a referral to another service. The next most frequent outcome was medicine for Transitioned ADF, 68.46% and information for 2015 Regular ADF at 46.17%. Then information was next most frequent for Transitioned ADF (50.17%) and supportive counselling for 2015 Regular ADF (38.91%).

Table 6.4 and Figure 6.2 show the proportions of Transitioned ADF and 2015 Regular ADF members who accessed GP or MO for a mental health concern in the last 12 months, by satisfaction with the services they received. Transitioned ADF members were most satisfied with referrals to another service (74.70%), other services (70.39%) and medicine (66.98%). 2015 Regular ADF members were most satisfied with trauma-focused CBT or EMDR (87.40%), referral to another service (82.33%) and CBT (81.18%).

Table 6.5 and Figure 6.3 outline the proportions of Transitioned ADF members who accessed a GP or MO for a mental health concern in the last 12 months, by category. The majority of visits for Ex-Serving ADF members (77.31%), Inactive Reservists (69.87%) and Active Reservists (63.44%) resulted in a referral to another service. The next most frequent outcome was provision of medicine (74.39%, 55.42% and 62.78%, respectively).

Table 6.3 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed each type of service from a GP or MO in the previous 12 months

	Transitioned ADF n = 4,616			2015 Regular ADF n = 7,868		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Referral	540	3387	73.37 (69.12, 77.22)	950	6603	83.92 (77.45, 88.81)
Information	329	2316	50.17 (45.70, 54.64)	496	3675	46.71 (36.17, 57.54)
Medicine	521	3161	68.48 (64.03, 72.62)	495	2770	35.21 (26.50, 45.02)
Other	47	329	7.12 (5.09, 9.88)	62	242	3.07 (2.13, 4.40)
CBT	199	1278	27.69 (23.84, 31.90)	273	1563	19.86 (13.13, 28.89)
Psychotherapy	112	753	16.31 (13.22, 19.97)	138	517	6.57 (5.00, 8.58)
Supportive counselling	319	1970	42.68 (38.34, 47.13)	514	3062	38.91 (29.38, 49.38)
Trauma-focused CBT or EMDR	126	767	16.62 (13.68, 20.03)	116	886	11.26 (5.65, 21.18)

Denominator: Those who were concerned about their mental health and sought assistance from a GP in last 12 months
Notes:
The totals correspond with the '< 12 months ago' categories in Table 6.1.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 6.1 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed each type of service from a GP or MO in the previous 12 months

Table 6.4 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed each type of service from a GP or MO in the previous 12 months and were satisfied with the service

	Transitioned ADF n = 4616			2015 Regular ADF n = 7868		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
CBT	106	630	49.28 (40.81, 57.79)	205	1269	81.18 (67.42, 89.99)
Information	230	1530	66.07 (59.31, 72.24)	380	2713	73.84 (55.87, 86.29)
Medicine	363	2115	66.89 (61.67, 71.73)	368	1968	71.04 (55.99, 82.55)
Other	32	231	70.39 (53.06, 83.33)	44	171	70.90 (54.35, 83.30)
Psychotherapy	66	394	52.25 (40.92, 63.36)	103	405	78.30 (70.28, 84.62)
Referral	414	2530	74.70 (69.83, 79.02)	727	5436	82.33 (74.88, 87.93)
Supportive counselling	215	1214	61.61 (54.70, 68.08)	386	2309	75.41 (61.50, 85.48)
Trauma-focused CBT or EMDR	69	392	51.15 (40.85, 61.35)	86	774	87.40 (73.71, 94.49)

Denominator: Those who were concerned with their mental health and sought assistance from a GP in the last 12 months. Each service has a denominator presented in Table 6.3.
Notes:
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 6.2 **Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed each type of service from a GP or MO in the previous 12 months and were satisfied with the service**

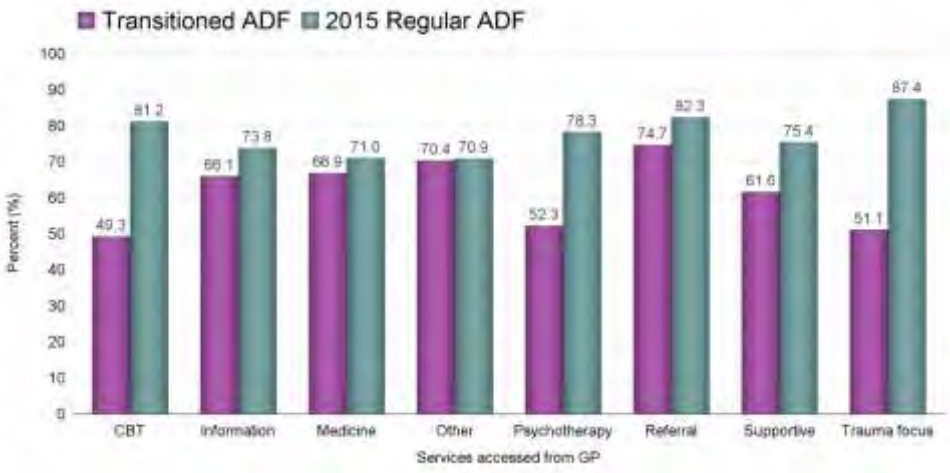
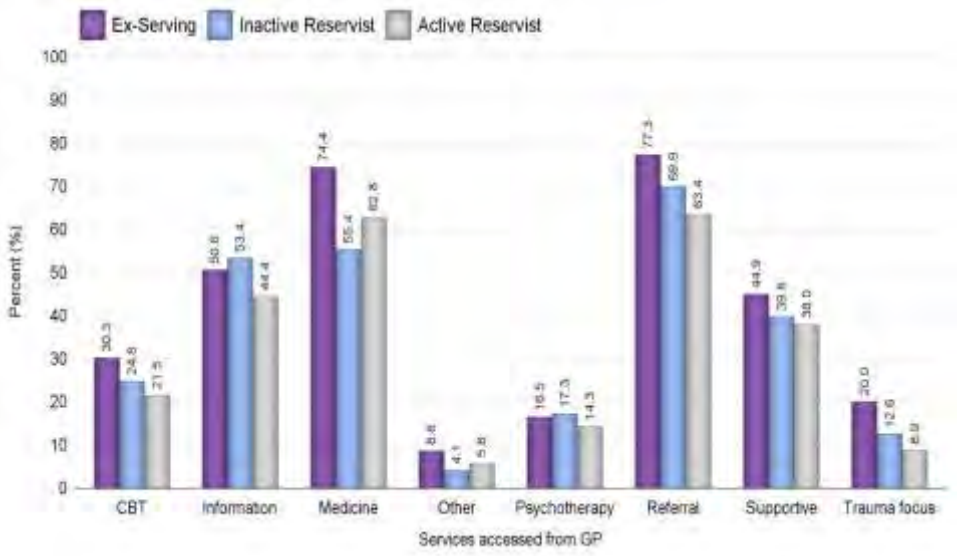


Table 6.5 Weighted estimate of Transitioned ADF members who accessed each type of service from a GP or MO in the previous 12 months

	Ex-Serving n = 2866			Inactive Reservists n = 1070			Active Reservists n = 656		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Referral	348	2216	77.31 (71.72, 82.07)	109	748	69.87 (60.48, 77.85)	81	416	63.44 (51.59, 73.86)
Information	209	1450	50.60 (44.76, 56.42)	74	571	53.36 (43.85, 62.62)	45	291	44.40 (33.27, 56.12)
Medicine	344	2132	74.39 (68.63, 79.42)	98	593	55.42 (45.48, 64.95)	75	412	62.78 (51.66, 72.70)
Other	34	247	8.63 (5.77, 12.72)	6	43	4.06 (1.60, 9.91)	7	38	5.81 (2.35, 13.65)
CBT	135	867	30.27 (25.22, 35.84)	35	265	24.78 (16.85, 34.88)	28	141	21.52 (13.81, 31.94)
Psychotherapy	72	474	16.52 (12.74, 21.16)	22	186	17.33 (10.52, 27.22)	18	94	14.32 (7.96, 24.41)
Supportive counselling	207	1287	44.92 (39.29, 50.68)	63	426	39.79 (30.65, 49.70)	47	249	37.97 (27.65, 49.50)
Trauma-focused CBT or EMDR	94	574	20.01 (15.93, 24.83)	20	135	12.64 (7.45, 20.63)	12	58	8.88 (4.72, 16.07)

Denominator: Those who were concerned with their mental health and sought assistance
Notes:
The totals correspond with the '< 12 months ago' categories in Table 6.2.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 6.3 Weighted estimate of Transitioned ADF members who accessed each type of service from a GP or MO in the previous 12 months



Satisfaction with services provided for the three transitioned groups has not been reported here due to small cell sizes.

6.3.2 Psychologist

Table 6.6 and Figure 6.4 describe proportions of Transitioned ADF and 2015 Regular ADF members who accessed a psychologist for help with a mental health concern in the last 12 months, by the services they received. The majority of visits for both Transitioned ADF (80.55%) and 2015 Regular ADF (85.67%) members resulted in supportive counselling. The next most frequent outcome was CBT for both Transitioned ADF (63.69%) and 2015 Regular ADF (63.91%) members. Then information provision was the next most frequent outcome for Transitioned ADF (55.86%) and 2015 Regular ADF (51.90%) members.

Table 6.7 and Figure 6.5 describe the proportions of Transitioned ADF and 2015 Regular ADF members who accessed a psychologist for help with a mental health concern in the last 12 months, by satisfaction with the services they received. Transitioned ADF members were most satisfied with referrals (72.62%) and information (68.56%). 2015 Regular ADF members were most satisfied with access to other services (89.92%), trauma-focused CBT or EMDR (85.46%) and medicine (85.26%).

Table 6.8 and Figure 6.6 describe the proportions of Transitioned ADF members who accessed a psychologist for a mental health concern in the last 12 months. The

majority of psychologist visits in the past 12 months resulted in supportive counselling for Ex-Serving ADF members (79.94%), Inactive Reservists (76.66%) and Active Reservists (87.82%). The next most frequent outcome was CBT for Ex-Serving ADF members (69.31%), Inactive Reservists (56.74%) and Active Reservists (51.56%).

Table 6.6 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed each type of service from a psychologist in the previous 12 months

	Transitioned ADF n = 3878			2015 Regular ADF n = 9148		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
CBT	410	2470	63.69 (59.04, 68.10)	720	5847	63.91 (55.02, 71.94)
Information	329	2166	55.86 (51.21, 60.41)	525	4748	51.90 (42.03, 61.61)
Medicine	92	626	16.13 (12.90, 19.99)	87	538	5.88 (3.03, 11.10)
Other	51	339	8.75 (6.37, 11.90)	71	502	5.49 (1.90, 14.79)
Psychotherapy	211	1287	33.18 (28.91, 37.74)	306	2181	23.84 (15.94, 34.07)
Referral	154	1070	27.60 (23.38, 32.26)	297	2850	31.15 (22.00, 42.06)
Supportive counselling	526	3124	80.55 (76.48, 84.06)	1054	7837	85.67 (80.26, 89.79)
Trauma-focused CBT or EMDR	242	1493	38.51 (34.03, 43.19)	268	2285	24.97 (16.71, 35.57)

Denominator: Those who were concerned with their mental health and sought assistance from a psychologist
Notes:
The totals correspond with the '< 12 months ago' categories in Table 6.1.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 6.4 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who received each type of service from a psychologist in the previous 12 months

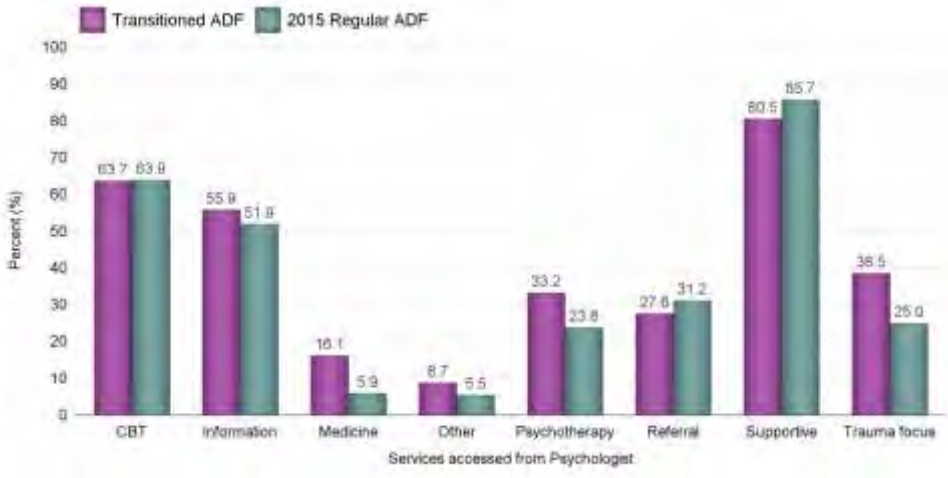


Table 6.7 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed each type of service from a psychologist in the previous 12 months and were satisfied with the service

	Transitioned ADF n = 3878			2015 Regular ADF n = 9148		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
CBT	265	1480	59.93 (54.06, 65.53)	572	4906	83.92 (72.49, 91.18)
Information	232	1485	68.56 (62.15, 74.33)	392	3892	81.99 (69.32, 90.17)
Medicine	56	394	62.93 (50.94, 73.51)	64	458	85.26 (69.46, 93.63)
Other	29	162	47.76 (32.33, 63.62)	53	451	89.92 (71.70, 96.92)
Psychotherapy	129	735	57.11 (48.90, 64.95)	235	1628	74.64 (49.31, 89.90)
Referral	114	777	72.62 (63.13, 80.42)	212	2415	84.74 (72.52, 92.12)
Supportive counselling	355	1953	62.53 (57.32, 67.48)	797	6226	79.44 (70.04, 86.47)
Trauma-focused CBT or EMDR	152	894	59.85 (52.15, 67.09)	199	1952	85.46 (74.34, 92.27)

Denominator: Those who were concerned with their mental health and sought assistance from a psychologist in the previous 12 months
Each service has a denominator presented in Table 6.6.
Notes:
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 6.5 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed each type of service from a psychologist in the previous 12 months and were satisfied with the service

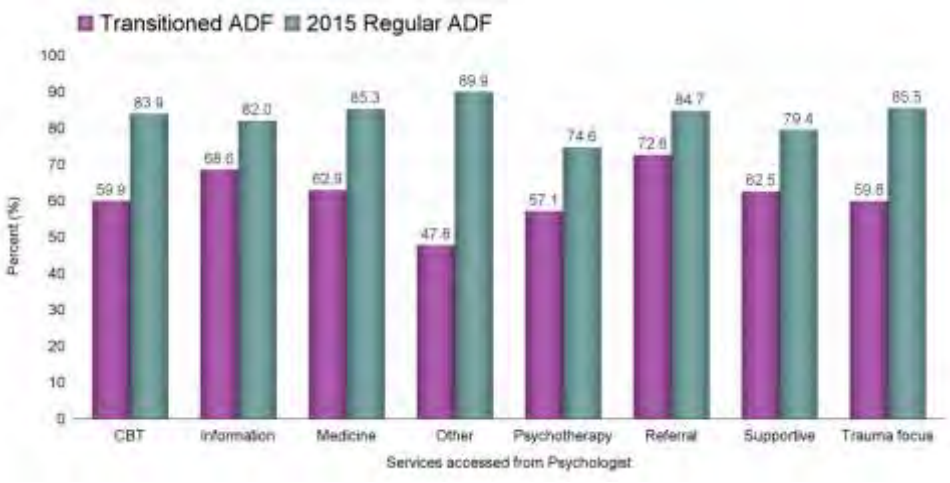
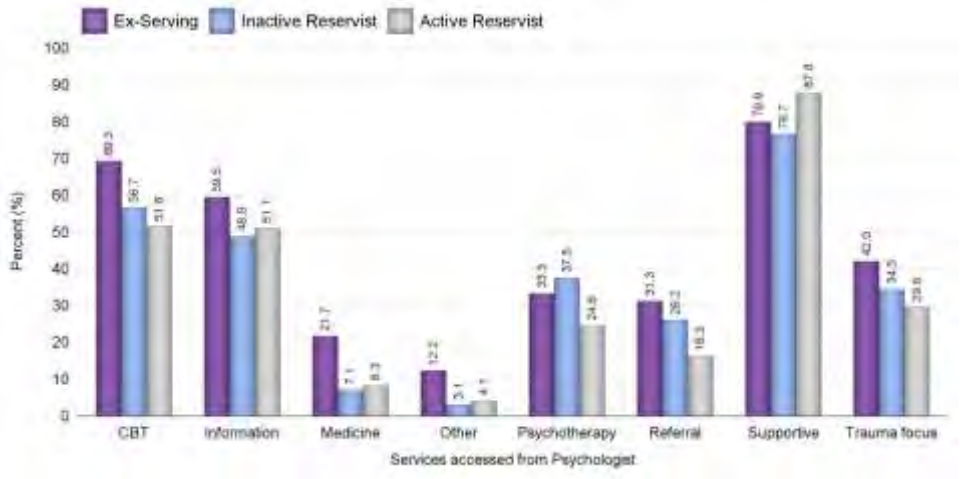


Table 6.8 Weighted estimate of Transitioned ADF members who accessed each type of service from a psychologist in the previous 12 months

	Ex-Serving n = 2327			Inactive Reservists n = 907			Active Reservists n = 623		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
CBT	270	1613	69.31 (63.33, 74.70)	75	515	56.74 (45.84, 67.03)	62	321	51.56 (40.27, 62.70)
Information	215	1384	59.46 (53.42, 65.23)	55	443	48.87 (38.23, 59.61)	56	318	51.05 (39.90, 62.10)
Medicine	73	505	21.70 (16.98, 27.29)	8	65	7.12 (2.93, 16.28)	10	52	8.32 (4.06, 16.30)
Other	39	285	12.25 (8.56, 17.23)	5	29	3.14 (1.10, 8.68)	7	26	4.14 (2.01, 8.32)
Psychotherapy	134	775	33.33 (27.98, 39.14)	43	340	37.53 (27.32, 48.99)	32	153	24.56 (17.02, 34.06)
Referral	112	727	31.25 (25.81, 37.27)	23	237	26.18 (16.81, 38.37)	18	101	16.26 (8.88, 27.91)
Supportive counselling	317	1860	79.94 (74.31, 84.59)	104	695	76.66 (66.32, 84.56)	102	547	87.82 (81.47, 92.20)
Trauma-focused CBT or EMDR	169	978	42.05 (36.22, 48.11)	38	313	34.47 (24.70, 45.74)	33	185	29.63 (20.02, 41.47)

Denominator: Those who were concerned with their mental health and sought assistance from a psychologist
Notes:
Totals correspond with the '< 12 months ago' categories in Table 6.2.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 6.6 Weighted estimate of Transitioned ADF members who accessed each type of service from a psychologist in the previous 12 months



Satisfaction with psychologists' services for the three transitioned groups has not been reported here due to small cell sizes.

6.3.3 Psychiatrists

Table 6.9 and Figure 6.7 describe the proportions of Transitioned ADF and 2015 Regular ADF members who accessed a psychiatrist for a mental health concern in the last 12 months, by the services they received. The majority of visits for both Transitioned ADF (77.86%) and 2015 Regular ADF (54.52%) members resulted in medicine being prescribed. The next most frequent outcome for Transitioned ADF members was receiving supportive counselling (63.39%) and for 2015 Regular ADF members was receiving information provision (53.84%).

Table 6.9 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who received each type of service from a psychiatrist in the previous 12 months

	Transitioned ADF n = 2818			2015 Regular ADF n = 3201		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
CBT	201	1156	41.04 (35.86, 46.44)	139	1061	33.14 (18.23, 52.43)
Information	272	1693	60.09 (54.72, 65.22)	252	1724	53.84 (37.13, 69.74)
Medicine	376	2194	77.86 (72.81, 82.20)	270	1745	54.52 (37.74, 70.33)
Other	68	419	14.88 (11.38, 19.23)	55	390	12.17 (4.82, 27.51)
Psychotherapy	125	723	25.65 (21.31, 30.53)	98	657	20.54 (9.44, 39.05)
Supportive counselling	295	1786	63.39 (58.07, 68.41)	237	1441	45.03 (29.22, 61.91)
Trauma-focused CBT or EMDR	180	1019	36.16 (31.20, 41.43)	89	869	27.15 (12.85, 48.52)

Denominator: Those who were concerned with their mental health and sought assistance from a psychiatrist
Notes:
The totals correspond with the '< 12 months ago' categories in Table 6.1.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 6.7 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed each type of service from a psychiatrist in the previous 12 months

Table 6.10 and Figure 6.8 describe the proportions of Transitioned ADF and 2015 Regular ADF members who accessed a psychiatrist for a mental health concern in the last 12 months, by satisfaction with the services they received. Transitioned ADF members were most satisfied with information provision (69.52%), medicine prescribing (66.69%) and CBT (63.04%). The services that 2015 Regular ADF were most satisfied with included information provision (85.24%), medicine prescribing (78.32%) and supportive counselling (66.80%). Caution is recommended in interpreting findings here relating particularly to CBT, trauma-focused CBT or EMDR, and psychotherapy due to the width of the confidence intervals.

Table 6.10 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed each type of service from a psychiatrist in the previous 12 months and were satisfied with the service

	Transitioned ADF n = 2818			2015 Regular ADF n = 3201		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
CBT	136	729	63.04 (54.69, 70.68)	106	653	61.54 (24.97, 88.49)
Information	197	1177	69.52 (62.35, 75.84)	195	1469	85.24 (75.58, 91.51)
Medicine	259	1463	66.69 (60.63, 72.25)	200	1367	78.32 (60.14, 89.64)
Other	43	241	57.52 (42.86, 70.98)	29	100	25.58 (8.40, 56.29)
Psychotherapy	80	418	57.77 (47.17, 67.71)	75	280	42.66 (14.95, 75.89)
Supportive	201	1082	60.60 (53.37, 67.40)	185	963	66.80 (36.11, 87.75)
Trauma-focused CBT or EMDR	120	615	60.36 (51.29, 68.78)	63	501	57.65 (17.95, 89.44)

Denominator: Those who were concerned with their mental health and sought assistance from a psychiatrist in the previous 12 months
Each service has a denominator presented in Table 6.9.
Notes:
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 6.8 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed each type of service from a psychiatrist in the previous 12 months and were satisfied with the service

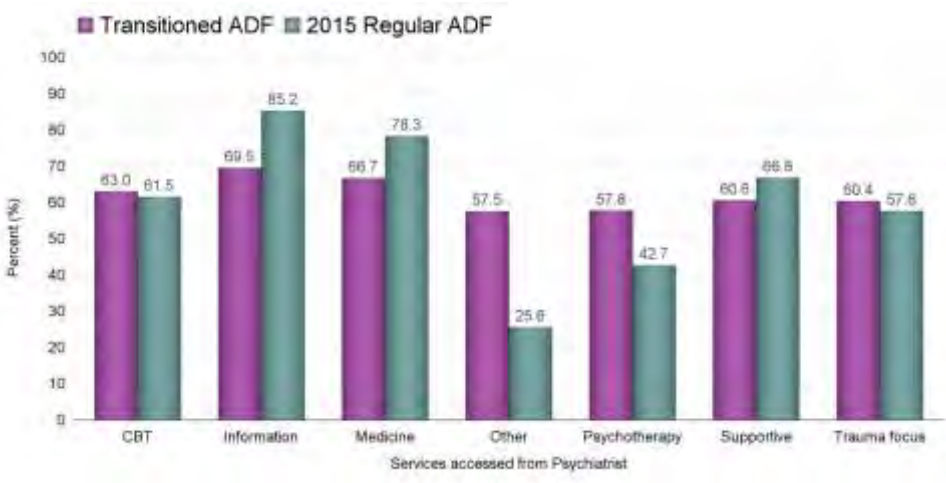


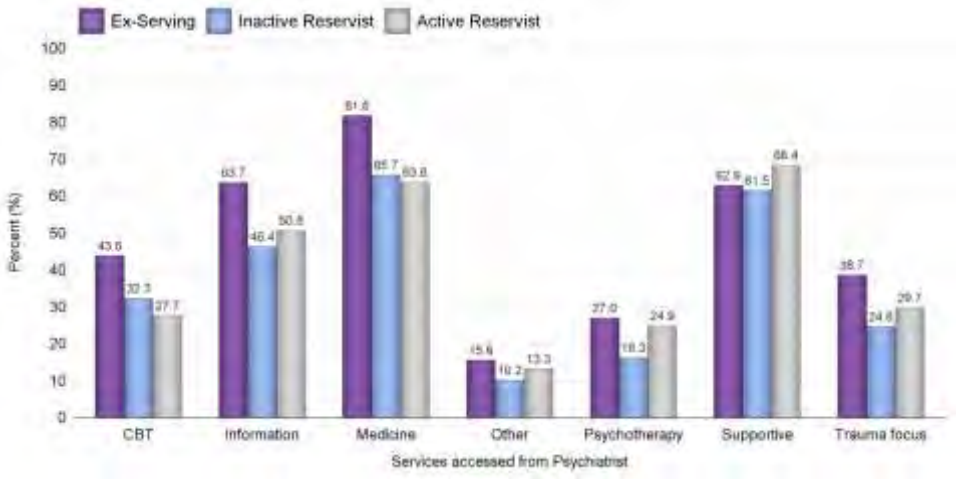
Table 6.11 and Figure 6.9 present the proportions of Transitioned ADF who accessed a psychiatrist for a mental health concern in the last 12 months by the services they received. The psychiatrist services that Transitioned ADF accessed most included: for Ex-Serving, medicine prescribing (81.81%), information provision (63.68%) and supportive counselling (62.89%). Inactive Reservists were most satisfied with medicine provision (65.72%), supportive counselling (61.52%) and information provision (46.38%). For Active Reservists, the highest satisfaction occurred with supportive counselling (68.40%), medicine provision (63.79%) and information provision (50.76%).

Table 6.11 Weighted estimate of Transitioned ADF members who accessed each type of service from a psychiatrist in the previous 12 months

	Ex-Serving n = 2109			Inactive Reservists n = 456			Active Reservists n = 232		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
CBT	154	924	43.81 (37.58, 50.24)	28	147	32.31 (21.04, 46.08)	16	64	27.74 (16.61, 42.53)
Information	209	1343	63.68 (57.52, 69.42)	32	211	46.38 (32.39, 60.97)	28	118	50.76 (33.74, 67.61)
Medicine	295	1726	81.81 (76.12, 86.39)	48	299	65.72 (49.98, 78.63)	30	148	63.79 (45.44, 78.84)
Other	52	328	15.57 (11.36, 20.98)	6	47	10.21 (4.18, 22.87)	9	31	13.32 (7.01, 23.86)
Psychotherapy	94	570	27.02 (21.80, 32.96)	14	74	16.34 (8.44, 29.28)	14	58	24.90 (14.53, 39.26)
Supportive	218	1327	62.89 (56.56, 68.80)	45	280	61.52 (46.52, 74.62)	29	159	68.40 (53.03, 80.58)
Trauma-focused CBT or EMDR	139	816	38.70 (32.72, 45.04)	23	113	24.76 (15.15, 37.75)	15	69	29.74 (17.19, 46.34)

Denominator: Those who were concerned with their mental health and sought assistance from a psychiatrist
Notes:
The totals correspond with the '< 12 months ago' categories in Table 6.2.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 6.9 Weighted estimate of Transitioned ADF members who accessed each type of service from a psychiatrist in the previous 12 months



Satisfaction with psychiatrists' services for the three transitioned groups has not been reported here due to small cell sizes.

6.3.4 Other mental health professional

This section describes the proportions of Transitioned ADF and 2015 Regular ADF members who accessed another type of mental health professional for a mental health concern in the last 12 months by the services they received. Other mental health professional included social worker, occupational therapist, or mental health nurse, as described in Table 6.12 and Figure 6.10. The majority of visits for both Transitioned ADF (68.96%) and 2015 Regular ADF (62.56%) members resulted in supportive counselling. The next most frequent outcome was information provision for Transitioned ADF (59.88%) and 2015 Regular ADF (39.24%). CBT was next most frequent for Transitioned ADF (35.59%) and 2015 Regular ADF (24.40%).

Table 6.12 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed each type of service from another mental health professional in the previous 12 months

	Transitioned ADF n = 1177			2015 Regular ADF n = 2058		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
CBT	69	419	35.59 (27.92, 44.06)	95	502	24.40 (12.21, 42.82)
Information	107	705	59.88 (51.71, 67.54)	172	808	39.24 (24.80, 55.86)
Other	49	294	24.95 (18.39, 32.90)	62	407	19.79 (8.38, 39.95)
Psychotherapy	37	280	23.76 (16.86, 32.39)	44	289	14.03 (6.00, 29.43)
Supportive counselling	128	811	68.96 (60.82, 76.07)	242	1287	62.56 (44.74, 77.52)
Trauma-focused CBT or EMDR	53	351	29.87 (22.58, 38.35)	27	99	4.83 (2.80, 8.22)

Denominator: Those who were concerned with their mental health and sought assistance from other mental health professionals
Notes:
The totals correspond with the '< 12 months ago' categories in Table 6.1.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 6.10 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed each type of service from another mental health professional in the previous 12 months

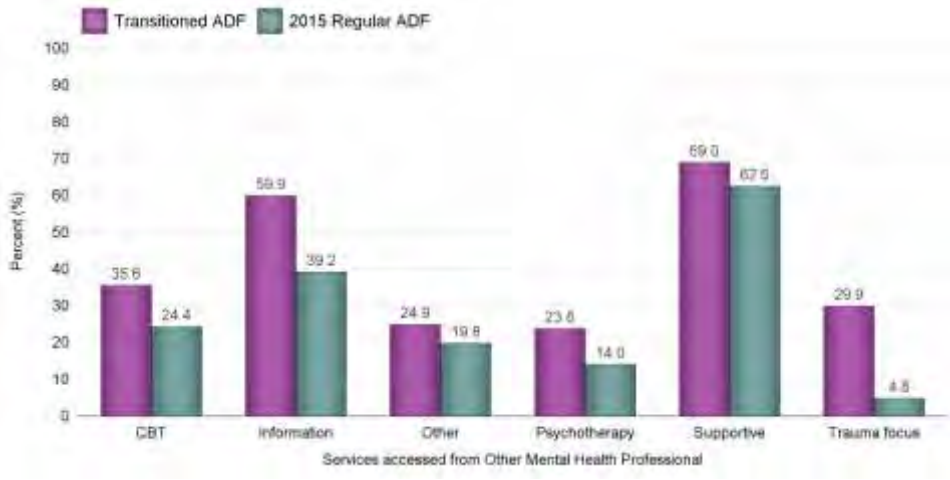


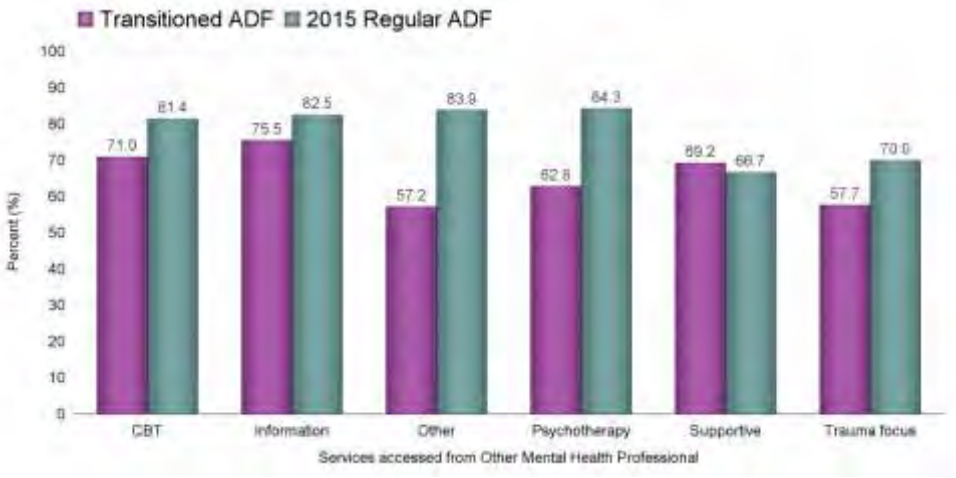
Table 6.13 and Figure 6.11 describe the proportions of Transitioned ADF and 2015 Regular ADF who accessed another mental health professional for a mental health concern in the last 12 months, by satisfaction with the services they received. The services that the Transitioned ADF members were most satisfied with were information provision (75.52%), CBT (70.95%) and supportive counselling (69.23%). The services 2015 Regular ADF members were most satisfied with were psychotherapy (84.31%), other services (83.87%) and information provision (82.54%).

Table 6.13 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed each type of service from other mental health professionals in the previous 12 months, and were satisfied with the service

	Transitioned ADF n = 2818			2015 Regular ADF n = 3201		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
CBT	46	297	70.95 (56.95, 81.85)	70	409	81.45 (61.47, 92.35)
Information	78	532	75.52 (65.08, 83.62)	133	667	82.54 (70.81, 90.21)
Other	31	168	57.23 (40.14, 72.75)	53	342	83.87 (55.11, 95.66)
Psychotherapy	26	176	62.85 (42.08, 79.75)	29	243	84.31 (62.95, 94.44)
Supportive counselling	95	562	69.23 (58.29, 78.36)	181	859	66.72 (42.76, 84.33)
Trauma-focused CBT or EMDR	32	203	57.69 (41.22, 72.60)	15	70	69.98 (52.11, 83.31)

Denominator: Those who were concerned with their mental health and sought assistance from other mental health professionals in the previous 12 months. Each service has a denominator presented in Table 6.12.
Notes:
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 6.11 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed each type of service from other mental health professionals in the previous 12 months, and were satisfied with the service



Services from other mental health professionals for the three Transitioned groups have not been reported here due to small cell sizes.

6.3.5 Other mental health services

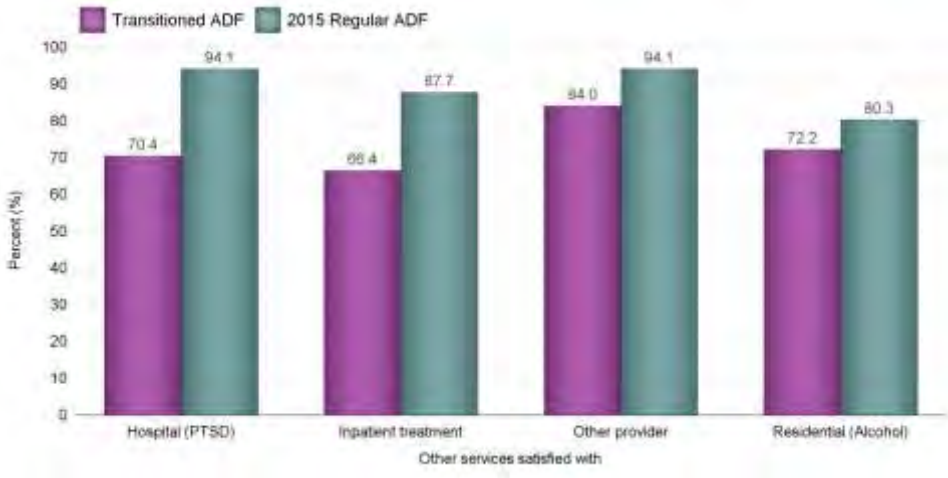
Table 6.1 (earlier in this chapter) describe the proportions of Transitioned ADF and 2015 Regular ADF members who accessed another mental health service for a mental health concern in the last 12 months, by service used. Table 6.14 and Figure 6.12 address satisfaction with these services. The services that Transitioned ADF (84.04%) and 2015 Regular ADF (94.14%) members were most likely to be satisfied with included a counsellor, complementary or alternative therapist (herbalist or naturopath) or a life coach;, for 2015 Regular ADF (94.09%), hospital-based PTSD programs.

Table 6.14 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who were satisfied by each type of other mental health service received in the previous 12 months

	Transitioned ADF n = 1177			2015 Regular ADF n = 2058		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Inpatient hospital admission	89	457	66.42 (55.01, 76.18)	99	561	87.66 (75.38, 94.28)
Hospital-based PTSD program	40	186	70.39 (52.78, 83.49)	29	380	94.09 (73.70, 98.91)
Residential alcohol or other drug program	19	112	72.17 (44.87, 89.21)	24	102	80.31 (55.13, 93.13)
Other provider	114	622	84.04 (73.77, 90.79)	157	969	94.14 (88.34, 97.15)

Denominator: Those who were concerned with their mental health and sought assistance from categories listed
Notes:
The totals (the denominator for each category) correspond to the '< 12 months ago' categories in Table 6.1.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 6.12 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who were satisfied by each type of other mental health service in the previous 12 months



Satisfaction with other mental health services for the three transitioned groups has not been reported here due to small cell sizes.

6.3.6 Satisfaction with service factors

Overall, Table 6.15 and Figure 6.13 show the proportions of Transitioned ADF and 2015 Regular ADF who reported receiving assistance for a mental health problem from a mental health professional ever, by satisfaction with different factors across the services received, and by probable 30-day disorder. Research indicates that ratings for those with a probable disorder may be different.

In the Transitioned ADF, respondents were most likely to rate friendliness as the service factor they were most satisfied with (71.55%). Respondents with a probable 30-day disorder rated confidentiality as the factor they were most satisfied with (61.92%).

In the 2015, Regular ADF respondents were also most likely to rate friendliness as the service factor they were most satisfied with (90.85%). Respondents who had a probable 30-day disorder rated location highest (71.29%).

Table 6.16 shows the overall proportions of Transitioned ADF and 2015 Regular ADF members by category who reported receiving assistance for a mental health problem from a mental health professional ever, by satisfaction with different factors, and by probable 30-day disorder.

In the Transitioned ADF, Ex-Serving respondents were most likely (64.41%) to rate friendliness as the service factor they were most satisfied with, as were Active Reservists (85.59%). Inactive Reservists were most likely (73.00%) to rate confidentiality as the factor they were most satisfied with.

Table 6.15 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who reported receiving assistance for a mental health problem from a mental health professional in the last 12 months, by satisfaction with different factors, stratified by probable 30-day disorder

	Transitioned ADF n = 2199			2015 Regular ADF n = 6183		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Accessibility						
All	224	1412	64.22 (57.65, 70.31)	645	5192	83.98 (77.42, 88.90)
Probable 30-day disorder	58	396	52.11 (41.18, 62.84)	74	381	63.52 (51.35, 74.18)
No probable 30-day disorder	166	1016	70.63 (62.49, 77.63)	571	4811	86.17 (79.14, 91.10)
Cost						
All	103	663	44.95 (36.82, 53.35)	207	1770	69.72 (52.01, 83.04)
Probable 30-day disorder	28	205	41.44 (28.32, 55.90)	21	89	43.71 (24.71, 64.75)
No probable 30-day disorder	75	458	46.72 (36.63, 57.08)	186	1681	71.99 (52.53, 85.65)
Location						
All	207	1342	61.02 (54.47, 67.20)	643	5398	87.31 (83.36, 90.44)
Probable 30-day disorder	50	354	46.50 (35.77, 57.56)	79	427	71.29 (59.04, 81.05)
No probable 30-day disorder	157	988	68.70 (60.56, 75.83)	564	4971	89.03 (85.23, 91.95)
Effectiveness						
All	178	1056	48.02 (41.48, 54.62)	569	4765	77.06 (68.85, 83.63)
Probable 30-day disorder	32	240	31.53 (21.87, 43.09)	56	291	48.64 (37.34, 60.07)
No probable 30-day disorder	146	816	56.74 (48.21, 64.88)	513	4473	80.11 (71.25, 86.75)
Competence						
All	219	1369	62.27 (55.70, 68.42)	635	5296	85.65 (81.23, 89.17)
Probable 30-day disorder	50	334	43.95 (33.39, 55.08)	71	367	61.23 (49.01, 72.19)
No probable 30-day disorder	169	1035	71.96 (63.82, 78.88)	564	4929	88.27 (84.17, 91.42)
Friendliness						
All	258	1573	71.55 (65.06, 77.26)	704	5617	90.85 (87.57, 93.33)
Probable 30-day disorder	70	445	58.48 (47.32, 68.84)	85	420	70.14 (57.26, 80.46)
No probable 30-day disorder	188	1128	78.46 (70.41, 84.79)	619	5197	93.07 (90.27, 95.11)
Convenience						
All	193	1148	52.21 (45.55, 58.80)	620	5184	83.85 (78.62, 88.00)
Probable 30-day disorder	49	326	42.86 (32.43, 53.98)	72	349	58.28 (46.15, 69.48)
No probable 30-day disorder	144	822	57.16 (48.64, 65.27)	548	4835	86.60 (81.47, 90.47)
Confidentiality						
All	248	1546	70.33 (63.92, 76.03)	656	4817	77.91 (67.47, 85.72)

	Transitioned ADF n = 2199			2015 Regular ADF n = 6183		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Probable 30-day disorder	72	471	61.92 (50.90, 71.84)	75	369	61.67 (49.26, 72.72)
No probable 30-day disorder	176	1075	74.78 (66.70, 81.43)	581	4448	79.66 (67.90, 87.88)
Medicare cap						
All	36	274	25.91 (17.90, 35.93)	50	331	27.73 (11.09, 54.13)
Other						
All	11	81	6.6 (3.41, 12.36)	19	69	4.00 (1.98, 7.90)

Denominator: Those who were concerned about their mental health and sought assistance in the last 12 months
Notes:
Numbers in the table refer to those who were satisfied (answered 'satisfied' or 'very satisfied').
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval
For Cost, Medicare and Other, percentages have been derived by removing those who endorsed the N/A category. Denominators for these categories are:

- Cost: Transitioned ADF n = 1476 (496 with probable 30-day disorder; 980 without probable 30-day disorder); 2015 Regular ADF n = 2538 (203 with probable 30-day disorder; 2335 without probable 30-day disorder)
- Medicare: Transitioned ADF n = 1056 and 2015 Regular ADF n = 1195
- Other: Transitioned ADF n = 1226 and 2015 Regular ADF n = 1718

Figure 6.13 **Weighted estimate of Transitioned ADF and 2015 Regular ADF members who reported receiving assistance for a mental health problem from a mental health professional in the past 12 months, by satisfaction with different factors, stratified by probable 30-day disorder**

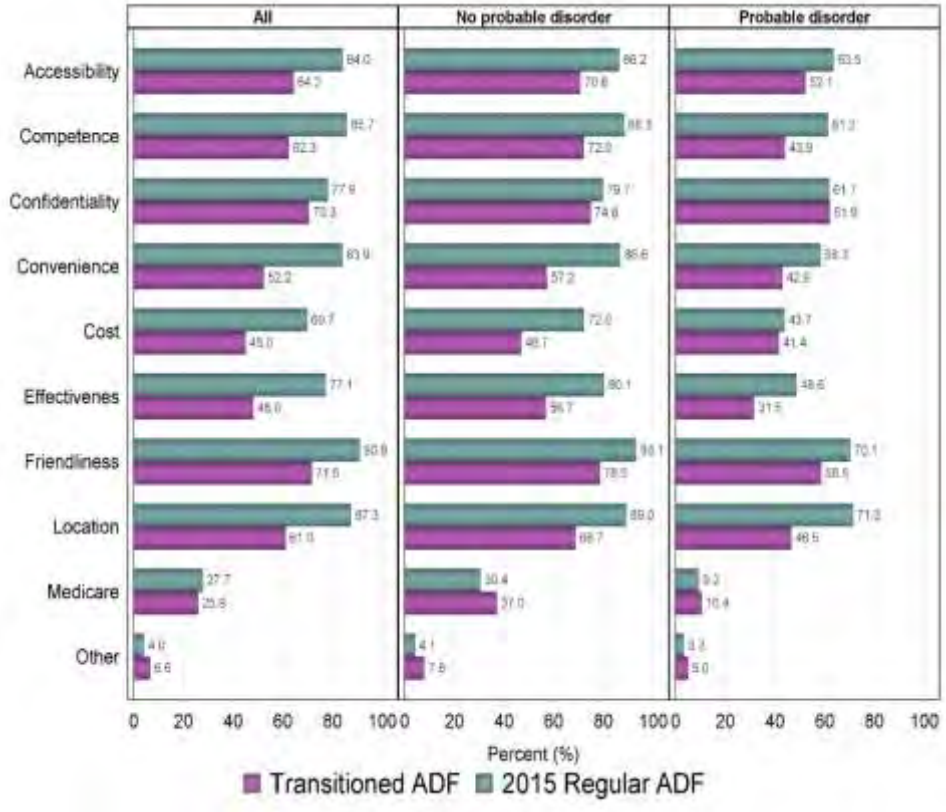


Table 6.16 Weighted estimate of Transitioned ADF members who reported receiving assistance for a mental health problem from a mental health professional ever, by satisfaction with different factors

	Ex-Serving n = 1033			Inactive Reservists n = 630			Active Reservists n = 531		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Accessibility	88	637	61.65 (51.41, 70.95)	61	384	60.92 (47.48, 72.89)	74	387	72.90 (61.19, 82.11)
Cost	40	306	29.58 (20.88, 40.08)	27	180	28.48 (18.08, 41.80)	36	178	33.52 (23.07, 45.88)
Location	80	579	56.02 (45.79, 65.77)	59	394	62.44 (49.26, 74.01)	67	366	68.80 (57.16, 78.46)
Effectiveness	61	352	34.06 (25.47, 43.84)	52	362	57.49 (44.45, 69.56)	64	338	63.56 (51.03, 74.48)
Competence	82	555	53.75 (43.57, 63.63)	60	404	64.06 (50.84, 75.44)	76	406	76.47 (64.97, 85.07)
Friendliness	98	665	64.41 (54.18, 73.47)	71	449	71.25 (57.67, 81.85)	88	455	85.59 (73.53, 92.70)
Convenience	72	437	42.28 (32.84, 52.31)	56	370	58.76 (45.60, 70.78)	64	337	63.44 (50.92, 74.37)
Confidentiality	96	662	64.07 (53.86, 73.15)	71	460	73.00 (59.78, 83.11)	80	420	79.12 (67.50, 87.36)
Services by Medicare	12	89	8.63 (4.13, 17.16)	10	65	10.32 (4.60, 21.55)	14	119	22.47 (12.36, 37.33)

Denominator: Those who were concerned about their mental health and sought assistance in the last 12 months
Notes:
Numbers in the table refer to those who were satisfied (answered 'satisfied' or 'very satisfied').
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

7 Funding for professional mental health services in the last 12 months

Key findings

Funding

- For 2015 Regular ADF, 93.0% reported receiving Medical Officer (MO) or General Practitioner (GP) services funded by Defence and 10.8% reported receiving these services funded through DVA.
- For Transitioned ADF, 57.1% reported receiving GP or MO services funded by DVA, followed by Medicare-funded (40.6%), self-funded (22.1%) and Defence-funded (14.9%) care.
- This pattern varied within Transitioned groups, with 68.8% Ex-Serving, but only 37% Inactive and Active Reservists, reporting receiving GP/MO services funded by DVA.
- Within 2015 Regular ADF, 85.9% reported receiving psychology services funded by Defence, followed by Veterans and Veterans Families Counselling Service (VVCS) (17.1% with an additional 5.1% of Defence-funded VVCS services).
- For Transitioned ADF, 47.4% reported receiving psychology services funded by DVA, followed by VVCS self-referral (25.8% with an additional 5.9% of Defence-funded VVCS services) and Medicare (20.8%).
- This pattern varied within Transitioned groups: 59.9% of Ex-Serving ADF but only 29% of Inactive Reservists and 26% of Active Reservists reported receiving psychology services funded by DVA.
- 89.2% of 2015 Regular ADF members reported receiving psychiatry services funded by Defence and 12.1% reported receiving these services funded through DVA.
- 76.5% of Transitioned ADF members reported receiving psychiatry services funded by DVA, followed by services funded by Defence (18.7%) and Medicare (15.8%).
- This pattern varied within Transitioned groups, with 81.8% of Ex-Serving members but only 60.2% and 60.4% Inactive and Active Reservists, respectively, reporting receiving psychiatry services funded by DVA. By contrast, 26.6% of Inactive Reservists and 25.4% of Active Reservists reported receiving psychiatry services funded by Medicare, compared to 12.5% of Ex-Serving ADF.

Glossary: refer to the Glossary of terms for definitions of key terms in this section.

7.1 Introduction

This section describes the types of doctors and other professionals from whom the Transitioned ADF and 2015 Regular ADF members sought or received help for their mental health in the past 12 months, and how each of these consultations was funded. It also provides detailed information about this funding.

Survey items used in this section were developed by study investigators who have specific knowledge and experience in the field. Specific questions on the types of doctors and other professionals consulted were derived from the World Mental Health Survey Initiative Version of the World Health Organization Composite International Diagnostic Interview – version 3 (CIDI) (Haro et al., 2006) Help-Seeking Section, which was used in the 2007 National Survey of Mental Health and Wellbeing (NSMHW).

7.1.1 Funding for mental health services

Participants who sought and/or received help from a health professional or service in the last 12 months were asked how the service was paid for from the following options, depending on the health professional:

- Medicare
- DVA
- Defence
- VVCS self-referral (psychologist and other mental health professional only)
- VVCS Defence referral (psychologist and other mental health professional only)
- Private health fund
- Fully self-funded
- Other (such as WorkCover)
- Don't know.

It is worth noting that this question relies on participants correctly knowing who funded the service/professional they accessed, which could be a limitation to the interpretation of this data. In addition, service costs can be attributed to multiple sources, which could also be a limitation to the interpretation of this data.

7.1.2 Key questions addressed in this chapter

This chapter examines the question: *Do Transitioned ADF and 2015 Regular ADF members differ in the mental health services that they reported receiving funding for?*

7.2 Self-reported mental health service use and funding among Transitioned ADF and 2015 Regular ADF members

7.2.1 GP or MO

The funding arrangements for Transitioned ADF and 2015 Regular ADF members to visit a GP or MO for a mental health problem are outlined in Table 7.1 and Figure 7.1.

Table 7.2 and Figure 7.2 describe the funding arrangements for a visit to a GP or MO for a mental health problem for Transitioned ADF members, by category of Ex-Serving ADF members, Inactive Reservists and Active Reservists. Within the Ex-Serving ADF, DVA funded 68.83% of GP or MO visits. Within the Inactive Reservists and the Active Reservists, the majority of visits were funded by Medicare (58.06% and 47.49%).

Table 7.1 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed a GP or MO in the previous 12 months, by funding source

	Transitioned ADF n = 4616			2015 Regular ADF n = 7868		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Medicare	271	1872	40.55 (36.19, 45.07)	25	78	0.99 (0.63, 1.55)
DVA	452	2638	57.14 (52.64, 61.52)	104	847	10.76 (5.10, 21.29)
Defence	118	688	14.90 (12.04, 18.29)	1116	7316	92.99 (82.85, 97.33)
Fully self-funded	135	1021	22.13 (18.43, 26.33)	49	160	2.03 (1.42, 2.90)
Other – incl. WorkCover	31	192	4.17 (2.73, 6.30)	9	33	0.42 (0.21, 0.82)
Don't know	23	144	3.13 (1.94, 4.99)	15	82	1.04 (0.53, 2.03)

Denominator: Those who were concerned with their mental health and sought assistance from a GP
Notes:
Totals correspond with the '< 12 months ago' categories in Table 6.1.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 7.1 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who consulted a GP or MO in the previous 12 months, by funding source

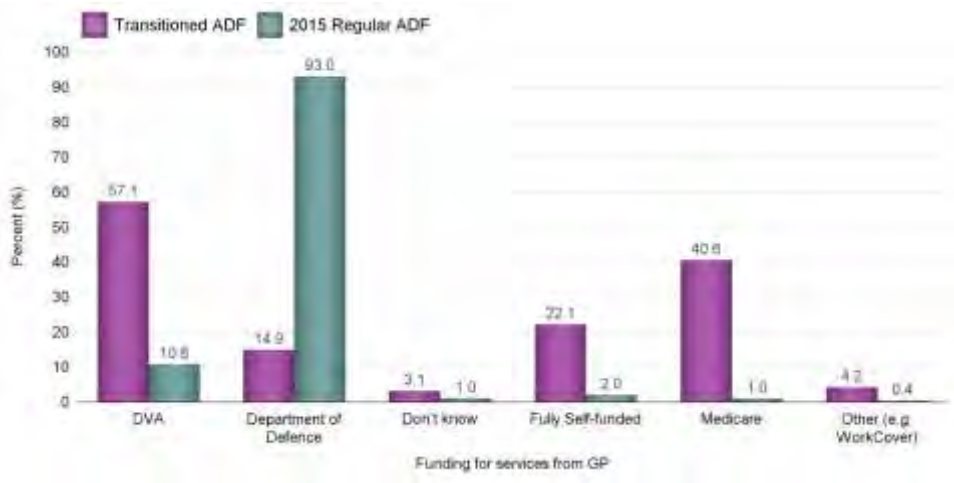
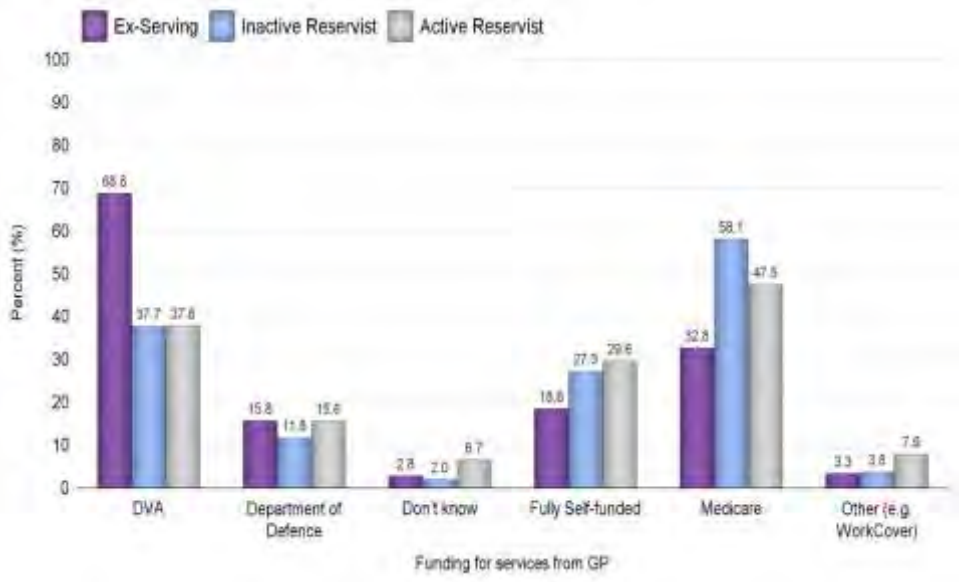


Table 7.2 Weighted estimate of Transitioned ADF members who accessed a GP or MO in the previous 12 months, by funding source

	Ex-Serving n = 2866			Inactive Reservists n = 1070			Active Reservists n = 656		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Medicare	132	939	32.77 (27.46, 38.56)	84	621	58.06 (48.51, 67.03)	55	312	47.49 (36.48, 58.76)
DVA	335	1972	68.83 (62.78, 74.29)	64	404	37.71 (28.80, 47.55)	52	248	37.84 (27.91, 48.90)
Defence	72	452	15.76 (11.95, 20.50)	22	126	11.80 (7.12, 18.93)	22	102	15.62 (9.15, 25.39)
Fully self-funded	57	532	18.56 (13.98, 24.20)	40	292	27.29 (19.38, 36.95)	37	194	29.57 (20.39, 40.77)
Other – incl. WorkCover	15	96	3.35 (1.79, 6.19)	7	40	3.77 (1.62, 8.52)	8	52	7.89 (3.22, 18.06)
Don't know	11	79	2.76 (1.40, 5.35)	5	22	2.01 (0.86, 4.61)	7	44	6.66 (2.56, 16.22)

Denominator: Those who were concerned with their mental health and sought assistance from a GP in the previous 12 months
Each service has a denominator presented in Table 6.3.
Notes:
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 7.2 Weighted estimate of Transitioned ADF members who accessed a GP or MO in the previous 12 months, by funding source



7.2.2 Psychologist

Table 7.3 and Figure 7.3 outline the funding arrangements for Transitioned ADF and 2015 Regular ADF members visiting a psychologist for help with a mental health problem. Within the 2015 Regular ADF, Defence funded 85.92% of psychologist visits, but 17.05% were conducted under VVCS self-referral and 1.21% were fully self-funded. Within the Transitioned ADF, funding was most commonly provided by DVA (47.42%), and the second most common funding arrangement was VVCS self-referral (25.84%).

Table 7.4 and Figure 7.4 describe funding arrangements for Transitioned ADF members visiting a psychologist for a mental health problem, by category of Ex-Serving ADF member, Inactive Reservist and Active Reservist. Within the Ex-Serving ADF, the DVA funded 59.89% of psychologist visits. Within the Inactive Reservists, the largest category was Medicare-funded (30.18%), and the largest category for Active Reservists was VVCS self-referral (33.31%).

Table 7.3 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed a psychologist in the previous 12 months, by funding source

	Transitioned ADF n = 3878			2015 Regular ADF n = 9148		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Medicare	128	808	20.82 (17.26, 24.90)	17	56	0.61 (0.35, 1.06)
DVA	319	1839	47.42 (42.80, 52.08)	49	427	4.66 (1.34, 14.94)
Defence	106	600	15.47 (12.43, 19.08)	1096	7861	85.92 (78.93, 90.87)
Fully self-funded	79	503	12.97 (10.03, 16.61)	32	111	1.21 (0.79, 1.85)
Other – incl. WorkCover	31	164	4.22 (2.76, 6.42)	7	18	0.19 (0.11, 0.35)
Private health fund	32	155	4.00 (2.67, 5.95)	*		
VVCS self-referral	175	1002	25.84 (22.00, 30.11)	248	1560	17.05 (11.13, 25.23)
VVCS Defence referral	39	228	5.87 (4.16, 8.21)	92	462	5.05 (3.40, 7.46)
Don't know	8	50	1.28 (0.58, 2.79)	12	34	0.38 (0.23, 0.63)

Denominator: Those who were concerned with their mental health and sought assistance from a psychologist
Notes:
Totals correspond with the '< 12 months ago' categories in Table 6.1.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval
* Cell sizes less than 5

Figure 7.3 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed a psychologist in the previous 12 months, by funding source

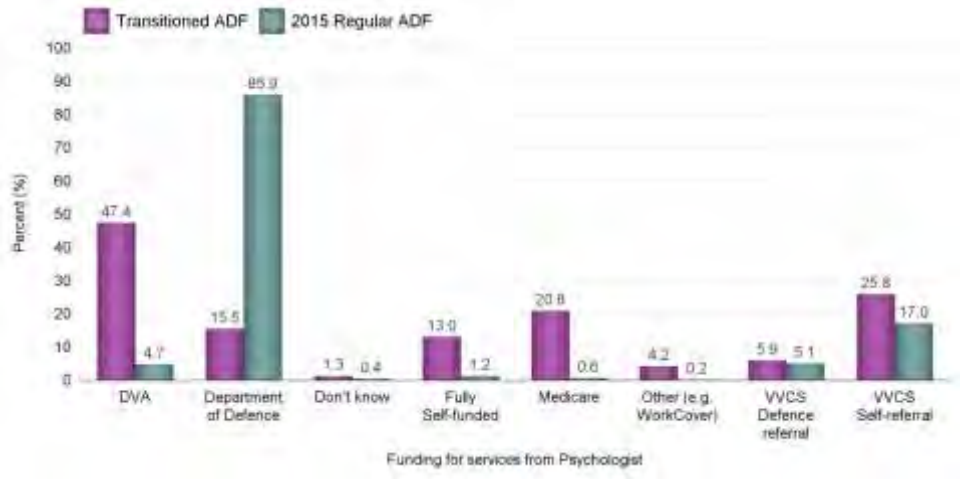


Table 7.4 Weighted estimate of Transitioned ADF members who accessed a psychologist in the previous 12 months, by funding source

	Ex-Serving n = 2327			Inactive Reservists n = 907			Active Reservists n = 623		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Medicare	61	400	17.19 (13.07, 22.29)	40	274	30.18 (21.17, 41.03)	27	134	21.49 (14.37, 30.85)
DVA	246	1394	59.89 (53.68, 65.80)	39	263	29.03 (20.30, 39.65)	31	161	25.79 (17.02, 37.05)
Defence	66	416	17.87 (13.53, 23.22)	16	97	10.70 (5.82, 18.86)	23	83	13.27 (8.81, 19.50)
Fully self-funded	31	219	9.40 (6.22, 13.96)	27	173	19.08 (11.93, 29.09)	21	111	17.86 (10.57, 28.55)
Other – incl. WorkCover	15	58	2.48 (1.51, 4.05)	6	45	4.95 (1.77, 13.06)	10	61	9.82 (4.47, 20.22)
Private health fund	18	99	4.27 (2.38, 7.55)	6	26	2.91 (1.29, 6.43)	8	29	4.72 (2.41, 9.05)
VVCS self-referral	102	559	24.04 (19.41, 29.36)	34	236	25.97 (17.51, 36.71)	39	207	33.31 (23.37, 44.98)
VVCS ADF referral	28	156	6.72 (4.46, 10.01)	6	42	4.64 (1.84, 11.23)	5	29	4.67 (1.67, 12.37)
Don't know	6	41	1.77 (0.70, 4.41)	*			*		

Denominator: Those who were concerned with their mental health and sought assistance from a psychologist
Note: Totals correspond with the '< 12 months ago' categories in Table 6.2
Note: These are not mutually exclusive groups and therefore do not sum to 100%.
Note: 95% CI: 95% confidence interval
* Cell sizes less than 5

Figure 7.4 Weighted estimate of Transitioned ADF members who accessed a psychologist in the previous 12 months, by funding source

7.2.3 Psychiatrist

Table 7.5 and Figure 7.5 outline the funding arrangements for Transitioned ADF and 2015 Regular ADF members who visited a psychiatrist for a mental health problem. Within the 2015 Regular ADF, 89.16% of psychiatrist visits were funded by Defence. Within the Transitioned ADF, DVA funded 76.54% of visits to a psychiatrist.

Table 7.6 describes visits to a psychiatrist for a mental health problem by funding arrangements for the Transitioned ADF, by category of Ex-Serving, Inactive Reservists and Active Reservists. Within the Ex-Serving ADF, the DVA funded 81.77% of psychiatrist visits. Within the Inactive Reservists, the majority of visits were funded by the DVA (60.15%), and the DVA also funded the majority of visits to psychiatrist for a mental health problem for the Active Reservists (60.36%).

Table 7.5 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed a psychiatrist in the previous 12 months, by funding source

	Transitioned ADF n = 2818			2015 Regular ADF n = 3201		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Medicare	63	444	15.77 (11.91, 20.58)	*		
DVA	384	2157	76.54 (71.16, 81.18)	27	386	12.05 (3.16, 36.54)
Defence	82	527	18.71 (14.66, 23.57)	453	2854	89.16 (62.80, 97.56)
Private health fund	8	52	1.84 (0.76, 4.37)	*		
Fully self-funded	35	262	9.29 (6.35, 13.41)	5	23	0.71 (0.23, 2.18)
Other – incl. WorkCover	8	31	1.10 (0.60, 2.00)	*		
Don't know	8	67	2.37 (1.02, 5.37)	*		

Denominator: Those who were concerned with their mental health and sought assistance from a psychiatrist
Notes:
The totals correspond with the '< 12 months ago' categories in Table 6.1.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval
* Cell sizes less than 5

Figure 7.5 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed a psychiatrist in the previous 12 months, by funding source

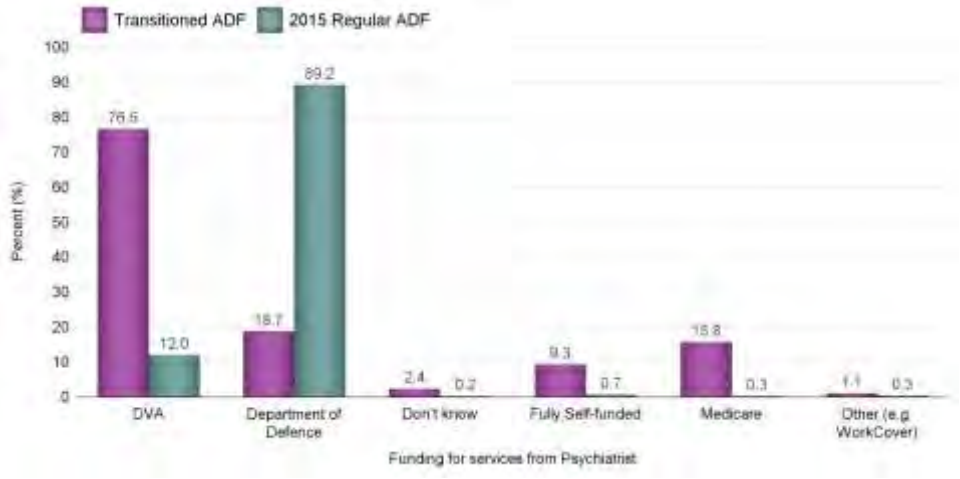


Table 7.6 Weighted estimate of Transitioned ADF members who accessed a psychiatrist in the previous 12 months, by funding source

	Ex-Serving n = 2109			Inactive Reservists n = 456			Active Reservists n = 232		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Medicare	37	264	12.53 (8.65, 17.80)	14	121	26.58 (14.46, 43.68)	12	59	25.44 (13.84, 42.02)
DVA	307	1725	81.77 (75.61, 86.64)	46	274	60.15 (44.20, 74.20)	29	140	60.36 (42.26, 76.01)
Defence	65	413	19.56 (14.79, 25.40)	8	73	16.03 (7.23, 31.86)	7	34	14.77 (6.19, 31.29)
Private health fund	*			*			*		
Fully self-funded	16	139	6.57 (3.70, 11.40)	10	85	18.67 (9.09, 34.52)	9	38	16.47 (8.49, 29.51)
Other – incl. WorkCover	*			*			*		
Don't know	*			*			*		

Denominator: Those who were concerned with their mental health and sought assistance from a psychiatrist
Notes:
The totals correspond with the '< 12 months ago' categories in Table 6.2.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval
* Cell sizes less than 5

7.2.4 Other mental health professional

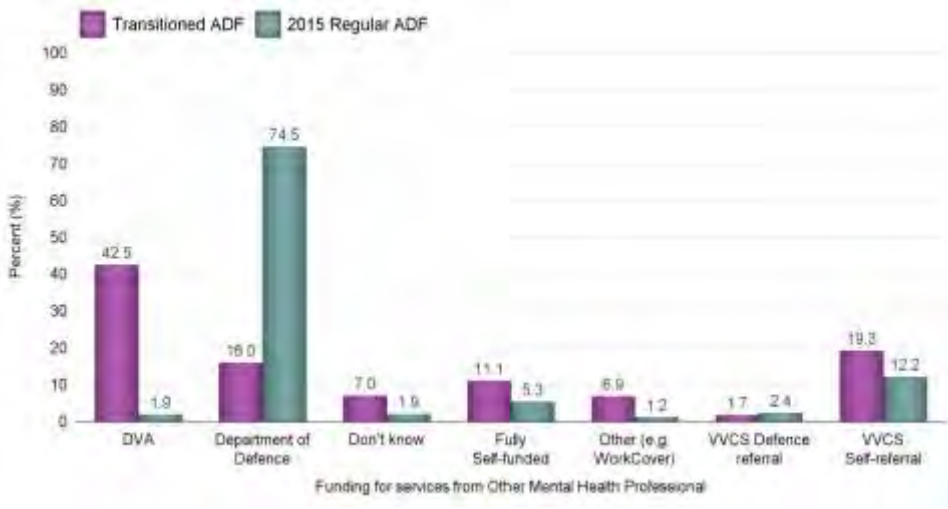
The funding arrangements for a visit to other mental health professionals, including a social worker, occupational therapist or mental health nurse for a mental health problem for the Transitioned ADF and 2015 Regular ADF are outlined in Table 7.7 and Figure 7.6. Within the Transitioned ADF, DVA funded 42.48% of other mental health professional visits. Defence funded the majority (74.46%) of 2015 Regular ADF members' visits to other mental health professionals.

Table 7.7 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed other mental health professionals in the previous 12 months, by funding source

	Transitioned ADF n = 1177			2015 Regular ADF n = 2058		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
DVA	91	500	42.48 (34.61, 50.74)	14	38	1.87 (1.09, 3.18)
Defence	28	188	16.01 (10.46, 23.73)	273	1532	74.46 (60.59, 84.69)
Fully self-funded	19	131	11.13 (6.43, 18.57)	23	109	5.32 (2.96, 9.38)
Other – incl. WorkCover	13	81	6.88 (3.58, 12.83)	8	24	1.16 (0.60, 2.24)
VVCS self-referral	34	227	19.25 (13.12, 27.36)	65	250	12.17 (8.01, 18.04)
VVCS Defence referral	*			16	49	2.36 (1.35, 4.10)
Don't know	14	83	7.03 (3.91, 12.30)	13	40	1.95 (1.11, 3.41)

Denominator: Those who were concerned with their mental health and sought assistance from other mental health professionals
Notes:
The totals correspond with the '< 12 months ago' categories in Table 6.1.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval
* Cell sizes less than 5

Figure 7.6 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed other mental health professionals in the previous 12 months, by funding source



Funding arrangements for other mental health professionals for the three Transitioned groups have not been reported here due to small cell sizes.

7.2.5 Inpatient treatment, hospital admission

Table 7.8 describes inpatient treatment or hospital admission for a mental health problem among Transitioned ADF and 2015 Regular ADF members, by funding arrangement. Within the Transitioned ADF, DVA funded 57.16% of inpatient treatments or hospital admissions. Within the 2015 Regular ADF, Defence funded the majority (96.92%) of inpatient treatments or hospital admissions for a mental health problem.

Table 7.8 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed an inpatient treatment or hospital admission in the previous 12 months, by funding source

	Transitioned ADF n = 688			2015 Regular ADF n = 641		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Medicare	22	142	20.67 (13.45, 30.41)	*		
DVA	77	393	57.16 (46.28, 67.39)	*		
Defence	23	158	22.98 (14.47, 34.46)	114	621	96.92 (88.88, 99.20)
Fully self-funded	7	61	8.92 (4.07, 18.44)	*		
Private health fund	8	34	4.99 (2.58, 9.43)	*		
Other – incl. WorkCover	*			*		
Don't know	10	60	8.77 (4.44, 16.58)	*		

Denominator: Those who were concerned with their mental health and sought assistance from an inpatient treatment or hospital admission
Notes:
The totals (denominator for each category) correspond with the '< 12 months ago' categories in Table 6.1.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval
* Cell sizes less than 5

Funding arrangements for inpatient treatment or hospital admission for the three Transitioned ADF groups have not been reported here due to small cell sizes.

7.2.6 Hospital-based PTSD program

Table 7.9 outlines the funding arrangements for the Transitioned ADF and 2015 Regular ADF members' participation in a hospital-based posttraumatic stress disorder (PTSD) program for help with a mental health problem. Within the Transitioned ADF, DVA funded 83.34% of participation in a hospital-based PTSD program. Within the 2015 Regular ADF, Defence funded the majority (99.45%) of participants in a hospital-based PTSD program.

Table 7.9 Weighted estimate of Transitioned ADF and 2015 Regular ADF members who accessed a hospital-based PTSD program in the previous 12 months, by funding source

	Transitioned ADF n = 264			2015 Regular ADF n = 404		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Medicare	*			*		--
DVA	41	220	83.34 (69.47, 91.66)	*		
Defence	8	39	14.75 (6.94, 28.66)	33	402	99.45 (96.15, 99.92)
Private health fund	*			*		
Other – incl. WorkCover	*			*		
Don't know	*			*		

Denominator: Those who were concerned with their mental health and sought assistance from a hospital-based PTSD program
Notes:
The totals (denominator for each category) correspond with the '< 12 months ago' categories in Table 6.1.
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval
* Cell sizes less than 5

Funding arrangements for hospital-based PTSD programs are not been reported here due to small cell sizes.

7.2.7 Residential alcohol or other drug program

Funding arrangements for drug and alcohol programs have not been reported due to very small cell sizes.

8 Self-help strategies for informing, assessing and maintaining mental health

Key findings

Self-help strategies

- 30.3% of Transitioned ADF and 25.0% of 2015 Regular ADF members reported using websites to inform or assess their mental health.
- In the Transitioned ADF, 18.6% reported using the DVA website, and an additional 10% using the ADF website. For 2015 Regular ADF members, 14.5% reported using the ADF website and 10.5% using the DVA website.
- The beyondblue website was the next most common website use by both groups – 8.0% of Transitioned ADF and 6.4% of 2015 Regular ADF.
- 18.1% of Transitioned ADF and 9.9% of 2015 Regular ADF members reported using social media to inform or assess their mental health.
- 9.2% of Transitioned ADF and 2.9% of 2015 Regular ADF members reported having contact with Ex-Service Organisations to inform or assess their mental health.
- Only around 2% of both the Transitioned ADF and 2015 Regular ADF groups used internet treatments such as MoodGYM and e-couch. This rate was slightly higher for those with a probable 30-day disorder.
- There was little use of mobile phone apps; only 6.9% of Transitioned ADF and 6.1% of 2015 Regular ADF members reporting using them. This rate increased to 14% in both Transitioned ADF and 2015 Regular ADF with probable 30-day disorder. Of those with a probable 30-day disorder, the most commonly used app was PTSD Coach, used by 9.1% and 9.8% of Transitioned ADF and Regular ADF members.
- 8.8% of the Transitioned ADF and 11.8% of 2015 Regular ADF members used Veteran and Defence helplines. The Veterans and Veterans Families Counselling Service (VVCS) Veterans Line was the most used helpline in both groups (approximately 8%) followed by 1800 IMSICK among 2015 Regular ADF members (4.3%). Approximately 16% of Transitioned ADF and the 2015 Regular ADF members with a probable 30-day disorder reported using the VVCS Veteran's Line.
- Other telephone helplines not military-specific, such as Lifeline, Mensline and Sane Australia were barely used across all groups (less than 2%). The exception was 2015 Regular ADF members with a probable 30-day disorder, where 6.4% of this group reported use of the Relationships Australia helpline.

- The Transitioned ADF and 2015 Regular ADF members reported similar rates of using physical activity (41.6% and 45.5%), enjoyable activities (36.8% and 37.2%) and support from others (34.1% and 34.7%) to maintain their mental health.

Glossary: refer to the Glossary of terms for definitions of key terms in this section.

8.1 Introduction

This section describes the specific self-help strategies Transitioned ADF and 2015 Regular ADF members used to inform or assess and maintain their mental health in the last 12 months.

Participants were asked whether or not they found these strategies to be helpful, as well as their preferred means of receiving mental health information.

The specific self-help strategies used to inform or assess mental health data are presented first, followed by self-help strategies used to maintain mental health.

The study investigators developed the survey items used in this section, based on specific knowledge and experience in the field. Other survey items were taken from the Australian Bureau of Statistics (ABS, 2008), the World Mental Health Survey Initiative Version of the World Health Organization Composite International Diagnostic Interview – version 3 (CIDI) (Haro et al., 2006) and the 2010 ADF Mental Health Wellbeing Prevalence Study (MHPWS) (McFarlane et al., 2011), then modified by investigators to suit the current research.

8.1.1 Strategies for informing or assessing mental health

Strategies used in the last 12 months to inform/assess and maintain mental health were assessed as follows.

A single item with 32 options was presented to each participant:

> 'The next series of questions are about ways in which people inform/assess their mental health. The phrase mental health includes but is not restricted to such things as stress, anxiety, depression, or problems with alcohol or drugs. Which of the following have you used in the last 12 months to inform/assess your mental health?'

The 32 self-help strategies were presented as broadly grouped into the following seven categories:

- websites (ADF website)
- internet treatments (MoodGYM)
- smartphone apps (PTSD Coach)

- other internet resources (including blogs)
- DVA or Defence telephone helplines (including ADF All-hours Support Line)
- other telephone helplines (such as the SANE Australia helpline)
- ex-service organisations.

8.1.2 Strategies for maintaining mental health

A single item asked participants to indicate the ways they have maintained their mental health in the past 12 months: *Which of the following have you used in the last 12 months to maintain your mental health?*

Options included:

- communicating with a chaplain or church leader
- increasing their levels of exercise or physical activity
- doing more of the things they enjoy
- seeking support from family members or friends.

8.1.3 Self-help strategies found helpful

Participants were asked to indicate if they found any of the strategies listed:

> 'Do/did you find this helpful?' Yes/No

8.1.4 Preferred means of receiving information

A single item asked participants to indicate their preferred means of receiving information about their mental health:

> 'Which is your preferred means of receiving information about your mental health?'

Options included:

- via telephone
- on the internet
- direct, in face-to-face communication.

The presence of a probable 30-day disorder was determined based on scores on the Kessler Psychological Distress Scale (K10) and Posttraumatic Stress Disorder Checklist (PCL).

Participants were deemed to have a probable 30-day disorder if they scored above the optimal epidemiological cut-off (25 on the K10, and 53 on the PCL) on any of the above measures. Epidemiological cut-offs were derived from the 2010 MHPWS (McFarlane et al., 2011) and the value that brings the number of false positives and false negatives

closest together, thereby accurately counterbalancing these sources of error. This combined probable cut-off would give the closest estimate of the true prevalence of 30-day affective and anxiety disorders and PTSD according to the International Statistical Classification of Diseases and Related Health Problems – 10th Revision (ICD-10) and as measured by the CIDI, and could be used to monitor disorder trends.

8.1.5 Key questions addressed in this chapter

This chapter examines the questions of whether Transitioned ADF and 2015 Regular ADF members differ in terms of:

- Do Transitioned ADF and 2015 Regular ADF members differ in the self-help strategies that they used to assess/inform their mental health in the last 12 months?
- Do Transitioned ADF and 2015 Regular ADF members differ in the self-help strategies that they used to maintain their mental health in the last 12 months?
- Do Transitioned ADF and 2015 Regular ADF members differ in their preferred means of receiving mental health information?
- Do Transitioned ADF and 2015 Regular ADF members differ in their perceptions of the helpfulness of these strategies?

8.2 Self-help strategies used to inform or assess mental health

8.2.1 Websites

Table 8.1 and Figure 8.1 examine the proportion of Transitioned ADF and 2015 Regular ADF using websites to specifically inform or assess their mental health. The proportion of respondents using any health website was 30.28% of Transitioned ADF members, and 24.98% of 2015 Regular ADF members – a statistically significant difference. Transitioned ADF members used the DVA website most (18.63%), and 58.01% found it helpful. 2015 Regular ADF used the ADF website most frequently (14.43%), and 70.22% found it helpful.

The percentage of respondents with a probable 30-day disorder using any health website was 46.90% of Transitioned ADF and 39.88% of 2015 Regular ADF members. Transitioned ADF members with a probable 30-day disorder used the DVA website most frequently (31.18%), and 48.90% found it helpful. 2015 Regular ADF members used the ADF website most frequently (20.33%), and 49.03% found it helpful.

Table 8.2 and Figure 8.2 show the proportion of Transitioned ADF members, by category, using websites to specifically inform or assess their mental health. The proportion of respondents using any health website was 34.95% of Ex-Serving ADF

members, 26.18% of Inactive Reservists and 26.61% of Active Reservists, which was significantly lower than the Ex-Serving ADF members. Ex-Serving ADF members used the DVA website most (22.88%) with 51.01% finding it helpful, the Inactive Reservists also used the DVA website most (15.09%) with 67.29% finding it helpful, and the Active Reservists also used the DVA website most frequently (15.22%) with 67.20% finding it helpful.

Table 8.1 Weighted estimate of Transitioned ADF and 2015 Regular ADF members using websites to inform or assess mental health in the last 12 months, by helpfulness, stratified by probable 30-day disorder

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
ADF website	401	2505	10.05 (8.94, 11.27)	1285	7577	14.43 (12.08, 17.15)
Helpful?	234	1407	56.17 (50.05, 62.11)	948	5320	70.22 (60.93, 78.09)
With probable 30-day disorder	143	838	11.93 (9.86, 14.37)	227	1540	20.33 (13.66, 29.17)
Helpful?	58	325	38.79 (29.77, 48.65)	132	755	49.03 (29.87, 68.47)
DVA website	815	4644	18.63 (17.26,20.07)	1005	5535	10.54 (8.83, 12.55)
Helpful?	510	2694	58.01 (53.82, 62.09)	*795*	*3863*	69.78 (59.82, 78.18)
With probable 30-day disorder	386	2190	31.18 (28.06, 34.49)	232	1374	18.13 (12.30, 25.91)
Helpful?	206	1071	48.90 (43.07, 54.75)	*168*	*679*	49.43 (31.36, 67.64)
At Ease website	84	437	1.75 (1.36, 2.25)	107	818	1.56 (0.83, 2.90)
Helpful?	39	187	42.82 (31.05, 55.46)	58	196	23.93 (11.64, 42.89)
With probable 30-day disorder	40	225	3.21 (2.22, 4.61)	23	270	3.56 (0.93, 12.73)
Helpful?	16	93	41.23 (24.41, 60.38)	11	30	11.26 (2.51, 38.47)
Black Dog Institute	135	750	3.01 (2.47, 3.66)	252	1812	3.45 (2.18, 5.42)
Helpful?	98	495	66.01 (55.44, 75.20)	203	1142	63.01 (38.80, 82.06)
With probable 30-day disorder	73	410	5.83 (4.51, 7.52)	65	435	5.74 (2.46, 12.82)
Helpful?	49	246	60.08 (46.27, 72.46)	55	225	51.83 (15.61, 86.22)
Headspace	69	463	1.86 (1.40, 2.45)	114	1016	1.94 (1.06, 3.51)
Helpful?	38	236	50.92 (37.10, 64.61)	77	460	45.28 (19.14, 74.30)
With probable 30-day disorder	35	262	3.73 (2.51, 5.51)	22	255	3.36 (0.81, 12.92)
Helpful?	17	113	43.06 (25.48, 62.59)	16	54	21.18 (3.89, 64.09)
beyondblue	302	1998	8.01 (6.99, 9.16)	531	3381	6.44 (4.70, 8.76)
Helpful?	208	1292	64.66 (57.41, 71.29)	444	2647	78.28 (61.94, 88.87)
With probable 30-day disorder	160	1109	15.79 (13.21, 18.76)	129	1043	13.76 (7.25, 24.59)
Helpful?	101	658	59.36 (49.50, 68.53)	105	791	75.89 (38.18, 94.13)
mindhealthconnect	29	179	0.72 (0.47, 1.11)	42	578	1.10 (0.46, 2.63)
Helpful?	8	50	28.01 (13.00, 50.34)	13	45	7.82 (2.66, 20.87)
With probable 30-day disorder	15	88	1.26 (0.72, 2.19)	6	209	2.76 (0.49, 14.13)
Helpful?	*			*		
Lifeline website	56	372	1.49 (1.09, 2.03)	87	737	1.40 (0.70, 2.79)
Helpful?	23	123	33.14 (21.36, 47.51)	50	178	24.14 (10.92, 45.23)
With probable 30-day disorder	37	222	3.16 (2.22, 4.48)	29	287	3.79 (1.07, 12.56)
Helpful?	17	85	38.51 (23.80, 55.67)	22	86	29.94 (6.22, 73.37)

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Kids Helpline website	24	141	0.57 (0.35, 0.91)	43	597	1.14 (0.48, 2.65)
Helpful?	*			14	56	9.32 (3.22, 24.08)
With probable 30-day disorder	13	72	1.02 (0.56, 1.84)	*		
Helpful?	*			*		
MensLine Australia website	84	548	2.20 (1.68, 2.87)	126	1459	2.78 (1.49, 5.13)
Helpful?	46	281	51.36 (38.01, 64.52)	85	865	59.25 (30.11, 83.07)
With probable 30-day disorder	51	298	4.24 (3.03, 5.90)	25	569	7.51 (2.46, 20.69)
Helpful?	29	156	52.29 (35.58, 68.50)	19	360	63.25 (14.86, 94.44)
Other health websites	222	1328	5.33 (4.55, 6.23)	312	1851	3.53 (2.35, 5.26)
Helpful?	164	955	71.89 (64.05, 78.59)	254	1190	64.30 (42.30, 81.56)
With probable 30-day disorder	114	682	9.72 (7.82, 12.01)	73	457	6.03 (2.69, 12.97)
Helpful?	81	474	69.42 (58.52, 78.52)	61	240	52.62 (16.84, 85.89)
Any health website	1230	7549	30.28 (28.55, 32.07)	2126	13,113	24.98 (21.77, 28.48)
With probable 30-day disorder	535	3294	46.90 (43.20, 50.63)	419	3021	39.88 (29.78, 50.92)

Denominator: Entire cohort
Notes:
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval
* Cell sizes less than 5

Figure 8.1 Weighted estimate of Transitioned ADF and 2015 Regular ADF members using websites to inform or assess mental health in the last 12 months, by helpfulness, stratified by probable 30-day disorder

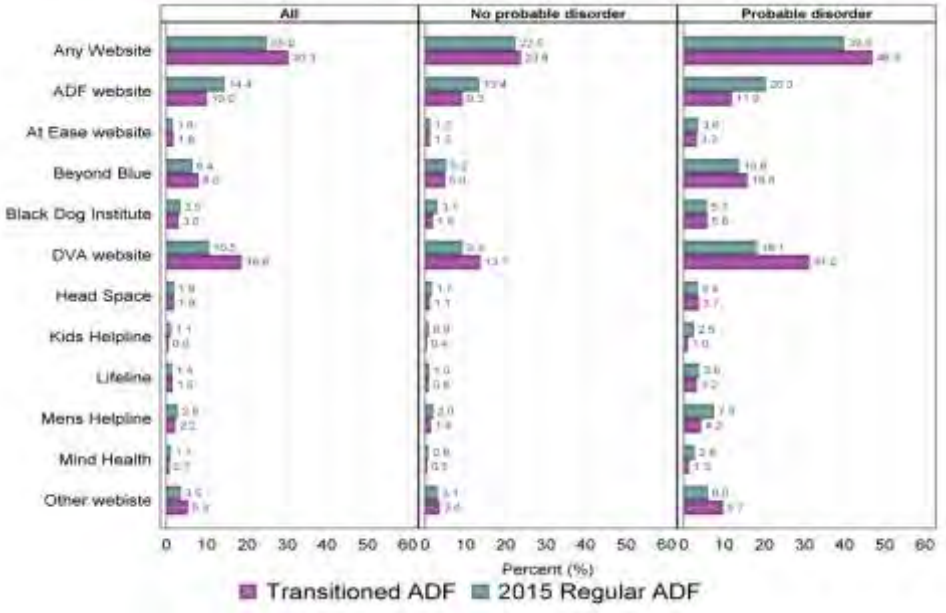
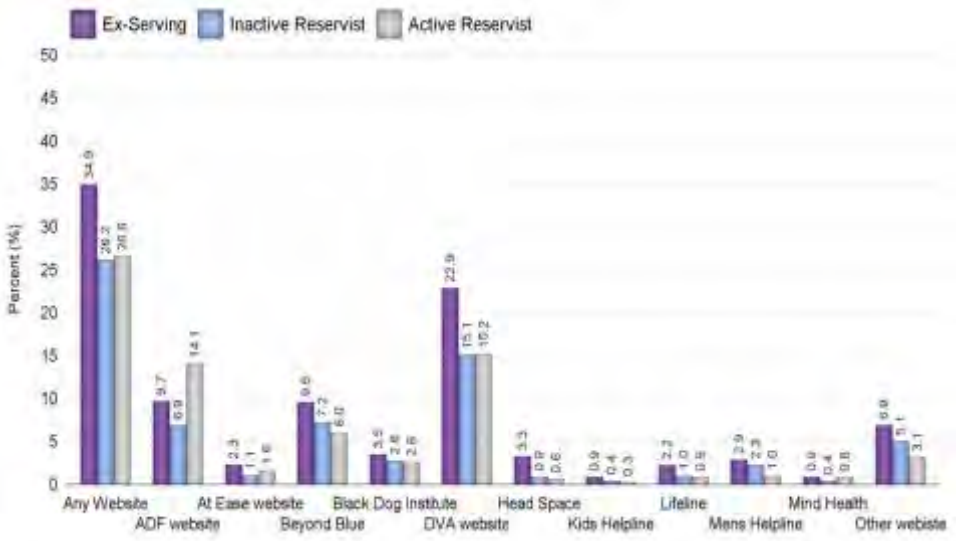


Table 8.2 Weighted estimate of Transitioned ADF members who used websites in the last 12 months to inform or assess their mental health, by helpfulness

	Ex-Serving n = 10,876			Inactive Reservists n = 7513			Active Reservists n = 6426		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
ADF website	136	1055	9.70 (7.92, 11.82)	77	516	6.87 (5.16, 9.08)	185	905	14.08 (11.98, 16.48)
Helpful?	61	463	43.87 (33.76, 54.52)	50	336	65.10 (50.25, 77.50)	120	579	63.98 (55.29, 71.85)
DVA website	415	2489	22.88 (20.58, 25.36)	190	1134	15.09 (12.66, 17.90)	206	978	15.22 (13.14, 17.55)
Helpful?	236	1269	51.01 (45.08, 56.91)	130	763	67.29 (57.98, 75.41)	143	657	67.20 (59.29, 74.25)
At Ease website	40	248	2.28 (1.55, 3.36)	18	80	1.06 (0.64, 1.74)	25	104	1.62 (1.07, 2.45)
Helpful?	13	81	32.58 (16.94, 53.38)	8	40	50.33 (27.08, 73.44)	17	62	59.07 (37.03, 77.98)
Black Dog Institute	66	375	3.45 (2.59, 4.59)	40	208	2.76 (1.87, 4.07)	29	167	2.59 (1.69, 3.95)
Helpful?	46	231	61.52 (46.12, 74.91)	31	148	71.11 (48.04, 86.76)	21	116	69.78 (48.18, 85.16)
Headspace	46	354	3.26 (2.29, 4.62)	14	67	0.90 (0.52, 1.52)	9	41	0.64 (0.34, 1.20)
Helpful?	29	187	52.71 (35.19, 69.59)	5	28	41.51 (18.85, 68.44)	*		
beyondblue	143	1045	9.61 (7.88, 11.67)	81	541	7.20 (5.44, 9.49)	76	388	6.04 (4.65, 7.82)
Helpful?	89	629	60.20 (49.74, 69.80)	60	362	66.81 (51.12, 79.48)	57	278	71.56 (57.23, 82.56)
mindhealthconnect	13	96	0.88 (0.45, 1.71)	8	32	0.42 (0.22, 0.82)	8	51	0.80 (0.35, 1.82)
Lifeline website	30	243	2.23 (1.45, 3.43)	14	73	0.97 (0.55, 1.70)	12	56	0.87 (0.47, 1.61)
Helpful?	13	79	32.47 (17.20, 52.68)	5	24	33.36 (13.32, 61.98)	5	20	35.78 (14.57, 64.53)
Kids Helpline website	12	93	0.85 (0.43, 1.69)	8	32	0.43 (0.22, 0.83)	*		
MensLine Australia website	46	314	2.89 (1.99, 4.17)	22	170	2.26 (1.32, 3.86)	16	64	1.00 (0.62, 1.59)
Helpful?	24	161	51.19 (33.16, 68.91)	10	72	42.44 (20.03, 68.46)	12	49	75.81 (51.73, 90.16)
Other health websites	115	747	6.87 (5.48, 8.57)	64	380	5.06 (3.70, 6.89)	43	201	3.13 (2.31, 4.23)
Helpful?	78	470	62.92 (51.10, 73.37)	54	337	88.63 (79.50, 94.00)	32	148	73.54 (55.38, 86.16)
Any health websites	572	3801	34.95 (32.05, 37.95)	304	1967	26.18 (22.97, 29.68)	347	1710	26.61 (23.90, 29.51)

Denominator: Entire cohort
Notes:
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.
* Cell sizes less than 5

Figure 8.2 Weighted estimate of Transitioned ADF members who used websites in the last 12 months to inform or assess their mental health, by helpfulness



8.2.2 Internet treatments

Table 8.3 and Figure 8.3 outline the proportion of Transitioned ADF members using internet treatments to specifically inform or assess their mental health. Overall, use of internet treatments in the Transitioned ADF was low; only 4.25% of the entire Transitioned ADF population reported using MoodGYM, e-couch or another type of internet treatment (unspecified) for their mental health. Similarly, 3.13% of 2015 Regular ADF used an internet treatment. Of those respondents with a probable 30-day disorder, 8.13% of Transitioned ADF members used any internet treatment, with 5.55% of 2015 Regular ADF using an internet treatment.

In both groups, the majority of respondents used another, non-specified internet treatment: 2.02% for Transitioned ADF, of whom 53.75% found it helpful, and 1.52% of 2015 Regular ADF, of whom 27.97% found it helpful. The same result of using another, non-specified internet treatment most was found in those respondents with a probable 30-day disorder: 3.79% for Transitioned ADF, of whom 49.11% found it helpful, and 3.42% of 2015 Regular ADF, of whom 26.11% found it helpful.

There were no significant differences between the proportion in both groups that used MoodGYM and e-couch, with low use rates for both groups.

Table 8.4 presents the proportion of Transitioned ADF members by category who used internet treatments to specifically inform or assess their mental health. The proportion

of respondents using any internet treatment was 5.13% of Ex-Serving ADF members, 3.24% of Inactive Reservists and 3.95% of Active Reservists.

All Transitioned ADF groups used another, non-specified internet treatment most, with the proportion of Ex-Serving ADF members at 2.34%, with 38.67% finding it helpful; Inactive Reservists at 1.52%, with 46.43% finding it helpful; and Active Reservists at 2.11%, with 88.29% finding it helpful.

Use of the MoodGYM and e-couch treatments was very low in all Transitioned ADF groups.

Table 8.3 Weighted estimate of Transitioned ADF and 2015 Regular ADF members using internet treatments in the last 12 months, by helpfulness, stratified by probable 30-day disorder

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
MoodGYM	29	182	0.73 (0.47, 1.14)	67	661	1.26 (0.58, 2.71)
Helpful?	10	43	23.82 (12.26, 41.18)	26	88	13.34 (5.40, 29.33)
With probable 30-day disorder	14	95	1.36 (0.72, 2.53)	9	225	2.96 (0.59, 13.62)
Helpful?	*			5	22	9.59 (1.26, 46.84)
e-couch	20	125	0.50 (0.30, 0.85)	42	586	1.12 (0.47, 2.64)
Helpful?	*			12	44	7.45 (2.52, 20.06)
With probable 30-day disorder	11	63	0.90 (0.47, 1.73)	*		
Helpful?	*			*		
Other	72	505	2.02 (1.52, 2.68)	101	799	1.52 (0.80, 2.88)
Helpful?	37	271	53.75 (39.60, 67.32)	63	224	27.97 (13.36, 49.44)
With probable 30-day disorder	42	267	3.79 (2.66, 5.39)	22	259	3.42 (0.84, 12.86)
Helpful?	20	131	49.11 (32.00, 66.43)	19	68	26.11 (4.75, 71.47)
Any internet treatment	171	1060	4.25 (3.54, 5.09)	248	1641	3.13 (1.98, 4.90)
With probable 30-day disorder	98	571	8.13 (6.47, 10.18)	59	421	5.55 (2.32, 12.73)

Denominator: Entire cohort
Notes:
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.
* Cell sizes less than 5

Figure 8.3 **Weighted estimate of Transitioned ADF and 2015 Regular ADF members using internet treatments in the last 12 months, by helpfulness, stratified by probable 30-day disorder**

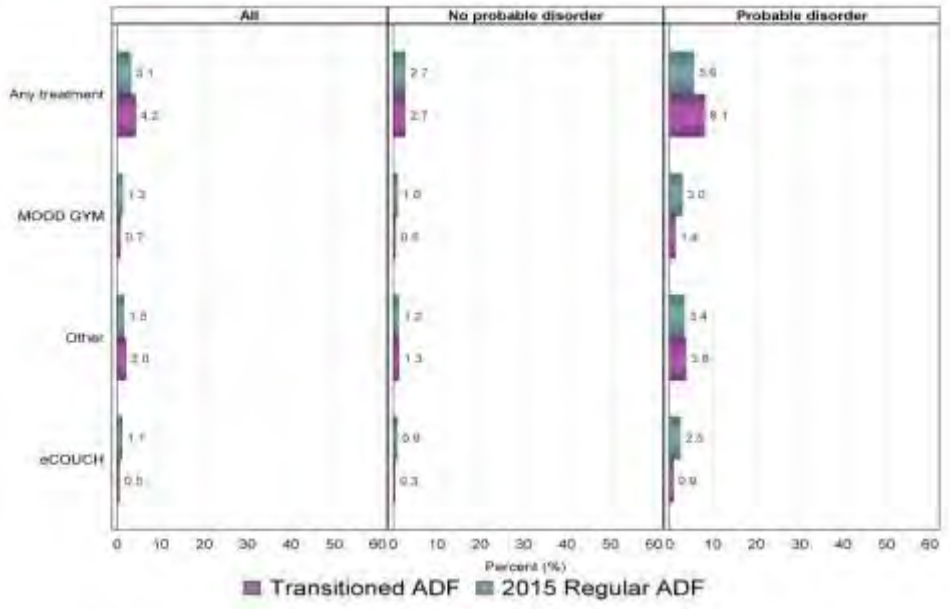


Table 8.4 Weighted estimate of Transitioned ADF members using internet treatments in the last 12 months, by helpfulness

	Ex-Serving n = 10,876			Inactive Reservists n = 7513			Active Reservists n = 6426		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
MoodGYM	12	95	0.87 (0.44, 1.72)	10	40	0.53 (0.29, 0.95)	7	47	0.73 (0.27, 1.95)
Helpful?	*			*			*		
e-couch	10	85	0.78 (0.37, 1.63)	7	29	0.38 (0.19, 0.77)	*		
Helpful?	*			*			*		
Other	35	255	2.34 (1.55, 3.53)	18	114	1.52 (0.86, 2.66)	19	136	2.11 (1.17, 3.78)
Helpful?	15	99	38.67 (21.29, 59.51)	7	53	46.43 (21.87, 72.86)	15	120	88.29 (70.87, 95.90)
Any internet treatment	84	558	5.13 (3.94, 6.66)	45	244	3.24 (2.27, 4.62)	41	254	3.95 (2.66, 5.81)

Denominator: Entire cohort
Notes:
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.
* Cell sizes less than 5

8.2.3 Smartphone apps

Table 8.5 and Figure 8.4 outline the proportion of Transitioned ADF members using smartphone apps to specifically inform or assess their mental health.

Overall, use of smartphone apps among Transitioned ADF members was low; only 6.88% of the entire Transitioned ADF population reporting using PTSD Coach, On Track or an unspecified other type of app to inform or assess their mental health.

Similarly, 6.09% of 2015 Regular ADF members used any smartphone app. Of those respondents with a probable 30-day disorder, 14.14% of Transitioned ADF members used a smartphone app, as did 14.33% of 2015 Regular ADF members.

In the Transitioned ADF, the largest percentage of respondents using apps (3.90%) used PTSD Coach, of whom 52.37% found it helpful. This increased to 9.11% of Transitioned ADF members with a probable 30-day disorder, of whom 50.89% found it helpful. In the 2015 Regular ADF group, 2.97% used the PTSD Coach app and 48.25% found it helpful. This also increased to 9.84% among 2015 Regular ADF members with a probable 30-day disorder, of whom 57.31% found it helpful.

There were no significant differences between the proportions of both groups that used PTSD Coach.

Table 8.6 and Figure 8.5 show the proportion of Transitioned ADF members by category who used smartphone apps to specifically inform or assess their mental health. The proportion of respondents using PTSD Coach, On Track or an unspecified other type of app to inform or assess their mental health was 9.52% of Ex-Serving ADF members, 4.77% of Inactive Reservists and 4.29% of Active Reservists.

Ex-Serving ADF members used the PTSD Coach most (5.84%, of whom 52.14% found it helpful), as did Active Reservists (2.62%, 52.44% of whom found it helpful). Inactive Reservists used an unspecified other smartphone app most (3.10%, of whom 72.17% found it helpful).

Table 8.5 Weighted estimate of Transitioned ADF and 2015 Regular ADF members using smartphone apps in the last 12 months, by helpfulness, stratified by probable 30-day disorder

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
PTSD Coach	156	973	3.90 (3.23, 4.72)	228	1558	2.97 (1.83, 4.77)
Helpful?	81	510	52.37 (42.68, 61.89)	137	752	48.25 (26.28, 70.91)
With probable 30-day disorder	107	640	9.11 (7.31, 11.31)	78	745	9.84 (4.22, 21.29)
Helpful?	55	326	50.89 (39.64, 62.04)	49	427	57.31 (19.65, 88.05)
On Track	56	353	1.42 (1.02, 1.97)	134	992	1.89 (1.12, 3.17)
Helpful?	17	119	33.58 (19.45, 51.43)	65	298	30.01 (16.28, 48.58)
With probable 30-day disorder	26	170	2.41 (1.52, 3.82)	23	266	3.51 (0.90, 12.77)
Helpful?	*			12	53	20.09 (3.88, 61.04)
Other app	126	876	3.51 (2.83, 4.35)	221	1925	3.67 (2.32, 5.75)
Helpful?	77	531	60.65 (49.64, 70.68)	155	1242	64.50 (40.95, 82.64)
With probable 30-day disorder	61	458	6.52 (4.81, 8.78)	59	557	7.36 (3.11, 16.40)
Helpful?	35	261	56.92 (41.30, 71.27)	40	302	54.25 (16.58, 87.62)
Any smartphone app	264	1714	6.88 (5.94, 7.94)	474	3196	6.09 (4.40, 8.37)
With probable 30-day disorder	151	993	14.14 (11.74, 16.94)	131	1085	14.33 (7.58, 25.44)

Denominator: Entire cohort
Notes:
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.
* Cell sizes less than 5

Figure 8.4 **Weighted estimate of Transitioned ADF and 2015 Regular ADF members using smartphone apps in the last 12 months, by helpfulness, stratified by probable 30-day disorder**

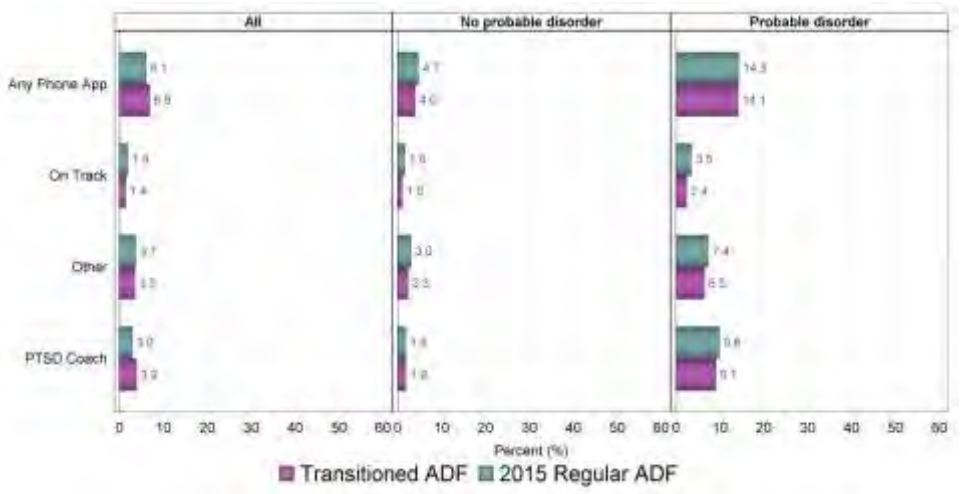
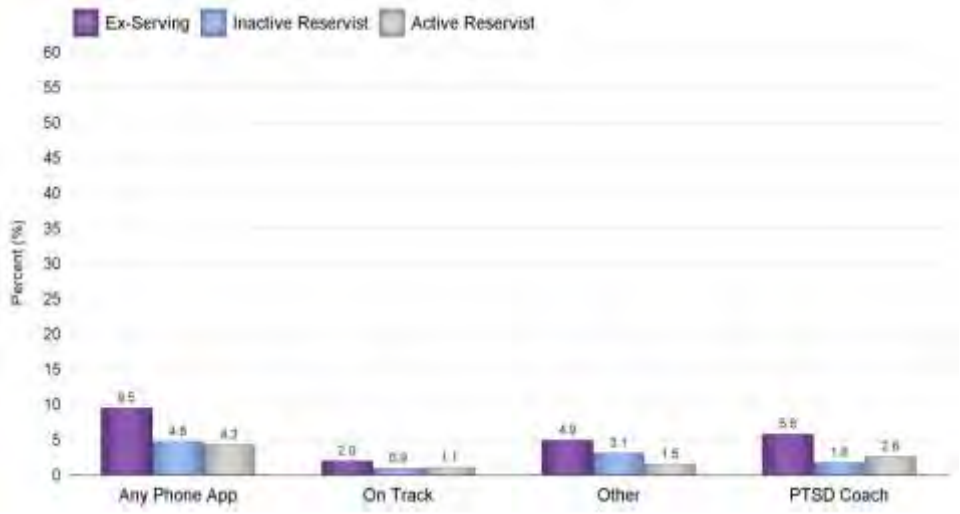


Table 8.6 Weighted estimate of Transitioned ADF members using smartphone apps in the last 12 months, by helpfulness

	Ex-Serving n = 10,876			Inactive Reservists n = 7513			Active Reservists n = 6426		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
PTSD Coach	99	636	5.84 (4.58, 7.44)	24	132	1.76 (1.08, 2.86)	30	168	2.62 (1.66, 4.10)
Helpful?	51	331	52.14 (39.83, 64.19)	12	66	50.10 (27.32, 72.84)	16	88	52.44 (30.38, 73.58)
On Track	27	215	1.98 (1.22, 3.18)	17	70	0.93 (0.59, 1.48)	12	68	1.05 (0.52, 2.12)
Helpful?	6	74	34.40 (14.86, 61.18)	7	26	37.26 (18.79, 60.39)	*		
Other app	63	534	4.91 (3.64,6.60)	41	233	3.10 (2.10, 4.55)	19	97	1.51 (0.84, 2.72)
Helpful?	32	275	51.37 (36.32, 66.18)	28	168	72.17 (54.31, 84.97)	14	77	79.35 (56.27, 91.98)
Any smartphone app	149	1035	9.52 (7.82, 11.54)	63	359	4.77 (3.51, 6.46)	47	276	4.29 (2.97, 6.17)

Denominator: Entire cohort
Notes:
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.
* Cell sizes less than 5

Figure 8.5 Weighted estimate of Transitioned ADF members using smartphone apps in the last 12 months, by helpfulness



8.2.4 Other internet

Table 8.7 and Figure 8.6 outline the proportion of Transitioned ADF and 2015 Regular ADF members who used other internet resources to specifically inform or assess their mental health.

Overall, 19.71% of the entire Transitioned ADF population reported using an email subscription, blog or social media to inform or assess their mental health. Similarly, 10.83% of 2015 Regular ADF members used any internet resources. Of those respondents with a probable 30-day disorder, 26.75% of Transitioned ADF members and 12.94% of 2015 Regular ADF members used any internet resources.

Social media was the most common internet resource Transitioned ADF members used; 18.12% of this group reporting using social media, of whom 54.48% found it helpful. The next most popular sources were email subscriptions and blogs. In the 2015 Regular ADF, social media was again the most commonly used (9.87%, of whom 54.25% found it helpful.

Respondents with a probable 30-day disorder most commonly used social media – 25.16% of Transitioned ADF and 12.47% of 2015 Regular ADF members used it (48.48% and 56.74% found it helpful, respectively).

Table 8.8 and Figure 8.7 explore the proportions of Transitioned ADF by category using any other internet resources to specifically inform or assess their mental health. Of Transitioned ADF members who used an email subscription, blog or social media to

inform or assess their mental health, 23.74% were Ex-Serving ADF members, 18.56% were Inactive Reservists and 14.51% were Active Reservists.

Ex-Serving ADF members used social media most (21.95%) with 51.00% finding it helpful, the Inactive Reservists also used this most (17.24%) with 57.22% finding it helpful, and the Active Reservists again using social media most frequently (12.94%) with 60.49% finding it helpful.

Table 8.7 Weighted estimate of Transitioned ADF and 2015 Regular ADF members using other internet resources in the last 12 months, by helpfulness, stratified by probable 30-day disorder

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Email subscription	135	880	3.53 (2.87, 4.33)	144	1363	2.60 (1.56, 4.30)
Helpful?	73	462	52.46 (42.13, 62.59)	96	523	38.36 (19.23, 61.92)
With probable 30-day disorder	45	262	3.73 (2.65, 5.23)	14	380	5.02 (1.43, 16.15)
Helpful?	21	127	48.53 (32.14, 65.24)	13	195	51.25 (7.56, 93.11)
Blogs	108	730	2.93 (2.34, 3.66)	126	872	1.66 (0.92, 2.98)
Helpful?	65	448	61.36 (49.89, 71.69)	81	443	50.78 (23.23, 77.86)
With probable 30-day disorder	47	325	4.63 (3.33, 6.39)	24	244	3.22 (0.73, 13.08)
Helpful?	31	213	65.39 (48.19, 79.33)	18	46	18.98 (3.48, 60.35)
Social media	655	4518	18.12 (16.63, 19.72)	755	5181	9.87 (7.74, 12.51)
Helpful?	378	2462	54.48 (49.73, 59.16)	487	2811	54.25 (41.84, 66.17)
With probable 30-day disorder	263	1767	25.16 (22.08, 28.52)	145	944	12.47 (7.41, 20.21)
Helpful?	144	857	48.48 (41.24, 55.77)	95	536	56.74 (30.42, 79.74)
Any of the above	711	4914	19.71 (18.16, 21.35)	835	5683	10.83 (8.62, 13.52)
With probable 30-day disorder	282	1879	26.75 (23.60, 30.15)	159	980	12.94 (7.84, 20.63)

Denominator: Entire cohort
Notes:
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 8.6 **Weighted estimate of Transitioned ADF and 2015 Regular ADF members using other internet resources in the last 12 months, by helpfulness, stratified by probable 30-day disorder**

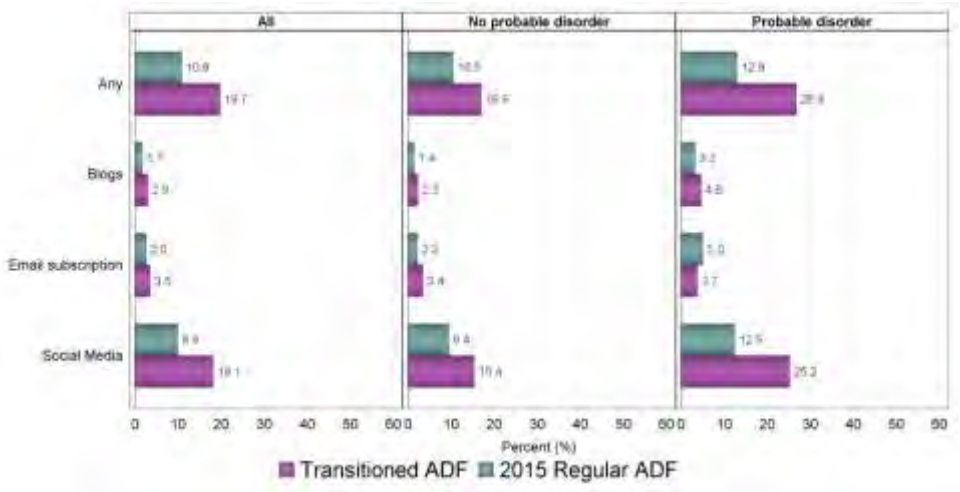
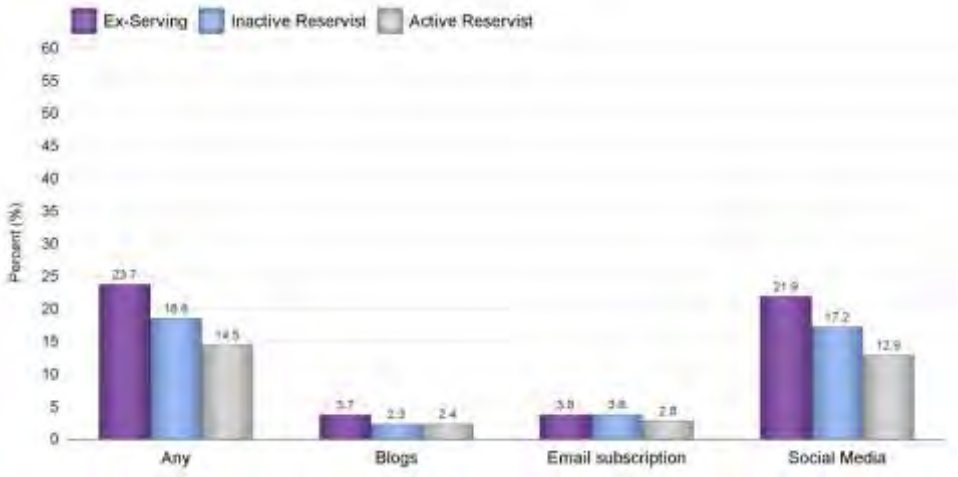


Table 8.8 Weighted estimate of Transitioned ADF members using other internet resources in the last 12 months, by helpfulness

	Ex-Serving n = 10,876			Inactive Reservists n = 7513			Active Reservists n = 6426		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Email subscription	55	411	3.78 (2.71, 5.24)	47	286	3.80 (2.64, 5.44)	33	183	2.85 (1.88, 4.28)
Helpful?	28	208	50.61 (34.46, 66.63)	24	125	43.89 (27.71, 61.49)	21	128	70.01 (51.92, 83.46)
Blogs	53	405	3.72 (2.71, 5.10)	29	172	2.29 (1.43, 3.65)	26	153	2.38 (1.47, 3.84)
Helpful?	33	237	58.63 (42.15, 73.39)	17	104	60.54 (36.99, 80.03)	15	106	69.49 (49.03, 84.35)
Social media	326	2387	21.95 (19.45, 24.68)	178	1296	17.24 (14.42, 20.49)	150	831	12.94 (10.79, 15.44)
Helpful?	183	1217	51.00 (44.35, 57.62)	106	741	57.22 (47.43, 66.47)	89	503	60.49 (50.64, 69.57)
Any of the above	349	2582	23.74 (21.14, 26.57)	194	1395	18.56 (15.65, 21.87)	167	933	14.51 (12.32, 17.02)

Denominator: Entire cohort
Notes:
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.

Figure 8.7 Weighted estimate of Transitioned ADF members using other internet resources in the last 12 months



8.2.5 DVA or Defence telephone helplines

Table 8.9 and Figure 8.8 show the proportion of Transitioned ADF members using DVA or Defence telephone helplines to specifically inform or assess their mental health.

Overall, 8.77% of the Transitioned ADF population used any DVA or Defence telephone helpline to inform or assess their mental health, including the Defence Family Helpline, ADF All-hours Support Line, 1800 IMSICK and the VVCS Veterans Line. Similarly, 11.76% of 2015 Regular ADF members used any DVA or Defence telephone helpline.

Of those respondents with a probable 30-day disorder, 17.53% of Transitioned ADF and 19.02% of 2015 Regular ADF members used any DVA or Defence telephone helpline.

The VVCS Veterans Line was the most common DVA or Defence telephone helpline Transitioned ADF members used – 7.97% of this group reported using this resource, and 73.06% found it helpful. The 2015 Regular ADF group also used the VVCS Veterans Line most commonly (7.89%, of whom 85.91% found it helpful).

Respondents with a probable 30-day disorder also used the VVCS Veterans Line most commonly. Of this group, 16.09% of Transitioned ADF members and 16.25% of 2015 Regular ADF members used it (75.26% and 77.17% found it helpful, respectively).

Table 8.10 and Figure 8.9 explore the proportions of Transitioned ADF by category using any DVA or Defence telephone helpline to specifically inform or assess their mental health. The proportion of Transitioned ADF respondents who reported using the Defence Family Helpline, ADF All-hours Support Line, 1800 IMSICK or the VVCS

Veterans Line to inform or assess their mental health was 10.91% of Ex-Serving ADF members, 6.96% of Inactive Reservists and 7.12% of Active Reservists.

The Ex-Serving ADF used the VVCS Vetline most (10.40%), with 69.22% finding it helpful, the Inactive Reservists also used this most (6.35%) with 68.89% finding it helpful, and the Active Reservists again using the VVCS Vetline most frequently (5.73%), with 89.45% finding it helpful.

Table 8.9 Weighted estimate of Transitioned ADF members using DVA or Defence telephone helplines in the last 12 months, by helpfulness, stratified by probable 30-day disorder

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Defence Family Helpline	41	251	1.01 (0.69, 1.46)	109	680	1.30 (0.74, 2.26)
Helpful?	13	65	26.06 (13.62, 44.08)	62	256	37.68 (19.31, 60.45)
With probable 30-day disorder	22	133	1.90 (1.16, 3.07)	22	266	3.51 (0.89, 12.77)
Helpful?	*			15	65	24.29 (4.65, 67.85)
ADF All-hours Support Line	30	190	0.76 (0.49, 1.18)	96	812	1.55 (0.82, 2.90)
Helpful?	*			50	359	44.20 (17.16, 75.19)
With probable 30-day disorder	15	79	1.13 (0.65, 1.96)	21	259	3.42 (0.84, 12.87)
Helpful?	*			13	47	18.19 (3.50, 57.69)
1800 IMSICK	46	247	0.99 (0.71, 1.37)	393	2235	4.26 (3.22, 5.60)
Helpful?	18	78	31.43 (19.99, 45.67)	282	1566	70.09 (55.12, 81.72)
With probable 30-day disorder	26	134	1.91 (1.26, 2.89)	57	385	5.08 (1.96, 12.50)
Helpful?	10	40	29.46 (16.09, 47.64)	44	150	39.06 (11.64, 75.73)
VVCS Veterans Line	312	1987	7.97 (6.98, 9.08)	534	4143	7.89 (5.83, 10.59)
Helpful?	243	1451	73.06 (66.11, 79.03)	452	3559	85.91 (74.57, 92.69)
With probable 30-day disorder	182	1130	16.09 (13.65, 18.87)	150	1231	16.25 (9.41, 26.61)
Helpful?	138	850	75.26 (67.31, 81.80)	128	950	77.17 (44.32, 93.49)
Any of the above	346	2186	8.77 (7.74, 9.92)	926	6176	11.76 (9.46, 14.54)
With probable 30-day disorder	199	1231	17.53 (14.99, 20.39)	210	1440	19.02 (11.90, 28.99)

Denominator: Entire cohort
Notes:
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.
* Cell sizes less than 5

Figure 8.8 **Weighted estimate of Transitioned ADF members using DVA or Defence telephone helplines in the last 12 months, by helpfulness, stratified by probable 30-day disorder**

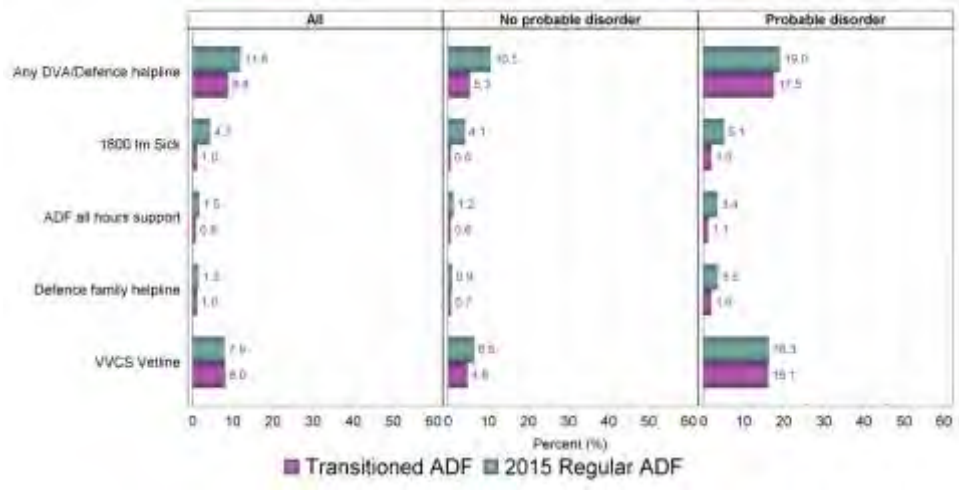
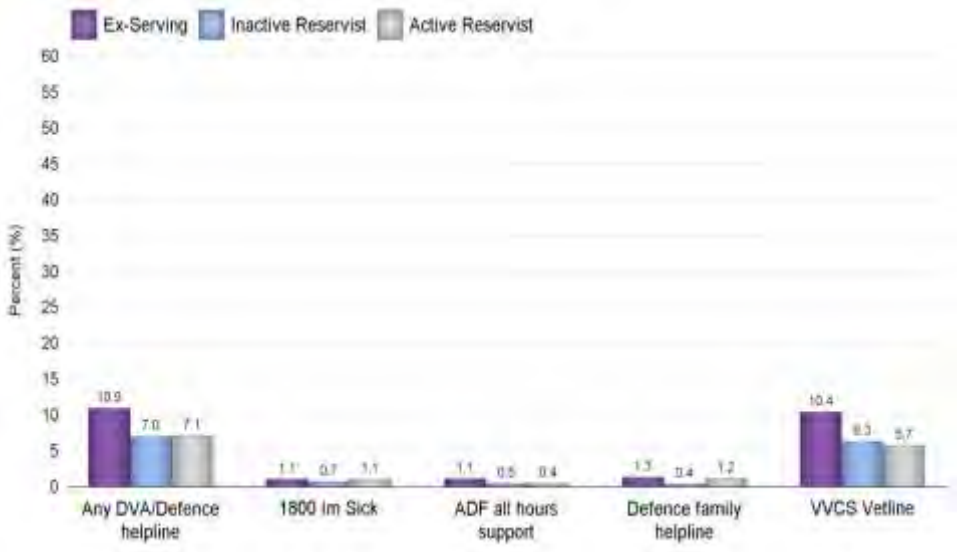


Table 8.10 Weighted estimate of Transitioned ADF members using DVA or Defence helplines in the last 12 months, by helpfulness

	Ex-Serving n = 10,876			Inactive Reservists n = 7513			Active Reservists n = 6426		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Defence Family Helpline	19	145	1.34 (0.77, 2.31)	8	32	0.42 (0.22, 0.81)	14	74	1.15 (0.59, 2.25)
Helpful?	*			*			8	32	42.81 (17.59, 72.42)
ADF All-hours Support	16	125	1.15 (0.62, 2.12)	7	37	0.50 (0.22, 1.14)	7	28	0.44 (0.22, 0.88)
Helpful?	*			*			*		
1800 IMSICK	18	115	1.06 (0.60, 1.87)	13	55	0.73 (0.43, 1.24)	13	69	1.07 (0.59, 1.91)
Helpful?	6	21	18.14 (7.49, 37.75)	6	27	48.68 (24.69, 73.29)	5	26	37.43 (15.76, 65.68)
VVCS Veterans Line	172	1131	10.40 (8.70, 12.39)	62	477	6.35 (4.63, 8.65)	75	368	5.73 (4.37, 7.47)
Helpful?	130	783	69.22 (59.57, 77.44)	45	328	68.89 (51.70, 82.08)	65	329	89.45 (81.37, 94.27)
Any of the above	181	1187	10.91 (9.16, 12.94)	71	523	6.96 (5.18, 9.29)	89	458	7.12 (5.56, 9.09)

Denominator: Entire cohort
Notes:
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.
* Cell sizes less than 5

Figure 8.9 Weighted estimate of Transitioned ADF members using DVA or Defence helplines in the last 12 months, by helpfulness



8.2.6 Other telephone helplines

Table 8.11 and Figure 8.10 list any other telephone helplines respondents used to inform or assess their mental health.

Overall, 2.24% of the entire Transitioned ADF population used any helpline to inform or assess their mental health, including Lifeline, MensLine Australia, MindSpot, Relationships Australia, SANE Australia and other helplines. Similarly, 2.27% of 2015 Regular ADF members used any helpline.

Of those respondents with a probable 30-day disorder, 4.00% of Transitioned ADF members and 7.39% of 2015 Regular ADF members used any telephone helpline.

The most common telephone helpline used by Transitioned ADF was another helpline, with 1.24% of this group reporting the use of this resource and 49.32% finding this helpful. In the 2015 Regular ADF, the Relationships Australia helpline was the most commonly used, at 1.75%, with 29.71% finding it helpful.

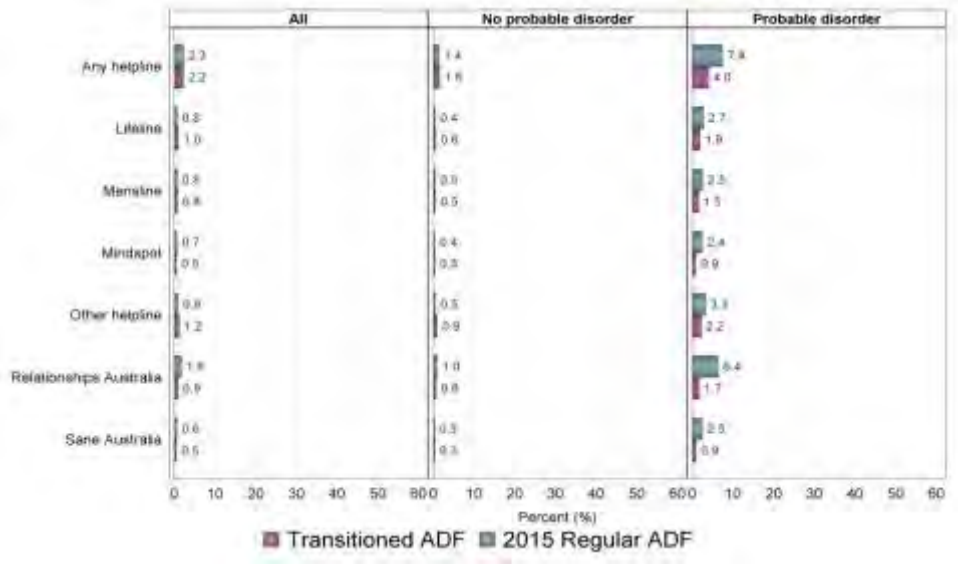
Of respondents with a probable 30-day disorder, Transitioned ADF again most commonly used other helplines (2.16%) and 50.59% found this helpful; and 6.36% of 2015 Regular ADF again using the Relationships Australia helpline.

Table 8.11 Weighted estimate of Transitioned ADF and 2015 Regular ADF members using other telephone helplines in the last 12 months, by helpfulness, stratified by probable 30-day disorder

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Lifeline	40	239	0.96 (0.66, 1.39)	45	407	0.77 (0.31, 1.92)
Helpful?	12	66	27.58 (15.27, 44.60)	17	61	14.92 (5.06, 36.60)
With probable 30-day disorder	26	131	1.86 (1.22, 2.82)	9	205	2.70 (0.46, 14.26)
Helpful?	10	52	40.10 (22.25, 61.04)	5	12	5.91 (0.84, 31.74)
MensLine Australia	32	199	0.80 (0.53, 1.20)	42	411	0.78 (0.32, 1.93)
Helpful?	7	37	18.81 (8.33, 37.13)	16	70	16.93 (5.64, 41.01)
With probable 30-day disorder	18	108	1.54 (0.92, 2.57)	*		
Helpful?	*			*		
MindSpot	20	125	0.50 (0.30, 0.85)	28	348	0.66 (0.23, 1.91)
Relationships Australia	41	234	0.94 (0.65, 1.35)	73	919	1.75 (0.79, 3.82)
Helpful?	13	72	30.78 (16.64, 49.77)	36	273	29.71 (8.24, 66.55)
With probable 30-day disorder	24	118	1.68 (1.10, 2.55)	9	482	6.36 (1.71, 21.01)
SANE Australia	20	125	0.50 (0.30, 0.85)	25	339	0.65 (0.22, 1.91)
With probable 30-day disorder	11	63	0.89 (0.46, 1.71)	*		
Other helpline	56	309	1.24 (0.91, 1.69)	67	491	0.94 (0.44, 1.99)
Helpful?	29	152	49.32 (34.22, 64.55)	39	139	28.37 (11.59, 54.47)
With probable 30-day disorder	29	152	2.16 (1.45, 3.21)	14	246	3.25 (0.74, 13.10)
Helpful?	15	77	50.59 (31.51, 69.50)	11	51	20.61 (3.43, 65.44)
Any helpline	99	559	2.24 (1.78, 2.83)	149	1192	2.27 (1.23, 4.16)
With probable 30-day disorder	56	281	4.00 (3.02, 5.29)	29	560	7.39 (2.39, 20.68)

Denominator: Entire cohort
Notes:
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.
* Cell sizes less than 5

Figure 8.10 Weighted estimate of Transitioned ADF and 2015 Regular ADF members using other telephone helplines in the last 12 months, by helpfulness, stratified by probable 30-day disorder



8.2.7 Ex-service organisation

Table 8.12 outlines the proportion of Transitioned ADF and 2015 Regular ADF members who used an ex-service organisation to inform or assess their mental health.

In total, 9.22% of Transitioned ADF members reported using an ex-service organisation to inform or assess their mental health, and 75.75% found this service helpful. Of the 2015 Regular ADF members, 2.94% used an ex-service organisation and 69.39% found it helpful.

Of those respondents with a probable 30-day disorder, 18.45% of Transitioned ADF members and 6.54% of 2015 Regular ADF members used an ex-service organisation (77.36% and 50.78% found it helpful, respectively).

Table 8.13 outlines the proportion of Transitioned ADF members by category who used an ex-service organisation to inform or assess their mental health. The proportion of Transitioned ADF respondents reporting using an ex-service organisation to inform or assess their mental health, was 12.32% for the Ex-Serving ADF, where 77.14% found this helpful; 7.39% for the Inactive Reservists, where 73.99% found it helpful; and 6.07% for the Active Reservists, where 76.09% found it helpful.

Table 8.12 Weighted estimate of Transitioned ADF and 2015 Regular ADF members using an ex-service organisation in the last 12 months, by helpfulness, stratified by probable 30-day disorder

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Ex-service organisation	409	2299	9.22 (8.23, 10.32)	257	1543	2.94 (1.91, 4.50)
Helpful?	320	1742	75.75 (70.05, 80.67)	201	1071	69.39 (46.88, 85.34)
With probable 30-day disorder	235	1296	18.45 (15.95, 21.25)	71	495	6.54 (3.08, 13.33)
Helpful?	190	1002	77.36 (69.66, 83.57)	59	251	50.78 (18.32, 82.60)

Denominator: Entire cohort
Notes:
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval

Table 8.13 Weighted estimate of utilisation of Transitioned ADF members using an ex-service organisation in the last 12 months, by helpfulness

	Ex-Serving n = 10,876			Inactive Reservists n = 7513			Active Reservists n = 6426		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Ex-service organisation	241	1340	12.32 (10.61, 14.27)	80	555	7.39 (5.57, 9.75)	87	390	6.07 (4.83, 7.60)
Helpful?	192	1034	77.14 (69.58, 83.28)	62	411	73.99 (58.69, 85.06)	66	297	76.09 (65.15, 84.41)

Denominator: Entire cohort
Note: 95% CI: 95% confidence interval

8.3 Self-help strategies used to maintain mental health

Table 8.14 and Figure 8.11 outline a number of self-help strategies Transitioned ADF and 2015 Regular ADF members used to maintain their mental health. These strategies include communicating with a chaplain, church leader or faith group; increasing their level of physical activity; doing more of the things they enjoy; and seeking support from family members or friends. Among Transitioned ADF members, 41.56% increased their physical activity to maintain their mental health, and 86.51% found this helpful. Similarly, 45.46% of 2015 Regular ADF did this, and 90.45% found it helpful. Transitioned ADF were least likely to talk to a chaplain/church leader or faith group, at 7.25%, but of those who did, 73.92% found this helpful. Similarly, 15.13% of 2015 Regular ADF talked to a chaplain/church leader or faith group, with 83.67% finding this helpful.[3]

Table 8.15 and Figure 8.12 explore the proportion of Transitioned ADF members by category of self-help strategies used to maintain their mental health. Increasing physical activity was the most common strategy for Transitioned ADF respondents who reported using self-help strategies to maintain their mental health. This included 42.41% of Ex-Serving ADF members (83.78% of whom found it helpful), 41.04% of Inactive Reservists (86.78% of whom found it helpful) and 40.57% of Active Reservists (90.72% of whom found it helpful).

[3] It is worth noting the unique role of an ADF chaplain in helping support general welfare and provide counselling, regardless of the individual's faith or religious beliefs. The data do not capture this particular aspect of the chaplain's role.

Table 8.14 Weighted estimate of Transitioned ADF and 2015 Regular ADF members using self-help strategies to maintain their mental health in the last 12 months, by helpfulness

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Chaplain, church leader or faith group	270	1809	7.25 (6.26, 8.39)	966	7942	15.13 (12.29, 18.49)
Helpful?	210	1337	73.92 (66.49, 80.19)	823	6646	83.67 (72.62, 90.83)
Increased physical activity	1590	10,361	41.56 (39.61, 43.53)	3890	23,864	45.46 (41.75, 49.22)
Helpful?	1391	8963	86.51 (84.18, 88.54)	3581	21,584	90.45 (86.51, 93.33)
Do more things you enjoy	1403	9182	36.83 (34.93, 38.77)	3187	19,551	37.24 (33.71, 40.91)
Helpful?	1224	7968	86.78 (84.37, 88.86)	2977	18,060	92.37 (88.19, 95.15)
Support from family members or friends	1304	8511	34.14 (32.29, 36.04)	2800	18233	34.73 (31.13, 38.51)
Helpful?	1143	7335	86.18 (83.59, 88.41)	2580	16,821	92.25 (88.09, 95.04)

Denominator: Entire cohort
Notes:
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 8.11 Weighted estimate of Transitioned ADF and 2015 Regular ADF members using self-help strategies to maintain their mental health in the last 12 months, stratified by probable 30-day disorder

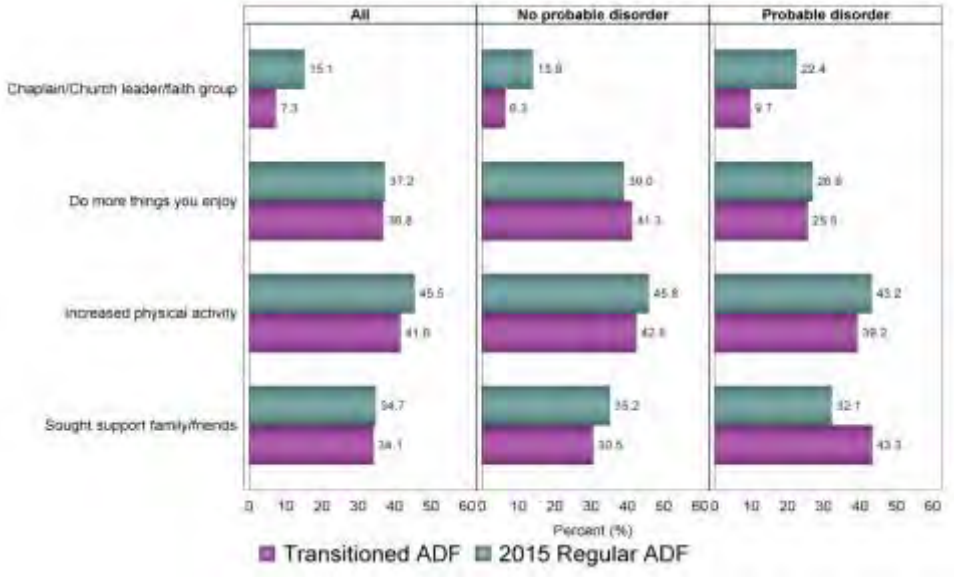
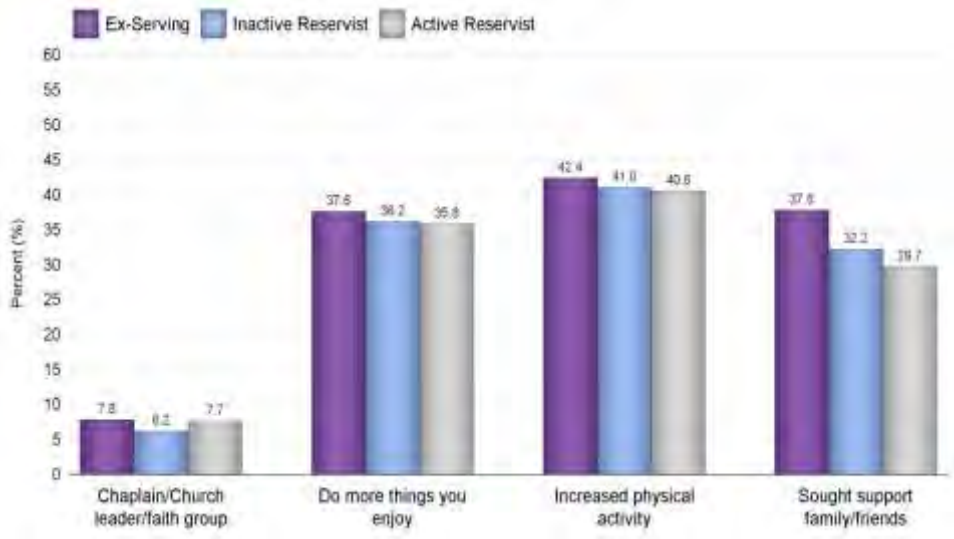


Table 8.15 Weighted estimate of Transitioned ADF members using self-help strategies to maintain their mental health in the last 12 months, by helpfulness

	Ex-Serving n = 10,876			Inactive Reservists n = 7513			Active Reservists n = 6426		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Chaplain, church leader or faith group	116	851	7.83 (6.26, 9.75)	61	465	6.19 (4.47, 8.50)	93	492	7.66 (5.92, 9.87)
Helpful?	86	619	72.71 (61.64, 81.54)	48	367	79.02 (62.44, 89.51)	76	351	71.20 (55.75, 82.91)
Increased physical activity	607	4613	42.41 (39.23, 45.66)	463	3083	41.04 (37.25, 44.93)	512	2607	40.57 (37.25, 43.98)
Helpful?	511	3865	83.78 (79.76, 87.13)	404	2676	86.78 (82.01, 90.43)	468	2365	90.72 (86.85, 93.53)
Do more things you enjoy	515	4092	37.62 (34.52, 40.83)	412	2719	36.19 (32.51, 40.04)	469	2302	35.81 (32.69, 39.06)
Helpful?	429	3410	83.34 (78.94, 86.96)	364	2439	89.70 (85.51, 92.77)	424	2049	89.04 (84.57, 92.33)
Support from family members or friends	589	4114	37.83 (34.82, 40.94)	337	2421	32.22 (28.60, 36.07)	371	1908	29.68 (26.69, 32.86)
Helpful?	501	3404	82.74 (78.44, 86.33)	297	2122	87.64 (82.12, 91.63)	338	1740	91.23 (87.16, 94.10)

Denominator: Entire cohort
Notes:
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.

Figure 8.12 Weighted estimate of Transitioned ADF members using self-help strategies to maintain their mental health in the last 12 months



8.4 Preferred means of receiving mental health information

Table 8.16 and Figure 8.13 outline Transitioned ADF and 2015 Regular ADF members' preferred means of receiving mental health information, including face to face, over the telephone and via the internet.

Transitioned ADF member's preferred method of receiving mental health information is via direct face-to-face communication; 49.44% of the population choosing this option. This was similar (59.67%) if the respondent had a probable 30-day disorder. 2015 Regular ADF members were also most likely to prefer face-to-face communication (55.88%), dropping to 52.17% if they had a probable 30-day disorder.

Table 8.17 and Figure 8.14 present Transitioned ADF members' preferred method of receiving health information, by category. The majority of Transitioned ADF respondents preferred to receive health information face to face; 53.39% of Ex-Serving ADF members, 45.57% of Inactive Reservists and 46.82% of Active Reservists reported this.

Table 8.16 Weighted estimate of Transitioned ADF and 2015 Regular ADF members' preferred methods of receiving health information, stratified by probable 30-day disorder

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
All	n = 24,932			n = 52,500		
Face to face	1902	12,325	49.44 (47.44, 51.44)	4484	29,335	55.88 (52.01, 59.67)
Telephone	151	1219	4.89 (4.01, 5.95)	178	1106	2.11 (1.22, 3.61)
Internet	1182	7825	31.39 (29.56, 33.27)	2199	14,975	28.52 (25.15, 32.15)
Probable 30-day disorder	n = 7023			n = 7575		
Face to face	637	4191	59.67 (55.89, 63.33)	630	3952	52.17 (41.30, 62.83)
Telephone	45	350	4.98 (3.45, 7.13)	33	429	5.67 (1.64, 17.78)
Internet	261	1881	26.78 (23.57, 30.27)	209	2235	29.50 (19.96, 41.24)
No probable 30-day disorder	n = 17,909			n = 44,925		
Face to face	1265	8135	45.42 (43.07, 47.79)	3854	25,383	56.50 (52.37, 60.55)
Telephone	106	869	4.85 (3.83, 6.13)	145	677	1.51 (1.01, 2.23)
Internet	921	5944	33.19 (31.00, 35.46)	1990	12740	28.36 (24.83, 32.18)

Denominator: Entire cohort
Notes:
Based on weighted counts, 7085 (13.49%) of 2015 Regular ADF members and 3562 (14.29%) of Transitioned ADF members had missing values for this question. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval

Figure 8.13 Weighted estimate of Transitioned ADF and 2015 Regular ADF members' preferred methods of receiving health information, stratified by probable 30-day disorder

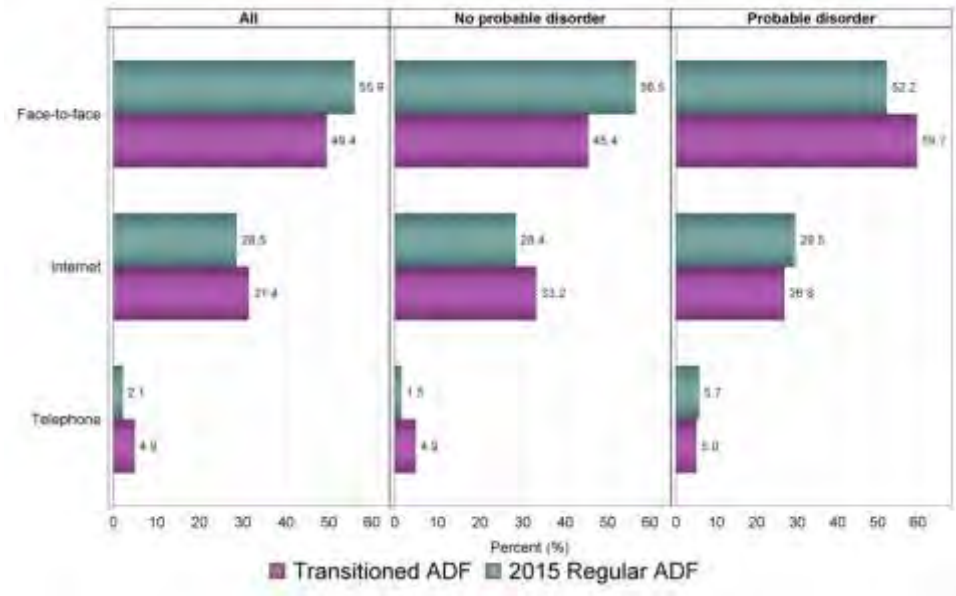
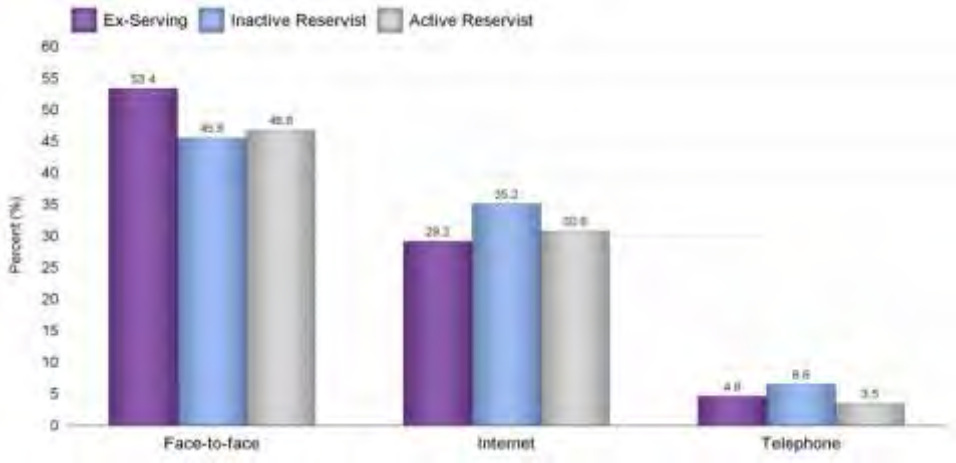


Table 8.17 Weighted estimate of Transitioned ADF members' preferred methods of receiving health information

	Ex-Serving n = 10,876			Inactive Reservists n = 7513			Active Reservists n = 6426		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Face to face	807	5807	53.39 (50.13, 56.62)	485	3424	45.57 (41.66, 49.54)	600	3009	46.82 (43.48, 50.19)
Telephone	60	502	4.61 (3.36, 6.30)	51	492	6.55 (4.66, 9.13)	40	225	3.50 (2.34, 5.20)
Internet	404	3175	29.19 (26.30, 32.27)	397	2641	35.15 (31.54, 38.93)	378	1981	30.83 (27.72, 34.12)

Denominator: Entire cohort
Notes:
Based on weighted counts, 1392 (12.80%) of Ex-Serving members, 1211 (18.85%) of Active Reservists and 956 (12.72%) of Inactive Reservists had a missing value for this question.
However, distributions are calculated by including those with a missing value to allow for correct weighted totals
95% CI: 95% confidence interval

Figure 8.14 Weighted estimate of Transitioned ADF members' preferred methods of receiving health information



9 Stigmas, and barriers to and facilitators of help-seeking

Key findings

Stigmas and barriers to care

- Stigma items Transitioned ADF and 2015 Regular ADF members most commonly endorsed were perceptions that they would be subject to others losing confidence in them (40.0% and 44.6%), be seen as weak (28.8% and 31.3%), be treated differently (32.5% and 36.3%), feel worse due to being unable to solve their own problems (35.5% and 27.2%), and feel embarrassed (31.7% and 24.8%).
- Transitioned ADF and 2015 Regular ADF members with a probable 30-day disorder were more likely to endorse each stigma item.
- The most common reasons for Transitioned ADF and 2015 Regular ADF members not seeking assistance were a perceived ability to self-manage (76.7% and 80.1%), ability to function effectively (80.6% and 82.4%) and feeling afraid to ask (42.6% and 44.9%).
- The proportion of Transitioned ADF and 2015 Regular ADF with a probable 30-day disorder who reported a lack of confidence or trust in mental health professionals was double (21.9% and 17.0%) those who reported mental health concerns but had no disorder (12.2% and 9.5%).
- While 34.9% and 37.4% of the Transitioned ADF and 2015 Regular ADF groups respectively did not report any stigmas, 33.6% and 30.0% respectively held four or more. Among Transitioned ADF and 2015 Regular ADF members with a probable 30-day disorder, 56.2% and 43.8% respectively held four or more stigma-related beliefs.
- The most common barriers to care among all three Transitioned ADF sub-groups were expense and the possibility that seeking assistance could harm their career or career prospects.

Glossary: refer to the Glossary of terms for definitions of key terms in this section.

9.1 Introduction

The following chapter will examine stigmas and barriers to care among Transitioned ADF members, according to their transition status (Ex-Serving, Inactive Reservist or Active Reservist); whether they meet diagnostic symptoms cut-offs for a probable 30-day mental disorder, and in comparison to the 2015 Regular ADF.

9.1.1 Key questions addressed in this chapter

This chapter examines:

- What are the perceived stigmas and barriers to receiving care in Transitioned ADF and 2015 Regular ADF members?
- Is there a significant difference in types of stigmas and perceived barriers endorsed by Transitioned ADF and 2015 Regular ADF members?
- Is there a significant difference in type and number of stigmas and perceived barriers reported by those who have never had assistance or sought help from a general practitioner (GP), psychologist, psychiatrist, other mental health professional (for non-help-seekers) compared to those who have sought and/or received help, and is this pattern different in Transitioned ADF versus 2015 Regular ADF members (help-seekers)?
- Is there a significant difference in the types of stigmas and barriers to care endorsed by those who score above (probable 30-day mental disorder) and below the epidemiological cut-off on the Posttraumatic Stress Disorder Checklist (PCL), Kessler Psychological Distress Scale (K10) and Alcohol Use Disorders Identification Test (AUDIT) (no probable 30-day mental disorder) in Transitioned ADF and 2015 Regular ADF members?
- Among the Transitioned ADF and 2015 Regular ADF members who have been concerned about their mental health but never sought assistance, what are the reasons why?

9.2 Measures

9.2.1 Stigmas and barriers to care

To examine stigmas and barriers to care, participants were asked to rate the degree to which a list of 'concerns' might affect their decision to seek help. These concerns included six 'barriers' to care – such as 'I wouldn't know where to get help' and 'It's too expensive' – and 12 stigmas, including 'Might lose control of emotions or reactions' and 'People would treat me differently'. Each item was anchored from 'strongly disagree' to 'strongly agree'. Response categories of 'strongly agree' and 'agree' were combined to produce prevalence rates for each concern. Items in this section were taken from the 2010 ADF Mental Health Prevalence Wellbeing Study (MHPWS) (McFarlane et al., 2011), the Canadian Air Forces Recruit Mental Health Service Use Questionnaire (Fikretoglu et al., 2014), and the Solider Wellbeing Survey (Riviere, 2011), (Thomas, 2010), with several additions by investigators.

9.2.2 Grouping variables – probable 30-day mental disorder

The probable 30-day mental disorder category includes all those scoring equal to or above 26 on the K10, or 53 on the PCL. Those who scored under these cut-offs on all measures were grouped as no probable 30-day mental disorder. These cut-offs were derived using Receiver Operating Characteristic (ROC) analysis in order to detect 30-day ICD-10 disorder and are described in detail in the MHPWS report.

9.3 Stigmas and barriers to care for Transitioned ADF and 2015 Regular ADF members

9.3.1 Stigmas about seeking help

Table 9.1 and Figure 9.1 summarise the self-reported stigmas about seeking help for a mental health problem that might affect Transitioned ADF and 2015 Regular ADF respondents' decisions to seek care. The most commonly held stigma was that 'People have less confidence in me' if they sought help, at 39.96% for Transitioned ADF members. This was also the case with 2015 Regular ADF, at 44.61%. The next most commonly cited categories for Transitioned ADF members were 'Feel worse if can't solve own problems' (35.51%) and 'People would treat me differently' (32.51%). For 2015 Regular ADF members, the next most common stigmas were 'People would treat me differently' (36.25%) and 'Would be seen as weak' (31.25%).

Similar results were found in those respondents with a probable 30-day disorder. Again, the most commonly held stigma was 'People have less confidence in me' if they sought help, at 57.61% for Transitioned ADF and 59.76% for 2015 Regular ADF respondents. The next most commonly cited categories for Transitioned ADF members were 'Feel worse if can't solve own problems' (51.47%) and 'People would treat me differently' (50.81%). For 2015 Regular ADF members, these were 'Would be seen as weak' (47.93%) and 'People would treat me differently' (47.61%). Endorsing stigma items was more prevalent in those with a probable 30-day disorder compared to those without a probable 30-day disorder.

Table 9.2 and Figure 9.2 explain the self-reported stigmas about seeking help for a mental health problem that might affect Transitioned ADF members' decision to seek care, by category. The most commonly reported stigma among all Transitioned ADF respondents was 'People have less confidence in me', reported by 40.99% of Ex-Serving ADF members, 42.82% of Inactive Reservists and 35.15% of Active Reservists. The next most common stigma was 'Feel worse if can't solve own problems' for all Transitioned ADF members, and then 'People would treat me differently' for Ex-Serving ADF and Inactive Reservists, and 'would feel embarrassed' for Active Reservists.

Table 9.1 Weighted estimate of Transitioned ADF and 2015 Regular ADF members endorsing stigmas about seeking help for mental health problems, stratified by probable 30-day disorder

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
All	n = 24,932			n = 52,500		
Wouldn't understand problems	822	5712	22.91 (21.24, 24.67)	747	5499	10.47 (8.21, 13.27)
Outcome beyond my control	559	3645	14.62 (13.26, 16.09)	1135	7644	14.56 (12.04, 17.50)
Would feel inadequate	728	4725	18.95 (17.45, 20.55)	1100	6838	13.02 (10.80, 15.63)
Would feel embarrassed	1186	7894	31.66 (29.82, 33.56)	2048	13,040	24.84 (21.71, 28.25)
Feel worse if can't solve own problems	1320	8854	35.51 (33.62, 37.45)	2248	14,263	27.17 (23.96, 30.64)
Should be able snap out of it	155	1056	4.24 (3.50, 5.12)	182	1421	2.71 (1.54, 4.71)
Might feel worse	453	3165	12.70 (11.41, 14.11)	579	4308	8.21 (6.10, 10.95)
Might lose control of emotions/reactions	640	4133	16.58 (15.18, 18.07)	834	5641	10.74 (8.47, 13.54)
People would treat me differently	1210	8104	32.51 (30.64, 34.42)	2600	19,029	36.25 (32.54, 40.12)
Would be seen as weak	1105	7185	28.82 (27.05, 30.65)	2132	16,404	31.25 (27.66, 35.07)
People have less confidence in me	1511	9964	39.96 (38.01, 41.95)	3296	23,422	44.61 (40.77, 48.52)
Don't trust mental health professionals	540	3727	14.95 (13.54, 16.48)	772	5572	10.61 (8.40, 13.32)
Probable 30-day disorder	n = 7023			n = 7575		
Wouldn't understand problems	406	2725	38.81 (35.21, 42.53)	186	1558	20.57 (12.74, 31.47)
Outcome beyond my control	302	2000	28.47 (25.22, 31.97)	239	1675	22.11 (14.48, 32.26)
Would feel inadequate	329	2260	32.18 (28.76, 35.80)	246	2179	28.77 (19.50, 40.24)
Would feel embarrassed	485	3372	48.02 (44.27, 51.78)	401	2579	34.05 (25.15, 44.24)
Feel worse if can't solve own problems	525	3615	51.47 (47.71, 55.21)	415	2601	34.34 (25.47, 44.45)
Should be able snap out of it	78	531	7.56 (5.79, 9.81)	34	156	2.06 (1.32, 3.20)
Might feel worse	232	1691	24.08 (20.98, 27.49)	136	1141	15.07 (8.38, 25.62)
Might lose control of emotions/reactions	338	2308	32.87 (29.45, 36.47)	232	1891	24.96 (16.24, 36.33)
People would treat me differently	528	3568	50.81 (47.04, 54.57)	524	3607	47.61 (37.07, 58.37)
Would be seen as weak	514	3443	49.02 (45.27, 52.78)	481	3630	47.93 (37.23, 58.81)
People would have less confidence in me	603	4046	57.61 (53.83, 61.30)	615	4527	59.76 (48.85, 69.79)
Don't trust mental health professionals	225	1540	21.92 (18.95, 25.22)	153	1289	17.02 (10.08, 27.28)

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
No probable 30-day disorder	n = 17,909			n = 44,925		
Wouldn't understand problems	416	2987	16.68 (14.91, 18.61)	561	3940	8.77 (6.65, 11.48)
Outcome beyond my control	257	1645	9.19 (7.90, 10.65)	896	5969	13.29 (10.71, 16.37)
Would feel inadequate	399	2464	13.76 (12.25, 15.43)	854	4659	10.37 (8.55, 12.53)
Would feel embarrassed	701	4521	25.25 (23.25, 27.35)	1647	10,461	23.29 (20.01, 26.92)
Feel worse if can't solve own problems	795	5239	29.26 (27.13, 31.48)	1833	11,662	25.96 (22.57, 29.66)
Should be able snap out of it	77	525	2.93 (2.23, 3.85)	148	1265	2.82 (1.50, 5.21)
Might feel worse	221	1474	8.23 (7.00, 9.65)	443	3166	7.05 (5.00, 9.86)
Might lose control of emotions/reactions	302	1824	10.19 (8.90, 11.64)	602	3750	8.35 (6.32,10.95)
People would treat me differently	682	4536	25.33 (23.29, 27.48)	2076	15,423	34.33 (30.46, 38.42)
Would be seen as weak	591	3742	20.89 (19.05, 22.86)	1651	12,774	28.43 (24.70, 32.49)
People have less confidence in me	908	5918	33.04 (30.84, 35.32)	2681	18,895	42.06 (38.03, 46.20)
Don't trust mental health professionals	315	2187	12.21 (10.68, 13.93)	619	4282	9.53 (7.34, 12.29)

Denominator: Entire cohort
Notes:
A 'stigma' refers to the participant providing a response of 'Strongly agree' or 'Agree' for the related question
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
These are not mutually exclusive groups and therefore do not sum to 100%.
95% CI: 95% confidence interval

Figure 9.1 Weighted estimate of Transitioned ADF and 2015 Regular ADF members endorsing stigmas about seeking help for mental health problems, stratified by probable 30-day disorder

Table 9.2 Weighted estimate of Transitioned ADF members believing stigmas about seeking help with mental health problems

	Ex-Serving n = 10,876			Inactive Reservists n = 7513			Active Reservists n = 6426		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Wouldn't understand problems	423	3031	27.87 (25.08, 30.85)	226	1745	23.23 (19.99, 26.82)	172	920	14.32 (12.06, 16.92)
Outcome beyond my control	279	1909	17.55 (15.27, 20.09)	152	1114	14.82 (12.19, 17.91)	126	614	9.55 (7.82, 11.63)
Would feel inadequate	333	2329	21.42 (18.95, 24.11)	208	1463	19.47 (16.52, 22.81)	185	925	14.40 (12.23, 16.89)
Would feel embarrassed	507	3654	33.60 (30.64, 36.70)	336	2336	31.10 (27.55, 34.88)	339	1887	29.37 (26.24, 32.70)
Feel worse if can't solve own problems	567	4109	37.78 (34.76, 40.90)	383	2814	37.46 (33.66, 41.42)	365	1900	29.56 (26.50, 32.81)
Should be able snap out of it	72	484	4.45 (3.35, 5.90)	43	341	4.53 (3.09, 6.60)	40	231	3.59 (2.47, 5.19)
Might feel worse	213	1567	14.41 (12.32, 16.78)	138	996	13.25 (10.82, 16.14)	99	580	9.03 (7.10, 11.41)
Might lose control of emotions or reactions	308	2092	19.24 (16.94, 21.77)	181	1223	16.28 (13.63, 19.34)	150	813	12.66 (10.55, 15.11)
People would treat me differently	541	3829	35.21 (32.22, 38.33)	336	2501	33.29 (29.58, 37.21)	328	1743	27.12 (24.09, 30.38)
Would be seen as weak	500	3441	31.64 (28.80, 34.62)	317	2207	29.37 (25.91, 33.09)	284	1521	23.67 (20.77, 26.83)
People have less confidence in me	640	4458	40.99 (37.89, 44.17)	445	3217	42.82 (38.90, 46.82)	418	2259	35.15 (32.00, 38.42)
Don't trust Mental Health Professionals	249	1818	16.71 (14.46, 19.24)	157	1152	15.33 (12.63, 18.50)	133	742	11.54 (9.39, 14.11)

Denominator: Those who were concerned but did not seek care
Notes:
A 'stigma' refers to the participant providing a response of 'Strongly agree' or 'Agree' for the related question.
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.

Figure 9.2 Weighted estimate of Transitioned ADF members believing stigmas about seeking help with mental health problems

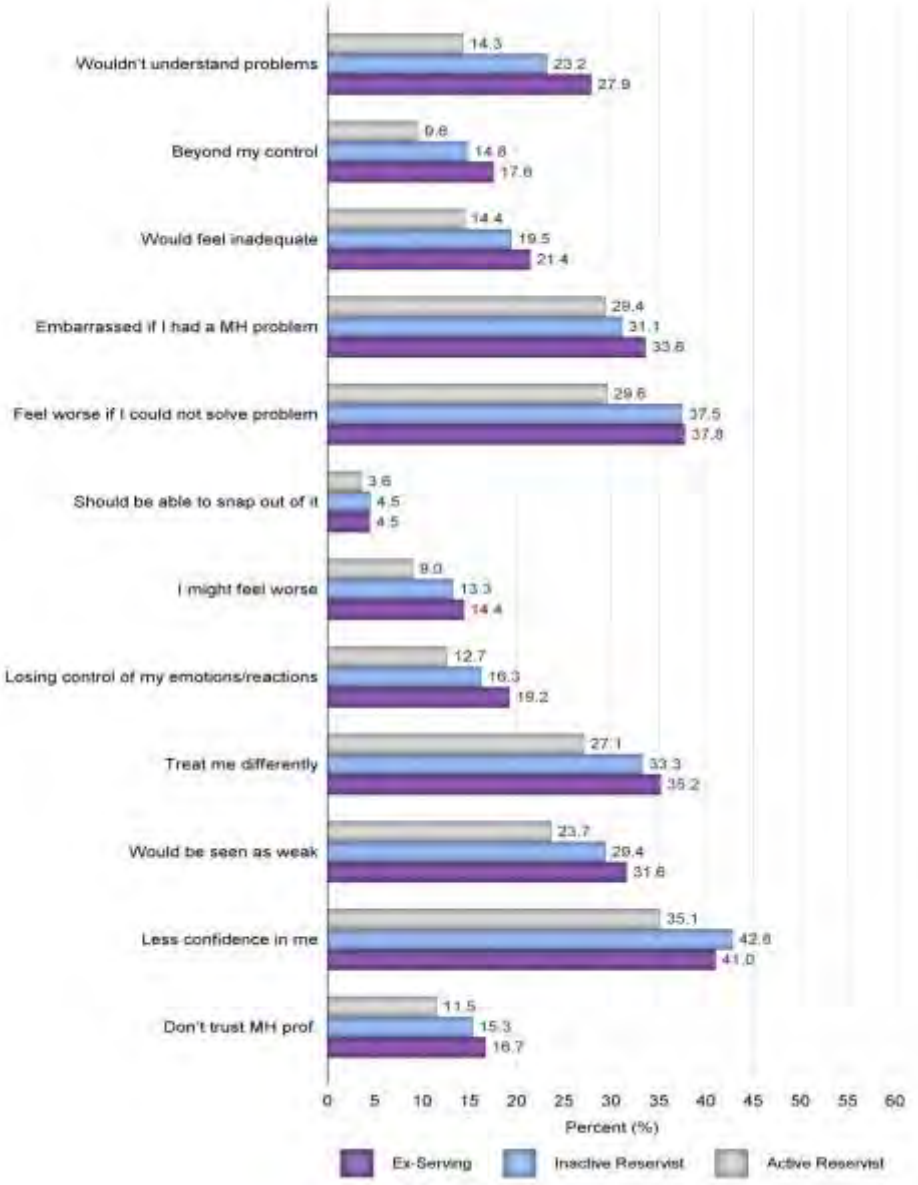


Table 9.3 and Figure 9.3 summarise the number of self-reported stigmas about seeking help with a mental health problem that might affect Transitioned ADF and 2015 Regular ADF members' decision to seek care.

Fortunately, the largest group of respondents for the Transitioned ADF (34.96%) and 2015 Regular ADF (37.39%) groups did not endorse any stigmas. However, 33.60% of Transitioned ADF and 30.01% of 2015 Regular ADF members did endorse four or more stigmas in relation to seeking help with their mental health care.

The results were similar for those with a probable 30-day disorder. For both Transitioned ADF (18.64%) and 2015 Regular ADF (32.82%) groups, many respondents did not endorse any stigmas, although this was significantly different between the two groups. Additionally, 56.23% of Transitioned ADF members with a probable 30-day disorder and 43.80% of 2015 Regular ADF members with a probable 30-day disorder did endorse four or more stigmas in relation to seeking help with their mental health care. The investigators more closely examined engagement with services in the last 12 months for Transitioned ADF and 2015 Regular ADF members who had a probable 30-day disorder, in each of these five stigma endorsement categories. This closer examination indicated that care-seeking was largely proportional to group size. For example, those with a probable 30-day disorder who endorsed four or more stigma-related beliefs – representing 56.23% and 43.80% of Transitioned ADF and 2015 Regular ADF members – also represented 61.59% and 53.64% of Transitioned ADF and 2015 Regular ADF members who had sought care in the last 12 months.

Table 9.4 and Figure 9.4 summarise the number of self-reported stigmas about seeking help for a mental health problem that might affect respondents' decision to seek care in Transitioned ADF by category.

The proportion of Transitioned ADF respondents reporting no stigmas was 30.22% for the Ex-Serving ADF, 35.01% for the Inactive Reservists and 3.03% for the Active Reservists. However, 36.01% of the Ex-Serving ADF and 34.46% of Inactive Reservists reported four or more stigmas, with 42.67% of Active Reservists reporting one stigma.

Table 9.3 Weighted estimate of the number of stigmas about seeking help with a mental health problem Transitioned ADF and 2015 Regular ADF members endorsed, stratified by probable 30-day disorder

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
All	n = 24,932			n = 52,500		
None	1392	8717	34.96 (33.10, 36.88)	3069	19,630	37.39 (33.86, 41.06)
One	384	2630	10.55 (9.36, 11.87)	880	5498	10.47 (8.45, 12.92)
Two	318	2207	8.85 (7.75, 10.10)	713	4752	9.05 (7.07, 11.52)
Three	296	2124	8.52 (7.42, 9.77)	708	5294	10.08 (7.76, 13.00)
Four or more	1266	8377	33.60 (31.73, 35.52)	2212	15,756	30.01 (26.53, 33.74)
Probable 30-day disorder	n = 7023			n = 7575		
None	199	1309	18.64 (15.93, 21.69)	245	2486	32.82 (23.20, 44.13)
One	67	398	5.67 (4.28, 7.47)	63	316	4.17 (2.93, 5.89)
Two	67	474	6.75 (5.08, 8.91)	61	626	8.26 (3.44, 18.53)
Three	92	707	10.07 (7.92, 12.71)	102	770	10.17 (4.98, 19.64)
Four or more	576	3949	56.23 (52.47, 59.92)	482	3318	43.80 (33.54, 54.61)
No probable 30-day disorder	n = 17,909			n = 44,925		
None	1193	7408	41.36 (39.06, 43.71)	2824	17,144	38.16 (34.44, 42.03)
One	317	2232	12.46 (10.94, 14.17)	817	5182	11.54 (9.20, 14.36)
Two	251	1733	9.68 (8.32, 11.24)	652	4126	9.18 (7.14, 11.74)
Three	204	1417	7.91 (6.68, 9.36)	606	4524	10.07 (7.60, 13.23)
Four or more	690	4427	24.72 (22.74, 26.82)	1730	12,439	27.69 (24.10, 31.59)

Denominator: Entire cohort
Notes:
Based on weighted counts. 1570 (2.99%) 2015 Regular ADF members and 877 (3.52%) Transitioned ADF members had a missing value for all questions related to stigmas. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval

Figure 9.3 **Weighted estimate of number of stigmas about seeking help for mental health problem in the Transitioned ADF and 2015 Regular ADF, stratified by probable 30-day disorder**

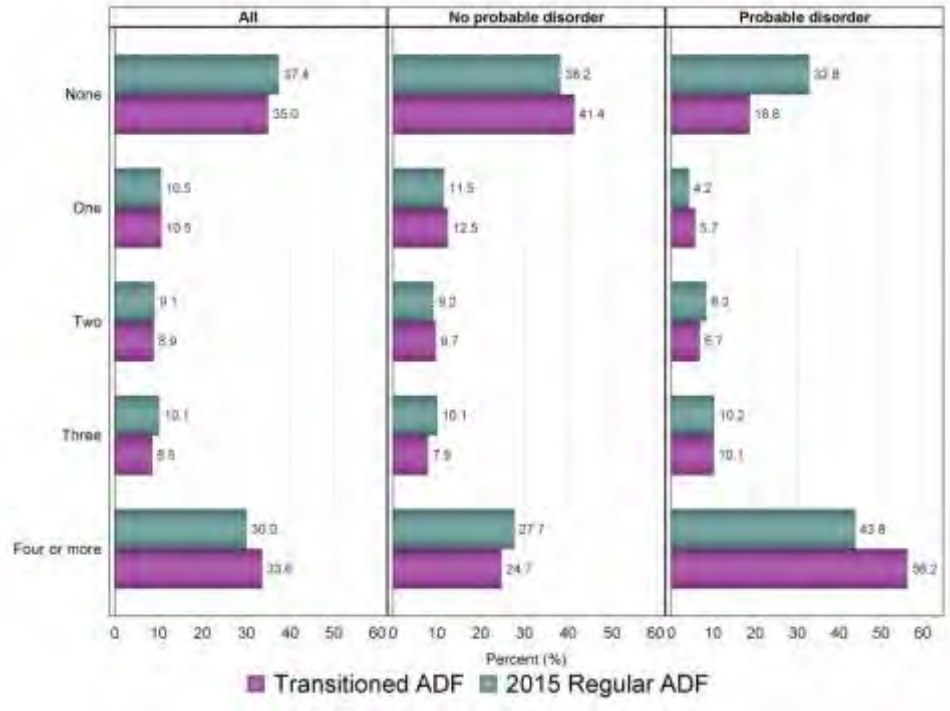
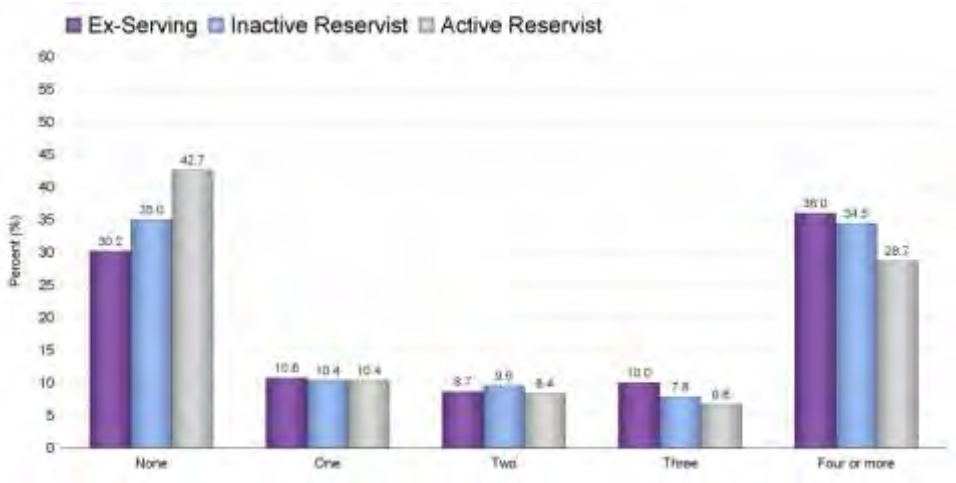


Table 9.4 Weighted estimate of number of stigmas about seeking help for mental health problem in the Transitioned ADF

	Ex-Serving n = 10,876			Inactive Reservists n = 7513			Active Reservists n = 6426		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
None	430	3286	30.22 (27.31, 33.29)	402	2630	35.01 (31.37, 38.84)	556	2742	42.67 (39.36, 46.05)
One	143	1172	10.78 (8.88, 13.02)	109	785	10.45 (8.22, 13.20)	131	670	10.43 (8.51, 12.72)
Two	118	941	8.65 (6.96, 10.71)	97	719	9.57 (7.39, 12.30)	101	540	8.41 (6.63, 10.61)
Three	130	1091	10.03 (8.19, 12.23)	80	590	7.85 (5.92, 10.34)	84	435	6.77 (5.16, 8.84)
Four or more	564	3917	36.01 (33.04, 39.10)	361	2589	34.46 (30.75, 38.38)	337	1844	28.69 (25.61, 31.99)

Denominator: Entire cohort
Notes:
Based on weighted counts, 469 (4.31%) Ex-Serving ADF members, 200 (2.66%) Inactive Reservists and 195 (3.03%) Active Reservists had a missing value on all related stigma questions.
However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
95% CI: 95% confidence interval

Figure 9.4 Weighted estimate of number of stigmas about seeking help for mental health problem in the Transitioned ADF



9.3.2 Barriers to seeking help

Table 9.5 and Figure 9.5 summarise the self-reported barriers to seeking help for a mental health problem that might affect Transitioned ADF and 2015 Regular ADF respondents' decision to seek care. The most commonly held barrier was that 'Harm my career/career prospects' if they sought help, at 30.34% for Transitioned ADF members. For the 2015 Regular ADF this was 'Stop me from being deployed', at 47.38%. The next most commonly cited barriers for Transitioned ADF members were 'Too expensive' (29.99%) and 'Difficulty getting time off work' (20.60%). For 2015 Regular ADF member, these were 'Harm my career/career prospects' (38.69%) and 'Difficulty getting time off work' (19.88%).

Results were similar among those with a probable 30-day disorder. For Transitioned ADF members, the most commonly held barrier was 'too expensive' (42.20%), 'Harm my career or career prospects' (41.89%) and 'Difficulty getting time off work' (29.69%). For 2015 Regular ADF members, these barriers were 'Stop me from being deployed' (47.17%) 'Harm my career/career prospects' (46.02%) and 'Difficulty getting time off work' (26.90%).

Table 9.5 Weighted estimate of barriers to seeking help with mental health problems among Transitioned ADF and 2015 Regular ADF members, stratified by probable 30-day disorder

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
All	n = 24,932			n = 52,500		
Too expensive	974	7477	29.99 (28.14, 31.91)	474	3432	6.54 (4.83, 8.80)
Wouldn't know where to get help	406	3226	12.94 (11.57, 14.44)	484	4226	8.05 (5.89, 10.92)
Difficulty getting time off work	693	5136	20.60 (18.96, 22.34)	1110	10,435	19.88 (16.57, 23.65)
Harm my career/ career prospects	1098	7563	30.34 (28.49, 32.25)	2795	20,314	38.69 (34.93, 42.59)
Stop me from being deployed	711	4525	18.15 (16.66, 19.74)	3791	24,874	47.38 (43.55, 51.24)
Difficult to get an appointment	493	3281	13.16 (11.86, 14.58)	1259	7672	14.61 (12.41, 17.13)
Probable 30-day disorder	n = 7023			n = 7575		
Too expensive	372	2964	42.20 (38.52, 45.98)	103	639	8.43 (4.65, 14.81)
Wouldn't know where to get help	178	1440	20.50 (17.46, 23.91)	83	392	5.17 (3.67, 7.23)
I would have difficulty getting time off work	274	2085	29.69 (26.25, 33.37)	264	2038	26.90 (18.23, 37.78)
Harm my career/ career prospects	426	2942	41.89 (38.22, 45.66)	530	3486	46.02 (35.61, 56.79)
Stop me from being deployed	221	1336	19.03 (16.39, 21.98)	591	3573	47.17 (36.70, 57.89)
Difficult to get an appointment	249	1619	23.06 (20.06, 26.35)	237	1533	20.24 (13.02, 30.08)
No probable 30-day disorder	n = 17,909			n = 44,925		
Too expensive	602	4513	25.20 (23.11, 27.41)	371	2793	6.22 (4.39, 8.75)
Wouldn't know where to get help	228	1786	9.97 (8.55, 11.61)	401	3835	8.54 (6.07, 11.88)
Difficulty getting time off work	419	3051	17.04 (15.25, 18.98)	846	8397	18.69 (15.17, 22.81)
Harm my career/ career prospects	672	4621	25.80 (23.72, 28.00)	2265	16,828	37.46 (33.46, 41.63)
Stop me from being deployed	490	3189	17.81 (16.05, 19.71)	3200	21,300	47.41 (43.36, 51.50)
Difficult to get an appointment	244	1662	9.28 (7.97, 10.78)	1022	6139	13.67 (11.47, 16.20)

Denominator: Entire cohort
Notes:
A 'barrier' refers to the participant providing a response of 'Strongly agree' or 'Agree' for the related question.
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.

Figure 9.5 Weighted estimate of barriers to seeking help with mental health problems among Transitioned ADF and 2015 Regular ADF members, stratified by probable 30-day disorder

Table 9.6 and Figure 9.6 explain the self-reported barriers to seeking help for a mental health problem that might affect Transitioned ADF respondents' decision to seek care, by category. The most commonly reported barrier was 'Too expensive' for Ex-Serving (33.56%); however, for Inactive Reservists (33.00%) and Active Reservists (28.12%) it was 'Harm my career/career prospects'. The next most popular responses were 'Harm my career/career prospects', reported by 29.85% of the Ex-Serving Transitioned ADF; 'Too expensive' reported by 31.39% of the Inactive Reservists; and 'Stop me from being deployed', reported by 25.43% of Active Reservists.

Table 9.6 Weighted estimate of barriers to Transitioned ADF members seeking help with mental health problems

	Ex-Serving n = 10,876			Inactive Reservists n = 7513			Active Reservists n = 6426		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Too expensive	440	3650	33.56 (30.58, 36.67)	272	2358	31.39 (27.75, 35.26)	258	1445	22.49 (19.67, 25.58)
Wouldn't know where to get help	181	1572	14.45 (12.24, 16.99)	111	920	12.24 (9.73, 15.29)	111	710	11.05 (8.86, 13.71)
Difficulty getting time off work	283	2293	21.08 (18.49, 23.94)	225	1757	23.39 (20.09, 27.05)	182	1075	16.72 (14.15, 19.66)
Harm my career/career prospects	453	3246	29.85 (26.96, 32.90)	324	2479	33.00 (29.31, 36.91)	316	1807	28.12 (24.98, 31.48)
Stop me from being deployed	232	1606	14.76 (12.64, 17.17)	168	1265	16.84 (14.01, 20.12)	306	1634	25.43 (22.49, 28.61)
Difficult to get an appointment	246	1721	15.83 (13.71, 18.21)	124	898	11.95 (9.54, 14.86)	121	654	10.17 (8.23, 12.50)

Denominator: Entire cohort
Notes:
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.

Figure 9.6 Weighted estimate of barriers to seeking help for mental health problems in the Transitioned ADF

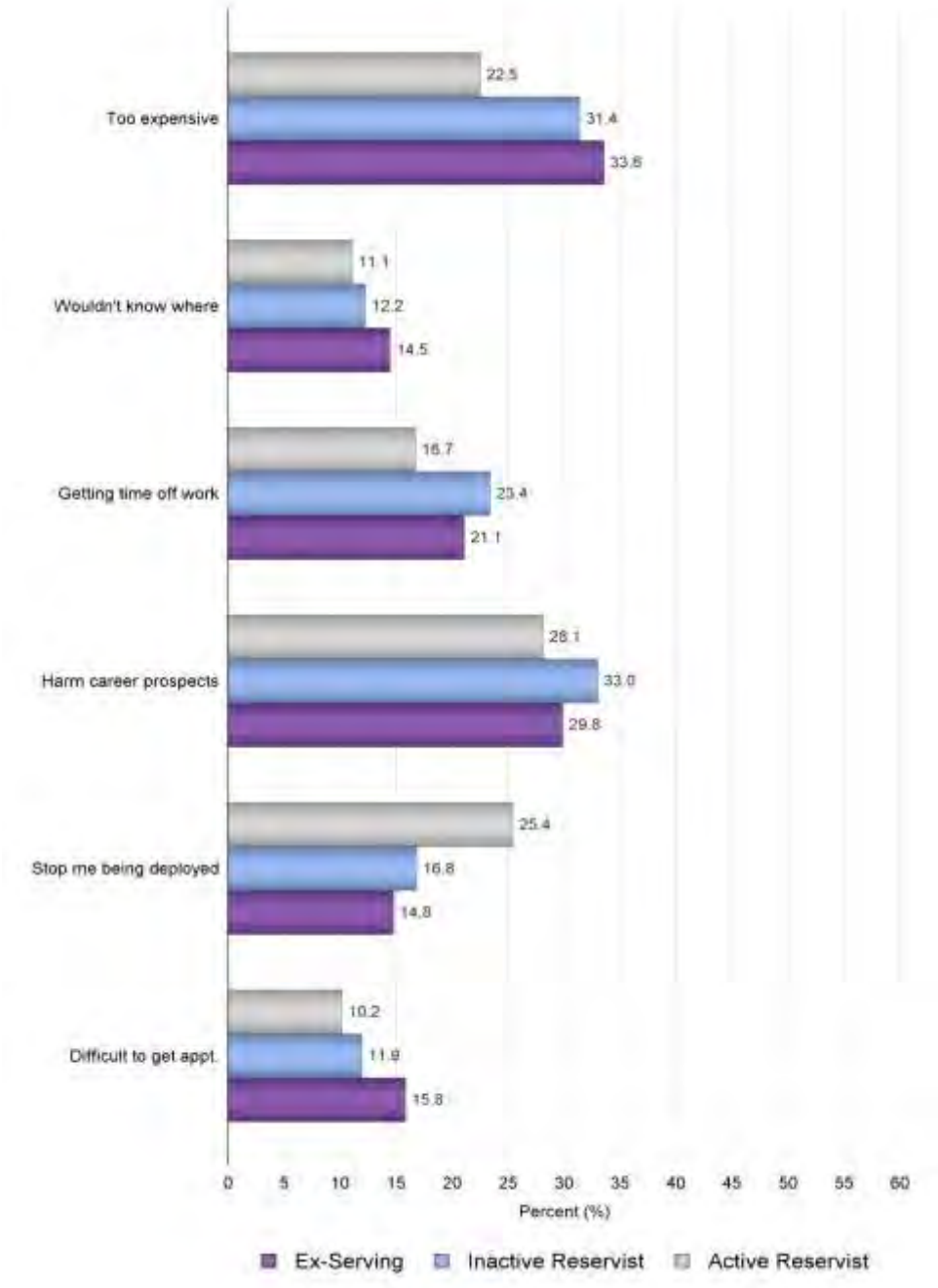


Table 9.7 and Figure 9.7 summarise the number of self-reported barriers that might affect Transitioned ADF and 2015 Regular ADF members' decision to seek help with a mental health problem.

Fortunately, Transitioned ADF (38.76%) and 2015 Regular ADF (35.23%) members did not report any barriers. However, 22.45% of Transitioned ADF members and 20.99% of 2015 Regular ADF members did hold one barrier in relation to seeking help about their health care.

Similar results were found in those with a probable 30-day disorder. For both Transitioned ADF (25.68%) and 2015 Regular ADF (35.42%) members, many respondents did not hold any barriers. Additionally, 15.38% of Transitioned ADF members with a probable 30-day disorder and 12.32% of 2015 Regular ADF members with a probable 30-day disorder did hold four or more barriers in relation to seeking help about their health care.

Table 9.7 Weighted estimate of the number of barriers to seeking help with mental health problems among Transitioned ADF and 2015 Regular ADF members, stratified by probable 30-day disorder

	Transitioned ADF n = 24,932			2015 Regular ADF n = 52,500		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
All	n = 24,932			n = 52,500		
None	1583	9665	38.76 (36.86, 40.70)	2795	18,498	35.23 (31.63, 39.01)
One	859	5597	22.45 (20.83, 24.15)	1801	11,019	20.99 (18.30, 23.96)
Two	574	4074	16.34 (14.87, 17.93)	1568	10,837	20.64 (17.64, 24.00)
Three	369	2707	10.86 (9.61, 12.25)	906	6240	11.89 (9.65, 14.56)
Four or more	288	2128	8.53 (7.42, 9.80)	523	4647	8.85 (6.59, 11.80)
Probable 30-day disorder	n = 7023			n = 7575		
None	293	1804	25.68 (22.69, 28.91)	228	2683	35.42 (25.16, 47.22)
One	214	1467	20.89 (18.02, 24.08)	179	1351	17.84 (10.92, 27.77)
Two	203	1432	20.39 (17.48, 23.64)	224	1396	18.43 (12.28, 26.71)
Three	147	1095	15.59 (12.95, 18.64)	178	1165	15.38 (9.54, 23.86)
Four or more	149	1080	15.38 (12.75, 18.44)	147	933	12.32 (6.91, 21.00)
No probable 30-day disorder	n = 17,909			n = 44,925		
None	1290	7861	43.90 (41.57, 46.25)	2567	15,815	35.20 (31.46, 39.14)
One	645	4130	23.06 (21.14, 25.10)	1622	9668	21.52 (18.66, 24.68)
Two	371	2642	14.75 (13.09, 16.59)	1344	9442	21.02 (17.74,24.72)
Three	222	1613	9.01 (7.66, 10.56)	728	5075	11.30 (8.91, 14.22)
Four or more	139	1047	5.85 (4.76, 7.17)	376	3714	8.27 (5.87, 11.52)

Denominator: Entire cohort
Notes:
Based on weighted counts, 1257 (2.40%) 2015 Regular ADF members and 761 (3.05%) Transitioned ADF members had a missing value for all questions related to barriers. However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.

Figure 9.7 Weighted estimate of the number of barriers to seeking help with mental health problems among Transitioned ADF and 2015 Regular ADF members, stratified by probable 30-day disorder

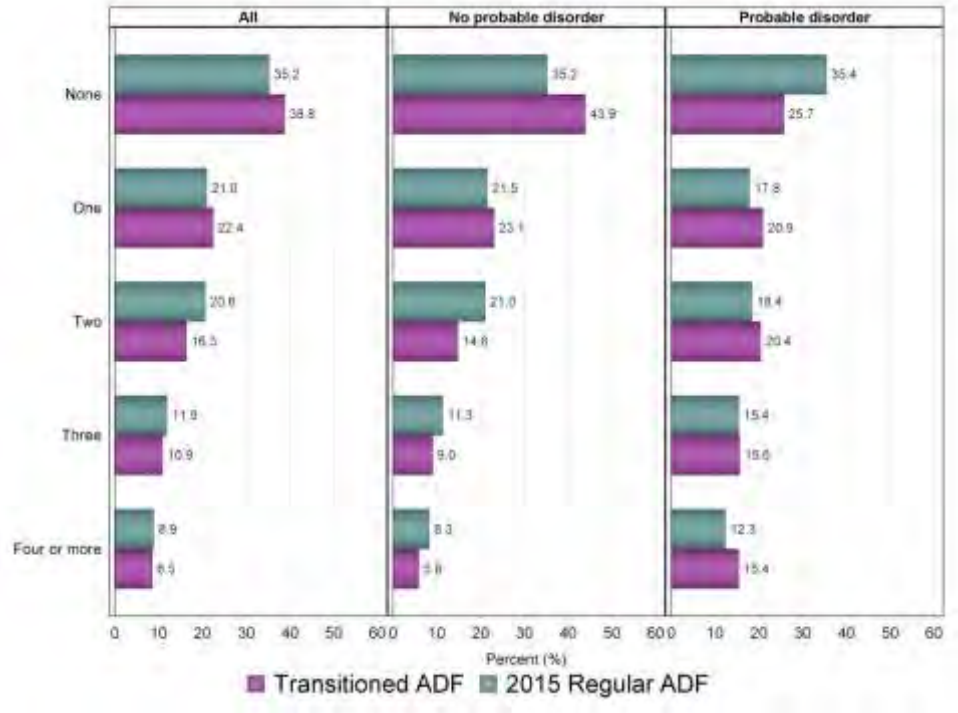


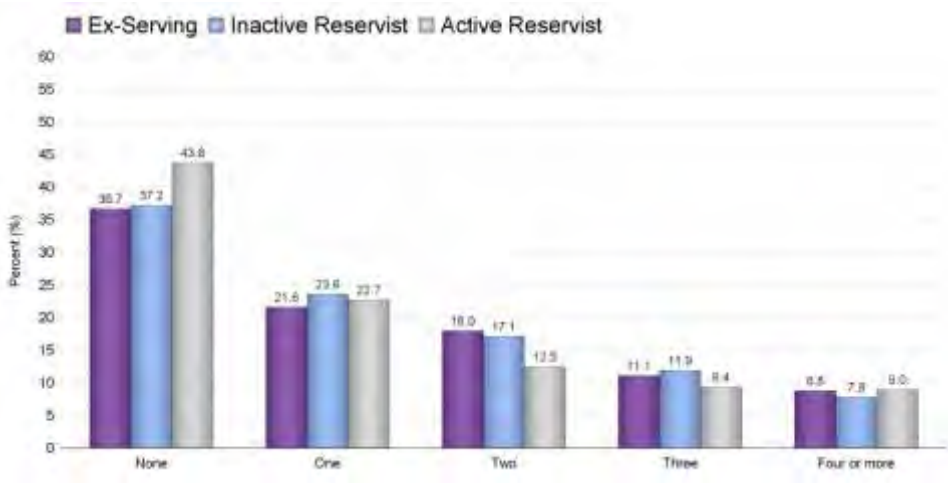
Table 9.8 and Figure 9.8 describe the number of self-reported barriers to seeking help with a mental health problem that might affect Transitioned ADF members' decision to seek care by category. The proportion of Transitioned ADF respondents reporting no barriers was 36.69% of Ex-Serving ADF members, 37.23% of Inactive Reservists and 43.77% of Active Reservists. However, 8.79% of Ex-Serving ADF members, 7.81% of Inactive Reservists and 8.96% of Active Reservists reported four or more barriers.

Table 9.8 Weighted estimate of the number of barriers to seeking help with mental health reported by Transitioned ADF members

	Ex-Serving n = 10,876			Inactive Reservists n = 7513			Active Reservists n = 6426		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
None	543	3990	36.69 (33.61, 39.87)	457	2797	37.23 (33.59, 41.01)	577	2813	43.77 (40.45, 47.14)
One	329	2350	21.61 (19.14, 24.30)	241	1775	23.63 (20.36, 27.24)	288	1459	22.70 (19.99, 25.67)
Two	243	1956	17.98 (15.58, 20.67)	172	1286	17.12 (14.27, 20.41)	154	801	12.46 (10.34, 14.95)
Three	152	1209	11.12 (9.20, 13.38)	113	896	11.93 (9.48, 14.92)	104	602	9.36 (7.39, 11.79)
Four or more	128	957	8.79 (7.13, 10.81)	68	587	7.81 (5.77, 10.49)	90	576	8.96 (6.95, 11.48)

Denominator: Entire cohort
Notes:
Based on weighted counts, 144 (3.80%) of Ex-Serving ADF members, 172 (2.28%) Inactive Reservists and 176 (2.74%) Active Reservists had a missing value on all related barrier questions.
However, distributions are calculated by including those with a missing value to allow for correct weighted totals.
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.

Figure 9.8 Weighted estimate of number of barriers to seeking help for mental health problem in the Transitioned ADF



9.3.3 Reasons for not seeking help

Table 9.9 and Figure 9.9 explain why Transitioned ADF and 2015 Regular ADF members concerned with their mental health never sought assistance.

The most common reason for not seeking help was that 'I can still function' at 80.62% for Transitioned ADF and this was also the case with 2015 Regular ADF at 82.44%. The next most commonly cited reason was 'prefer to manage it myself' for Transitioned ADF at 76.74% and for 2015 Regular ADF, 80.07%.

In those respondents with a probable 30-day disorder, the most common reason was 'afraid to ask' at 69.54% for Transitioned ADF and 77.07% for 2015 Regular ADF. The next most commonly cited category was 'prefer to manage it myself' for Transitioned ADF (67.70%) and for 2015 Regular ADF (59.49%).

Table 9.10 and Figure 9.10 examine the reasons why Transitioned ADF members concerned with their mental health did not seek help, by the proportion of respondents. Among the Ex-Serving ADF group, 73.53% reported that they 'preferred to manage it themselves', while 84.28% of Inactive Reservists and 85.46% of Active Reservists reported that 'I can still function'. The next most common responses flipped this result: 71.95% of Ex-Serving ADF members reported that 'I can still function', while 78.03% of Inactive Reservists and 78.41% of Active Reservists reported that they 'preferred to manage it themselves'.

Table 9.9 Weighted estimate of reasons why Transitioned ADF and 2015 Regular ADF members concerned with their mental health did not seek help, stratified by probable 30-day disorder

	Transitioned ADF n = 3922			2015 Regular ADF n = 6546		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
All	n = 3922			n = 6546		
Afraid to ask	236	1671	42.60 (37.44, 47.93)	354	2938	44.88 (33.99, 56.29)
Nothing could help	157	1171	29.85 (25.16, 35.00)	203	1439	21.99 (14.40, 32.07)
I can still function	454	3162	80.62 (76.16, 84.41)	838	5397	82.44 (69.73, 90.54)
Couldn't afford it	131	1131	28.83 (24.04, 34.14)	57	306	4.67 (2.67, 8.05)
Help from other sources	144	1062	27.07 (22.54, 32.14)	339	2343	35.80 (25.71, 47.33)
Prefer to manage myself	437	3010	76.74 (71.93, 80.94)	805	5241	80.07 (67.90, 88.41)
Where to get help?	78	681	17.36 (13.47, 22.08)	69	488	7.46 (3.50, 15.19)
Probable 30-day disorder	n = 960			n = 1006		
Afraid to ask	78	668	69.54 (58.82, 78.49)	60	775	77.07 (53.21, 90.86)
Nothing could help	53	446	46.48 (35.54, 57.76)	32	222	22.06 (8.65, 45.83)
I can still function	75	590	61.46 (50.07, 71.72)	67	582	57.90 (24.45, 85.39)
Couldn't afford it	43	414	43.09 (32.29, 54.58)	9	30	3.02 (1.19, 7.44)
Help from other sources	19	144	15.03 (8.72, 24.68)	22	382	38.00 (11.56, 74.19)
Prefer to manage myself	82	650	67.70 (56.35, 77.29)	69	598	59.49 (25.05, 86.57)
Where to get help?	27	257	26.77 (17.85, 38.07)	6	30	3.01 (0.98,8.91)
No probable 30-day disorder	n = 2962			n = 5540		
Afraid to ask	158	1003	33.87 (28.49, 39.69)	294	2163	39.04 (28.06, 51.25)
Nothing could help	104	724	24.45 (19.59, 30.07)	171	1218	21.98 (13.65, 33.42)
I can still function	379	2572	86.83 (82.62, 90.13)	771	4814	86.90 (74.64, 93.73)
Couldn't afford it	88	717	24.21 (19.17, 30.07)	48	276	4.97 (2.70, 8.99)
Help from other sources	125	918	30.98 (25.58, 36.95)	317	1961	35.40 (25.14, 47.21)
Prefer to manage myself	355	2360	79.67 (74.40, 84.08)	736	4643	83.81 (72.37, 91.09)
Where to get help?	51	424	14.31 (10.32, 19.51)	63	458	8.26 (3.72, 17.36)

Denominator: Those who were concerned but did not seek assistance
Notes:
Probable 30-day disorder = PCL ≥ 53 or K10 ≥ 25; No probable 30-day disorder = PCL < 53 and K10 < 25
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.

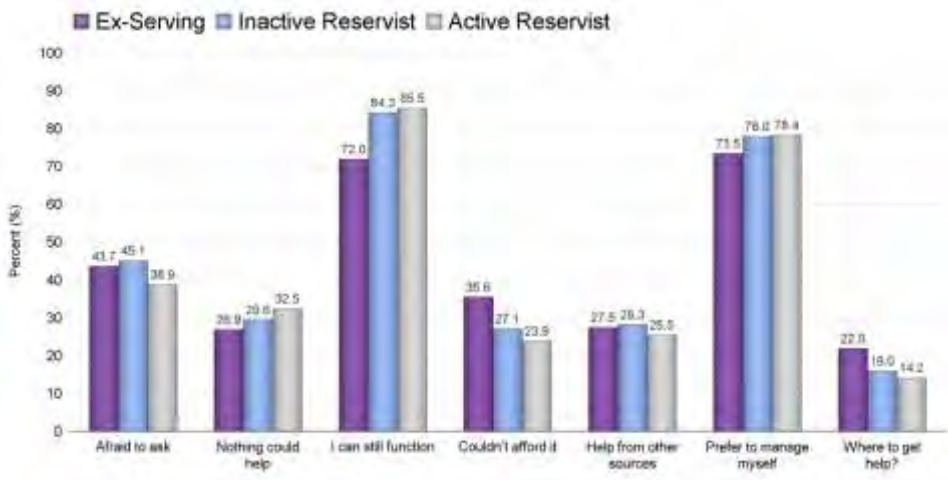
Figure 9.9 Weighted estimate of reasons why Transitioned ADF and 2015 Regular ADF members concerned with their mental health did not seek help, stratified by probable 30-day disorder

Table 9.10 Weighted estimate of reasons why Transitioned ADF members concerned with their mental health did not seek help

	Ex-Serving n = 1299			Inactive Reservists n = 1425			Active Reservists n = 1183		
	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)	n	Weighted n	% (95% CI)
Afraid to ask	66	568	43.69 (34.02, 53.87)	88	643	45.15 (36.10, 54.53)	82	460	38.89 (30.81, 47.63)
Nothing could help	43	350	26.95 (19.17, 36.47)	52	421	29.57 (21.57, 39.05)	61	384	32.46 (24.80, 41.19)
I can still function	118	935	71.95 (62.01, 80.12)	160	1201	84.28 (76.90, 89.62)	175	1011	85.46 (79.14, 90.10)
Couldn't afford it	48	462	35.56 (26.43, 45.87)	43	386	27.10 (19.28, 36.65)	40	283	23.90 (16.67, 33.03)
Help from other sources	41	357	27.50 (19.34, 37.51)	53	403	28.26 (20.55, 37.50)	50	302	25.52 (18.46, 34.15)
Prefer to manage myself	119	955	73.53 (63.46, 81.62)	153	1112	78.03 (69.39, 84.76)	164	928	78.41 (70.78, 84.48)
Where to get help?	25	285	21.96 (14.29, 32.20)	26	228	15.98 (10.04, 24.48)	27	168	14.19 (9.01, 21.64)

Denominator: Those who were concerned but did not seek assistance
Notes:
95% CI: 95% confidence interval
These are not mutually exclusive groups and therefore do not sum to 100%.

Figure 9.10 Weighted estimate of reasons why Transitioned ADF members concerned with their mental health did not seek help



10 Discussion

This report systematically investigated the patterns of Transitioned ADF and 2015 Regular ADF members seeking and using health services in relation to concerns about their mental health. In doing so, this report more specifically examined:

- What proportion of Transitioned ADF and 2015 Regular ADF sought professional care for their mental health concerns?
- What are the patterns of latency between onset of a mental health concern and seeking care?
- For those who sought care, what problems were driving their decision to seek care? Did someone else suggest they seek care? If so, who was that and did someone else assist them in actually getting to care?
- What types of professionals did they consult, what type of services did they report the professionals provided and how satisfied were they with what was provided?
- What other self-management strategies did they use to address their mental health concerns and what were their levels of satisfaction with those strategies?
- What were common attitudes and beliefs about mental health and seeking care, focusing initially on the entire cohort and then those with mental health concerns who did not seek care?

Researchers studied patterns of accessing mental health services within the respective Transitioned ADF and 2015 Regular ADF populations, and any comparisons between the two groups. Further investigation then examined differences between the three transitioned groups: Ex-Serving ADF, Active Reservist and Inactive Reservist. Researchers then compared patterns of help-seeking among those who met the criteria for having a current probable 30-day disorder, and those who did not. Examining predictors of service use – such as age, gender, service history and severity of symptoms – was beyond the scope of this study, although the research team strongly recommends considering these issues in further follow-up analyses.

The findings of this report will provide DVA and Defence with the information they need to guide future service delivery and mental health initiatives, to further improve outcomes for the Transitioned ADF and 2015 Regular ADF communities.

This discussion will commence with a summary and interpretation of the findings for each of the above questions before considering the broader considerations and implications of the findings, and highlighting questions that require a 'deeper dive' into the data and further study.

10.1 Summary and interpretations of findings

10.1.1 Extent of mental health concerns

The results indicate that 64% of Transitioned ADF and 52% of 2015 Regular ADF members had experienced concerns about their mental health at some point in their life. Among Transitioned ADF respondents, the Ex-Serving group reported higher rates of concern (71%) than did the Active Reservist (61%) and Inactive Reservist (58%) groups.

Approximately 28% and 14% of Transitioned ADF and 2015 Regular ADF respectively met the criteria for having a probable 30-day disorder, as calculated using the epidemiological cut-offs on the tests for anxiety and depression (the Kessler Psychological Distress Scale (K10)) and posttraumatic stress (the Posttraumatic Stress Disorder Checklist (PCL)).

It is worth noting that 11% of Transitioned ADF members and 27% of 2015 Regular ADF members who met criteria for a probable 30-day disorder did not report having any mental health concerns. This is consistent with – although encouragingly lower than – the findings from UK research, which found that 44% of current and ex-serving members who met the criteria for having a probable 30-day disorder did not identify having any mental health concerns (Iversen et al., 2011).

The current study explores the help-seeking patterns of participants who registered a concern about their mental health. However, the group identified here – those who met the criteria for a probable 30-day disorder but did not report having any mental health concerns – requires further examination in the future.

10.1.2 Extent of help-seeking among those with a mental health concern

Of those who were concerned about their mental health, a relatively high proportion – three in four Transitioned ADF and 2015 Regular ADF members – had sought assistance, of whom 53% in the Transitioned ADF group and 61% of 2015 Regular ADF members reported being in care currently or in the last 12 months.

Looking more specifically at those with a current probable 30-day disorder, 84% of Transitioned ADF members with a mental health concern have sought care, 75% of whom reported receiving care currently or within the last 12 months (that is, 63% of the total number who reported being concerned and qualified as having a probable

30-day disorder). Within the 2015 Regular ADF group, 82% had sought care, and 81% of that number were receiving care or had done so within the last 12 months (66% of the total number who were concerned about their mental health and qualified as having a probable 30-day disorder). As would be expected, rates of current or recent health service use were still substantial but lower (38% and 56% respectively) among Transitioned ADF and Regular ADF members who reported 'ever' having had a mental health concern, but who did not meet the criteria for a current probable 30-day disorder.

These findings reflect high rates of engagement with care among those with mental health concerns, far exceeding the help-seeking rates among members of the general Australian community who have mental health problems (T. Slade et al., 2009). This is consistent with the high rates reported in the 2010 ADF Mental Health Prevalence and Wellbeing Study (MHPWS) (McFarlane et al., 2011) and the upper range reported in international studies on help-seeking among veteran and military groups. By comparison, a number of US, UK and Canadian studies examining this issue reported that less than half of current serving populations with mental health problems receive help with their mental health concerns (Fikretoglu et al., 2008; Hoge et al., 2004; Ramchand et al., 2015; Sharp et al., 2015). Similarly, UK and US studies of discharged veterans found that approximately half of those with mental health concerns or a current disorder had sought care within the previous 12 months (Rosen et al., 2010). The exception to this is female veterans in the US, who sought care at rates comparable to those reported in the present study. This higher rate of help-seeking among women compared with men is well documented (McFarlane et al., 2011; T. Slade et al., 2009).

The rates of help-seeking reported here are consistent with *t*he recent *Australian peacekeepers report* (Hawthorne et al., 2014), which found that 83% of peacekeeping veterans who had mental health concerns sought help. Given the timing of that study involving ex-serving peacekeeping veterans, there would likely be minimal overlap between the participant populations between the Hawthorne report and this research report. As such, the consistency of the findings in the Hawthorne et al., (2014) report provide added strength to the validity of the findings reported here.

The international studies mentioned above separately examined rates of help-seeking among current serving and ex-serving ADF members; there has been little research focused on directly comparing the two populations. Based on the abovementioned studies, rates of help-seeking appear slightly lower for current serving military populations, although as stated this is preliminary and not a result of direct comparison. By contrast, the findings of this report indicate largely comparable rates of help-seeking across the two populations.

While these rates of seeking and receiving care for mental health concerns may be considered high at each point, for those with a current disorder, these figures still only result, for example, in 63% of Transitioned ADF members with a current probable 30-day disorder currently or recently receiving care. It is not being suggested here that all those with a current probable 30-day disorder need to be in care all the time. Indeed, effective specialist treatment can and often should be episodic. However, the notion of those with a current probable 30-day disorder not receiving any mental health care in the past 12 months, including primary care, raises concerns about the adequacy of support for this significant minority.

This chapter will explore the issue further, after considering the categories of service providers consulted and types of service provided.

10.1.3 Help-seeking latency

Examining the time elapsed between the onset of a mental health concern and seeking help with it, 45% of Transitioned ADF members with a concern sought care within three months, and another 25% waited between three months and a year. By way of comparison, international data on help-seeking latency in veteran and military populations varies considerably. Some studies found that 23–40% (Hoge et al., 2004) sought care in the first year, while others found that rate to be 58% (Rosen et al., 2011) and 66% (Seal et al., 2010). As noted, the latency period evident in this study – 70% seeking care within the first year – reflects relatively high levels of early engagement and compares positively with the international data, particularly in the reasonably strong rates of help-seeking within the first three months of being concerned. That said, a significant minority (14%) of Transitioned ADF members waited more than three years to seek care.

In contrast to the findings above, only 37% of those with a probable 30-day disorder sought care within three months of first being concerned, and 18% waited three or more years. This is compared with 51% and 12% in each group respectively in those expressing concerns about their mental health but without a probable 30-day disorder. These data seem to suggest that those with more severe mental health problems experience greater hesitation and help-seeking latency. These findings were consistent across the three Transitioned ADF groups. The issue will be discussed later in this chapter, after considering the findings regarding stigmas and barriers to care.

Among 2015 Regular ADF, however, 56% sought care within the first three months of concern onset, including 50% of those with a probable 30-day disorder. These rates of early help-seeking among 2015 Regular ADF members are significantly higher than those for the Transitioned ADF cohort. Similarly, only 7% of Regular ADF members with a probable 30-day disorder waited more than three years since onset to seek care, similar to the rate for those without a probable 30-day disorder. This finding is

consistent with UK research on the potential benefits of formal and informal awareness and mental health surveillance programs to promote early identification of mental health issues within the Defence system (Jones et al., 2013). These programs are also reflected in ADF policy and practice, such as routine screening and support from psychologists; promotion of informal peer support; and positioning mental health as a command responsibility.

10.1.4 Pathways to and facilitators of care

Was engaging in care suggested by others?

To better understand patterns of help-seeking, it is important to identify the most common pathways to care. For the majority of Transitioned ADF (62%) and 2015 Regular ADF (57%) members, someone else suggesting seeking professional care, a relatively consistent result across the two the groups. This finding is consistent with the limited research examining this issue among US veterans (Seal et al., 2009). It is also largely consistent across the three Transitioned ADF groups. For those with a probable 30-day disorder, this figure rose to 68% of Transitioned ADF members and reduced slightly to 55% for 2015 Regular ADF members.

At this point in this comparison, the results were significantly different. Transitioned participants with a probable 30-day disorder more likely to have help suggested to them than 2015 Regular ADF with a probable 30-day disorder. Partners (47% and 43%) and friends (28% and 29%) were the most likely sources to suggest care in each of the groups respectively.

Significant differences did emerge between Transitioned ADF and 2015 Regular ADF members when it came to suggestions from broader family members, where 21% and 10% reported that a family member suggested care. This could be partially explained by the fact that serving ADF members are likely to be posted away from their families, resulting in reduced contact.

In those with a probable 30-day disorder, partners and friends were still the most likely to suggest seeking mental health care, although for 2015 Regular ADF members with a probable 30-day disorder, supervisors and command were more likely to suggest care (36%) than among Transitioned ADF participants (22%). This reflects a level of awareness about mental health among Defence supervisors and command, and an understanding of the potential value of mental health support.

When comparing the Transitioned ADF groups, Medical Officers (MOs) and General Practitioners (GPs) were more likely to suggest mental health care for Ex-Serving ADF members (39%) compared to Inactive Reservists (21%) and Active Reservists (20%).

It is worth noting that most respondents still had someone suggest they seek care, rather than self-identifying this need. In addition, the suggestions primarily came from non-professional networks of partners and friends.

Was engaging in care assisted by others?

While the majority of Transitioned ADF and 2015 Regular ADF members who sought care had someone else suggest it to them, only a minority received active assistance in accessing this care.

Of those who sought care, 32% of Transitioned ADF and 28% of 2015 Regular ADF members had assistance in receiving mental health care – the rate did not differ between the two groups. Similarly, there were no differences between the groups with a probable 30-day disorder in this area, with rates of 36% and 31% between the Transitioned and 2015 Regular ADF groups respectively.

Within the Transitioned ADF group, Ex-Serving members were more likely (37%) to receive help in seeking care compared with 26% of Inactive Reservists and 27% of Active Reservists. For Transitioned ADF members, GPs or MOs and partners were the most likely to help engage with mental health care, although partners became the most common source of assistance (36%) for those with a probable 30-day disorder.

In the 2015 Regular ADF, 32% of both MOs and supervisors assisted in engagement with care, although this figure increased to 52% and 34% respectively for those with a probable 30-day disorder.

The findings in relation to who suggests care and who helps access it reinforce the benefit of targeting mental health awareness and treatment information to the broader network of Transitioned ADF and Regular ADF members – including their partners, families, peers, and commanders or supervisors. Given that these networks have a substantial impact on help-seeking behaviours, giving them critical information about service providers could enhance the rate of people seeking care and help direct serving and ex-serving ADF members to the most appropriate source of mental health care.

10.1.5 Problems driving mental health care seeking

There was considerable consistency between the Transitioned ADF and 2015 Regular ADF groups in the primary reasons for seeking mental health care. The most common reasons were depression (27% and 21%), anxiety (18% and 20%), relationship problems (11% and 18%) and anger (12% and 13%). The primacy of depression, anxiety and anger remained the most common in those with probable 30-day disorder, although less so with relationship problems. This pattern of four primary presenting problems driving engagement with treatment is consistent with studies of US veterans, even

those specifically diagnosed with posttraumatic stress disorder (PTSD) (Rosen, Adler, & Tiet, 2013).

These findings sit alongside those of the Transition and Wellbeing Research Programme's *Mental Health Prevalence Report*, helping to guide DVA and Defence in their service purchasing and planning decisions, to ensure the services provided have the breadth and competency to respond to these needs with best-practice care. Furthermore, this information supports and is consistent with the focus of the Veterans and Veterans Families Counselling Service (VVCS) in addressing mental health issues while also providing relationship counselling services. In addition, these findings offer guidance on the language, experiences and scenarios to use in mental health awareness and promotion information that may guide Transitioned and Regular ADF, and their support networks in identifying and seeking care as appropriate. The findings provide key areas that could be addressed in social media campaigns and in initiatives such as ADF's annual Mental Health Day, the Stepping Out program, and ADF transition seminars and interviews.

The study also examined the presenting problems for those who had mental health concerns but did not meet the criteria for a probable 30-day disorder. As would be expected, work and relationship problems were the most common reasons for Transitioned and 2015 Regular ADF participants seeking care. Relationship problems were the most common reason for 2015 Regular ADF members without probable 30-day disorder. In general, the same pattern was evident across the Transitioned ADF groups, where relationship problems were the most evident in Inactive Reservists. Again, while the focus is frequently on addressing more serious mental disorder, these data do provide guidance to ensure high-quality services are provided to a broad range of presenting concerns in those without disorder. Such services serve a critical role of not only ameliorating current subclinical or broader psychosocial issues of concern but also in the prevention of further deterioration in mental health and the maintenance of wellbeing and functioning. More recent international focus on the development of best-practice interventions in subclinical presentations may provide some guidance in this area (Forbes, O'Donnell & Bryant, 2017).

10.1.6 What types of professionals were consulted and what was provided?

The most commonly consulted professional groups were MOs and GPs, and psychologists. Eighty-one per cent and 78% of Transitioned ADF and 2015 Regular ADF, respectively, who had reported having mental health concerns at some point in their lives and sought assistance had consulted MOs and GPs for this concern, and 81% and 88% for each group had ever consulted a psychologist for these concerns. Of those who ever sought care from each of these professionals, 47% and 48% of Transitioned and 2015 Regular ADF, respectively, consulted GPs, and 40% and 48% in each group, respectively, consulted psychologists in the past 12 months for their mental health

care. In terms of engagement with psychiatrists, high rates of lifetime engagement were reported in both Transitioned and 2015 Regular ADF of 50% and 39%, respectively. These differences are also consistent with higher rates of probable 30-day disorders among the Transitioned ADF. These represent high rates of engagement for those with mental health concerns with health and mental health professionals for mental health care.

Of Transitioned and 2015 Regular ADF who had ever had a mental health concern, met criteria for a current probable 30-day disorder and had ever consulted a psychologist, 55% and 66%, respectively, had consulted a psychologist within the last 12 months. For psychiatry, this figure was approximately 63% and 62% in Transitioned and Regular ADF, respectively.

While these are high rates of engagement with mental health care at each point, these percentages become more concerning once selection at each point is considered. As an example, combining the information from this section and that of 10.1.2, and when considering Transitioned ADF:

- 84% of those with a lifetime mental health concern and current probable 30-day disorder have sought care, which is a very high percentage.
- Of these, 81% had ever consulted a psychologist for these concerns.
- Therefore, the total at this point is 68% of those with a mental health concern at some stage in their lives and reporting current probable 30-day disorder have sought care from a psychologist.
- Of this 68%, 55% have seen their psychologist in the last 12 months – that is, 38% of the total of those with a lifetime mental health concern and current probable 30-day disorder.

So despite the high rates of help-seeking at each point, selection throughout these stages results in 38% of Transitioned ADF with a lifetime mental health concern and current probable 30-day disorder having sought care from a psychologist in the last 12 months. By similar calculations, 35% of Transitioned ADF with current probable 30-day disorders have consulted psychiatrists within the last 12 months.

GPs and MOs

Of Transitioned ADF members consulting primary care for their mental health, 73% received a referral, 68% medication and 50% more information relating to their mental health concerns. These were also the most common services delivered by GPs and MOs provided to 2015 Regular ADF members.

It is worth noting there were also high rates of general psychological support and intervention including supportive counselling, psychotherapy, cognitive behavioural therapy (CBT) and trauma-focused treatment. While there are limitations to the confidence with which we can rely on the participants' understanding of the differentiations between these various interventions or provider types (and hence accuracy of endorsement), nevertheless it still likely reflects high frequency of psychological support. Importantly, delivery of this psychological assistance does not appear to have reduced the potential for referral for specialist mental health support. Given the high rates of fairly focused psychological care (CBT and trauma-focused CBT) reported as being delivered in primary care practice, consideration might be given as to how best to support GPs and MOs in further enhancing their knowledge and skills in delivering the relevant components of these interventions.

Psychologists

In terms of services delivered by psychologists, while all categories of services are important, the current evidence base for best-practice interventions for anxiety, mood and trauma-related disorders are CBT, and trauma-focused CBT or eye movement desensitisation and reprocessing (EMDR) in the context of trauma-related disorders such as PTSD. As such, indications of the use of CBT is our best proxy for the delivery of evidence-based psychological treatment in the most common veteran and military mental health problems.

From the data collected in this study, participants reported high rates of psychologists delivering CBT; 63% of Transitioned ADF and Regular 2015 ADF received this therapy. These rates are considerably higher than those reported by help-seeking UK veterans (12%) (Iversen et al., 2011) and US veterans (50%) (Rosen et al., 2011). It needs to be acknowledged, however, that the limitations of the data reported here cannot comment on quantity and 'adequate dose' of therapy or quality of this care.

Following on from the selection cascade outlined above, with 38% of Transitioned ADF members with a probable 30-day disorder seeing a psychologist in the last 12 months and 63% of these receiving CBT, it is possible to estimate that, overall, 24% with a mental health concern and probable 30-day disorder received CBT from a psychologist in the past 12 months. These figures, however, are higher for 2015 Regular ADF. For this population, 82% of those with a mental health concern and a probable 30-day disorder have sought care. Of those, 93% have sought care from a psychologist, 59% of which had consulted the psychologist in the last 12 months. With a likelihood of receiving CBT for this group of 63%, this results in an estimation that 28% with a mental health concern who have sought assistance have received CBT from a psychologist in the past 12 months. It needs to be noted that these rates of 63% delivery of CBT were based on those who had received care from psychologists and not analysed for those with a probable 30-day disorder separately.

As we see here again, the rates of engagement and uptake at each time point are reasonably high and exceed community and international standards in veteran and military mental health. Nevertheless, the selection occurring at each level results in a minority of Transitioned and Regular ADF with a probable 30-day disorder reporting receiving CBT, which would be considered the most evidence-supported treatment for the most prevalent conditions in Transitioned ADF and 2015 ADF. Interestingly, in comparison with the Ex-Serving group (69%), there are noteworthy reductions in the other two transitioned groups in the likelihood of receiving CBT with rates reported as 56% in Inactive Reservists and 51% in Active Reservists respectively. This may also be due to the lower rates of probable 30-day disorders in these groups.

Psychiatrists

In terms of services provided by psychiatrists, the most common services provided to Transitioned ADF were medication (78%), supportive counselling (64%) and information relating to their mental health (60%). Interestingly, 40% of Transitioned ADF consulting psychiatrists reported receiving CBT. These three areas of service were also reported most commonly by 2015 Regular ADF, although at lower rates of 53%, 45% and 53% respectively, with CBT 33%.

Other mental health providers

The services sought from other mental health professionals such as social workers, occupational therapists and mental health nurses to address these mental health concerns were also examined. The most commonly delivered service was supportive counselling (69% and 63%) and then information provision (60% and 39%) in Transitioned and 2015 Regular ADF respectively. Provision of CBT was significantly lower, at 36% and 24% respectively.

10.1.7 Satisfaction with services

This study examined satisfaction with services in two key ways. Firstly, satisfaction was assessed in relation to each specific service provided by each discipline type. Following this, participants were asked to provide satisfaction ratings on key dimensions across the service system more globally. Examining satisfaction with specific services for Transitioned ADF, overall satisfaction ratings for core activities outlined above for each of GPs, psychologists, psychiatrists, and other mental health professionals were approximately in the 60-70% range. Satisfaction reported by 2015 Regular ADF were considerably higher across MOs, psychologists and psychiatrists, with rates of satisfaction for core activities in 70-90%s.

As indicated above, more global ratings of satisfaction across key service system domains were also assessed. Two key overall findings emerged from these ratings. Firstly, satisfaction ratings were significantly higher in 2015 Regular ADF compared with the Transitioned ADF across all dimensions. The most notable here were the

domains of accessibility, effectiveness, competence, friendliness and convenience. The other notable finding is that rates of satisfaction are lower across domains in both Transitioned and Regular ADF in those with a probable 30-day disorder compared to those without a probable 30-day disorder. We will consider both of these findings here in more detail.

While satisfaction ratings for each domain can be seen in the results section, in Transitioned ADF members, overall rating in the domains of accessibility, competence, friendliness and confidentiality all vary within the 60-70% range. This is largely consistent with, if not slightly higher than US veterans' satisfaction rating of 49% (Rosen et al., 2011) and 42% (Hepner, 2014). However, notable areas where there is a drop in satisfaction for Transitioned ADF includes the domains of effectiveness (48%) and convenience (52%).

In comparing satisfaction ratings between Transitioned ADF and 2015 Regular ADF members, these differences emerge strongly in the areas of effectiveness and competence. For example, rates of satisfaction in competence are 85% in 2015 Regular ADF compared with 62% in Transitioned ADF members and similarly in the area of effectiveness, 77% and 44% in the two groups, respectively. These differences are also reflected the closer the transitioned groups come to Defence. That is, satisfaction ratings are lowest in the Ex-Serving group and highest in Active Reservists.

In understanding these findings, it is important to consider the service landscape for the two populations. One of the points of difference is that the mental health care for serving members is provided by a more circumscribed range of practitioners including uniformed and civilian employed practitioners, specially contracted services and VVCS. Given this, these practitioners are likely to have high levels of military cultural competence and more detailed knowledge and understanding of common mental health problems in current serving ADF members. There are a range of notable specialised service providers delivering care to Transitioned ADF members who also meet these criteria, such as the VVCS and specialised services in veteran and military mental health, such as facilities that deliver the accredited PTSD programs. However, a significant proportion of the services provided likely fall outside of these providers, including community GPs, psychologists, psychiatrists and other mental health professionals (National Mental Health Commission Report, 2017) who may not see a large number of veterans and hence understandably have limited knowledge and experience of the military context and its implications for treating common veterans' mental health problems.

Another system difference of note is the inherently more interconnected nature of the Defence health services provided to Regular ADF members compared with the broader and more disparate range of services and service providers operating for Transitioned

ADF members. Currently, as a more fragmented system with limited case management and coordination for more complex cases, it raises potential cracks and gaps in the pathways between points of care. This may also be reflected in the higher satisfaction ratings with each service provider in the Transitioned group but lower ratings of broader service satisfaction on the higher order effectiveness domain. It may also reflect a difference where the Transitioned ADF with a probable 30-day disorder cohort includes a significant subgroup for whom Defence or other mental health services have been unable to sufficiently assist to allow them to remain in Defence, impacting on their satisfaction with these services in areas of effectiveness and the other cited domains.

A factor to also be considered here is the degree to which there is a systematic bias between the Transitioned ADF and 2015 Regular ADF members in their propensity in ratings of satisfaction. In the absence of ratings by both populations of the same service, it is difficult to examine this directly. The closest data available in this report to examine this are the ratings of the hospital-based PTSD programs, where both populations access these programs. Of note is that while satisfaction ratings for this service were high across both groups, they were higher in 2015 Regular ADF (94%) than those of Transitioned ADF (70%). Access to these programs is not evenly distributed across these programs and a disproportionate number attend programs located in areas of Active service populations. So, whilst there is overlap but some variability in the facilities the respective populations attend, this is our best proxy for indicating some rating bias differences between the populations.

In further understanding the possibility of an overall rating bias, as outlined above, Defence health services are directly coordinated and managed for the member, and provided by practitioners who are knowledgeable and experienced in military health and mental health. This has the potential to set expectations among Transitioned ADF members regarding levels of coordination and integration across a service system. These standards are unlikely to be met, which may account for the propensity for Transitioned ADF members to be dissatisfied with services accessed outside Defence, in a community setting. Despite the high levels of availability and accessibility by community standards of these services, fragmentation and lower levels of coordination across these services and their variability in veteran and military knowledge or expertise, may be highlighted.

Also notable were the lower rates of satisfaction in both populations in those with a current probable 30-day disorder compared to those without. This is consistent with findings in the existing literature that those with more severe problems express lower satisfaction ratings with services (Hawthorne et al., 2014; Rosen et al., 2011). In interpreting this finding, we would understand that by definition those who still experience current disorder are less likely to have felt helped by the interventions

provided than either those with less severe difficulties or indeed those who have substantially benefited, no longer meeting criteria for disorder. It is also possible that the services are stronger and more effective at addressing less severe problems. The issues highlighted above in relation to cracks and loose connections between points of care in the health service systems for Transitioned ADF members may also be most keenly experienced by those with more severe mental health problems. Finally, it is also understood that anxiety and mood disorders also influence interpretations of experience.

As outlined above, examination of more specialist services such as the hospital-based PTSD programs revealed high rates of satisfaction of 70% in Transitioned ADF members and 95% in 2015 Regular ADF members. Future investigations in this data need to consider deeper examination of subgroups that differ on satisfaction – for example those seeking care from VVCS, which represents another veterans' specialised service – and whether service satisfaction varies by disorder as is indicated in recent findings (Hepner, 2014). This issue will be further considered in the implications section to follow.

10.1.8 Who is funding the treatment?

In considering the findings relating to the funding of treatment, it needs to be understood that this is derived through participant report. While this issue is relevant to interpretation of the findings more broadly across this study, it does pertain to this section most strongly as the funding source for treatment is not always visible or clear for those who access the service.

In examining the findings of the funding of for GP and MO treatment, Defence is the dominant funder for 2015 Regular ADF members (as would be expected), and DVA is the dominant funder of care for most Transitioned ADF members, although Medicare still funded 40% of GP care delivered to Transitioned ADF members. When examining funding among the sub-groups of Transitioned ADF members, these rates varied significantly, where among Ex-Serving members, DVA funded 68% of care and Medicare 32%, compared with reverse in Inactive Reservists where Medicare funded 68% and DVA 37% of care. Rates for Active Reservists were 47% and 37% for Medicare and DVA respectively. This is potentially an area for consideration as low rates of DVA payment for GPs by Inactive Reservists may reflect under engagement with DVA and potentially Inactive Reservists consulting GPs with limited understanding of their military experiences.

When considering funding for psychologist visits by Transitioned ADF participants, DVA is the largest source, funding 47% of consultations, but a strong and possibly higher than expected number of 25% attending psychological care at VVCS through self-referral, and 5% through Defence referral. Only 12% of care was reported to be self-

funded. For 2015 Regular ADF as expected, the vast majority of psychological care was funded through Defence (86%), with 17% also seeking care through VVCS self-referral and 5% Defence referral to VVCS. In breaking this down across the three transitioned groups, of interest was not only the significant VVCS presence among all three categories but that VVCS self-referral was the most commonly endorsed category of all the funding categories in the Active Reservists, with 33% seeking their psychological care through VVCS. This reflects a significant engagement of VVCS with the Active Reserve population, which has not been a traditional population base for VVCS.

In the examination of funding of psychiatric care, as expected, very high rates of care were funded for Transitioned ADF through DVA (76%), 18% through Defence and, notably, 15% through Medicare. For current serving ADF members, as expected, psychiatric care was almost exclusively funded through Defence or DVA. Examination of the transitioned cohort across the three categories, however, demonstrates that Medicare funding doubles from 12% to 25% in the two reservist categories, DVA funding reduces from 80% to 60% and self-funding triples from 6% to 16–18%.

Funding for Transitioned ADF members who consulted other mental health professionals including social workers, occupational therapists and mental health nurses for mental health care was primarily funded through DVA (42%), but also substantively delivered through VVCS (19%) and Defence (16%). Among 2015 Regular ADF members, 74% of this care was funded through Defence with 12% self-referral to VVCS. In this category, significant differences in funding source emerge between the transitioned categories, with DVA funding 62% for the Ex-Serving group compared with 10% and 14% respectively for the Inactive and Active Reservists. VVCS self-referral in this category was also twice the rate in Inactive Reservists (33%) than Inactive Reservists (17%) and Ex-Serving ADF members (14%).

10.1.9 Use of and satisfaction with self-help strategies

Websites, internet treatment and smartphone apps

Overall, the use rates for websites listed in the survey remained quite low; only 30% of Transitioned ADF members and 25% of 2015 Regular ADF members used any website. For Transitioned ADF members, the DVA website was the most commonly used (18%), followed by the ADF website (10%) and beyondblue (8%). The percentage of people using all other websites was low. Approximately 2% of Transitioned ADF members reported using the At Ease website, although given its DVA branding, it is questionable whether Transitioned ADF members distinguished between this website and the DVA website when responding to this question. Of those who used the DVA website, 58% found it helpful. Across most of the websites, usage rates increased for those with a probable 30-day disorder. However, as with the findings in the previous service satisfaction section, rates of satisfaction with the primary websites (DVA and ADF)

were lower for those with a probable 30-day disorder. In the case of the DVA website specifically, usage increased to 31% although satisfaction reduced to 48%. Use of the Defence website increased to 12% in those with a probable 30-day disorder although perceptions of its helpfulness reduced from 56% to 39%. Of note among the non-DVA websites, use of the beyondblue website doubled (to 16%) in those with a probable 30-day disorder and perceptions of its helpfulness remained largely stable from 65%, reducing only to 60%.

For 2015 Regular ADF, the Defence website was, as expected, the most commonly used (14%), with 11% using the DVA and 6% using the beyondblue website respectively. A high 70% found the Defence and DVA websites helpful and 80% found the beyondblue website helpful. As with the Transitioned ADF members, a higher proportion of those with current probable 30-day mental health problems used the websites, with this figure increasing to 20% and 18% respectively for the Defence and DVA websites, but also slightly lower rates of perceived helpfulness reported, with these rates lowering to 49% for each of these respectively.

Overall, these rates suggest that while satisfaction with the DVA and ADF websites are at reasonable levels, and that the Transitioned ADF and 2015 Regular ADF populations were both most likely to access websites designed specifically for military ADF members by either DVA or Defence, the proportion accessing them is low. This may speak to information dissemination processes or alternatively to preferred means of receiving information. There is also room for increase in satisfaction levels in these websites and given the significantly higher level of satisfaction reported in the beyondblue website (albeit lower use rates), perhaps some guidance may be drawn from that website as to structure and presentation of content.

Similarly, uptake rates for smartphone applications remained quite low; approximately 6% of Transitioned ADF and 2015 Regular ADF members used these applications, although these rates doubled to 14% in those with a probable 30-day disorder. The most commonly used app was PTSD Coach; 10% of Transitioned ADF and 2015 Regular ADF members with a probable 30-day disorder used this app, and rates of satisfaction were stable at around 50%. Notably the perceived helpfulness rates did not diminish in those with a probable 30-day disorder. This report does not analyse diagnosis-specific service use, so as with the use of trauma-focused CBT, the rate of PTSD Coach uptake may increase proportionately among the PTSD-specific subpopulation and could be a potential focus of future analyses.

The low uptake rates for the internet treatments and mobile phone applications reflected in this report suggests that the awareness of and preferences for use of these technologies across information provision and e-interventions needs to be explored in more detail. Currently, considerable effort and resources are being dedicated to the

use of e-health options. Indeed, there is much promise in these technologies, however, a better understanding of the reasons for the low uptake rates for current available resources needs to be explored. This is likely to be considered in more detail in the *Technology Use and Wellbeing Report*.

Other internet

This study then considered rates of broader internet usage such as blogs, social media and email subscriptions. Approximately 20% of Transitioned ADF and 10% of 2015 Regular ADF used some form of additional internet use for their mental health. These rates increasing to 27% and 13% respectively in those with a probable 30-day mental disorder. Of these, the most common form of additional internet use was social media, with 18% and 10% of Transitioned and 2015 Regular ADF members respectively using social media, and approximately 55% of those finding it helpful. These rates of use increased in those with a probable 30-day disorder to 25% and 12% respectively, with slightly reduced rates of perceived helpfulness in Transitioned ADF (49%) but stable rates in 2015 Regular ADF. Considering this across the transitioned groups, the Ex-Serving group reported considerably higher social media usage, 22% compared with 17% and 13% in Inactive and Active Reservists respectively. While not high, the potential use of social media in the promotion and dissemination of important health related information should be considered. This could include consideration of online support groups to promote recovery. It will be, however, important to better understand the manner in which social media is being used to leverage off this finding.

Use of telephone helplines

Overall, approximately 9% of Transitioned ADF members and 12% of 2015 Regular ADF members used a DVA or military helpline – rates that rose to 17% and 19% respectively for those with a probable 30-day disorder. The VVCS Veterans Line emerged as the most commonly used, by 8% of both the Transitioned ADF and 2015 Regular ADF groups, and these rates doubled in those with a probable 30-day disorder. Satisfaction rates were very high, at 75–85% for all users and 75% in those with a probable 30-day disorder. No non-veteran phone line was used to any great degree, with only 2% using any other non-veteran helpline. These findings speak strongly to the market presence and perceived satisfaction with the VVCS Veterans Line service. It appears to be a strong brand that could be built upon and integrated further into the service offerings of the health system. Rates of usage are twice as high in the Ex-Serving group compared to the two other transitioned groups, which indicates potential for the profile of this service to be further enhanced in these groups.

Ex-service organisations

Nine per cent of Transitioned ADF contacted ex-service organisations (ESOs) seeking information and assistance with their mental health. This figure doubled to 18% for those with a probable 30-day disorder. Rates of use were double in Ex-Serving

members (12%) compared with Active Reservists (6%) and Inactive Reservists (7%), and as expected rates are considerably lower among current serving ADF members. Rates of satisfaction with ESO services were also high, reinforcing the important role of ESOs within the veterans' service framework. This also highlights the importance of DVA and Defence continuing to collaborate with ESOs, which have the potential to act as a referral and access point to the evidence-based care provided by the broader veteran and ADF mental healthcare systems.

Other self-help strategies

In addition to using extant and newly developed digital and service-based resources to promote mental health and wellbeing, a critical part of mental health awareness activities for DVA and Defence has been promoting self-initiated activities. Importantly, reasonably substantial rates (30–40%) of Transitioned ADF and 2015 Regular ADF members reported using physical activity, engagement in pleasurable activities, and social and family support to aid their mental health, and 80–90% perceived these activities as helpful. The evidence base for the importance and effectiveness of these interventions is also robust (Ekers et al., 2014). The reasonably widespread use of these activities is an important outcome in the self-management of mental health and an important pathway to prevention upon which further initiatives can be built.

Preference for receiving mental health information

Participants were more likely to prefer receiving mental health information face to face rather than on the internet or by telephone, the latter of which was the least preferred of the three options. This effect was much stronger in those with a probable 30-day disorder, where 60% preferred to receive information face to face compared to via the internet (26%). For the group without probable 30-day disorders, the rates of interest in internet-delivered information rise, a finding that is also strongest in Ex-Serving compared with Inactive and Active Reservists. This does seem to suggest that for those with a probable 30-day disorder, consideration should be given to delivery of health-related information face to face where possible. This is also understood in terms of the capacity of those with a probable 30-day disorder to take in information, particularly possibly complex information at a time when their capacity to process this information is compromised. The most likely and frequent point of face-to-face contact in serving and ex-serving members' mental health care is their GP or MO. As such, it is important to focus on building the capacity of GPs and MOs to deliver clear and targeted mental health awareness, self-management and treatment information. These findings also support the current ADF approach of conducting face-to-face mental health screenings at high-risk points in service members' careers – including in post-deployment mental health screenings, which include a significant face-to-face psycho-educational component.

10.1.10 Stigmas and barriers to care

This study then examined the degree to which negative beliefs and attitudes about seeking care were evident among the Transitioned ADF and 2015 Regular ADF groups. The study first examined the prevalence of negative beliefs relating to what help-seeking would mean about them and their expectation of themselves, and how others would perceive them (that is, self-stigma and anticipated public stigma). The study then examined respondents' beliefs about barriers to accessing care, including beliefs about the negative consequences of help-seeking and any further barriers that impacted on health seeking. The study then examined these beliefs and attitudes in those with a probable 30-day disorder compared to those without. Finally, the study examined reasons for not seeking care in those with mental health concerns who did not seek assistance for their concerns.

Self-stigma and anticipated public stigma

The most common negative attitudes and beliefs about help-seeking were consistent across Transitioned ADF and 2015 Regular ADF members. These most common beliefs and attitudes included perceptions that others would perceive and behave differently towards them (anticipated public stigma); that is, that others would have less confidence in them, see them as weak and treat them differently. In addition, participants in both groups commonly reported a belief that they would feel worse if they could not solve their own problems (self-stigma). Rates of endorsement of these beliefs increased to approximately 50% for Transitioned ADF members with a probable 30-day disorder, particularly beliefs in losing the confidence of others and feeling worse if not solving their own problems. In 2015 Regular ADF members, beliefs about seeming as weak and being treated differently increased to 50% in those with a probable 30-day disorder. These beliefs reflect a mix of self and anticipated public stigma. There were no significant differences in the endorsement rates between Transitioned ADF and Regular ADF in this area. These specific attitudes and beliefs are highly consistent with the most prevalent attitudes and beliefs among military and veteran populations internationally (Hoge et al., 2004; Sharp et al., 2015). The current results also suggest that despite significant work to reduce stigma in both ADF and veteran populations, stigma appears to be increasing among current serving ADF members (McFarlane et al., 2011). Serious consideration is required to further exploring the optimal approaches to addressing these attitudes and beliefs, including in the broader Australian community.

Beliefs about self-reliance

In relation to an expectation that they should be able to solve problems on their own, it needs to be acknowledged that self-reliance, mastery and capacity to problem solve are highly valued and trained skills among military personnel (Britt et al., 2016). It is a common attitude that delays help-seeking across mental health populations more

generally (Jones et al., 2013; Momen et al., 2012) and that it is a powerful one in this population given its significance for the military role is unsurprising. Consideration needs to continue to be given as to the messaging and communication across all the domains of stigma reported here but also specifically to address the understandably strong and important self-reliance value in Defence populations. In addition, the perception that one is a trusted and reliable member of the team is also a core value in the context of the military. Education that directly targets negative beliefs (both of themselves and by others) in this area should be considered.

Attitudes about mental health treatment

The proportion of Transitioned ADF and 2015 Regular ADF members with a probable 30-day disorder reporting a lack of confidence or trust in mental health professionals was double (21% and 17%) those reporting mental health concerns but no disorder (12% and 9%). These findings are consistent with existing literature drawn from militaries internationally. The need for accurate and relevant treatment information and messaging around this issue will be addressed later in this discussion.

What proportion of the cohorts endorsed negative attitudes and beliefs about help-seeking?

The researchers then investigated whether, despite the rates of endorsing particular stigma-related beliefs, the degree to which these beliefs were spread across the respective populations under consideration. Importantly, 34% and 37% of the Transitioned and 2015 Regular ADF groups, respectively, did not endorse any stigma-related beliefs. This is most encouraging and speaks positively to the considerable amount of work conducted through the community at large but particularly through DVA and Defence to reduce negative attitudes and beliefs about mental health. The other notable group was that 33% and 30% respectively held four or more. Looking more closely at those with a probable 30-day disorder, respectively across Transitioned and Regular ADF, a high 56% and 43% held four or more negative beliefs.

Interestingly, while critical to address mental health stigma for a broad range of reasons, there is emerging evidence gathered through systematic reviews to indicate that its impact on attenuating access of treatment is limited (Sharp et al., 2015). These studies suggest that while stigma and negative beliefs about mental health and treatment represented a significant burden in those with mental health problems who held those beliefs, it does not necessarily determine engagement in care, supported here by the numbers endorsing many stigma-related items, but still engaging in care. Critical, however, is enhancing positive expectancies about mental health treatment, that treatment can benefit them and that they have the 'self-efficacy to carry out the behaviours (sic) that treatment requires' to improve the outcomes of the treatment itself (P. 883, Rosen et al., 2011). Hence, the messaging about treatment is critical.

The finding of the variability in stigma in attenuating engagement with care is to some degree supported by the data from this report, that despite the rates of endorsement of stigma-related beliefs, the vast majority of those with mental health concerns have engaged in care for these concerns. Critical is the extent to which they remain engaged in this care, have beliefs about its effectiveness and their own agency in recovery and receive an adequate dosage of best-practice treatment.

Two findings of this report for Transitioned ADF members with a probable 30-day disorder – firstly that the percentage of those seeking early service engagement is reduced and, secondly, that more than 50% endorsed four or more stigma-related beliefs – suggest this is likely to be a vulnerable subgroup requiring focused attention.

Barriers to care

In terms of the barriers identified, as expected and consistent within Australian and international literature, the most common belief was that seeking care would harm the respondent's career or career prospects, and among 2015 Regular ADF members, that it would prevent them from being deployed. For Transitioned ADF members, the next most common barriers were the belief that care was too expensive and they would have difficulty getting time off work. Similar results were found in those respondents with a probable 30-day disorder, which for Transitioned ADF members reflected concerns about expense, harm to career or career prospects and difficulty getting time off work, while for 2015 Regular ADF members were concerned about the impact on their potential for deployment, the effect on their career or career prospects, and difficulty getting time off work. The impact of help-seeking on career prospects for current serving and Transitioned ADF members is a critical issue and will be elaborated on later in this discussion.

What about those who had mental health concerns but did not seek care?

When examining the reasons outlined by those with mental health concerns who did not seek care, the strongest most commonly endorsed reasons were that they could still function (80%) and preferred to manage themselves (76%) and that they were afraid to ask (42%). Similar patterns were evident in the 2015 Regular ADF with rates of 80%, 82%, and 44% on each of these beliefs respectively. However, critically, in those with a probable 30-day disorder, being afraid to ask (for the reasons highlighted above) was the most common response. It is assumed although not tested here, that the reasons behind 'being too afraid to ask' carried with it, for those with a probable 30-day disorder, comparable beliefs about fears of the judgements of others and negative career consequences. Again, the issue of highly valuing self-reliance and capacity to self-manage while they can still function were evident. This information needs to be incorporated into any public messaging and approaches to shifting stigma and barrier related attitudes and behaviour across DVA and Defence and the broader support networks.

10.2 Broader consideration and service system implications from the findings

The findings reported in this study reflect reasonably high levels of initial engagement with care. Taking the first step in seeking care and – for the majority – doing so within the first 12 months (or for a significant number, within the first three months) is not an issue for most. As outlined above, however, the selection that occurs at each point of engagement, initial contact, seeing a mental health professional, getting our best proxy for evidence-based treatment and remaining in care for those with current disorder, is an outcome for a minority of identified cases. There does not appear to be a single point of vulnerability in this process, and the final rates of engagement appear to be the result of an accumulation of factors. It is also important to note, as stated early in this discussion, that this report does not assume that all those with a probable 30-day disorder need to be in care all the time. Effective treatment can and often should be episodic, although the rates reported here still suggest under-engagement with evidence-based treatment. It is important to consider strategies for maximising engagement on each level, at each time point and through each healthcare contact. While on many domains the satisfaction with services is comparable, if not slightly stronger than, international standards, there is still considerable room for improvement in satisfaction in key areas such as competency and effectiveness in the Transitioned ADF members compared with 2015 Regular ADF members.

10.2.1 Integration and coordination of services

The service system available to Transitioned ADF compared with that of Defence is that it is provided largely by a broad array of private services, tertiary- and community-based services, and private health and mental health practitioners across the country. The exception to this is the VVCS, a specialised veterans' service provided by the DVA. There is little systematic coordination across the full array of services, between levels of care and between providers of care. As such, there is considerable risk that individuals may fall out of care or into gaps between services. This lack of coordination may also explain the higher rates of satisfaction with specific service providers than with the service system effectiveness overall. The current health and mental health system is very difficult for veterans to navigate. Moving from a reasonably well coordinated system to one with significant coordination challenges – and the discrepancies between the systems apparent as soon as ADF members transition – may also heighten the dissatisfaction bias against health services among those who have transitioned.

Making the system more organised and coordinated across various levels and types of care can help veterans make informed decisions about their preferred options. A more clearly stepped (Bower & Gilbody, 2005) and integrated program within the service system would increase the potential for care to be delivered at the right level and

intensity according to veterans' needs. It would also put the veteran at the centre of the process, making it easier for them to take charge of facilitating their own care.

There is also potential to develop and integrate a more proactive and responsive health and non-health service capability that includes administration, chaplains, Defence Community Organisation, ESOs and others who see mental health as a part of their role. This could include enhancing skills in how to ask about mental health concerns, make those in need feel comfortable expressing concerns, and help someone access available supports.

For most respondents, someone else – often a partner or friend – suggested they seek care. This reinforces the importance of initiatives that promote mental health awareness and service-related information in personal and broader social networks. It also speaks to how partners and families are engaged in providing care, and managing serving and ex-serving members' disengagement with care. The types of problems that 2015 Regular ADF and Transitioned ADF members reported as driving their engagement with treatment also says something about the kind of language that can be helpful in promoting greater engagement with treatment.

10.2.2 Expertise in military culture and clinical presentations

With the exception of VVCS and facilities that provide accredited PTSD programs for veterans, services for Transitioned ADF members are largely delivered by an array of community practitioners and hospital-based services, many of which may not have sufficient exposure to military mental health issues. As such, they have variable levels of military cultural competence, relevant knowledge and appropriate skills required to treat veterans' common mental health problems. When satisfaction is examined more closely for specialised services such as the PTSD programs, satisfaction ratings are high and, as previously noted, very high in currently serving ADF members. These systems have clear specifications to guide services delivered and identified quality assurance and evaluation processes around them specifically. In bolstering engagement and the satisfaction ratings for the competence and effectiveness domains identified in this report, consideration needs to be given to the above features and factors in redressing these issues. One possibility may be to consider networks of excellence. This is an idea that has been discussed considerably over the past few years and also cited in the recent National Mental Health Commission report (National Mental Health Commission, 2017). These networks of excellence would identify services and practitioners with a cultural understanding of veterans' needs and high levels of skills and competence in addressing veterans' mental health problems within their specific discipline. The network would also promote high levels of connectedness between services within the network, allowing for closer communication between practitioners and allowing the veterans to make informed decisions in the navigation of their own

care with support, advice and guidance from a coordinated and sensitive service system.

10.2.3 Supporting identification and service engagement in mental health and wellbeing through the transition period

ADF members face considerable issues after their separation from Regular ADF service and during their transition into civilian life. These include psychological challenges to identity, role and fit, which can lead to various domestic, financial and vocational challenges. The service system needs to support these individuals effectively and efficiently, in a veteran-focused manner. This is particularly the case for those who experience a probable 30-day disorder, or who have fluctuating mental health issues but do not currently meet the criteria for a probable 30-day disorder. These problems may be evident when someone transitions from Regular ADF service, or may emerge over the course of many years following their separation from ADF, as they meet the challenges of this major life transition. A more detailed discussion about initiatives to support improved engagement, identification of mental health concerns, continuity of care and support following transition is beyond the scope of this report. However, these issues are critical in building targeted structures to support ADF members in their period of readjustment.

10.2.4 Bolstering effectiveness of treatment

Beyond engagement in care, it is worth considering the degree to which Transitioned ADF and 2015 Regular ADF experience evidence-based treatments and receive an 'adequate dose' of these treatments. Low rates of serving and ex-serving ADF members receiving CBT – the best proxy for evidence-based treatment for common mental health problems – is concerning. Current US research indicates that only a small percentage of veterans engaging in care receive an 'adequate dose' (Rosen et al., 2011). This is not evaluated directly in this study, but a minority of those with a probable 30-day disorder currently engaging in care suggests considerable room for improvement in treatment retention and delivery. There is potential to increase the extent to which evidence-based care is delivered to current serving and Transitioned ADF members who engage in care, and the degree to which they remain in care long enough to receive an effective intervention.

Even the most evidence-based best-practice interventions have limited effectiveness for a significant proportion of veterans. With this in mind, experts are continuing to explore adjunctive and innovative biological, social and psychological interventions for those who do not respond and broader complementary interventions. Nevertheless, it is important to ensure that the best existing treatment options are offered to as many individuals who would benefit from them as possible, and that this care is provided within a context that aids engagement and retention.

10.2.5 Stigma, beliefs about mental health treatment and barriers to care

In terms of stigma, a significant group of 30% (and up to 50% with a probable 30-day disorder) has been identified in this report who hold four or more negative beliefs about treatment-seeking. While many sought care anyway, these beliefs do impose a significant stress and emotional burden. For those with mental health concerns who elected not to seek care, being afraid to ask was the most commonly cited reason for not accessing help. Also prevalent among the cohort more generally was a negative belief about the trustworthiness and effectiveness of treatment. It is important to consider careful messaging in relation to the availability of helpful treatments, which is aligned with the evidence. In other words, it is important to promote the value of these treatments while making it clear there are limitations. Current public messaging is highly variable; all agencies, departments and researchers should pay serious attention to producing clear and accurate messaging regarding the potential availability and benefits of existing treatments. Messaging that understates the availability and effectiveness of care can have a significant impact on confidence and engagement. Similarly, messages about the effectiveness of any treatment should be realistic and not overstated.

As highlighted above, the desire to help oneself was evident in those with mental health concerns who did not seek care. This view is not inherently problematic – indeed, a sense of agency, self-reliance and self-efficacy in solving one's own problems is a highly valuable feature of resilience (Britt et al., 2016). However, this belief can become a barrier to seeking care when professional care is needed. Strategies to make self-help options more available, prominent, acceptable, non-threatening and effective should be considered. These may include developing digital options, and working on greater examination and promulgation of self-management strategies both in terms of prevention and staying well, addressing sub-clinical problems and in the addressing of probable 30-day mental health problems. Here there is the potential to explore recovery models based on increased control and self-management by those experiencing mental health problems (Commonwealth of Australia Department of Health, 2013). There also needs to be further consideration of the messaging delivered to a military population trained in the value of being able to solve their own problems and being generally self-reliant. This messaging needs to effectively convey to this population that care-seeking in areas of mental health can be consistent with these values.

Concerns that help-seeking will harm one's career can be addressed by providing evidence that this is not the case. This is a complicated issue, as declaring a mental health problem may well – for reasons of overall duty of care to the organisation and individuals – preclude participation in upcoming deployments or influence career outcomes. However, it is critical in dealing with those who seek care to focus on maximising vocational engagement and career aspirations. For the purposes of

changing the present culture, it is also important to publicise examples of members who have self-identified, sought care, and returned to meaningful and valued work, and for these examples reflect a range of mental health problems. No doubt seeing examples of the successful application of this policy will help boost members' confidence that the practice matches what they encounter in official communication.

10.3 Areas for future research

This study examined the overall patterns of help-seeking among Transitioned ADF and 2015 Regular ADF members. There are however, a number of suggested areas for further examination of this data that emerge from these findings. These include further examination, namely:

- the influence of gender, symptom severity, age, functioning and Service on help-seeking and perceived service satisfaction
- the 15% of Transitioned ADF and 25% of 2015 Regular ADF who met criteria for a probable 30-day disorder but did not identify as having a concern about their mental health
- the subgroup of Transitioned ADF with a probable 30-day disorder who endorsed four or more beliefs relating to stigma and barriers to care integration of the data from this report with the CIDI and suicidality data from *Mental Health Prevalence Report*, to examine the patterns of help-seeking among those with specific diagnosed mental disorders and levels of suicidality
- the patterns of service engagement in Transitioned ADF members based on their reported reasons for leaving the ADF, including a more detailed analysis of those who were medically or administratively discharged
- the profiles or combinations of services used, and its relationship to service satisfaction
- the use of internet treatments further to identify use differences, by those with a concern and those above and below epidemiological cut off
- patterns of service use and engagement, by mental health condition (for example PTSD, depression and substance use).

10.4 Limitations

There are a range of limitations in interpreting this report.

As outlined in *Mental Health Prevalence Report*, the response rate is a central issue in discussing the findings of the current study. The overall response rate for Transitioned ADF members was 17.9% of those who were invited – 4,114 individuals of the 24,049 who were eligible. Transition and Wellbeing Research Programme's *Mental Health Prevalence Report* elaborates on this issue, which does not need to be repeated here.

The findings in this report are based on participants self-reporting in relation to the categories of providers they accessed, the types of services they received from these providers and the sources of funding for each. As such, there is limited confidence in the accuracy in the results in these categories. For example, members of the general public are often unclear about the difference between a psychologist and psychiatrist, so reports of which mental health service used may be inaccurate. For example, a number of participants endorsed receiving medicine from psychologists, but given that psychologists are unauthorised to prescribe medication, it is likely that participants in these cases had consulted a psychiatrist. Similarly, participants may have been unable to differentiate the type of counselling they received. Although the descriptors in this section aimed to help participants discriminate between types of mental health services, in reality this can be quite difficult for veterans and members of the lay community to identify.

A further limitation is that questions requiring participants to estimate when their mental health concerns began and/or when they started seeking treatment are subject to recall biases.

When looking at the data for the three categories of Transitioned ADF members (Ex-Serving ADF members, Inactive Reservists and Active Reservists) cell sizes were sometimes too small to report the findings. The authors decided not to report any cell sizes less than five. In some cases (such as satisfaction with different mental health services or funding arrangements for the different services) this resulted in discrete cells not being reported, while at other times a whole table was not reported. Low cell sizes increase the unreliability of data, especially where confidence intervals are wide.

Interpreting the findings of this data has involved considering information across different time frames, including lifetime mental health concerns and help-seeking; 30-day probable disorder; and help-seeking within the last 12 months. As such, the findings of this report should be interpreted with the caution, in view of the data pertaining to variable time periods.

Finally, the relationship between probable disorder and mental health concern is relatively difficult to interpret and the findings here could, to some degree, be a function of how they were measured. For example, probable 30-day disorder was defined using self-report scales: the PCL (a measure of PTSD) and K10 (a measure of distress). As such, some mental disorders such as substance abuse may not have been captured. Similarly, those who reported having mental health concerns may include those with relationship difficulties, or those with mild symptoms.

10.5 Conclusion

In conclusion, the findings of this report suggest that in both the Transitioned ADF and 2015 Regular ADF groups, the vast majority of those with mental health concerns have received professional help with these problems. In addition, the majority do so within the first 12 months of the onset of this problem. GPs and MOs commonly provide this care, as do mental health professionals such as psychologists, psychiatrists and a range of other allied mental health providers. The most common services delivered are consistent with the core expected services. However, while the rates of engagement with and uptake of services are reasonably high, selection at each level of care means that only a minority of Transitioned ADF and Regular ADF members with probable 30-day disorders are getting the best-practice care required. This is more evident in the Transitioned ADF cohort than the Regular ADF cohort. Similarly, satisfaction with services is higher in the 2015 Regular ADF cohort. This indicates the need to consider strategies for improving engagement rates, retention and delivery of best-practice care at each contact point. While satisfaction with individual providers is at reasonably high levels (60–70%) among Transitioned ADF members, global ratings in key areas such as overall system effectiveness reduce in some cases to 50% and lower. This may highlight broader areas for development, improving coordination and integration of care across the service system available to Transitioned ADF members. There is also potential to increase care providers' understanding of military culture and other relevant contextual factors for those who provide care to the Transitioned ADF population.

Despite evidence of significant self-stigma and anticipated public stigma in up to 50% of those with probable 30-day disorders, most still sought care. Key beliefs held by those who did not seek care included being afraid to ask (anticipated public stigma) and career concerns. It is important to address the issue of concern about the career implications of seeking care. This will require a continued policy focus on improving rehabilitation and occupational retention after care has been delivered, but also clear evidence of work maintenance or re-engagement visible across all levels of the healthcare system.

Annex A Detailed tables

A.1 Denominators used in the analyses

Table A.1 Denominators

Cohort	Sample	Tables in report that use the denominator
Entire cohort		Chapter 4: 4.1, 4.2, 4.3, 4.4 Chapter 8: 8.1, 8.2, 8.3, 8.4, 8.5, 8.6, 8.7, 8.8, 8.9, 8.10, 8.11, 8.12, 8.13, 8.14, 8.15, 8.16, 8.17, 8.18 Chapter 9: 9.1, 9.2, 9.3, 9.4, 9.5, 9.6, 9.7, 9.8
2015 Regular ADF	52,500	
Transitioned ADF	24,932	
Ex-Serving	10,867	
Inactive Reservist	7513	
Active Reservist	6426	
Concerned about their mental health		Chapter 4: 4.5
2015 Regular ADF	27,372	
Transitioned ADF	16,052	
Concerned about their mental health and ever sought assistance		Chapter 5: 5.1, 5.2, 5.3, 5.4, 5.7, 5.8, 5.11 Chapter 6: 6.1, 6.2
2015 Regular ADF	20,740	
Transitioned ADF	12,022	
Ex-Serving	6338	
Inactive Reservist	3131	
Active Reservist	2504	
Concerned about their mental health, ever sought assistance and had someone suggest they seek assistance		Chapter 5: 5.5, 5.6
2015 Regular ADF	11,923	
Transitioned ADF	7518	
Ex-Serving	4144	
Inactive Reservist	1892	
Active Reservist	1461	
Concerned about their mental health, ever sought assistance and had someone help with seeking assistance		Chapter 5: 5.9, 5.10
2015 Regular ADF	5903	
Transitioned ADF	3924	
Ex-Serving	2375	
Inactive Reservist	833	
Active Reservist	658	
Concerned about their mental health and sought assistance in the last 12 months		Chapter 6: 6.21, 6.22
2015 Regular ADF	6183	
Transitioned ADF	2199	
Ex-Serving	1033	
Inactive Reservist	630	
Active Reservist	531	

Cohort	Sample	Tables in report that use the denominator
Concerned about their mental health and did not seek assistance		
2015 Regular ADF	6546	Chapter 9: 9.9
Transitioned ADF	3922	
Ex-Serving	1299	
Inactive Reservist	1425	
Active Reservist	1183	
Concerned about their mental health and sought assistance currently or in the last 12 months		
2015 Regular ADF	12,616	Chapter 10: 10.1, 10.2, 10.3, 10.4, 10.5, 10.6
Transitioned ADF	6573	
Ex-Serving	3975	
Inactive Reservist	1475	
Active Reservist	1094	

Note: Tables not listed use sub-populations within the cohorts listed above, and therefore are not listed here

A.2 Selected odds ratios for Transitioned ADF (2015 Regular ADF as a reference)

Table A.2 Selected odds ratios by corresponding table number for Transitioned ADF – 2015 Regular ADF is the reference group for all analyses presented

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation (for Transitioned ADF)	Strength of association
4.1	Probable 30-day disorder	All	2.10 (1.58, 2.79)	Twice as likely to have a probable 30-day disorder	Moderate
4.1	Concerned about mental health	All No probable 30-day disorder Probable 30-day disorder	1.63 (1.31, 2.02) 1.28 (1.01, 1.61) 3.10 (1.74, 5.53)	63% more likely to be concerned about mental health 28% more likely among those without a probable 30-day disorder Three times more likely among those with a probable 30-day disorder	Moderate Weak Strong
4.3	Ever sought assistance	All Not concerned about mental health Concerned about mental health	1.27 (1.02, 1.57) 0.96 (0.60, 1.54) 0.94 (0.67, 1.32)	Overall, 27% more likely to have ever sought assistance	Weak
4.5	Ever sought assistance	All No probable 30-day disorder Probable 30-day disorder	0.94 (0.66, 1.32) 0.77 (0.53, 1.12) 1.17 (0.53, 2.60)	No difference	
5.1	Sought assistance < 3 months of being concerned	All No probable 30-day disorder Probable 30-day disorder	0.61 (0.44, 0.85) 0.71 (0.49, 1.03) 0.54 (0.28, 1.02)	Less likely to have sought assistance <3m of being concerned	Moderate Weak Moderate
5.3	Someone suggested seeking help	All No probable 30-day disorder Probable 30-day disorder	1.12 (0.83, 1.51) 0.89 (0.64, 1.23) 1.80 (0.96, 3.37)	No difference	
5.7	Someone helped seek help	All No probable 30-day disorder Probable 30-day disorder	1.07 (0.73, 1.55) 0.97 (0.63, 1.51) 1.19 (0.58, 2.44)	No difference	

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation (for Transitioned ADF)	Strength of association
6.1	Ever saw a General Practitioner (GP)	All	1.07 (0.74, 1.55)	No difference	
		No probable 30-day disorder	0.99 (0.64, 1.53)		
		Probable 30-day disorder	0.69 (0.44, 1.08)		
	Saw a GP in the last 12 months	All	0.95 (0.66, 1.35)	No difference	
		No probable 30-day disorder	0.59 (0.38, 0.91)		
		Probable 30-day disorder	1.16 (0.59, 2.29)		
6.1	Ever saw a psychologist	All	0.57 (0.37, 0.87)	Less likely to have seen a psychologist	Moderate
		No probable 30-day disorder	0.57 (0.35, 0.94)		Moderate
		Probable 30-day disorder	0.41 (0.24, 0.71)		Moderate
	Saw a psychologist in the last 12 months	All	0.57 (0.40, 0.81)	Less likely to have seen a psychologist in the last 12 months	Moderate
		No probable 30-day disorder	0.38 (0.25, 0.59)		Strong
		Probable 30-day disorder	0.73 (0.38, 1.43)		Weak
6.1	Ever saw a psychiatrist	All	1.35 (0.97, 1.88)	Overall, 35% more likely to have seen a psychiatrist	Weak
		No probable 30-day disorder	1.04 (0.69, 1.57)		
		Probable 30-day disorder	1.24 (0.67, 2.30)		
	Saw a psychiatrist in the last 12 months	All	1.50 (0.95, 2.39)	No difference	
		No probable 30-day disorder	0.80 (0.41, 1.56)		
		Probable 30-day disorder	1.48 (0.73, 3.00)		
6.1	Ever saw another mental health professional	All	0.81 (0.56, 1.17)	Less likely to have seen another mental health professional	Weak
		No probable 30-day disorder	0.74 (0.48, 1.14)		
		Probable 30-day disorder	0.90 (0.45, 1.79)		
	Saw another mental health professional in the last 12 months	All	1.09 (0.74, 1.60)	No difference	
		No probable 30-day disorder	0.88 (0.50, 1.53)		
		Probable 30-day disorder	0.86 (0.43, 1.71)		

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation (for Transitioned ADF)	Strength of association
6.1	Ever saw another mental health provider	All	1.24 (0.82, 1.87)	No difference	
		No probable 30-day disorder	1.20 (0.76, 1.90)		
		Probable 30-day disorder	1.67 (0.85, 3.29)		
	Saw another mental health provider in the last 12 months	All	1.28 (0.55, 2.95)	Overall no difference; among those with a probable 30-day disorder, 2.4 times more likely	
		No probable 30-day disorder	1.06 (0.39, 2.90)		
		Probable 30-day disorder	2.39 (1.47, 3.89)		Moderate
6.1	Ever received inpatient treatment	All	2.22 (1.32, 3.75)	Overall, twice as likely to have inpatient support; among those with probable 30-day disorder, 3.0 times more likely	Moderate
		No probable 30-day disorder	1.34 (0.69, 2.62)		
		Probable 30-day disorder	3.24 (2.24, 4.68)		Strong
	Received inpatient treatment in the last 12 months	All	1.87 (1.01, 3.45)	Among those with probable 30-day disorder 2 times more likely	Weak
		No probable 30-day disorder	0.75 (0.27, 2.07)		
		Probable 30-day disorder	2.07 (1.31, 3.26)		Strong
6.1	Received hospital-based posttraumatic stress disorder (PTSD) treatment	All	1.69 (0.60, 4.77)	No difference	
		No probable 30-day disorder	0.66 (0.11, 4.04)		
		Probable 30-day disorder	1.75 (0.62, 4.94)		
	Received hospital-based PTSD treatment in the last 12 months	All	0.88 (0.17, 4.58)	No difference	
		No probable 30-day disorder	Not converged		
		Probable 30-day disorder	2.33 (1.27, 4.27)		Moderate
6.1	Ever participated in a residential alcohol program	All	1.05 (0.45, 2.46)	Overall no difference. Among those with probable 30-day disorder 2 times more likely	
		No probable 30-day disorder	0.74 (0.26, 2.12)		
		Probable 30-day disorder	2.28 (1.32, 3.93)		Moderate

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation (for Transitioned ADF)	Strength of association
	Participated in a residential alcohol program in the last 12 months	All	2.06 (1.07, 3.96)	Overall 2 times more likely	
		No probable 30-day disorder	1.46 (0.30, 7.20)		
		Probable 30-day disorder	1.32 (0.64, 2.71)		
6.21	Satisfied with accessibility	All	0.35 (0.21, 0.59)	Far less likely to be satisfied	
		No probable 30-day disorder	0.40 (0.21, 0.74)		
		Probable 30-day disorder	0.70 (0.37, 1.32)		
6.21	Satisfied with cost	All	1.08 (0.51, 2.30)	No difference	
		No probable 30-day disorder	1.12 (0.48, 2.60)		
		Probable 30-day disorder	2.52 (1.07, 5.93)		
6.21	Satisfied with location	All	0.22 (0.15, 0.31)	Far less likely to be satisfied	Strong (all)
		No probable 30-day disorder	0.29 (0.18, 0.46)		
		Probable 30-day disorder	0.29 (0.14, 0.57)		
6.21	Satisfied with effectiveness	All	0.25 (0.16, 0.39)	Far less likely to be satisfied	Strong (all)
		No probable 30-day disorder	0.30 (0.18, 0.50)		
		Probable 30-day disorder	0.37 (0.19, 0.74)		
6.21	Satisfied with competence	All	0.27 (0.19, 0.39)	Far less likely to be satisfied	Strong
		No probable 30-day disorder	0.38 (0.23, 0.62)		Strong
		Probable 30-day disorder	0.44 (0.23, 0.86)		Moderate
6.21	Friendliness (satisfied)	All	0.26 (0.17, 0.39)	Far less likely to be satisfied	Strong
		No probable 30-day disorder	0.30 (0.17, 0.53)		Strong
		Probable 30-day disorder	0.64 (0.31, 1.31)		Moderate
6.21	Satisfied with convenience	All	0.19 (0.13, 0.27)	Far less likely to be satisfied	Strong
		No probable 30-day disorder	0.19 (0.12, 0.31)		Strong
		Probable 30-day disorder	0.48 (0.25, 0.95)		Moderate

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation (for Transitioned ADF)	Strength of association
6.21	Satisfied with confidentiality	All	0.54 (0.31, 0.93)	Far less likely to be satisfied	Moderate
		No probable 30-day disorder	0.51 (0.27, 0.96)		Moderate
		Probable 30-day disorder	1.22 (0.62, 2.41)		Weak
6.21	Satisfied with Medicare cap	All	2.85 (1.22, 6.63)	Up to 3 times more likely to be satisfied	Moderate
		No probable 30-day disorder	4.34 (2.13, 8.87)		Strong
		Probable 30-day disorder	3.20 (1.10, 9.31)		Strong
6.21	Satisfied with another factor	All	3.21 (1.30, 7.91)		Strong
		No probable 30-day disorder	2.74 (1.04, 7.22)		Moderate
		Probable 30-day disorder	0.35 (0.03, 3.84)		
7.1	GP method of payment				
	Medicare	All	79.15 (47.58, 131.7)	Far more likely for various payment methods	Interpret with caution
	DVA	All	10.85 (4.80, 24.53)		
	Defence	All	0.01 (0.01, 0.02)		
	Fully self-funded	All	14.52 (9.48, 22.23)		
	Other – incl. WorkCover	All	9.99 (4.13, 24.20)		
7.3	Psychologist method of payment				
	Medicare	All	56.94 (28.12, 115.3)	Far more likely for various payment methods	Interpret with caution
	DVA	All	18.66 (7.33, 47.47)		
	Defence	All	0.02 (0.01, 0.04)		
	Fully self-funded	All	14.78 (8.95, 24.42)		
	Private health fund	All	32.61 (10.69, 99.48)		
	VVCS self-referral	All	1.53 (0.82, 2.88)		
	VVCS Defence referral	All	0.98 (0.59, 1.63)		
	Other – incl. WorkCover	All	25.05 (10.19, 61.57)		

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation (for Transitioned ADF)	Strength of association
7.5	Psychiatrist method of payment				
	Medicare	All	62.71 (23.16, 169.8)	Far more likely for various payment methods	Interpret with caution
	DVA	All	39.18 (17.27, 88.87)		
	Defence	All	0.02 (0.01, 0.04)		
	Fully self-funded	All	14.99 (4.39, 51.24)		
	Private health fund	All	9.82 (1.90, 50.64)		
	Other – incl. WorkCover	All	3.97 (0.52, 30.41)		
7.7	Other mental health professional method of payment				
	Medicare	All	72.99 (8.55, 623.1)	Far more likely for various payment methods	Interpret with caution
	DVA	All	4.53 (1.68, 12.18)		
	Defence	All	0.03 (0.02, 0.05)		
	Fully self-funded	All	2.84 (1.14, 7.07)		
	VVCS self-referral	All	1.16 (0.69, 1.94)		
	VVCS Defence referral	All	0.32 (0.06, 1.61)		
	Other – incl. WorkCover	All	7.46 (2.93, 18.95)		
8.1	Access to websites				
	ADF website	All	0.65 (0.49,0.86)	Less likely to use website	Moderate
		No probable 30-day disorder	0.63 (0.46, 0.87)		Moderate
		Probable 30-day disorder	0.53 (0.32, 0.87)		Moderate
	DVA website	All	1.92 (1.49, 2.47)	Overall more likely to use website; among those with a probable 30-day disorder, 2.0 times more likely	Weak
		No probable 30-day disorder	1.51 (1.12, 2.02)		Weak
		Probable 30-day disorder	2.14 (1.27, 3.63)		Moderate
	At Ease website	All	1.20 (0.63, 2.27)	No difference	
		No probable 30-day disorder	0.98 (0.47, 2.06)		
		Probable 30-day disorder	0.92 (0.26, 3.28)		

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation (for Transitioned ADF)	Strength of association
	Black Dog Institute	All	0.88 (0.50, 1.54)	No difference	
		No probable 30-day disorder	0.57 (0.29, 1.16)		
		Probable 30-day disorder	1.16 (0.47, 2.82)		
	Headspace	All	1.00 (0.51, 1.97)	No difference	
		No probable 30-day disorder	0.62 (0.27, 1.40)		
		Probable 30-day disorder	1.25 (0.35, 4.52)		
	beyondblue	All	1.27 (0.82, 1.97)	No difference	
		No probable 30-day disorder	1.00 (0.61, 1.64)		
		Probable 30-day disorder	1.14 (0.48, 2.67)		
	mindhealthconnect	All	0.68 (0.30, 1.56)	No difference	
		No probable 30-day disorder	0.60 (0.21, 1.69)		
		Probable 30-day disorder	0.41 (0.08, 2.07)		
	Lifeline	All	1.15 (0.58, 2.27)	No difference	
		No probable 30-day disorder	0.82 (0.34,2.00)		
		Probable 30-day disorder	0.96 (0.30,3.11)		
	Kids Helpline	All	0.56 (0.24,1.29)	No difference	
		No probable 30-day disorder	0.45 (0.16, 1.27)		
		Probable 30-day disorder	0.39 (0.07, 2.20)		
	MensLine Australia	All	0.67 (0.28, 1.56)	No difference	
		No probable 30-day disorder	0.60 (0.21, 1.75)		
		Probable 30-day disorder	0.46 (0.11, 1.89)		
	Other health websites	All	1.54 (0.93, 2.53)	No difference	
		No probable 30-day disorder	1.14 (0.62, 2.12)		
		Probable 30-day disorder	1.67 (0.70, 3.98)		

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation (for Transitioned ADF)	Strength of association
	Any health websites	All	1.25 (0.99, 1.59)	No difference	
		No probable 30-day disorder	1.04 (0.80, 1.36)		
		Probable 30-day disorder	1.28 (0.76, 2.15)		
8.3	Internet treatments				
	MoodGYM	All	0.60 (0.27, 1.31)	No difference	
		No probable 30-day disorder	0.48 (0.18, 1.25)		
		Probable 30-day disorder	0.34 (0.07, 1.62)		
	e-couch	All	0.49 (0.21, 1.14)	No difference	
		No probable 30-day disorder	0.39 (0.13, 1.14)		
		Probable 30-day disorder	0.32 (0.05, 1.90)		
	Other	All	1.36 (0.71, 2.58)	No difference	
		No probable 30-day disorder	1.12 (0.52, 2.44)		
		Probable 30-day disorder	1.05 (0.29, 3.78)		
	Any internet treatment	All	1.34 (0.77, 2.30)	No difference	
		No probable 30-day disorder	0.94 (0.47, 1.87)		
		Probable 30-day disorder	1.48 (0.59, 3.67)		
8.5	Phone apps				
	PTSD Coach	All	1.29 (0.69, 2.40)	No difference	
		No probable 30-day disorder	1.09 (0.60, 1.96)		
		Probable 30-day disorder	0.84 (0.30, 2.38)		
	On Track	All	0.84 (0.46, 1.52)	No difference	
		No probable 30-day disorder	0.70 (0.35, 1.43)		
		Probable 30-day disorder	0.72 (0.20, 2.63)		
	Other app	All	0.95 (0.54, 1.68)	No difference	
		No probable 30-day disorder	0.71 (0.35, 1.44)		
		Probable 30-day disorder	0.87 (0.39, 1.92)		

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation (for Transitioned ADF)	Strength of association
	Any phone app	All	1.13 (0.73, 1.76)	No difference	
		No probable 30-day disorder	0.86 (0.52, 1.43)		
		Probable 30-day disorder	0.92 (0.41, 2.07)		
8.7	Social media				
	Email subscription	All	1.35 (0.79, 2.32)	No difference	
		No probable 30-day disorder	1.49 (0.81, 2.75)		
		Probable 30-day disorder	0.72 (0.26, 1.97)		
	Blogs	All	1.87 (1.02, 3.45)	Overall, 87% more likely to use blogs	Moderate
		No probable 30-day disorder	1.70 (0.87, 3.34)		
		Probable 30-day disorder	1.48 (0.39, 5.64)		
	Social media	All	1.91 (1.38, 2.65)	Overall, almost 2.0 times more likely to use social media; among those with a probable 30-day disorder, 2.3 times more likely	Moderate
		No probable 30-day disorder	1.61 (1.10, 2.35)		Moderate
		Probable 30-day disorder	2.35 (1.42, 3.88)		Moderate
	Any of the above	All	1.93 (1.42, 2.62)	Overall, almost 2.0 times more likely to use social media; among those with a probable 30-day disorder, 2.3 times more likely	Moderate
		No probable 30-day disorder	1.63 (1.14, 2.33)		Moderate
		Probable 30-day disorder	2.43 (1.49, 3.98)		Moderate
8.9	Defence helplines				
	Defence Family Helpline	All	0.81 (0.42, 1.56)	No difference	
		No probable 30-day disorder	0.72 (0.38, 1.38)		
		Probable 30-day disorder	0.54 (0.15, 1.93)		
	ADF All-hours Support Line	All	0.52 (0.26, 1.04)	No difference	
		No probable 30-day disorder	0.50 (0.21, 1.20)		
		Probable 30-day disorder	0.31 (0.08, 1.23)		
	1800 IMSICK	All	0.23 (0.14, 0.36)	No difference	
		No probable 30-day disorder	0.15 (0.08, 0.27)		
		Probable 30-day disorder	0.32 (0.12, 0.88)		

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation (for Transitioned ADF)	Strength of association
	VVCS Veteran's Line	All	0.89 (0.58, 1.37)	No difference	
		No probable 30-day disorder	0.62 (0.36, 1.09)		
		Probable 30-day disorder	0.95 (0.45, 2.00)		
	Any of the above	All	0.67 (0.48, 0.93)	No difference	
		No probable 30-day disorder	0.45 (0.30, 0.68)		
		Probable 30-day disorder	0.86 (0.44, 1.68)		
8.11	Other helplines				
	Lifeline	All	1.26 (0.51, 3.14)	No difference	
		No probable 30-day disorder	1.25 (0.58, 2.68)		
		Probable 30-day disorder	0.74 (0.16, 3.43)		
	MensLine Australia	All	1.04 (0.42, 2.57)	No difference	
		No probable 30-day disorder	0.98 (0.45, 2.12)		
		Probable 30-day disorder	0.58 (0.11, 3.21)		
	MindSpot	All	0.75 (0.27, 2.09)	No difference	
		No probable 30-day disorder	0.85 (0.31, 2.31)		
		Probable 30-day disorder	0.32 (0.05, 2.08)		
	Relationships Australia	All	0.43 (0.15, 1.20)	No difference	
		No probable 30-day disorder	0.53 (0.18, 1.58)		
		Probable 30-day disorder	0.19 (0.04, 1.01)		
	SANE Australia	All	0.77 (0.27, 2.17)	No difference	
		No probable 30-day disorder	0.90 (0.32, 2.49)		
		Probable 30-day disorder	0.31 (0.05, 1.98)		
	Other helpline	All	1.32 (0.59, 2.91)	No difference	
		No probable 30-day disorder	1.59 (0.84, 3.00)		
		Probable 30-day disorder	0.59 (0.15, 2.31)		

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation (for Transitioned ADF)	Strength of association
	Any helpline	All	0.87 (0.39, 1.94)	No difference	
		No probable 30-day disorder	0.99 (0.46, 2.12)		
		Probable 30-day disorder	0.46 (0.12, 1.79)		
8.15	Consulting a chaplain, church leader or faith group	All	0.39 (0.27, 0.56)	Less likely to have seen a chaplain, church leader or faith group	Strong
	Increasing physical activity	All	0.94 (0.76, 1.15)	No difference	
	Doing more things you enjoy	All	1.10 (0.89, 1.35)	No difference	
	Seeking support from family members or friends	All	1.03 (0.82, 1.29)	No difference	
9.1	Stigmas				
	Wouldn't understand problems	All	2.39 (1.71, 3.33)	Twice as likely to have this stigma, highest among those with a probable 30-day disorder	Moderate
		No probable 30-day disorder	1.98 (1.35, 2.89)		Moderate
		Probable 30-day disorder	2.45 (1.31, 4.56)		Moderate
	Outcome beyond my control	All	1.04 (0.78, 1.39)	No difference	
		No probable 30-day disorder	0.72 (0.51, 1.01)		
		Probable 30-day disorder	1.43 (0.81, 2.52)		
	Would feel inadequate	All	1.72 (1.29, 2.27)	72% more likely to have this stigma, but not among those with a probable 30-day disorder	Moderate
		No probable 30-day disorder	1.72 (1.31, 2.26)		Moderate
		Probable 30-day disorder	1.13 (0.63, 2.01)		
	Would feel embarrassed	All	1.50 (1.19, 1.89)	Among those with a probable 30-day disorder, 85% more likely to have this stigma	Weak
		No probable 30-day disorder	1.22 (0.94, 1.58)		Weak
		Probable 30-day disorder	1.85 (1.13, 3.04)		Moderate
	Feel worse if I can't solve my own problems	All	1.55 (1.23, 1.95)	Among those with a probable 30-day disorder, twice as likely to have this stigma	Weak
		No probable 30-day disorder	1.26 (0.97, 1.64)		Weak
		Probable 30-day disorder	2.08 (1.27, 3.41)		Moderate

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation (for Transitioned ADF)	Strength of association
	Should be able snap out of it	All	1.89 (0.97, 3.70)	Among those with a probable 30-day disorder, 4.0 times more likely to have this stigma (highest of all stigmas)	Moderate
		No probable 30-day disorder	1.28 (0.58, 2.83)		Weak
		Probable 30-day disorder	4.05 (2.40, 6.83)		Strong
	Might feel worse	All	1.67 (1.10, 2.51)	No difference	
		No probable 30-day disorder	1.32 (0.80, 2.17)		
		Probable 30-day disorder	1.74 (0.84, 3.57)		
	Might lose control of emotions or reactions	All	1.60 (1.13, 2.26)	Overall, 60% more likely to have this stigma	Moderate
		No probable 30-day disorder	1.29 (0.85, 1.97)		
		Probable 30-day disorder	1.42 (0.79, 2.57)		
	People would treat me differently	All	0.86 (0.68, 1.08)	No difference	
		No probable 30-day disorder	0.66 (0.51, 0.86)		
		Probable 30-day disorder	1.18 (0.71, 1.97)		
	Would be seen as weak	All	0.87 (0.68, 1.10)	No difference	
		No probable 30-day disorder	0.67 (0.51, 0.88)		
		Probable 30-day disorder	1.06 (0.64, 1.75)		
	People would have less confidence in me	All	0.84 (0.68, 1.05)	Among those without a probable 30-day disorder, less likely to have this disorder	
		No probable 30-day disorder	0.71 (0.56, 0.91)		Weak
		Probable 30-day disorder	0.94 (0.57, 1.56)		
	Don't trust mental health professionals	All	1.42 (1.00, 2.00)	No difference	
		No probable 30-day disorder	1.32 (0.89, 1.96)		
		Probable 30-day disorder	1.32 (0.67, 2.59)		
9.5	Barriers				
	Too expensive	All	6.21 (4.31, 8.93)	Up to 8.0 times more likely to encounter this barrier, highest among those with a probable 30-day disorder	Strong
		No probable 30-day disorder	5.14 (3.36, 7.86)		Strong
		Probable 30-day disorder	8.77 (4.82, 15.96)		Strong

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation (for Transitioned ADF)	Strength of association
	Wouldn't know where to get help	All	1.63 (1.06, 2.50)	Among those with a probable 30-day disorder, 5.0 times more likely to encounter this barrier	Moderate
		No probable 30-day disorder	1.09 (0.66, 1.79)		
		Probable 30-day disorder	4.99 (3.32, 7.51)		Strong
	Difficulty getting time off work	All	1.05 (0.77, 1.42)	No difference	
		No probable 30-day disorder	0.90 (0.63, 1.29)		
		Probable 30-day disorder	1.20 (0.68, 2.13)		
	Would harm my career or career prospects	All	0.75 (0.59, 0.94)	Overall, less likely to encounter this barrier	Weak
		No probable 30-day disorder	0.64 (0.49, 0.83)		Moderate
		Probable 30-day disorder	0.94 (0.57, 1.55)		
	Would stop me from being deployed	All	0.25 (0.20, 0.31)	Overall, less likely to encounter this barrier	
		No probable 30-day disorder	0.24 (0.19, 0.31)		
		Probable 30-day disorder	0.26 (0.16, 0.43)		
	Difficult to get an appointment	All	0.95 (0.73, 1.24)	No difference	
		No probable 30-day disorder	0.72 (0.54, 0.96)		
		Probable 30-day disorder	1.19 (0.65, 2.19)		
9.9	Reason why assistance not sought				
	Afraid to ask	All	0.95 (0.51, 1.76)	No difference	
		No probable 30-day disorder	0.85 (0.43, 1.67)		
		Probable 30-day disorder	0.78 (0.31, 1.97)		
	Nothing could help	All	1.62 (0.90, 2.93)	Among those with a probable 30-day disorder, 3.0 times more likely to report this reason	
		No probable 30-day disorder	1.28 (0.65, 2.54)		
		Probable 30-day disorder	2.96 (1.09, 8.01)		Moderate
	I can still function	All	0.88 (0.39, 1.99)	No difference	
		No probable 30-day disorder	0.94 (0.33, 2.73)		
		Probable 30-day disorder	1.06 (0.31, 3.65)		

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation (for Transitioned ADF)	Strength of association
	Couldn't afford it	All	7.85 (4.53, 13.58)	Far more likely to have this reason among all respondents, and highest among those with a probable 30-day disorder	Strong
		No probable 30-day disorder	5.96 (3.21, 11.10)		Strong
		Probable 30-day disorder	26.32 (6.98, 99.20)		Strong
	Can get help from other sources	All	0.72 (0.39, 1.31)	No difference	
		No probable 30-day disorder	0.90 (0.47, 1.72)		
		Probable 30-day disorder	0.17 (0.03, 0.92)		
	Prefer to manage myself	All	0.82 (0.39, 1.70)	No difference	
		No probable 30-day disorder	0.74 (0.31, 1.76)		
		Probable 30-day disorder	1.47 (0.40, 5.41)		
	Don't know where to get help	All	2.49 (0.97, 6.35)	Among those with a probable 30-day disorder, 9.0 times more likely to report this reason	
		No probable 30-day disorder	1.75 (0.60, 5.13)		
		Probable 30-day disorder	9.29 (3.30, 26.15)		Strong
10.1	Disruption to family life (moderate or higher)	All	2.66 (1.72, 4.13)	Overall, 2.5 times more likely to have at least moderate disruption, and 6.0 times more likely among those with a probable 30-day disorder	Moderate
		No probable 30-day disorder	1.09 (0.65, 1.81)		
		Probable 30-day disorder	5.95 (2.10, 16.86)		Strong
10.3	Disruption to social life (moderate or higher)	All	2.09 (1.36, 3.20)	Overall, 2.0 times more likely to have at least moderate disruption, and 4.0 times more likely among those with a probable 30-day disorder	Moderate
		No probable 30-day disorder	0.85 (0.51, 1.42)		
		Probable 30-day disorder	4.44 (1.43, 13.78)		Strong
10.5	Disruption to work life (moderate or higher)	All	2.34 (1.56, 3.52)	Overall, 2.0 times more likely to have at least moderate disruption, and 3.0 times more likely among those with a probable 30-day disorder	Moderate
		No probable 30-day disorder	1.04 (0.62, 1.73)		
		Probable 30-day disorder	2.95 (1.27, 6.84)		Moderate

Table A.3 Selected odds ratios by corresponding table number for Transitioned ADF members (multiple comparisons)

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation	Strength of association
4.2	Concerned about mental health	Ex-Serving vs Active	1.92 (1.54, 2.39)	Ex-Serving group is 92% more likely	Moderate
		Inactive vs Active	1.16 (0.93, 1.44)		
		Ex-Serving vs Inactive	1.66 (1.32, 2.08)		
4.4	Ever sought assistance	Ex-Serving vs Active	2.38 (1.73, 3.27)	Ex-Serving 2 times more likely to have sought assistance when concerned about MH, compared to Active and Inactive Reservists	Moderate
		Inactive vs Active	1.12 (0.81, 1.53)		
		Ex-Serving vs Inactive	2.13 (1.55, 2.91)		Moderate
5.2	Sought assistance < 3 months of being concerned	Ex-Serving vs Active	0.90 (0.67, 1.21)	No differences	
		Inactive vs Active	1.11 (0.81, 1.54)		
		Ex-Serving vs Inactive	0.81 (0.60, 1.09)		
5.4	Someone suggested seeking help	Ex-Serving vs Active	1.09 (0.81, 1.46)	No differences	
		Inactive vs Active	0.95 (0.69, 1.32)		
		Ex-Serving vs Inactive	1.14 (0.84, 1.55)		
5.8	Someone assisted with seeking help	Ex-Serving vs Active	1.41 (1.02, 1.94)	Weak association	Weak
		Inactive vs Active	0.91 (0.62, 1.32)		
		Ex-Serving vs Inactive	1.55 (1.11, 2.17)	Ex-Serving group is 50% more likely	Moderate
6.2	Ever saw a General Practitioner (GP)	Ex-Serving vs Active	2.17 (1.48, 3.18)	Ex-Serving 2 times more likely to have seen GP compared to both Active and Inactive Reservists	Moderate
		Inactive vs Active	0.94 (0.63, 1.40)		
		Ex-Serving vs Inactive	2.31 (1.56, 3.42)		Moderate
	Saw a GP in the last 12 months	Ex-Serving vs Active	2.21 (1.59, 3.08)	Ex-Serving 2 times more likely to have seen GP (<12 m) compared to Active Reservists	Moderate
		Inactive vs Active	1.41 (0.97, 2.04)		
		Ex-Serving vs Inactive	1.57 (1.16, 2.13)		Moderate
6.2	Ever saw a psychologist	Ex-Serving vs Active	1.60 (1.04, 2.44)	Ex-Serving group is 60–77% more likely than Active Reservists and Inactive Reservists	Moderate
		Inactive vs Active	0.90 (0.58, 1.40)		
		Ex-Serving vs Inactive	1.77 (1.19, 2.64)		Moderate

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation	Strength of association
	Saw a psychologist in the last 12 months	Ex-Serving vs Active	1.73 (1.24, 2.42)	Ex-Serving group is 73% more likely than Active Reservists	Moderate
		Inactive vs Active	1.15 (0.79, 1.67)	Ex-Serving group is 50% more likely than Inactive Reservists	
		Ex-Serving vs Inactive	1.51 (1.10, 2.08)		Moderate
6.2	Ever saw a psychiatrist	Ex-Serving vs Active	2.82 (2.07, 3.85)	Ex-Serving almost 3.0 times more likely than Active Reservist and Inactive Reservists	Moderate
		Inactive vs Active	0.96 (0.68, 1.35)		
		Ex-Serving vs Inactive	2.95 (2.17, 4.02)		Moderate
	Saw a psychiatrist in the last 12 months	Ex-Serving vs Active	5.15 (3.35, 7.90)	Ex-Serving group is almost 5.0 times more likely than Active Reservists and Inactive Reservists	Strong
		Inactive vs Active	1.70 (1.03, 2.81)		Moderate
		Ex-Serving vs Inactive	3.02 (2.05, 4.44)		Strong
6.2	Ever saw another mental health professional	Ex-Serving vs Active	1.02 (0.74, 1.40)	No differences	
		Inactive vs Active	0.75 (0.52, 1.09)		
		Ex-Serving vs Inactive	1.36 (0.97, 1.91)		
	Saw another mental health professional in the last 12 months	Ex-Serving vs Active	1.41 (0.84, 2.36)	No differences	
		Inactive vs Active	0.99 (0.52, 1.86)		
		Ex-Serving vs Inactive	1.43 (0.84, 2.44)		
6.2	Ever saw another mental health provider	Ex-Serving vs Active	0.64 (0.46, 0.89)	Ex-Serving group is less likely than Active Reservists	Moderate
		Inactive vs Active	1.09 (0.76, 1.57)		
		Ex-Serving vs Inactive	0.59 (0.41, 0.84)		
	Saw another mental health provider in the last 12 months	Ex-Serving vs Active	1.00 (0.61, 1.65)	No differences	
		Inactive vs Active	0.95 (0.50, 1.83)		
		Ex-Serving vs Inactive	1.05 (0.55, 2.03)		
6.2	Ever received inpatient treatment	Ex-Serving vs Active	4.30 (2.92, 6.32)	Ex-Serving group is up to 5.0 times more likely than Active Reservists and Inactive Reservists	Strong
		Inactive vs Active	0.85 (0.46, 1.55)		
		Ex-Serving vs Inactive	5.06 (2.90, 8.83)		Strong

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation	Strength of association
	Received inpatient treatment in the last 12 months	Ex-Serving vs Active	5.19 (2.47, 10.89)	Ex-Serving group is 5.0 times more likely than Active Reservists, and 8.0 times more likely than Inactive Reservists	Strong
		Inactive vs Active	0.60 (0.20, 1.82)		
		Ex-Serving vs Inactive	8.61 (3.62, 20.45)		Strong
6.1	Ever received hospital-based posttraumatic stress disorder (PTSD) treatment	Ex-Serving vs Active	9.39 (4.73, 18.64)	Ex-Serving group is 9.0 times more likely than Active Reservists, and 4.0 times more likely than Inactive Reservists	Strong
		Inactive vs Active	2.14 (0.92, 4.95)		
		Ex-Serving vs Inactive	4.39 (2.48, 7.78)		Strong
	Received hospital-based PTSD treatment in the last 12 months	Ex-Serving vs Active	12.95 (3.40, 49.37)	Ex-Serving group is 12.0 times more likely than Active Reservists, and 4.0 times more likely than Inactive Reservists	Strong
		Inactive vs Active	3.33 (0.75, 14.67)		Strong
		Ex-Serving vs Inactive	3.90 (1.77, 8.55)		Strong
6.1	Ever participated in a residential alcohol program	Ex-Serving vs Active	2.09 (1.02, 4.28)	Ex-Serving group is 2.0 times more likely than Active Reservists and Inactive Reservists	Moderate
		Inactive vs Active	0.85 (0.33, 2.17)		
		Ex-Serving vs Inactive	2.47 (1.09, 5.57)		Moderate
	Participated in a residential alcohol program in the last 12 months	Ex-Serving vs Active	6.31 (1.53, 25.92)	Ex-Serving group is 6.0 times more likely than Active Reservists and Inactive Reservists	Strong
		Inactive vs Active	0.95 (0.14, 6.42)		
		Ex-Serving vs Inactive	6.62 (1.62, 27.01)		Strong
6.22	Satisfied with accessibility	Ex-Serving vs Active	0.63 (0.32, 1.24)	No differences	
		Inactive vs Active	0.67 (0.32, 1.43)		
		Ex-Serving vs Inactive	0.94 (0.42, 2.09)		
6.22	Satisfied with cost	Ex-Serving vs Active	0.86 (0.40, 1.87)	No differences	
		Inactive vs Active	0.77 (0.34, 1.72)		
		Ex-Serving vs Inactive	1.12 (0.51, 2.46)		
6.22	Satisfied with location	Ex-Serving vs Active	0.53 (0.28, 1.00)	No differences	
		Inactive vs Active	0.75 (0.36, 1.55)		
		Ex-Serving vs Inactive	0.71 (0.33, 1.54)		

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation	Strength of association
6.22	Satisfied with effectiveness	Ex-Serving vs Active Inactive vs Active Ex-Serving vs Inactive	0.34 (0.16, 0.70) 0.91 (0.41, 2.03) 0.37 (0.18, 0.77)	Ex-Serving group is less likely than Active Reservists and Inactive Reservists	Strong
6.22	Satisfied with competence	Ex-Serving vs Active Inactive vs Active Ex-Serving vs Inactive	0.37 (0.18, 0.72) 0.57 (0.26, 1.24) 0.64 (0.30, 1.38)	Ex-Serving group is 2.0 times less likely than Active Reservists	Strong
6.22	Satisfied with friendliness	Ex-Serving vs Active Inactive vs Active Ex-Serving vs Inactive	0.37 (0.16, 0.89) 0.47 (0.18, 1.20) 0.80 (0.35, 1.82)	Ex-Serving group is 2.0 times less likely than Active Reservists	Strong
6.22	Satisfied with convenience	Ex-Serving vs Active Inactive vs Active Ex-Serving vs Inactive	0.47 (0.23, 0.94) 0.97 (0.43, 2.17) 0.48 (0.23, 1.01)	Ex-Serving group is 2.0 times less likely than Active Reservists	Moderate
6.22	Satisfied with confidentiality	Ex-Serving vs Active Inactive vs Active Ex-Serving vs Inactive	0.54 (0.24, 1.22) 0.80 (0.33, 1.95) 0.67 (0.29, 1.55)	No differences	
6.22	Satisfied with Medicare cap	Ex-Serving vs Active Inactive vs Active Ex-Serving vs Inactive	0.23 (0.07, 0.76) 0.29 (0.08, 1.01) 0.79 (0.22, 2.79)	Ex-Serving group is 4.0 times less likely than Active Reservists	Strong
6.22	Satisfied with another factor	Ex-Serving vs Active Inactive vs Active Ex-Serving vs Inactive	4.54 (0.44, 47.05) 15.83 (1.40, 179.3) 0.29 (0.05, 1.78)	CI is too large for interpretation	
8.2	Access to websites ADF website	 Ex-Serving vs Active Inactive vs Active Ex-Serving vs Inactive	 0.65 (0.47, 0.89) 0.45 (0.32, 0.65) 1.43 (0.98, 2.08)	Ex-Serving group is less likely than Active Reservists	Moderate

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation	Strength of association
	DVA website	Ex-Serving vs Active	1.94 (1.53, 2.46)	Ex-Serving group is 94% more likely than Active Reservists and Inactive Reservists	Moderate
		Inactive vs Active	1.07 (0.82, 1.39)		
		Ex-Serving vs Inactive	1.81 (1.40, 2.35)		Moderate
	At Ease website	Ex-Serving vs Active	1.92 (1.06, 3.48)	Ex-Serving group is 2.0 times more likely than Inactive Reservists	Moderate
		Inactive vs Active	0.81 (0.42, 1.55)		
		Ex-Serving vs Inactive	2.38 (1.26, 4.51)		Moderate
	Black Dog Institute	Ex-Serving vs Active	1.73 (1.00, 3.02)	No differences	
		Inactive vs Active	1.38 (0.76, 2.51)		
		Ex-Serving vs Inactive	1.25 (0.76, 2.07)		
	Headspace	Ex-Serving vs Active	5.59 (2.95, 10.59)	Ex-Serving group is 5.0 times more likely than Active Reservists, and 3.0 times more likely than Inactive Reservists	Strong
		Inactive vs Active	1.61 (0.71, 3.62)		
		Ex-Serving vs Inactive	3.48 (1.90, 6.38)		Strong
	beyondblue	Ex-Serving vs Active	1.83 (1.27, 2.65)	No difference, or weak association	
		Inactive vs Active	1.23 (0.81, 1.87)		
		Ex-Serving vs Inactive	1.49 (1.04, 2.15)		
	mindhealthconnect	Ex-Serving vs Active	1.07 (0.38, 3.02)	No differences	
		Inactive vs Active	0.53 (0.17, 1.63)		
		Ex-Serving vs Inactive	2.04 (0.83, 5.06)		
	Lifeline	Ex-Serving vs Active	2.99 (1.47, 6.07)	Ex-Serving group is 3.0 times more likely than Active Reservists, and 2.0 times more likely than Inactive Reservists	Strong
		Inactive vs Active	1.28 (0.54, 3.07)		
		Ex-Serving vs Inactive	2.33 (1.18, 4.61)		Moderate
	Kids Helpline	Ex-Serving vs Active	3.29 (1.29, 8.37)	Ex-Serving group is 3.0 times more likely than Active Reservists	Strong
		Inactive vs Active	1.67 (0.54, 5.10)		
		Ex-Serving vs Inactive	1.97 (0.81, 4.82)		

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation	Strength of association
	MensLine Australia	Ex-Serving vs Active	3.53 (2.07, 6.02)	Ex-Serving group is almost 4.0 times more likely than Active Reservists	Strong
		Inactive vs Active	2.04 (1.04, 4.02)		Moderate
		Ex-Serving vs Inactive	1.73 (0.89, 3.38)		
	Other health websites	Ex-Serving vs Active	2.59 (1.73, 3.86)	Ex-Serving group is 2.0 times more likely than Active Reservists	Moderate
		Inactive vs Active	1.79 (1.16, 2.77)		
		Ex-Serving vs Inactive	1.44 (0.97, 2.15)		
	Any health websites	Ex-Serving vs Active	1.63 (1.32, 2.01)	Ex-Serving group is 63% more likely than Active Reservists	Moderate
		Inactive vs Active	1.02 (0.81, 1.28)		
		Ex-Serving vs Inactive	1.59 (1.28, 1.99)		
8.4	Internet treatments				
	MoodGYM	Ex-Serving vs Active	1.00 (0.24, 4.11)	No differences	
		Inactive vs Active	0.56 (0.14, 2.28)		
		Ex-Serving vs Inactive	1.78 (0.75, 4.26)		
	e-couch	Ex-Serving vs Active	3.87 (1.34, 11.20)	Ex-Serving group is 3.0 times more likely than Active Reservists	Strong
		Inactive vs Active	1.86 (0.53, 6.53)		
		Ex-Serving vs Inactive	2.08 (0.79, 5.43)		
	Other	Ex-Serving vs Active	0.89 (0.39, 2.06)	No differences	
		Inactive vs Active	0.61 (0.25, 1.47)		
		Ex-Serving vs Inactive	1.46 (0.73, 2.93)		
	Any internet treatment	Ex-Serving vs Active	1.31 (0.74, 2.29)	No difference or weak association	Weak
		Inactive vs Active	0.81 (0.45, 1.45)		
		Ex-Serving vs Inactive	1.62 (1.03, 2.54)		
8.6	Phone apps				
	PTSD Coach	Ex-Serving vs Active	2.31 (1.26, 4.23)	Ex-Serving group is up to 3.0 times more likely than Active Reservists and Inactive Reservists	Moderate
		Inactive vs Active	0.61 (0.30, 1.22)		
		Ex-Serving vs Inactive	3.79 (2.20, 6.54)		Strong

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation	Strength of association
	On Track	Ex-Serving vs Active	2.06 (0.72, 5.89)	Ex-Serving group is 2.0 times more likely than Inactive Reservists	Moderate
		Inactive vs Active	0.92 (0.33, 2.52)		
		Ex-Serving vs Inactive	2.24 (1.17, 4.30)		Moderate
	Other app	Ex-Serving vs Active	3.31 (1.70, 6.43)	Ex-Serving group is 3.0 times more likely than Active Reservists	Strong
		Inactive vs Active	2.09 (1.01, 4.31)		Moderate
		Ex-Serving vs Inactive	1.58 (0.97, 2.59)		
	Any phone app	Ex-Serving vs Active	2.29 (1.40, 3.75)	Ex-Serving group is 2.0 times more likely than Active Reservists and Inactive Reservists	Moderate
		Inactive vs Active	1.07 (0.63, 1.82)		
		Ex-Serving vs Inactive	2.14 (1.47, 3.13)		Moderate
8.8	Social media				
	Email subscription	Ex-Serving vs Active	1.49 (0.85, 2.59)	No differences	
		Inactive vs Active	1.43 (0.81, 2.54)		
		Ex-Serving vs Inactive	1.04 (0.63, 1.73)		
	Blogs	Ex-Serving vs Active	1.47 (0.79, 2.74)	No differences	
		Inactive vs Active	0.89 (0.44, 1.82)		
		Ex-Serving vs Inactive	1.64 (0.92, 2.92)		
	Social media	Ex-Serving vs Active	1.74 (1.32, 2.29)	Ex-Serving group is 74% more likely than Active Reservists	Moderate
		Inactive vs Active	1.32 (0.98, 1.77)		
		Ex-Serving vs Inactive	1.32 (1.01, 1.72)		Weak
	Any of the above	Ex-Serving vs Active	1.68 (1.29, 2.19)	Ex-Serving group is 68% more likely than Active Reservists	Moderate
		Inactive vs Active	1.26 (0.95, 1.68)		
		Ex-Serving vs Inactive	1.33 (1.03, 1.72)		Weak

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation	Strength of association
8.10	Defence helplines				
	Defence Family Helpline	Ex-Serving vs Active	1.23 (0.46, 3.33)	Ex-Serving group is 3.0 times more likely than Inactive Reservists	
		Inactive vs Active	0.38 (0.13, 1.15)		
		Ex-Serving vs Inactive	3.23 (1.48, 7.06)		Strong
	ADF All-hours Support Line	Ex-Serving vs Active	2.64 (1.24, 5.63)	Ex-Serving group is 2.0 times more likely than Active Reservists	Moderate
		Inactive vs Active	1.12 (0.37, 3.41)		
		Ex-Serving vs Inactive	2.35 (0.83, 6.66)		Moderate
	1800 IMSICK	Ex-Serving vs Active	1.16 (0.52, 2.57)	No differences	
		Inactive vs Active	0.71 (0.31, 1.64)		
		Ex-Serving vs Inactive	1.62 (0.78, 3.36)		
	VVCS Veterans Line	Ex-Serving vs Active	1.67 (1.14, 2.44)	Ex-Serving group is 67% more likely than Active Reservists	Moderate
		Inactive vs Active	0.94 (0.62, 1.45)		
		Ex-Serving vs Inactive	1.77 (1.19, 2.64)		Moderate
	Any of the above	Ex-Serving vs Active	1.43 (0.99, 2.06)	Ex-Serving group is 69% more likely than Inactive Reservists	
		Inactive vs Active	0.85 (0.57, 1.28)		
		Ex-Serving vs Inactive	1.69 (1.16, 2.46)		Moderate
8.12	Other helplines				
	Lifeline	Ex-Serving vs Active	2.44 (0.95, 6.26)	Ex-Serving group is 2.0 times more likely than Active Reservists	Moderate
		Inactive vs Active	1.58 (0.54, 4.58)		
		Ex-Serving vs Inactive	1.55 (0.61, 3.92)		
	MensLine Australia	Ex-Serving vs Active	5.05 (2.02, 12.64)	Ex-Serving group is 5.0 times more likely than Active Reservists	Strong
		Inactive vs Active	2.26 (0.71, 7.20)		
		Ex-Serving vs Inactive	2.23 (0.94, 5.30)		
	MindSpot	Ex-Serving vs Active	2.88 (1.11, 7.51)	Ex-Serving group is 2.0 times more likely than Active Reservists	Moderate
		Inactive vs Active	1.21 (0.37, 3.99)		
		Ex-Serving vs Inactive	2.38 (0.87, 6.51)		

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation	Strength of association
	Relationships Australia	Ex-Serving vs Active	2.90 (1.24, 6.79)	Ex-Serving group is almost 3.0 times more likely than Active Reservists	Moderate
		Inactive vs Active	1.78 (0.67, 4.73)		
		Ex-Serving vs Inactive	1.63 (0.65, 4.08)		
	SANE Australia	Ex-Serving vs Active	2.88 (1.11, 7.51)	Ex-Serving group is almost 3.0 times more likely than Active Reservists	Moderate
		Inactive vs Active	1.21 (0.37, 3.99)		
		Ex-Serving vs Inactive	2.38 (0.87, 6.51)		
	Other helpline	Ex-Serving vs Active	2.89 (1.34, 6.26)	Ex-Serving group is almost 3.0 times more likely than Active Reservists	Moderate
		Inactive vs Active	1.35 (0.59, 3.09)		
		Ex-Serving vs Inactive	2.14 (1.19, 3.84)		
	Any helpline	Ex-Serving vs Active	3.37 (1.81, 6.29)	Ex-Serving group is 3.0 times more likely than Active Reservists	Strong
		Inactive vs Active	2.03 (1.02, 4.02)		Moderate
		Ex-Serving vs Inactive	1.66 (0.93, 2.98)		
8.16	Consulting a chaplain, church leader or faith group	Ex-Serving vs Active	0.90 (0.60, 1.35)	No differences	
		Inactive vs Active	0.76 (0.49, 1.18)		
		Ex-Serving vs Inactive	1.19 (0.78, 1.80)		
	Increasing physical activity	Ex-Serving vs Active	1.07 (0.87, 1.31)	No differences	
		Inactive vs Active	1.02 (0.82, 1.26)		
		Ex-Serving vs Inactive	1.05 (0.85, 1.29)		
	Doing more things you enjoy	Ex-Serving vs Active	1.12 (0.91, 1.37)	No differences	
		Inactive vs Active	1.06 (0.85, 1.32)		
		Ex-Serving vs Inactive	1.05 (0.85, 1.31)		
	Seeking support from family members or friends	Ex-Serving vs. Active	1.43 (1.15, 1.77)	No difference or weak association	Weak
		Inactive vs Active	1.14 (0.90, 1.43)		
		Ex-Serving vs Inactive	1.26 (1.01, 1.57)		Weak

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation	Strength of association
9.2	Stigmas				
	Wouldn't understand problems	Ex-Serving vs Active	2.06 (1.59, 2.66)	Ex-Serving group is 2.0 times more likely than Active Reservists	Moderate
		Inactive vs Active	1.66 (1.27, 2.18)		Moderate
		Ex-Serving vs Inactive	1.24 (0.97, 1.58)		
	Outcome is beyond my control	Ex-Serving vs Active	2.18 (1.65, 2.89)	Ex-Serving group is 2.0 times more likely than Active Reservists	Moderate
		Inactive vs Active	1.67 (1.23, 2.28)		
		Ex-Serving vs Inactive	1.30 (0.98, 1.74)		
	Would feel inadequate	Ex-Serving vs Active	1.69 (1.30, 2.19)	Ex-Serving group is 69% more likely than Active Reservists	Moderate
		Inactive vs Active	1.45 (1.10, 1.91)		
		Ex-Serving vs Inactive	1.17 (0.90, 1.50)		
	Would feel embarrassed	Ex-Serving vs Active	1.14 (0.91, 1.44)	No differences	
		Inactive vs Active	1.03 (0.81, 1.30)		
		Ex-Serving vs Inactive	1.12 (0.90, 1.39)		
	Feel worse if I can't solve my own problems	Ex-Serving vs Active	1.42 (1.15, 1.76)	No difference or weak association	Weak
		Inactive vs Active	1.39 (1.11, 1.75)		Weak
		Ex-Serving vs Inactive	1.02 (0.82, 1.26)		
	Should be able snap out of it	Ex-Serving vs Active	1.33 (0.78, 2.29)	No differences	
		Inactive vs Active	1.28 (0.72, 2.27)		
		Ex-Serving vs Inactive	1.04 (0.63, 1.71)		
	Might feel worse	Ex-Serving vs Active	1.60 (1.14, 2.26)	Ex-Serving group is 60% more likely than Active Reservists	Moderate
		Inactive vs Active	1.49 (1.04, 2.14)		
		Ex-Serving vs Inactive	1.07 (0.79, 1.45)		
	Might lose control of emotions or reactions	Ex-Serving vs Active	1.75 (1.33, 2.30)	Ex-Serving group is 75% more likely than Active Reservists	Moderate
		Inactive vs Active	1.45 (1.08, 1.95)		Weak
		Ex-Serving vs Inactive	1.21 (0.93, 1.57)		

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation	Strength of association
	People would treat me differently	Ex-Serving vs Active	1.34 (1.07, 1.68)	No difference or weak association	Weak
		Inactive vs Active	1.22 (0.96, 1.54)		
		Ex-Serving vs Inactive	1.10 (0.88, 1.37)		
	Would be seen as weak	Ex-Serving vs Active	1.52 (1.20, 1.91)	Ex-Serving group is 52% more likely than Active Reservists	Moderate
		Inactive vs Active	1.33 (1.04, 1.70)		Weak
		Ex-Serving vs Inactive	1.14 (0.91, 1.42)		
	People would have less confidence in me	Ex-Serving vs Active	1.20 (0.97, 1.48)	No difference or weak association	
		Inactive vs Active	1.26 (1.01, 1.57)		Weak
		Ex-Serving vs Inactive	0.95 (0.77, 1.18)		
	Don't trust mental health professionals	Ex-Serving vs Active	1.44 (1.05, 1.98)	No difference or weak association	Weak
		Inactive vs Active	1.33 (0.95, 1.84)		
		Ex-Serving vs Inactive	1.09 (0.81, 1.46)		
9.6	Barriers				
	Too expensive	Ex-Serving vs Active	1.46 (1.15, 1.85)	No difference or weak association	Weak
		Inactive vs Active	1.44 (1.12, 1.86)		Weak
		Ex-Serving vs Inactive	1.01 (0.80, 1.28)		
	Wouldn't know where to get help	Ex-Serving vs Active	1.11 (0.78, 1.57)	No differences	
		Inactive vs Active	0.99 (0.69, 1.44)		
		Ex-Serving vs Inactive	1.12 (0.81, 1.55)		
	Difficulty getting time off work	Ex-Serving vs Active	1.13 (0.86, 1.49)	No differences	
		Inactive vs Active	1.33 (1.00, 1.76)		
		Ex-Serving vs Inactive	0.85 (0.66, 1.11)		
	Would harm my career or career prospects	Ex-Serving vs Active	0.92 (0.72, 1.17)	No differences	
		Inactive vs Active	1.06 (0.83, 1.36)		
		Ex-Serving vs Inactive	0.87 (0.69, 1.09)		

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation	Strength of association
	Would stop me from being deployed	Ex-Serving vs Active	0.45 (0.34, 0.59)	Differences, but not relevant for the Ex-Serving group	
		Inactive vs Active	0.52 (0.39, 0.68)		
		Ex-Serving vs Inactive	0.86 (0.65, 1.15)		
	Difficult to get an appointment	Ex-Serving vs Active	1.59 (1.16, 2.18)	Ex-Serving group is 59% more likely than Active Reservists	Moderate
		Inactive vs Active	1.14 (0.81, 1.60)		
		Ex-Serving vs Inactive	1.40 (1.03, 1.90)		
9.10	Reason why assistance not sought				
	Afraid to ask	Ex-Serving vs Active	1.09 (0.59, 2.01)	No differences	
		Inactive vs Active	1.32 (0.76, 2.30)		
		Ex-Serving vs Inactive	0.83 (0.46, 1.49)		
	Nothing could help	Ex-Serving vs Active	0.59 (0.32, 1.11)	No differences	
		Inactive vs Active	0.77 (0.43, 1.40)		
		Ex-Serving vs Inactive	0.77 (0.40, 1.47)		
	I can still function	Ex-Serving vs Active	0.41 (0.20, 0.86)	Ex-Serving group is 2.0 times less likely than Active Reservists	Moderate
		Inactive vs Active	0.88 (0.42, 1.82)		
		Ex-Serving vs Inactive	0.47 (0.24, 0.94)		Moderate
	Couldn't afford it	Ex-Serving vs Active	1.30 (0.63, 2.66)	No differences	
		Inactive vs Active	0.92 (0.46, 1.84)		
		Ex-Serving vs Inactive	1.42 (0.73, 2.76)		
	Can get help from other sources	Ex-Serving vs Active	1.02 (0.52, 2.01)	No differences	
		Inactive vs Active	1.15 (0.60, 2.17)		
		Ex-Serving vs Inactive	0.89 (0.46, 1.69)		
	Prefer to manage myself	Ex-Serving vs Active	0.90 (0.44, 1.83)	No differences	
		Inactive vs Active	1.17 (0.61, 2.26)		
		Ex-Serving vs Inactive	0.77 (0.39, 1.53)		

Results table	Outcome	Cohort (in results table)	Adjusted odds ratio (95% CI)	Interpretation	Strength of association
	Don't know where to get help	Ex-Serving vs Active	1.16 (0.49, 2.73)	No differences	
		Inactive vs Active	0.99 (0.47, 2.11)		
		Ex-Serving vs Inactive	1.17 (0.52, 2.65)		
10.2	Disruption to family life (moderate or higher)	Ex-Serving vs Active	3.14 (2.01, 4.89)	Ex-Serving group is 3.0 times more likely than Active Reservists	Strong
		Inactive vs Active	1.07 (0.65, 1.76)		
		Ex-Serving vs Inactive	2.94 (1.83, 4.73)		Moderate
10.4	Disruption to social life (moderate or higher)	Ex-Serving vs Active	3.79 (2.36, 6.10)	Ex-Serving group is 3.0 times more likely than Active Reservists	Strong
		Inactive vs Active	1.17 (0.69, 1.97)		
		Ex-Serving vs Inactive	3.24 (2.00, 5.23)		Strong
10.6	Disruption to work life (moderate or higher)	Ex-Serving vs Active	4.13 (2.66, 6.41)	Ex-Serving group is 4.0 times more likely than Active Reservists	Strong
		Inactive vs Active	1.48 (0.90, 2.44)		
		Ex-Serving vs Inactive	2.78 (1.81, 4.29)		Moderate

A.3 Methodological Interpretive Tables

Table A.4 Strata description – Military Health Outcomes Program (MilHOP), 2015 Regular ADF

Strata Sex | Rank | Medical fitness | Service	2015 Regular ADF Population	Responder	%	Number of persons in the population each responder represents
MilHOP				
Female | OFFR | Fit | Navy	170	88	51.8	1.9
Female | OFFR | Fit | Army	237	120	50.6	2.0
Female | OFFR | Fit | Air Force	249	121	48.6	2.1
Female | OFFR | Unfit | Navy	48	27	56.3	1.8
Female | OFFR | Unfit | Army	75	39	52.0	1.9
Female | OFFR | Unfit | Air Force	76	34	44.7	2.2
Female | NCO | Fit | Navy	197	71	36.0	2.8
Female | NCO | Fit | Army	245	99	40.4	2.5
Female | NCO | Fit | Air Force	255	110	43.1	2.3
Female | NCO | Unfit | Navy	65	23	35.4	2.8
Female | NCO | Unfit | Army	117	49	41.9	2.4
Female | NCO | Unfit | Air Force	100	37	37.0	2.7
Female | Other Rank | Fit | Navy	41	12	29.3	3.4
Female | Other Rank | Fit | Army	33	4	12.1	8.3
Female | Other Rank | Fit | Air Force	51	18	35.3	2.8
Female | Other Rank | Unfit | Navy	31	5	16.1	6.2
Female | Other Rank | Unfit | Army	19	9	47.4	2.1
Female | Other Rank | Unfit | Air Force	31	5	16.1	6.2
Male | OFFR | Fit | Navy	902	418	46.3	2.2
Male | OFFR | Fit | Army	1585	723	45.6	2.2
Male | OFFR | Fit | Air Force	1428	596	41.7	2.4

Strata Sex | Rank | Medical fitness | Service	2015 Regular ADF			
	Population	Responder	%	Number of persons in the population each responder represents
Male | OFFR | Unfit | Navy	81	54	66.7	1.5
Male | OFFR | Unfit | Army	153	75	49.0	2.0
Male | OFFR | Unfit | Air Force	117	58	49.6	2.0
Male | NCO | Fit | Navy	1386	522	37.7	2.7
Male | NCO | Fit | Army	2629	1037	39.4	2.6
Male | NCO | Fit | Air Force	2153	789	36.6	2.7
Male | NCO | Unfit | Navy	214	96	44.9	2.2
Male | NCO | Unfit | Army	503	244	48.5	2.1
Male | NCO | Unfit | Air Force	309	130	42.1	2.4
Male | Other Rank | Fit | Navy	176	46	26.1	3.8
Male | Other Rank | Fit | Army	433	57	13.2	7.6
Male | Other Rank | Fit | Air Force	320	75	23.4	4.3
Male | Other Rank | Unfit | Navy	39	11	28.2	3.5
Male | Other Rank | Unfit | Army	105	25	23.8	4.2
Male | Other Rank | Unfit | Air Force	43	13	30.2	3.3

Table A.5 Strata description – non-MilHOP, 2015 Regular ADF

Strata Sex | Rank | Medical fitness | Service	2015 Regular ADF Population	Responder	%	Number of persons in the population each responder represents
Non-MilHOP				
Female | OFFR | Fit | Navy	305	114	37.4	2.7
Female | OFFR | Fit | Army	374	112	29.9	3.3
Female | OFFR | Fit | Air Force	406	139	34.2	2.9
Female | OFFR | Unfit | Navy	66	23	34.8	2.9
Female | OFFR | Unfit | Army	87	31	35.6	2.8
Female | OFFR | Unfit | Air Force	70	28	40.0	2.5
Female | NCO | Fit | Navy	120	50	41.7	2.4
Female | NCO | Fit | Army	138	70	50.7	2.0
Female | NCO | Fit | Air Force	157	79	50.3	2.0
Female | NCO | Unfit | Navy	48	24	50.0	2.0
Female | NCO | Unfit | Army	50	32	64.0	1.6
Female | NCO | Unfit | Air Force	69	36	52.2	1.9
Female | Other Rank | Fit | Navy	256	39	15.2	6.6
Female | Other Rank | Fit | Army	271	33	12.2	8.2
Female | Other Rank | Fit | Air Force	226	58	25.7	3.9
Female | Other Rank | Unfit | Navy	59	14	23.7	4.2
Female | Other Rank | Unfit | Army	58	14	24.1	4.1
Female | Other Rank | Unfit | Air Force	55	20	36.4	2.8
Male | OFFR | Fit | Navy	1450	188	13.0	7.7
Male | OFFR | Fit | Army	2977	269	9.0	11.1
Male | OFFR | Fit | Air Force	2098	213	10.2	9.8

Strata Sex | Rank | Medical fitness | Service	2015 Regular ADF			
	Population	Responder	%	Number of persons in the population each responder represents
Male | OFFR | Unfit | Navy	95	11	11.6	8.6
Male | OFFR | Unfit | Army	238	31	13.0	7.7
Male | OFFR | Unfit | Air Force	157	26	16.6	6.0
Male | NCO | Fit | Navy	2257	149	6.6	15.1
Male | NCO | Fit | Army	3447	311	9.0	11.1
Male | NCO | Fit | Air Force	1866	268	14.4	7.0
Male | NCO | Unfit | Navy	334	23	6.9	14.5
Male | NCO | Unfit | Army	575	59	10.3	9.7
Male | NCO | Unfit | Air Force	257	28	10.9	9.2
Male | Other Rank | Fit | Navy	4451	28	0.6	159.0
Male | Other Rank | Fit | Army	10,074	43	0.4	234.3
Male | Other Rank | Fit | Air Force	2659	47	1.8	56.6
Male | Other Rank | Unfit | Navy	491	4	0.8	122.8
Male | Other Rank | Unfit | Army	1375	14	1.0	98.2
Male | Other Rank | Unfit | Air Force	268	12	4.5	22.3

Table A.6 Strata description – Transitioned ADF

Strata Sex | Rank | Medical fitness | Service	Transitioned ADF			
	Population	Responder	%	Number of persons in the population each responder represents
Female | OFFR | Fit | Navy	122	32	26.2	3.8
Female | OFFR | Fit | Army	224	68	30.4	3.3
Female | OFFR | Fit | Air Force	133	41	30.8	3.2
Female | OFFR | Unfit | Navy	63	21	33.3	3.0
Female | OFFR | Unfit | Army	90	31	34.4	2.9
Female | OFFR | Unfit | Air Force	59	25	42.4	2.4
Female | NCO | Fit | Navy	198	49	24.7	4.0
Female | NCO | Fit | Army	263	80	30.4	3.3
Female | NCO | Fit | Air Force	188	56	29.8	3.4
Female | NCO | Unfit | Navy	101	26	25.7	3.9
Female | NCO | Unfit | Army	139	48	34.5	2.9
Female | NCO | Unfit | Air Force	92	30	32.6	3.1
Female | Other Rank | Fit | Navy	411	25	6.1	16.4
Female | Other Rank | Fit | Army	421	34	8.1	12.4
Female | Other Rank | Fit | Air Force	156	21	13.5	7.4
Female | Other Rank | Unfit | Navy	226	34	15.0	6.6
Female | Other Rank | Unfit | Army	270	40	14.8	6.8
Female | Other Rank | Unfit | Air Force	105	19	18.1	5.5
Male | OFFR | Fit | Navy	583	173	29.7	3.4
Male | OFFR | Fit | Army	1409	401	28.5	3.5
Male | OFFR | Fit | Air Force	772	253	32.8	3.1
Male | OFFR | Unfit | Navy	124	47	37.9	2.6
Male | OFFR | Unfit | Army	350	114	32.6	3.1
Male | OFFR | Unfit | Air Force	134	53	39.6	2.5

Strata Sex | Rank | Medical fitness | Service	Transitioned ADF			
	Population	Responder	%	Number of persons in the population each responder represents
Male | NCO | Fit | Navy	1285	225	17.5	5.7
Male | NCO | Fit | Army	2735	752	27.5	3.6
Male | NCO | Fit | Air Force	1148	291	25.3	3.9
Male | NCO | Unfit | Navy	343	92	26.8	3.7
Male | NCO | Unfit | Army	1055	337	31.9	3.1
Male | NCO | Unfit | Air Force	319	111	34.8	2.9
Male | Other Rank | Fit | Navy	1697	88	5.2	19.3
Male | Other Rank | Fit | Army	5639	327	5.8	17.2
Male | Other Rank | Fit | Air Force	889	65	7.3	13.7
Male | Other Rank | Unfit | Navy	518	51	9.8	10.2
Male | Other Rank | Unfit | Army	2443	231	9.5	10.6
Male | Other Rank | Unfit | Air Force	228	35	15.4	6.5

Annex B Mental Health and Wellbeing Transition Study method

This annex outlines the study design, selection criteria, instrumentation, recruitment strategy and statistical procedures used in the Mental Health and Wellbeing Transition Study. Details pertaining to the Impact of Combat Study and the Family Wellbeing Study will be outlined in future reports.

B.1 Summary of the research

The Transition and Wellbeing Research Programme is a joint research initiative of the Department of Veterans' Affairs (DVA) and the Department of Defence (Defence) to examine the impact of contemporary military service on the mental, physical and social health of serving and ex-serving Australian Defence Force (ADF) members and their families. It builds on previous research and will inform the provision of effective evidence-based health and mental health services.

The Programme was conducted by a consortium of six of Australia's leading research institutions, led by the Centre for Traumatic Stress Studies (CTSS) at the University of Adelaide, and the Australian Institute of Family Studies (AIFS). It included researchers from Phoenix Australia: Centre for Posttraumatic Mental Health, the University of New South Wales, Monash University and the University of Sydney.

The 2010 Military Health Outcomes Program (MilHOP) detailed the prevalence of mental disorder among Regular ADF members in 2010 and the deployment-related health issues for those deployed to the Middle East Area of Operations (MEAO) between 2010 and 2012. Several research gaps were identified following the MilHOP, including the mental health of ex-serving ADF members, Reservists, family members and ADF members in high-risk roles, as well as the course of mental disorders and pathways to care for individuals over time.

The Programme aimed to address these research gaps through three separate but related studies:

- the Mental Health and Wellbeing Transition Study
- the Impact of Combat Study
- the Family Wellbeing Study.

B.2 Aims of the Programme

The Transition and Wellbeing Research Programme aimed to:

1. Determine the prevalence of mental disorders among ADF members who have transitioned from Regular ADF service between 2010 and 2014.
2. Examine self-reported mental health status of Transitioned ADF and the 2015 Regular ADF.
3. Assess pathways to care for Transitioned ADF and the 2015 Regular ADF, including those with a diagnosed mental disorder.
4. Examine the physical health status of Transitioned ADF and the 2015 Regular ADF.
5. Investigate technology and its utility for health and mental health programmes including implications for future health service delivery.
6. Conduct predictive modelling of the trajectory of mental health symptoms/disorder of Transitioned ADF and the 2015 Regular ADF, removing the need to rely on estimated rates.
7. Investigate the mental health and wellbeing of currently serving 2015 Ab initio Reservists.
8. Examine the factors that contribute to the wellbeing of Transitioned ADF and the 2015 Regular ADF.
9. Follow up on the mental, physical and neurocognitive health and wellbeing of participants who deployed to the Middle East Area of Operations between 2010 and 2012.
10. Investigate the impact of ADF service on the health and wellbeing of the families of Transitioned ADF and the 2015 Regular ADF.

These objectives will allow Defence and DVA to:

- build on the 2010 MilHOP Research, to develop an understanding of how mental health changes and manifests itself during the post-separation re-adjustment phase
- develop insights into improving communication between contemporary veterans, DVA and Defence
- further develop research outcomes and optimise the use of existing datasets within DVA and Defence to improve understanding of serving and ex-serving ADF members' mental health, their access to clinical services and the outcomes of accessing these services

- build the objective knowledge base of DVA and Defence staff members, and of other parties who are interested in the mental health of current serving and Transitioned members
- improve mental health (and associated physical health) outcomes for serving and ex-serving ADF members across all age cohorts
- review the optimal method of conducting scientifically valid and reliable research involving ADF and ex-serving ADF members, that is acceptable to the participants, the ex-serving ADF community, ADF and DVA.

B.3 Sample

To achieve the aims of the broader research program, the researchers targeted the following five overlapping samples for data collection.

B.3.1 Sample 1: Transitioned ADF

This sample comprised all ADF members who transitioned from Regular ADF service between 2010 and 2014. This included those who transitioned into the Active Reserves and Inactive Reserves as well as those who had been completely discharged from the Regular ADF.

This sample comprised three groups of Transitioned ADF members:

- MHPWS Transitioned ADF: ADF members who participated in the 2010 ADF Mental Health Prevalence and Wellbeing Study as a Regular ADF member but had since transitioned
- Combat Transitioned ADF: ADF members who participated in the MEAO Prospective Health Study between 2010 and 2012 and have since transitioned
- ADF members who transitioned from Regular ADF since 2010 who were not part of the 2010 MHPWS or the MEAO Prospective Health Study.

Results from these three groups combined were weighted to represent the entire Transitioned ADF cohort in 2015.

B.3.2 Sample 2: 2015 Regular ADF

This sample comprised three separate groups of Regular ADF members in 2015 who were invited to participate in the study:

- those who participated in the 2010 MHPWS and remained a Regular ADF member in 2015

- those who participated in the MEAO Prospective Health Study between 2010 and 2012, and remained a Regular ADF member in 2015
- a stratified random sample of Regular ADF members from 2015 who were not part of the 2010 MHPWS or the MEAO Prospective Health Study.

Results from these three groups combined were weighted to represent the entire Regular ADF in 2015.

B.3.3 Sample 3: Ab initio Reservists

This sample comprised all ADF members who joined the ADF Reserves, continue to serve in a Reserve capacity and have never been a Regular ADF member.

B.3.4 Sample 4: ADF Families

A sample of ADF families, nominated by 2015 Regular ADF and ex-serving ADF members participating in the programme.

Two MilHOP samples, which were incorporated into samples 1 and 2 above for the purposes of analysis, were also specifically followed up as part of an ongoing program of longitudinal health surveillance:

B.3.5 Sample 5: Combat Zone

This group comprised all ADF members who participated in the MEAO Prospective Health Study, all of whom been deployed to the MEAO after June 2010 and returned from deployment by June 2012.

B.3.6 Sample 6: MHPWS

Individuals who participated in the 2010 MHPWS component of MilHOP (2010 ADF) formed two groups:

- MHPWS Transitioned ADF: ADF members who participated in the 2010 MHPWS as a Regular ADF member but have since transitioned
- MHPWS 2015 ADF: Regular ADF members who participated in the 2010 MHPWS and were still Regular ADF members in 2015.

B.4 Population comparison samples

B.4.1 Sample 7: 2010 Regular ADF comparison

Results drawn from the 2010 ADF MHPWS report were directly input into this report to indicate the change in self-reported mental health between Regular ADF members in 2010 and in 2015. These results should be interpreted with caution due to the overlapping nature of the two populations.

B.4.2 Sample 8: Comparing Transitioned ADF with the Australian Community (2014–2015)

To enable a comparison between Transitioned ADF estimates and the Australian community population, direct standardisation was applied to estimates made within 2014–2015 Australian Bureau of Statistics (ABS) National Health Survey (NHS) data. The NHS is the most recent in a series of Australia-wide ABS health surveys that assess various aspects of the health in the Australian population, including long-term health conditions, health risk factors and use of health services. The NHS data were restricted to those aged 18 to 71 (consistent with the Transitioned ADF cohort). The NHS data were standardised by sex, employment status and age category (18 to 27, 28 to 37, 38 to 47, 48 to 57, and 58+), and estimates were generated on the outcomes of interest. Standard errors for the NHS data were estimated using the replication weights provided in the NHS data file.

Table B.1 Commissioned reports

Report	Programme goal	Samples	Data collection method
Mental Health Prevalence Report: Findings from the 2015 Mental Health and Wellbeing Transition Study	Determine the baseline prevalence rates of mental disorders among ADF members who transitioned from current serving ADF service.	• ADF members who transitioned from current serving ADF status between 2010 and 2014. • 2015 Regular ADF members. • Comparison against 2010 ADF and Australian community, where appropriate.	• Self-report questionnaire • Composite International Diagnostic Interview (CIDI) (sub-group)
Pathways to Care Report: Findings from the 2015 Mental Health and Wellbeing Transition Study	Pathways to mental health care for current serving and Transitioned ADF members, including those with a mental disorder. This includes: • how care is accessed • usage patterns • stigmas and barriers.	• ADF members who transitioned from regular serving ADF status between 2010 and 2014. • 2015 Regular ADF members.	• Self-report survey
Physical Health Status Report: Findings from the 2015 Mental Health and Wellbeing Transition Study	Physical health status of 2015 Regular ADF and Transitioned ADF members, covering: • symptom reporting, including pain and sleep • doctor-diagnosed medical conditions • physical injuries • satisfaction with health.	• ADF members who transitioned from current serving ADF status between 2010 and 2014. • 2015 Regular ADF members.	• Self-report survey
Technology Use and Wellbeing Report: Findings from the 2015 Mental Health and Wellbeing Transition Study	The utility of technology for use in mental health care and mental health programs, including implications for the future delivery of health services.	• ADF members who transitioned from current serving ADF status between 2010 and 2014. • 2015 Regular ADF members.	• Self-report survey
Mental Health Changes Over Time: a Longitudinal Perspective: Findings from the 2015 Mental Health and Wellbeing Transition Study	Longitudinal disorder development, including: • changes in symptom and disorder status over two time points • predictors and outcomes of these changes.	• 2015 Regular ADF members. • Transitioned ADF members who previously participated in the MilHOP (MHPWS CIDI sample).	• Self-report questionnaire • CIDI (sub-group)
Impact of Combat Report: Findings from the 2015 Impact of Combat Study	The longitudinal impact of deployment to the MEAO, based on: • psychological, biological and social factors • risk and protective factors • traumatic brain injury.	• Serving and ex-serving ADF members who were deployed to the MEAO between June 2010 and June 2012, and participated in the MilHOP (Combat Zone sample).	• Self-report survey • CIDI (sub-group) • Neurocognitive and/or biological tests (sub-groups) • MRI (sub-group)
Family Wellbeing Report: Findings from the 2015 Family Wellbeing Study	Family member experiences and perspectives regarding: • the impact of military service on families • pathways to available care.	• Nominated family members of current serving members and ADF members who transitioned from current serving ADF status between 2010 and 2014.	• Self-report survey (quantitative component) • Semi-structured telephone interviews (qualitative component)
The Transition and Wellbeing Research Programme Key Findings Report	Key findings from the Programme, and implications for Defence and DVA.	All ADF members.	All methods

B.5 Response rates

B.5.1 Survey Responders

The overall survey response rate was 29.10% of Transitioned ADF and Regular ADF members (total responders divided by the total number invited to participate). As at 15 December 2015, 18.04% (4326) of the 23,974 Transitioned ADF members invited to participate had completed a survey. In contrast, response rates for invited 2015 Regular ADF members (20,031) were much higher; 42.3% of the 2015 Regular ADF members who were invited to participate completed a survey. It is important to note that not all Regular ADF members were invited to participate in the survey; invitations were restricted to a stratified random sample of 5040 ADF members and Regular ADF members who had previously participated in MilHOP. Table B.2 and Figure B.1 summarise the Transitioned ADF and 2015 Regular ADF members who had enough data to be included in the survey. Table B.3 describes the demographic profile of this group.

Table B.2 Transitioned ADF and the 2015 Regular ADF survey response rates by Service, sex, rank and medical fitness

	Transitioned ADF n = 24,932				2015 Regular ADF n = 52,500			
	Population	Invited	Responders	Response rate (%)	Population	Invited	Responders	Response rate (%)
Service								
Navy	5671	5495	863	15.71	13,282	5113	2040	39.90
Army	15,038	14,465	2463	17.03	25,798	8067	3500	43.39
Air Force	4223	4014	1000	24.91	13,420	6851	2940	42.91
Sex								
Male	21,671	20,713	3646	17.60	47,645	15,176	6693	44.10
Female	3261	3261	380	20.85	4855	4855	1787	36.81
Rank								
OFFR	4063	3939	1259	31.96	13,444	7847	3538	45.09
NCO	7866	7393	2097	28.36	17491	9117	4336	47.56
Other Ranks	13,003	12,642	970	7.67	21,565	3067	606	19.73
Medical fitness								
Fit	18,273	17,525	2981	17.01	46,022	17,097	7116	41.62
Unfit	6659	6449	1345	20.86	6478	2934	1364	46.49
Total	24,932	23,974	4326	18.04	52,500	20,031	8480	42.33

Notes:
Unweighted data
95% CI' represents a 95% confidence interval

The characteristics of survey respondents were as follows.

Sex: Consistent with the Transitioned ADF population, the sample was predominantly male, although female members were being significantly more likely to respond than male members. In the 2015 Regular ADF population, female members were less likely to respond than males.

Age: Transitioned ADF survey responders (mean age: 41.93, SE: 0.177) were similar in age to 2015 Regular ADF responders (mean age: 41.08, SE: 0.101).

Rank: Survey responders from the Transitioned ADF comprised 29.10% Officers, 48.47% Non-Commissioned Officers and 22.42% Other Ranks. The 2015 Regular ADF group had a similar distribution: 41.72% Officers, 51.13% Non-Commissioned Officers and 7.15% Other Ranks. The Transitioned ADF population had significantly lower response rates for Officers and Non-Commissioned Officers but significantly higher response rates in the Other Ranks compared to the 2015 Regular ADF group. In both groups, the lower ranks were the poorest responders.

Service: In the Transitioned ADF group, 19.95% of survey responders were from the Navy, 56.93% from the Army and 23.12% from the Air Force. However, for the Regular 2015 ADF group, 34.67% of responders were from the Air Force, 41.27% from the Army and 24.06% from the Navy. Comparing response rates in the different services, Transitioned Air Force members were most likely to respond, whereas Transitioned Navy and Army members were least likely to respond. In the 2015 Regular ADF group, Army members had the highest response rate at 43.39%

Medical fitness: Transitioned ADF members who were medically unfit when they transitioned from 2015 Regular ADF were slightly over-represented in the responder group (31.09%) compared to the 2015 Regular ADF population (16.08%). Transitioned ADF members who were medically unfit had a response rate of 20.86% compared to 46.49% in 2015 Regular ADF population.

Figure B.1 Survey response rates for Transitioned ADF and 2015 ADF members

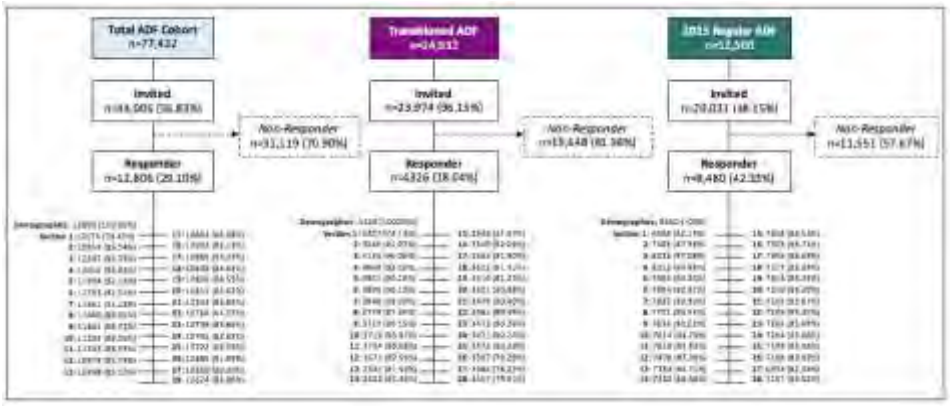


Table B.3 Unweighted demographic characteristics of Transitioned ADF and Regular ADF responders

	Transitioned ADF n = 4326			2015 Regular ADF n = 8480		
	n	%	% (95% CI)	n	%	% (95% CI)
Age (M, SE)	41.93	0.177		41.08	0.101	
Age group						
18–27	471	10.89	(10.0, 11.9)	602	7.10	(6.6, 7.7)
28–37	1262	29.17	(27.8, 30.5)	2484	29.29	(28.3, 30.3)
38–47	1119	25.87	(24.6, 27.2)	2976	35.09	(34.1, 36.1)
48–57	871	20.13	(19.0, 21.4)	2069	24.40	(23.5, 25.3)
58+	548	12.67	(11.7, 13.7)	201	2.37	(2.1, 2.7)
Sex						
Male	3646	84.28	(83.2, 85.3)	6693	78.93	(78.0, 79.8)
Female	680	15.72	(14.7, 16.8)	1787	21.07	(20.2, 22.0)
Rank						
OFFR	1259	29.10	(27.8, 30.5)	3538	41.72	(40.7, 42.8)
NCO	2097	48.47	(47.0, 50.0)	4336	51.13	(50.1, 52.2)
Other Ranks	970	22.42	(21.2, 23.7)	606	7.15	(6.6, 7.7)
Service						
Navy	863	19.95	(18.8, 21.2)	2940	34.67	(33.7, 35.7)
Army	2463	56.93	(55.5, 58.4)	3500	41.27	(40.2, 42.3)
Air Force	1000	23.12	(21.9, 24.4)	2040	24.06	(23.2, 25.0)
Medical fitness						
Fit	2981	68.91	(67.5, 70.3)	7116	83.92	(83.1, 84.7)
Unfit	1345	31.09	(29.7, 32.5)	1364	16.08	(15.3, 16.9)

M= mean; SE = standard error
Denominator: Those who were invited and responded to the survey
Notes:
Unweighted data
'95% CI' represents a 95% confidence interval

B.5.2 CIDI responders

In phase 2 of the research, a sub-sample of 1384 individuals from the stratified Transitioned ADF group, 1088 individuals belonging to the MHPWS group, and 183 individuals from the Combat Zone group were selected to participate in a 1 hour telephone interview using the World Mental Health Survey Initiative Version of the World Health Organization Composite International Diagnostic Interview – version 3 (CIDI) (Kessler & Ustun, 2004). Data from all three groups – including Service, sex, rank and Medical Employment Classification (MEC) – was used to estimate prevalence of mental disorder in Transitioned ADF.

Stratified Transitioned ADF

A total of 1384 participants were stratified and sought for participation (selected) in the CIDI. Of those selected, 53.83% (745) completed the interview. Table B.4 describes the response rates for the stratified Transitioned ADF undertaking the CIDI and Table B.5 describes the demographic profile of this group.

Table B.4 CIDI response rates for stratified Transitioned ADF by Service, sex, rank and MEC status

	Stratified Transitioned ADF CIDI response n = 1384 (selected); n = 745 (responded)			
	Population	Selected	Responders	Response rate (%)
Service				
Navy	5671	285	150	52.63
Army	15,038	795	424	53.33
Air Force	4223	304	171	56.25
Sex				
Male	21,671	1140	631	55.35
Female	3261	235	109	44.95
Rank				
OFFR	4063	423	252	59.57
NCO	7866	694	389	56.05
Other Ranks	13,003	267	104	38.95
Medical fitness				
Fit	18,273	932	521	55.90
Unfit	6659	443	219	49.44
Total	24,932	1384	745	53.83

Denominator: Transitioned ADF members invited to participate in the CIDI
Notes:
Unweighted data
'95% CI' represents a 95% confidence interval

The characteristics of the Transitioned CIDI respondents were as follows.

Sex: Consistent with the Transitioned ADF population, the CIDI sample was predominantly male. Transitioned female members were less likely than transitioned male members to complete the CIDI.

Age: Transitioned CIDI responders were significantly older at 45.61 years (SE = 0.44) compared to 40.36 (SE = 0.45) for non-responders.

Rank: CIDI responders comprised 33.83% Officers, 52.22%% Non-Commissioned Officers and 13.96% Other Ranks. ADF members in the Other Ranks had a significantly lower response rate (38.95%) compared to invited Non-Commissioned Officers and Officers who at more than 50% were more likely to respond.

Service: 20.13% of CIDI responders were from the Navy, 56.91% from the Army and 22.95% from the Air Force. There was no significant difference between CIDI responders and non-responders in terms of which Service they worked within.

Medical fitness: Transitioned ADF members who were medically unfit when they transitioned from Regular ADF comprised 29.40% of CIDI responders.

Table B.5 Demographic characteristics of stratified Transitioned ADF CIDI responders

	Stratified Transitioned ADF CIDI responders n = 745		
	n	%	% (95% CI)
Age (M, SE)	45.61	0.436	
Age group			
18–27	50	6.71	(5.1, 8.7)
28–37	171	22.95	(20.1, 26.1)
38–47	177	23.76	(20.8, 26.9)
48–57	179	24.03	(21.1, 27.2)
58+	163	21.88	(19.1, 25.0)
Sex			
Male	631	84.70	(81.9, 87.1)
Female	109	14.63	(12.3, 17.4)
Rank			
OFFR	252	33.83	(30.5, 37.3)
NCO	389	52.21	(48.6, 55.8)
Other Ranks	104	13.96	(11.7, 16.6)
Service			
Navy	150	20.13	(17.4, 23.2)
Army	424	56.91	(53.3, 60.4)
Air Force	171	22.95	(20.1, 26.1)
Medical fitness			
Fit	521	69.93	(66.5, 73.1)
Unfit	219	29.40	(26.2, 32.8)

M = mean; SE = standard error
Denominator: Transitioned ADF members invited to participate in the CIDI
Notes:
Unweighted data
'95% CI' represents a 95% confidence interval

MHPWS group

A total of 1088 participants from this group were invited to participate in the CIDI. Of those invited, 76.75% (835) completed the interview. Table B.6 describes the response rates for this group.

Table B.6 CIDI response rates for the MHPWS group by Service, sex, rank and MEC status

	MHPWS CIDI response n = 1088 (invited); n = 835 (responded)		
	Invited	Responders	Response rate (%)
Service			
Navy	237	175	73.84
Army	462	349	75.54
Air Force	389	311	79.95
Sex			
Male	903	698	77.30
Female	182	135	74.18
Missing	3	2	66.67
Rank			
OFFR	451	375	83.15
NCO	576	425	73.78
Other Ranks	61	35	57.38
Medical fitness			
Fit	758	590	77.84
Unfit	327	243	74.31
Missing	3	2	66.67
Total	1088	835	76.75

Denominator: MHPWS sample invited to participate in the CIDI
Notes:
Unweighted data
'95% CI' represents a 95% confidence interval

The characteristics of the MHPWS group CIDI respondents were as follows.

Sex: The MHPWS sample comprised 2015 Regular ADF and Transitioned ADF members. Consistent with the ADF population, the CIDI sample was predominantly male, and female members were less likely to respond than male members.

Rank: CIDI responders in this group comprised of 44.9% Officers, 50.9% Non-Commissioned Officers and 4.2% Other Ranks. Other Ranks were less likely to respond than the other two ranking categories.

Service: 21.0% of survey responders were from the Navy, 41.8% from the Army and 37.2% from the Air Force. There was no difference between CIDI responders and non-responders in relation to the Service they worked within.

Medical fitness: ADF members who were medically unfit were similarly represented among those who responses to the CIDI (29.1%) and those who were selected to participate (30.1%). ADF members who were medically fit were also similarly represented in the CIDI responder group (70.7%) compared to 69.7% in the invited population. In other words, the responder sample was representative in terms of medical fitness of the selected group.

Combat Zone group

A total of 183 participants from this group were invited to participate in the CIDI. Of those invited, 76.50% (140) completed the interview. Table B.7 describes the response rates for this group.

Table B.7 CIDI response rates for the combat zone group by Service, sex, rank and MEC status

	Combat Zone group CIDI response n = 183 (invited); n = 140 (responded)		
	Invited	Responders	Response rate (%)
Service			
Navy	10	10	100
Army	143	111	77.62
Air Force	0	0	0
Missing	30	19	63.33
Sex			
Male	148	118	79.73
Female	2	2	100
Missing	33	20	60.61
Rank			
OFFR	20	16	80.00
NCO	101	77	76.24
Other Ranks	47	39	82.98
Missing	15	8	53.33
Medical fitness			
Fit	130	103	79.23
Unfit	21	17	80.95
Missing	32	20	62.50
Total	183	140	76.50

Denominator: Combat Zone sample invited to participate in the CIDI
Notes:
Unweighted data
'95% CI' represents a 95% confidence interval

The characteristics of the Combat Zone group CIDI respondents were as follows.

Sex: The Combat Zone CIDI sample comprised 2015 Regular ADF and Transitioned ADF members. Consistent with the ADF population, the CIDI sample was almost entirely male, and of the two females selected, both responded.

Rank: CIDI responders in this group comprised 11% Officers, 55% Non-Commissioned Officers and 28% Other Ranks. Other Ranks were less likely to respond than the other two ranking categories.

Service: 7% of survey responders were from the Navy, 79% from the Army and 0% from the Air Force. There was no difference between CIDI responders and non-responders regarding the Service they worked within.

Medical fitness: ADF members who were medically unfit were similarly represented in the CIDI responder group (12%) and in the group of those selected to participate (11%). ADF members who were medically fit were also similarly represented in the CIDI responder group (74%) compared to 71% in the invited population. In other words, the responder sample was representative in terms of medical fitness of the selected group.

B.6 Study overview

Prevalence estimates were obtained using a two-phase design. This is a well-accepted approach to epidemiological research (Salim & Welsh, 2009), and was used in the 2010 MHPWS (McFarlane et al., 2011). In the first phase, participants completed a screening questionnaire. This provided the research team with a clear picture of psychological symptoms from a dimensional perspective.

Based on certain key results from the survey and specific demographic factors, a subset of participants was also selected to participate in a one-hour diagnostic mental health telephone interview. Participants in the Combat Zone sample underwent additional biological, neurocognitive testing and Magnetic Resonance Imaging (MRI), the details of which will be provided in a later report.

Interview data for the Transitioned ADF members were weighted to ensure the representativeness of the prevalence estimates for key sub-groups within the total Transitioned ADF population. Self-report survey data were also weighted to be representative of both the Transitioned ADF and the 2015 Regular ADF groups.

B.7 Measures

B.7.1 Phase 1: Self-report survey

In Phase 1 of the Mental Health and Wellbeing Transition Study, Transitioned ADF and 2015 Regular ADF members were screened for mental health problems, psychological distress, physical health problems, wellbeing factors, pathways to care and occupational exposures, using a 60-minute self-report questionnaire completed either online or in hard copy. This survey was developed at the beginning of the study period in close consultation between DVA and Defence. Survey anonymity was preserved by allocating a unique study ID number to each participant. Participants who previously completed a survey as part of the 2010 MHPWS were allocated their existing MilHOP study ID number.

Participants could complete the survey:

- online, after receiving an email with a secure link to an online invitation package containing the web-based survey. Participants could only access the survey by entering their unique study ID number and password, provided in the invitation email
- on paper, mailed to a participant's current postal address.

Each participating sample received a slightly different questionnaire relevant to their current ADF status – Transitioned ADF member, 2015 Regular ADF member or Ab initio Reservist – in regard to demographics, Service and deployment history. The core-validated measures of psychological and physical health remained the same, and replicated where possible the measures previously administered as part of the MHPWS in 2010. This component of the design is critical to the longitudinal comparisons across time, and highlights the importance of taking a consistent approach to overseeing the design of research into military and veteran populations over time.

Before rolling out the survey, the online and hard-copy versions were piloted on a selected group of 2015 Regular ADF and ex-serving ADF members. Individuals in the pilot group were asked to provide detailed feedback pertinent to the content and adequacy of the survey, and the usability of the system or form. Their comments and feedback were then subsequently incorporated into the final version of the survey, ensuring there were no mistakes in the survey or glitches in the system before the study began.

Details of the survey provided to Combat Zone participants will be provided in a later report.

Part 1: Demographics and service details

Part 1 of the survey was completed by all sample groups and comprised the following major sections.

Demographic information: Participants were asked to provide demographic information regarding their gender, date of birth and highest educational qualification. These items were taken directly from the 2010 MHPWS (McFarlane et al., 2011).

Household and family: Participants were asked a series of questions about their relationship status, household structure and children. Items in this section were derived from several sources including the Timor-Leste Family Study (McGuire et al., 2012); the Household, Income and Labour Dynamics in Australia (HILDA) Survey (Watson & Wooden, 2002); and the 2014 Vietnam Veterans Family Study (Forrest et al., 2014).

Financial status: Items assessing participants' current financial status and financial hardships were taken from the HILDA Survey (Watson & Wooden, 2002) and Phase 2 of the Health and Wellbeing Survey of Serving and Ex-Serving Personnel of the UK Armed Forces (Fear et al., 2010).

Homelessness: This section of the survey comprised eight questions from the 2010 ABS General Social Survey (GSS) (Australian Bureau of Statistics, 2011) addressing lifetime and recent episodes of homelessness. The questions specifically focused on:

- experiences of homelessness
- reasons for homelessness
- frequency of homelessness
- most recent experience of homelessness (reason for homelessness, time frame and recency)
- assistance sought during period(s) of homelessness, and the helpfulness of these services
- barriers to seeking support.

ADF service details: Participants were asked a series of questions specific to their employment with the ADF, including the number of years served, current service status, hours worked per week, rank and Service. Depending on their rank and Service, participants were also asked a series of questions pertaining to their specialty and specific role within the ADF. Items in this section were taken from the ABS (Australian Bureau of Statistics, 2008) and the 2011 Australian Defence Force Exit Survey (Shirt, 2012).

Feelings about the ADF: This section of the survey aimed to assess participants' level of organisational commitment. Four items were taken from Allen and Myer's Affective Commitment Scale (Allen, 1990) and the other four were developed by researchers for the present study.

Transitioned ADF members were also asked additional questions in part 1 pertaining to the following topics.

Employment status: Participants were asked about their current employment activities. Examples of options included 'full-time work greater than or equal to 30 hours paid employment per week', 'home duties' and 'unemployed or looking for work'. Unemployed members were also required to provide a reason for their unemployment. Items in this section were taken from the Young and Well Cooperative Research Centre standard suite of measures (Young and Well Cooperative Research

Centre, 2013) and Phase 2 of the Health and Wellbeing Survey of Serving and Ex-Serving Personnel of the UK Armed Forces (Fear et al., 2010).

Participants were also required to provide details about their current civilian employment including the number of hours worked per week, industry of employment and main source of income. Items in this section were derived from Phase 2 of the Health and Wellbeing Survey of Serving and Ex-Serving Personnel of the UK Armed Forces (Fear et al., 2010), the Australian Defence Force Exit Survey (Shirt, 2012) and HILDA Survey (Watson & Wooden, 2002). Participants were also asked to indicate whether they had experienced a period of unemployment greater than three months since transitioning from the ADF, and if so when this period began. This item was taken from the Australian Gulf War Veterans' Health Study 2011 follow-up (Sim et al., 2015).

Reservist status: Participants were asked about their Reservist status and, where relevant, details pertaining to their Reservist employment – including full-time or part-time status, number of hours worked, and weeks spent away from home on Reservist work. Items in this section were taken from the Soldier Wellbeing Survey (Riviere, 2011; Thomas et al., 2010).

Year of transition: Participants were asked to indicate what year they transitioned into Active Reservist or Inactive Reservist status, or out of the ADF. These questions were taken from Phase 2 of the Health and Wellbeing Survey of Serving and Ex-Serving Personnel of the UK Armed Forces (Fear et al., 2010) and the Australian Gulf War Veterans' Health Study 2011 follow-up (Sim et al., 2015).

Change in relationship status: Participants were asked to indicate whether their relationship status had changed since transitioning from Regular ADF service. If divorced, separated or widowed since their transition, participants were asked to provide the date this occurred. This item in the survey was taken from the Australian Gulf War Veterans' Health Study 2011 follow-up (Sim et al., 2015).

ADF separation details: This section of the survey comprise two parts. Firstly, participants were asked about their discharge or resignation category. Examples of options included 'medical discharge', 'compassionate grounds' and 'end of fixed-period engagement'. In the second part, participants were given a comprehensive list of reasons for leaving the ADF and asked to mark all that played a role in their decision to leave. Participants were also asked to indicate the main reason out of those they selected. Items in this section were based on the current ADF Exit Survey (Shirt, 2012).

ADF Reservists were asked additional questions pertaining to the following topics.

Reservist details: Participants were asked to provide details on the length of time they served as a Reservist, their Reservist status, their periods of continuous full-time

service, hours worked per week in the past month, weeks away from home in the past five years, and satisfaction with participation in the Reserves. Items in this section were derived from the Soldier Wellbeing Survey (Riviere, 2011; Thomas et al., 2010); Phase 2 of the Health and Wellbeing Survey of Serving and Ex-Serving Personnel of the UK Armed Forces (Fear et al., 2010); and the RAND Guard/Reserve Survey of Officer and Enlisted Personnel (Kirby, 1998). Other items were developed by researchers specifically for use in the present study.

Civilian employment: Participants were asked a series of questions about their civilian role (if relevant), in particular about their employer's knowledge of their Reservist role; their employer's attendance at Reservist events; their employer's support of their military affiliation; the impact of their Reservist duties on their civilian role; and a comparison of the duties and responsibilities that apply in their Reservist and civilian roles. Items in this section were derived from the Soldier Wellbeing Survey (Riviere, 2011; Thomas et al., 2010), the Middle East Area of Operations (MEAO) Health Study: Prospective Study (Davy, 2012) and the current ADF Exit Survey (Shirt, 2012). Information surrounding current employment activities and details of civilian employment were collected as described in the previous section relating to Transitioned ADF members.

Contribution to the ADF: Participants' perception of their contribution to the ADF was measured by asking a single question: *How important do you think your contribution is towards the ADF?* Potential answers ranged from 'not at all important' to 'very important'. This item was taken from the RAND Guard/Reserve Survey of Officer and Enlisted Personnel (Kirby, 1998).

How the ADF deals with Reservists: Participants were asked about their perceptions of how well the ADF deals with, understands and accepts Reservists. This topic was assessed via three questions, with answers measured on a five-point scale ranging from 'very poor' to 'very good'.

Getting help (Reservists only): The researchers developed this section of the survey, which looked at mental health problems resulting from the Reservist experience; help sought in dealing with these problems; help sought and received from ADF services or non-Defence organisations; and benefits sought and received from DVA.

Part 2: Health and wellbeing survey

All groups completed part 2 of the survey, which was specific to the Mental Health and Wellbeing Transition Study and comprised the following major sections.

Deployments: Participants were asked to provide detailed information about their deployment history with the ADF. Deployments were grouped into the following categories:

- War-like or Active Service
- Non–war-like (Peacekeeping) Service
- Humanitarian or Disaster Relief
- Defence Aid
- Border Protection.

For each applicable deployment type, participants were asked to indicate which country they were deployed to, the name of the operation, the dates they were deployed, the number of times they were deployed, the total number of months deployed and whether they were deployed in a combat capacity. Items in this section were adapted from the 2010 MHPWS (McFarlane et al., 2011).

Deployment exposure: Participants were presented with a list of deployment exposures and asked to indicate how many times they had experienced each one during their military career. Response categories ranged from 'never' to '10+ times'. Examples of events included 'exposure to hazardous materials', 'discharge of weapon in direct combat' and 'handled or saw dead bodies'. Items in this section were drawn from the MEAO Census Study (Dobson et al., 2012).

Quality of life: This section of the survey comprised three items designed to assess general health, satisfaction with health and quality of life. General health was measured using the first item of the Short Form 36 Health Survey (SF36) (Ware, 1992), referred to as Form 1 (SF1). SF1 is often used in population studies as an indicator of overall health status. Items assessing general health and satisfaction with health were taken from the Australian Gulf War Veterans Health Study 2011 follow-up (Sim et al., 2015).

Depression: Depression was examined using the self-report Patient Health Questionnaire-9 (PHQ‑9) (Kroenke et al., 2001). Respondents score the nine items of the PHQ-9 from 0 to 3 and the results are summed to give a total score between 0 and 27. The PHQ-9 identifies various levels of diagnostic severity; higher scores indicate greater depression symptoms.

Generalised anxiety disorder: Generalised anxiety disorder was measured on the Generalised Anxiety Disorder 7-item Scale (GAD-7) (Spitzer, 2006). Seven items are scored from 1 to 3, providing a total generalised anxiety score between 0 and 21. Participants were asked to rate each item in the GAD-7 in relation to their experience in the last two weeks only.

Sleep problems: Self-perceived insomnia was examined using the Insomnia Severity Index (ISI) (Bastien et al., 2001). The ISI comprises seven items assessing the severity of

sleep-onset and sleep-maintenance difficulties, satisfaction with current sleeping pattern, interference with daily functioning, noticeability of impairment attributed to the sleep problem, and degree of distress or concern caused by the sleep problem. Each item is rated on a scale from 0 to 4, resulting in a total score between 0 and 28. A higher score suggests more severe insomnia.

General psychological distress: The Kessler Psychological Distress Scale (K10) (Kessler et al., 2002) is a 10-item screening questionnaire that yields a global measure of psychological distress based on symptoms of anxiety and depression experienced in the most recent four-week period. Items are scored from 1 to 5 and summed to give a total score between 10 and 50. Various methods have been used to stratify K10 scores. The categories of low (10–15), moderate (16–21), high (22–29) and very high (30–50) used in this report are derived from K10 cut-offs that were used in the ABS's 2007 Australian National Mental Health and Wellbeing Survey (Slade et al., 2009), and to identify levels of psychological distress in the 2010 MHPWS (McFarlane et al., 2011).

Anger: The Dimensions of Anger Reactions Scale (DAR-5) (Forbes et al., 2004) is a concise measure of anger. It consists of five items that address anger frequency, intensity, duration, aggression and interference with social functioning. Items are scored on a 5-point Likert scale generating a severity score between 5 and 25, where higher scores indicate worse symptomatology. This scale has been previously used to assess Australian Vietnam veterans and US veterans from Afghanistan and Iraq. It shows strong unidimensionality, and high levels of internal consistency and criterion validity.

Physical violence: Items addressing participants' personal experiences with physical violence or threatened violence were taken from the 2010 MHPWS (McFarlane et al., 2011).

Suicidal ideation and behaviour: 12-month suicidal ideation and behaviour was assessed using four items that looked specifically at suicidal thoughts, plans and attempts. Three of the items in this section were adapted from the National Survey of Mental Health and Wellbeing (Australian Bureau of Statistics, 2008) and the final item was devised by researchers for use in the current study.

Perceptions of mental health: Researchers developed items addressing participants' perceptions of their current and future physical and mental health, specifically for use in the present study.

Lifetime exposure to traumatic events: Lifetime exposure to trauma was examined as part of the posttraumatic stress disorder (PTSD) module of the CIDI (Haro et al., 2006). Participants were asked to indicate whether or not they had experienced:

- combat – in the military, or an organised non-military group
- being a peacekeeper in a war zone or a place of ongoing terror
- being an unarmed civilian in a place of war, revolution, military coup or invasion
- living as a civilian in a place of ongoing terror for political, ethnic, religious or other reasons
- being a refugee
- being kidnapped or held captive
- being exposed to a toxic chemical that could cause serious harm
- being in a life-threatening automobile accident
- being in any other life-threatening accident
- being in a major natural disaster
- being in a man-made disaster
- having a life-threatening illness
- being beaten by a spouse or romantic partner
- being badly beaten by anyone else
- being mugged, held up or threatened with a weapon
- being raped
- being sexually assaulted
- being stalked
- having someone close to you die
- having a child with a life-threatening illness or injury
- witnessing serious physical fights at home as a child
- having someone close experience a traumatic event
- witnessing someone badly injured or killed, or unexpectedly seeing a dead body
- accidentally injuring or killing someone
- purposefully injuring, torturing or killing someone
- seeing atrocities or carnage such as mutilated bodies or mass killings
- experiencing any other traumatic event.

For each applicable event, participants were required to provide further information regarding their age the first and last time the event took place; the number of times each event took place; and the number of times each event was related to their ADF service. Participants were then required to indicate which of the events they had answered 'yes' to was their worst event.

PTSD: The Post Traumatic Stress Disorder Checklist – civilian version (PCL-C) (Weathers, 1993) is a 17-item self-report measure designed to assess the symptomatic criteria of PTSD according to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV). The 17 questions of the PCL-C are scored from 1 to 5 and are summed to give a total symptom severity score of between 17 and 85. An additional four items from the newly released PCL-5 were also included, allowing researchers to also measure PTSD symptoms according to the most recent definitional criteria.

Recent life events: Participants completed a modified 15-item version of the List of Threatening Experiences (Brugha et al., 1985), a brief questionnaire frequently used to assess recent stressful life events. Participants were asked to indicate 'yes' if the event had occurred in the last 12 months, and indicate whether it was still having an effect on their life. Examples of events include 'your parent, child or spouse died', 'you had a major financial crisis' and 'you broke off a steady relationship'.

Alcohol use: Alcohol consumption and problem drinking was examined using the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993), a brief self-report screening instrument developed by the World Health Organization (WHO). This instrument consists of 10 questions examining the quantity and frequency of alcohol consumption, possible symptoms of dependence, and reactions or problems related to alcohol. AUDIT is widely used in epidemiological and clinical practice to define at-risk patterns of drinking (Babor et al., 2001). The recommended WHO risk categories are used within ADF populations, so were used as the scoring categories in the present study. This process identifies four risk bands: Band 1 (a score of 0–7) represents those who would benefit from alcohol education; Band 2 (8–15) represents those that are likely to require simple advice; Band 3 (16–19) indicates those for whom counselling and continued monitoring is recommended; and Band 4 (20–40) includes those who require diagnostic evaluation and treatment, including counselling and monitoring (Babor et al., 1989; Babor et al., 2001).

The following two additional supplementary AUDIT items were included in the questionnaire, as well as additional items on consumption to ensure comparability with the Australian National Health Survey 2011–2012 (Australian Bureau of Statistics, 2012).

Tobacco use: Items assessing tobacco use were taken from the 2013 National Drug Strategy Survey (Australian Institute of Health and Welfare, 2011) and the 2010

MHPWS (McFarlane et al., 2011). Participants were asked a series of questions about their past and present tobacco use, including frequency of use, the age they started and stopped smoking daily, and the types of tobacco products they had smoked in the last year.

Drug use: 12-month and lifetime drug use among Transitioned ADF members was measured using modified Items from the 2013 National Drug Strategy Survey (Australian Institute of Health and Welfare, 2011). Transitioned ADF members were asked a series of questions about two categories of drugs. The first was illicit drugs, which included amphetamines and methamphetamines; cocaine, ecstasy, GHB, hallucinogens; heroin; inhalants; ketamine; marijuana; methadone or buprenorphine; and opiates and opioids. The second category was prescription drugs, including analgesics and painkillers, tranquilisers and sleeping pills, which they used for non-medical purposes – that is, alone or with other drugs order to induce or enhance a drug experience. Participants were asked if they had ever used these drugs in their lifetime or the last 12 months, and the age that they first used them.

Functioning: Functional impairment was assessed using the Sheehan Disability Scale (Sheehan, 1983), a five-item self-report measure of disability as a result of mental health symptoms, in three inter-related domains: work or school; social life; and family life. The three items assessing impairment in the three domains are scored from 0 to 10 and can yield a total global functional impairment score between 0 and 30.

Getting help: This section of the survey was developed by key researchers with specific knowledge and experience within the field. Other items were taken from the ABS (2008), the CIDI (Haro et al., 2006) and the 2010 MHPWS (McFarlane et al., 2011), modified to suit the current research.

Means of informing, assessing and maintaining mental health: The first series of questions looked at specific help-seeking strategies participants used to inform, assess and maintain their mental health in the last 12 months, and whether or not they found these strategies to be helpful. Researchers developed the 32 items – which look at how people informed or assessed their mental health – specifically for use in the present study. Four items looking at how people maintain their mental health were taken from the CIDI (Haro et al., 2006).

A single item asked participants to indicate their preferred means of receiving information about their mental health. Options included via telephone, on the internet or in person (face to face). Researchers developed this item for use in the present study.

Barriers and stigmas to care: Participants were asked to rate on a five-point scale the degree to which a list of 'concerns' might affect their decision to seek help. Answers

ranged from 'strongly disagree' to 'strongly agree'. Items in this section were taken from the 2010 MHPWS (McFarlane et al., 2011), the Canadian Air Forces Recruit Mental Health Service Use Questionnaire (Fikretoglu et al., 2014), and the Solider Wellbeing Survey (Riviere, 2011; Thomas et al., 2010), with several additions from researchers in the current study. Sample answers include 'I wouldn't know where to get help', 'It's too expensive' and 'I don't trust mental health professionals'.

This section of the survey also included a question about unmet need for help, targeting individuals who expressed concerns about their mental health but never sought help. Participants were presented with a list of seven barriers and asked to indicate how much they disagreed with each one on a five-point scale, ranging from 'strongly disagree' to 'strongly agree'. Examples of statements include 'I can still function effectively' and 'I didn't know where to get help'.

Barriers to care in both of sets of questions listed above fell into the following categories:

- perceived control
- self-stigma
- public stigma
- perceived stigma
- mental health literacy
- physical barriers
- career barriers.

Concerns about mental health: Researchers developed questions addressing participants' concerns about their mental health specifically for the present study.

Assistance with mental health: Items addressing assistance sought for mental health were taken from the 2010 MHPWS (McFarlane et al., 2011).

Help received and pathways to care: Participants were asked whether, within or outside the past 12 months, they had ever sought or received help with their mental health from:

- a General Practitioner (GP) or Medical Officer (MO)
- a psychologist
- a psychiatrist
- any other mental health professional.

For each of the professionals listed above, participants were asked to indicate what services they received, whether they were satisfied with the services and what compensation (if any) they received. These items were taken from the CIDI (Haro et al., 2006) and adapted for use in the current study.

Participants were also asked whether, within or outside the past 12 months, they had ever accessed:

- inpatient treatment or hospital admission
- a hospital-based PTSD program
- a residential alcohol or other drug program.

For each of the treatments and programs listed above, participants were asked to indicate whether they were satisfied with the service and how the service was paid for. These items were taken from the CIDI (Haro et al., 2006) and adapted for use in the current study.

Satisfaction with mental health services received: Participants were asked to rate their satisfaction or dissatisfaction with a series of factors associated with receiving mental health care. Items included accessibility, cost, location, effectiveness, health professional competence, health professional friendliness, convenience, confidentiality and Medicare cap. Participants asked to provide answers in relation to their experiences in the past 12 months only.

Doctor-diagnosed mental health conditions: Participants were asked about mental health problems or conditions that they had ever been diagnosed with or treated for by a medical doctor at any point in their lifetime. If a participant answered 'yes' to any of the items listed, they were also asked to specify the year they were first diagnosed, whether a doctor had treated them for the condition in the past year, and whether they had taken medication for the condition in the past month. Items in this section were derived from the Australian Gulf War Veterans Health Study 2011 follow-up (Sim et al., 2015).

Undiagnosed mental health conditions: Participants were presented with a list of mental disorders and asked to indicate whether they currently had (or ever had) each disorder even though they had not been diagnosed or treated for it. Conditions included alcohol abuse or dependence; drug abuse or dependency; stress or anxiety; depression; and PTSD. Researchers developed this question at the Centre for Traumatic Stress Studies (CTSS) to tap into undiagnosed mental conditions.

Help-seeking latency: Participants were asked to indicate when they first sought help with their own mental health. The options were 'Within three months of becoming

concerned' or 'Within one year of becoming concerned'. Alternatively, participants were able to specify the number of years since they became concerned. Researchers developed this item for use in the present study.

Recommendation to seek help, and assistance with seeking help: This section of the survey comprised two questions: the first asked participants whether someone else had suggested they seek help with their mental health condition; the second asked whether someone else practically assisted them in seeking care. Options for who provided this assistance or advice included a GP or MO; a partner; another family member; a friend or colleague; or the individual's supervisor, manager or commander. Researchers developed these questions for specific use in the present study.

Reasons for seeking care: Participants were asked to indicate what primary and secondary reason led them to seeking care. Examples included 'anger', 'depression' and 'gambling'. Researchers developed these two questions for specific use in the current study.

Health professionals: Participants were presented with an exhaustive list of health professionals and asked to indicate which they had consulted for help with their own health in the past 12 months. Participants were also asked to indicate how many times they had consulted a GP and/or specialist doctor in the last two weeks. All items in this section were taken from the Australian Gulf War Veterans Health Study 2011 follow-up (Sim et al., 2015).

Family and children: This section of the survey comprised several scales looking at participants' relationships with their families, particularly any children.

- Family support and strain was assessed using questions from an adapted version of the Schuster Social Support Scale (Schuster et al., 1990). Effective support was indicated by responses to questions about how often family members made the respondent feel cared for, and how often family members expressed interest in how the respondent was doing. Negative interactions were indicated by responses to questions about how often family members made too many demands of the respondent, criticised the respondent and created tensions or arguments with the respondent. All items were answered on four-point Likert-type scale, ranging from 'often' to 'never'.

- Items assessing participants' relationship with their current partner, arguments with their current partner and abuse experienced by the partner were taken from the Timor-Lest Family Study (McGuire et al., 2012).

- A single item looking at how often participants had contact with family members not living with them was taken from the 2014 Vietnam Veterans Family Study (Forrest et al., 2014).

- Items assessing the impact of military service on participants' relationships, employment, physical health, mental health and financial situation were also taken from the 2014 Vietnam Veterans Family Study (Forrest et al., 2014).

- Two items assessing relationship satisfaction were taken from the HILDA Survey (Watson & Wooden, 2002). Participants were required to rate their relationship with their partner and their children on an 11-point Likert-type scale, ranging from 'completely dissatisfied' to 'completely satisfied'.

- Items measuring conflict during childhood, parental mental health and parental substance abuse were taken from the Longitudinal Study of Australian Children (Gray, 2005).

- Global parental self-efficacy was assessed using a single item also taken from the Longitudinal Study of Australian Children (Gray, 2005). Participants were required to rate their competency as a parent on a 5-point Likert-type scale, ranging from 'not very good at being a parent' to 'a very good parent'.

- Parental warmth was measured using six items from the Child Rearing Questionnaire (Paterson & Sanson, 1999), which were also used in the Longitudinal Study of Australian Children (Gray, 2005). Participants were required to answer questions in relation to first-born children aged between four and 17 who lived with them 50% or more of the time in the last six months. Participants were required to indicate how often each listed event took place on a 5-point Likert-type scale, ranging from 'never or almost never' to 'always or almost always'. Examples of events included 'How often did you hug or hold this child for no particular reason?' and 'How often did you enjoy listening to this child and doing things with him or her?'

- Parental anger was measured using five items from the National Longitudinal Study of Children & Youth (Statistics Canada, 2003). Participants were required to indicate how often each listed event took place on a 5-point Likert-type scale, ranging from 'never or almost never' to 'all the time'. Examples of events included 'How often are you angry when you punish this child?' and 'How often do you tell this child that he or she is not as good as the others?'

Friends and other social contacts: This section comprised several scales looking at participants' friends and social contacts.

- Social support and strain was assessed using questions from an adapted version of the Schuster Social Support Scale (Schuster et al., 1990). Affective support was indicated by responses to questions about how often friends made them feel cared for, and how often friends expressed interest in how they were doing. Negative interactions were indicated by responses to questions about how often friends made too many demands of the respondent, criticised the respondent, and created tensions or arguments with the respondent. All items were answered on four-point Likert-type scale, ranging from 'often' to 'never'.

- A single items about how often participants had contact with friends not living with them was taken from the 2014 Vietnam Veterans Family Study (Forrest et al., 2014).

- A single item assessing how satisfied participants were with their friendships was taken from the HILDA Survey (Watson & Wooden, 2002). Participants were required to rate their relationship on an 11-point Likert-type scale, ranging from 'completely dissatisfied' to 'completely satisfied'.

- Questions looking at how many ex-service organisations participants belonged to and how these organisations benefited them were taken from the Australian Gulf War Veterans Health Study 2011 follow-up (Sim et al., 2015).

Resilience: Researchers used the Ohio State University Brief Resilience Scale (BRS) (Smith et al., 2008) to assess participants' ability to bounce back or recover from stress. Participants were asked to indicate the extent to which they agreed or disagreed with six anchored statements. The BRS is scored by reverse-coding items 2, 6 and 6, and finding the mean of the six items.

The final item in this section assessed global happiness on the Delighted–Terrible scale (Andrews & Crandall, 1976), one of the more common approaches to collecting subjective data on perceived quality of life.

Gambling: The Problem Gambling Severity Index (PGSI) (Stinchfield, 2007) is a widely used nine-item scale for measuring the severity of gambling problems in the general population. Each item is scored from 0 to 3; the higher the total score, the greater the risk of problem gambling behaviour.

Driving: Items examining risky driving were sourced from the Australian Institute of Family Studies (Smart, 2005) and looked specifically at driving over the speed limit and driving while affected by alcohol. Participants were asked to consider the last 10 times they drove, and how many times in that period they engaged in risky driving behaviour.

Experience with the law: Participants were asked a series of questions about their experiences with the law, including whether they had ever been arrested, convicted of a crime in a court of law or sent to prison. For any that applied, participants were also asked to indicate whether the event occurred prior to their entry into the ADF, prior to their transition from the Regular ADF service, or since their transition from Regular ADF service. Items in this section of the survey were sourced from the Australian Gulf War Veterans Health Study 2011 follow-up (Sim et al., 2015).

Internet use: This section of the survey aimed to ascertain what role the internet played in improving participants' mental health and wellbeing. Items looking at internet use were taken from the Young and Well National Survey (Burns, 2013) and focused specifically on internet use patterns, means of accessing the internet, internet use for social support, internet use to obtain information relating to mental health, internet use in managing mental health, barriers to using the internet for help with mental health and the efficacy of the internet in meeting mental health care needs.

Emerging technologies: A series of questions developed by the Young and Well Cooperative Research Centre (Burns, 2013; Young and Well Cooperative Research Centre, 2013) examined the use of new and emerging technologies to support health and wellbeing. These questions looked at participants' current use of new and emerging technologies; barriers to use; types of new and emerging technologies used; the use of new and emerging technologies to improve personal health and wellbeing; reasons for using new and emerging technologies for health and wellbeing; other reasons for using new and emerging technologies; the types of new and emerging technologies participants would use if money was not a factor; and the early adoption of new technologies

Head injuries: This section of the survey comprised two scales. The first was a self-report version of the Ohio State University Traumatic Brain Injury Identification Method (OSU TBI-ID) (Corrigan & Bogner, 2007), adapted by researchers for specific use in the current study. The OSU TBI-ID is a standardised measure designed to determine an individual's lifetime history of traumatic brain injury (TBI). Questions focused on the types of head or neck injuries incurred; symptoms experienced (such as loss of consciousness, being dazed and confused, and loss of memory); age at when the symptoms first and last occurred; frequency of symptoms; loss of consciousness related to a drug overdose or being choked; and occurrence of multiple blows to the head in relation to a history of abuse, contact sports, or ADF training or deployment. The second scale was a modified version of the Post-concussion Syndrome Checklist (PSC) (Gouvier, 1992), which was used as part of the 2012 MEAO Health Study (Davy, 2012). This modified version of the scale required participants to indicate the degree to which they had experienced a list of 11 symptoms in the past four weeks as a result of an injury to their head or neck.

Physical exercise: Participants were asked to complete the short 'last seven days' self-administered version of the International Physical Activity Questionnaire (IPAQ, 2002). Questions gauged the number of days, number of times and amount of time spent doing vigorous, moderate and light physical activity in the last seven days, as well as the amount of time spent being sedentary.

Pain: Items assessing pain intensity and disability were taken from the Australian Gulf War Veterans Health Study 2011 follow-up (Sim et al., 2015). Participants were asked to answer a series of questions on a scale of 1 to 10, about their current pain, worst pain experienced and average pain in the last six-month period. Participants were also asked to indicate how much their pain had interfered with their daily activities, their recreational or social activities, and their ability to work in the last six months.

Injuries: Researchers developed this section of the survey specifically for the current study, looking at injuries sustained during an individual's military career that required time off work. For each injury type, participants were asked to specify how many injuries were sustained during their military career, how many were sustained while deployed and how many were sustained during training. Participants were also asked to indicate all the parts of the body where the injuries occurred.

Respiratory health: Participants were asked about any respiratory symptoms experienced in the last 12 months, using questions derived from the European Community Respiratory Health Survey 1 (Burney et al., 1994). Examples of symptoms included wheezing or whistling, breathlessness, tightness in the chest, shortness of breath, coughing, phlegm, nasal allergies and asthma.

Physical health: Questions assessing current physical health were taken from the Australian Gulf War Veterans Health Study 2011 follow-up (Sim et al., 2015). This 67-item version of the self-report symptom questionnaire focused on respiratory, cardiovascular, musculoskeletal, dermatological, gastrointestinal, genitourinary, neurological and cognitive symptoms. For every symptom experienced within the past month, participants were also required to indicate how sever the symptoms were on a three-point Likert scale (mild, moderate or severe).

Doctor-diagnosed medical conditions: This 44-item self-report questionnaire asked participants about medical problems or any conditions they had been diagnosed with or treated for by a medical doctor within their lifetime. If a participant answered 'yes' to any of the items listed, they were also asked to specify the year they were first diagnosed, whether a doctor had treated them for the condition in the past year, and whether they had taken medication for the condition in the past month. Items in this section were derived from the Australian Gulf War Veterans Health Study 2011 follow-up (Sim et al., 2015).

For more detail about the individual measures listed in this section, including information about scoring, refer to the relevant chapters within each commissioned report.

B.7.2 Phase 2: Diagnostic interview

In phase 2 of the research, a sub-sample of individuals was selected to participate in a one-hour telephone interview using the World Mental Health Survey Initiative Version of the World Health Organization Composite International Diagnostic Interview – version 3 (CIDI) (Kessler & Ustun, 2004).

The CIDI helped the research team assess mental disorders based on the definitions and criteria of two classification systems: the DSM-IV, and the WHO International Statistical Classification of Diseases and Related Health Problems – 10th Revision (ICD-10) (World Health Organisation, 1994). The CIDI was selected because of its highly structured nature and vast use in epidemiological studies worldwide, including CTSS's 2010 MHPWS, and ABS's 2007 Australian National Survey of Mental Health and Wellbeing (NSMHW).

A team of trained interviewers from the Hunter Research Foundation (HRF) administered the CIDI to consenting participants in Newcastle, New South Wales. Supervisors based at the research centre closely monitored the diagnostic inter-rater reliability throughout the study period.

12-month and lifetime ICD-10 mental disorders

The researchers used the CIDI to assess 12-month and lifetime ICD-10 rates of the following mental disorders: adult separation disorder, agoraphobia, bipolar affective disorder, depressive episode, dysthymia, generalised anxiety disorder (GAD), harmful alcohol use and dependence, intermittent explosive disorder, panic attack, panic disorder, obsessive-compulsive disorder (OCD), PTSD, social phobia, specific phobia, and suicidal ideation and behaviour.

Clinical calibration studies report that the CIDI has good validity rating (Haro et al., 2006). The report presents ICD-10 prevalence rates with hierarchy rules applied, so they can be directly compared against Australian national rates (Slade et al., 2009). Standard CIDI algorithms were applied for all ICD-10 disorders, so to qualify for a 12-month diagnosis, individuals would need to initially meet lifetime criteria and have also reported symptoms in the 12 months prior to the interview.

Lifetime trauma exposure

Lifetime exposure to trauma was examined as part of the CIDI PTSD module, by identifying events listed in the CIDI:

- engaging in combat within a military or organised non-military group

- being a peacekeeper in a war zone or place of ongoing terror
- being an unarmed civilian in a place of war, revolution, military coup or invasion
- living as a civilian in a place of ongoing terror for political, ethnic, religious or other reasons
- being a refugee
- being kidnapped or held captive
- being exposed to a toxic chemical that could cause serious harm
- being in a life-threatening automobile accident
- being in any other life-threatening accident
- being in a major natural disaster
- being in a man-made disaster
- having a life-threatening illness
- being beaten by a parent or guardian as a child
- being beaten by a spouse or romantic partner
- being badly beaten by anyone else
- being mugged, held up or threatened with a weapon
- being raped
- being sexually assaulted
- being stalked
- having someone close to you die
- having a child with a life-threatening illness or injury
- witnessing serious physical fights at home as a child
- having someone close experience a traumatic event
- witnessing someone badly injured or killed or unexpectedly seeing a dead body
- accidentally injuring or killing someone
- purposefully injuring, torturing or killing someone
- seeing atrocities or carnage such as mutilated bodies or mass killings
- experiencing any other traumatic event
- experiencing any other event that the participant did not want to talk about.

B.8 Stratification procedure

In phase 2 of the research, 1807 Transitioned ADF members were invited to participate in a one-hour telephone interview following the CIDI format (Kessler & Ustun, 2004). In addition to two sub-groups of Transitioned ADF members within Sample 5 (Combat Zone) and Sample 6 (MHPWS) who were all eligible to complete a CIDI, CIDI invitations preferenced groups accounting for the smallest proportion of the actual population (females) and those with high scores on the PCL and AUDIT, to make the sample more representative and help capture low-prevalence mental disorders.

As such, participants were selected for the CIDI based on rank, sex, Service, and PCL and AUDIT scores. PCL and AUDIT scores were categorised into three bands:

- Band 3 = PCL > 27, AUDIT >9
- Band 2 = PCL 21-27, AUDIT 7-9
- Band 1 = PCL <=20, AUDIT <=6

Using the method proposed by Salim & Welsh (2009), the stratification procedure aimed to over-sample respondents in Band 3 – those with the greatest likelihood of disorder. A smaller proportion from bands 2 and 1 were also sampled, to control for the possibility of over-inflated mental disorder estimates. Transitioned ADF members in samples 5 and 6 were also allocated a band to ensure that these participants were also accounted for during sampling.

Using the predicted proportions of Transitioned ADF survey responders who would score in each PCL and AUDIT band – and the population characteristics of sex, rank and Service – the following stratification algorithm generated lists of eligible CIDI participants among Transitioned ADF members who completed the survey and consented to complete a CIDI:

- Band 3
- Female, Band 2
- Female, Band 1
- Male, Navy, Band 2
- Male, Navy, Band 3
- Male, Army, Band 3
- Male, Army, Band 1
- Male, Air Force, Band 2.

Table B.8 Stratification characteristics of entire Transitioned ADF CIDI sample

	Transitioned ADF CIDI stratification							
	No Band*		Band 1		Band 2		Band 3	
	Invited (n = 110)	Completed (n = 72)	Invited (n = 408)	Completed (n = 258)	Invited (n = 335)	Completed (n = 225)	Invited (n = 954)	Completed (n = 494)
Navy								
Male	20	8	73	43	57	41	140	71
Female	1	1	17	10	8	4	40	20
Army								
Male	52	37	152	94	155	109	515	272
Female	15	10	35	19	31	15	66	25
Air Force								
Male	17	13	104	77	74	50	152	86
Female	4	3	25	14	8	5	34	16
Missing	1	-	2	1	2	1	7	4

*Includes Combat Zone and MHPWS participants who were invited to participate but were not stratified

Table B.8 shows the final distribution of eligible Transitioned ADF members across the strata used for CIDI selection, and the number who responded. Of the 1049 Transitioned ADF members who completed a CIDI, 47.1% were in Band 3, 21.4% were in Band 2 and 24.6% were in Band 1. The final sample comprised 18.9% Navy members, 55.4% Army members and 25.2% Air Force members, and the majority of respondents were male (85.9%). A total of 78 CIDI responders were missing band, sex or Service information, and so were excluded from the final weighted population.

B.9 Weighting

The statistical weighting process used in the Mental Health and Wellbeing Transition Study replicated that used in the 2010 MHPWS, allowing researchers to infer results for the entire Transitioned ADF and 2015 Regular ADF populations.

Two types of weights were used in the study:

- Survey responder weights, which were used to correct for differential non-response on the survey for both Transitioned and 2015 Regular ADF.
- Two phase CIDI responder weights, which compensated for both differential non-response on the survey, then for the over or under sampling of specific cases who went on to be interviewed with the CIDI. These weights apply to the Transitioned ADF only, and were used to generate 12-month and lifetime ICD-10 mental disorder prevalence estimates for the entire Transitioned ADF.

The weighting procedure involves allocating a representative value or 'weight' to the data for each responder, based on key variables known for the entire population

(including responders and non-responders). This weight indicates how many individuals in the entire population each actual responder represents. Weighting data allows researchers to infer results for an entire population – in this case, the Transitioned ADF group – by assigning a representative value to each 'actual' case (responder) in the data. If a case has a weight of 4, that case counts in the data as four identical cases. By using known characteristics about each individual within the population (in this case, age, sex, rank and medical fitness), the weight assigned to responders indicates how many 'like' individuals in the entire population each responder represents, based on those characteristics. Weighting is used to correct for differential non-responses and to account for systematic biases that may be present in study responders, such as over-sampling of CIDI high scorers. Both types of weights were used in this study.

The researchers combined these two weights to give each responder a single weight within the data. This methodology provides representative weights for the population, improves the accuracy of the estimated data and requires every individual within the population to have actual data on the key variables that determine representativeness.

The Transitioned ADF weights were derived from the distinct strata of sex, Service, rank, and medical fitness, a dichotomous variable derived from Medical Employment Classification (MEC) status (see details of reclassification below). Constraints due to consent meant that MEC status was missing for a number of participants. As medical fitness was a key weighting variable for providing a proxy health status for each individual in the population and to enable comparisons with the 2010 ADF MHPWS, the researchers took a data perturbation approach to deal with the missing data (see section 13.10). Once the missing MEC status information was addressed, 313 (1.24%) of the Transitioned ADF members were still missing information on the strata variables, so the final population was 24,932, and all weighted analyses of the Transitioned ADF group summed to this.

2015 Regular ADF weights were derived from the distinct strata of sex, Service, rank, medical fitness and whether the individual completed a study as part of MilHOP. The inclusion of this additional stratification variable was to account for the targeted sampling of the MilHOP cohort, who were then over-represented within the current serving responders. A MilHOP flag variable (yes/no = 1/0) was used in the weighting process in order to reduce this bias. Of all 2015 Regular ADF participants, 192 (0.36%) were missing information on the strata variables, reducing the final weighted population for analysis to 52,500. Tables B.4 and B.5 present the study population and responders within each stratum used for weighting, and show approximately how many persons within each sub-population each study responder represents.

Re-classification of MEC for study

The MEC is an administrative process designed to monitor physical fitness and medical standards in the ADF. It is divided into four levels that apply to current serving ADF members or those discharged from Regular ADF service:

- MEC 1- Members who are medically fit for employment in a deployed or seagoing environment without restriction.

- MEC 2- Members who have medical conditions that require access to various levels of medical support or employment restrictions, however, they remain medically fit for duties in their occupation in a deployed or seagoing environment. In allocation of sub-classifications of MEC 2 access to the level of medical support will always take precedence over specified employment restrictions.

- MEC 3- Members who have medical conditions that make them medically unfit for duties in their occupation in a deployed or seagoing environment. The member so classified should be medically managed towards recovery and should be receiving active medical management with the intention of regaining MEC 1 or 2 within 12 months of allocation of MEC 3. After a maximum of 12 months their MEC is to be reviewed. If still medically unfit for military duties in any operational environment, they are to be downgraded to MEC 4 or, if appropriate, referred to a Medical Employment Classification Review Board (MECRB) for consideration of an extension to remain MEC 3.

- MEC 4- Members who are medically unfit for deployment or seagoing service in the long-term. Members who are classified as MEC 4 for their military occupation will be subject to review and confirmation of their classification by a MECRB.

For this study, the four MEC status levels were collapsed to create a new 'medical fitness' variable, defined as:

- **Fit:** Individuals are categorised as 'fit' if they are fully employable and deployable, or employable and deployable with restrictions. Participants were classified as 'fit' if they fell into MEC 1 or MEC 2 as described above, or were assigned 'fit' as a perturbed MEC value.

- **Unfit:** 'Unfit' members are not fit for deployment, their original occupation and/or further service. This could include those undergoing rehabilitation or transitioning to alternative return-to-work arrangements, or those who are in the process of medically separating from the ADF. Participants were classified as 'unfit' if they fell into MEC 3 or MEC 4 as described above, or were assigned an 'unfit' perturbed MEC value.

B.9.1 Estimates from the survey

To maximise the actual real data available for analysis, survey weights were calculated for each section of the survey separately. This addressed the issue of differential responses to various sections; that is, where individuals potentially completed some but not all parts of the survey. A 'survey section responder' was defined as anyone who answered at least one question in that particular section of the survey. A total of 29 section responder weight variables were available, and for the purpose of analysis, the weights were always used to determine the primary outcome variable of interest.

B.9.2 Estimates from the CIDI

CIDI weights were derived for the Transitioned ADF group based on strata including band (cut-offs based on PCL and AUDIT), sex and Service, which were then used to weight the CIDI responses to the entire population. Within each stratum, the weight was calculated as the population size divided by the number of CIDI respondents within that stratum. As there was no band for non-respondents, the population size within each stratum was estimated by multiplying the known numbers for each sex, by the Service population total, by the observed proportion belonging to the band of interest from within the corresponding stratum. A finite population correction was also applied to adjust the variance estimates for the reasonably large sampling fraction within each stratum.

Post-stratification by the variables of sex, Service and rank helped adjust the weights so the known population totals could be reproduced by the estimates, and to correct for differential non-response by rank.

B.10 Unit-level perturbation of MEC values

B.10.1 Methodology

Due to the nature of the consent provided for individuals on the Study Roll, access to identified data for weighting purposes required the consent of the individual participants. The Australian Institute of Health and Welfare (AIHW) carried out a perturbation approach that provided each non-consenting record with a releasable MEC value. Perturbation used the observed values of MEC for the non-consenters to give an appropriate value to each non-consenting record. This was achieved simply by fitting a model using releasable data items as predictors in a model of MEC using the non-consenters. The model used was a logistic regression model. This resulted in a set of probabilities of each record taking on MEC values. A Monte Carlo approach used these probabilities to randomly assign a synthetic MEC value to each record. These synthetic MEC values reflect each individual's characteristics. The generation was constrained so that aggregate totals remained consistent with totals of unperturbed values.

The perturbation approach allowed the unit records to better reflect the MEC status of individuals. This allowed researchers to use the unit records to undertake more accurate analyses and tabulations.

The unit record perturbation allowed for tabulation and analyses. The perturbed values did not assume a broad level of homogeneity within the combinations of variables as an aggregate weighting approach, but rather allowed the individual characteristic of each person to inform the perturbed value that they were assigned.

B.10.2 Results

The perturbation process was constrained at the source level. Tables B.9 and B.10 illustrate how this was achieved, rendering the counts of fit, unfit and missing values the same for the original and perturbed values.

The missing values were assumed to happen at random within the source file. As such, an original missing value from a participant could be given to any other participant regardless of the gender, Service type, rank or age. As such, the number of fit and unfit totals at these constraining levels for the perturbed data do not exactly line up with the original totals (see Table B.10 for totals by Service type).

Table B.9 Counts of categories, by source

	Original MEC value (n)			Perturbed MEC value (n)		
Source	Fit	Unfit	Missing	Fit	Unfit	Missing
ABIN	138	7	0	138	7	0
CURR	891	196	2	891	196	2
TRAN	271	159	1	271	159	1

Table B.10 Counts of categories, by service type

	Original MEC value (n)			Perturbed MEC value (n)		
Source	Fit	Unfit	Missing	Fit	Unfit	Missing
Navy	613	191	3	614	193	0
Army	254	63	0	255	60	2
Air Force	433	108	0	431	109	1

B.11 Contact strategy and recruitment methods

B.11.1 Promoting the study

Prior to initial direct contact with the research team, the following strategies were used to promote the study to participants.

Advertising in print media: The study team developed promotional posters and placed them in Service newspapers; on the DVA and Defence internet and intranet sites; on base; at ex-service organisations; and on the University of Adelaide website.

Ministerial media release: On 11 June 2014, a ministerial media release launched the study to the wider community, disseminating information and generating interest among ADF members. Minister for Veterans' Affairs The Hon Michael Ronaldson was in attendance, as was the Executive Dean of the Faculty of Health Sciences, and members of the Scientific Advisory Committee (SAC) and research team. The research team followed strict protocol in responding promptly and effectively to enquiries resulting from the media release.

Targeted briefs to ADF leaders: A series of informational sessions briefed commanders and other key influencers within the broader Defence community about the importance of the research.

Letters to ex-service organisations: All relevant ex-service organisations received a letter introducing the Transition and Wellbeing Research Programme, together with an accompanying fact sheet. This served to disseminate information and generate support for the study.

Study briefing packs: Briefing packs containing study and promotional materials were distributed to ex-service organisations as another means of promoting the study among the target population.

Social media: A series of social media conversations, promotions and advertisements were rolled out via the Transition and Wellbeing Research Programme Facebook page (facebook.com/AuMilResearch) and Twitter account (@aumilresearch) throughout the study period. The CTSS research team managed these accounts, with the primary objectives of raising awareness of the research program among 2015 Regular ADF and ex-serving ADF members, their families and their social networks; engaging other advocates and key stakeholders; providing another platform for participants to engage with the research team; and disseminating previous military research conducted by CTSS.

B.11.2 Developing the Military and Veteran Health Research Study Roll

The AIHW, in collaboration with DVA and Defence, created the Military and Veteran Health Research Study Roll (Study Roll) to obtain and record participants' contact details and demographic information. This process involved integrating contact information from:

- the Defence Personnel Management Key Solution (PMKeyS) database
- DVA client databases

- the National Death Index
- the ComSuper member database
- the MilHOP dataset.

To ensure that the information was current and reflected the most recent posting cycles, a final PMKeyS download received immediately before the study commenced was integrated into the dataset.

This integrated dataset was only passed on to the research team following an opt-out process. This involved DVA and Defence contacting participants via their websites, email, hard-copy letters, service newspapers and a media campaign, and providing detailed information about the Study Roll and its broader purpose. The contact information, basic service history and demographic information of individuals who did not opt out of this process within four weeks of the campaign commencing were then passed on to CTSS for the purpose of conducting the Transition and Wellbeing Research Programme. Participants could still opt out of the Study Roll after the four-week campaign via an opt-out website and email account managed and maintained by Defence. This website was open for a period of three months, and individuals who used it to opt out of the Study Roll were excluded from sampling for the Programme.

To avoid unintentionally approaching the families of deceased Defence members, the Study Roll was cross-checked against the National Death Index prior to sending out the opt-out email, and again approximately four weeks before data collection commenced. All new deaths recorded by Defence were communicated to the research team as they occurred.

B.11.3 Self-selection procedure

The details of eligible ex-serving ADF members who were not passed on to CTSS at the beginning of the study period but who subsequently self-selected into the study were sent to AIHW for inclusion in the Study Roll. These members were sent an invitation package as per the standard study protocol. Participants who Defence deemed ineligible were required to provide proof of their service to CTSS before they could participate. Reservists who self-selected into the study were only included in the dataset if they appeared on the original Study Roll.

B.11.4 Sampling by data integrator

Prior to recruitment, AIHW created appropriate samples for the Programme, including:

- all members who transitioned from being Regular ADF between 2010 and 2014
- all ADF members who participated in MilHOP, except those who indicated that they did not wish to be contacted for further research

- a stratified random sample of 5040 2015 Regular ADF members
- 22,638 current serving Ab initio Reservists, although only Reservists with registered contact information were invited to participate.

The stratified random sample of 5040 2015 Regular members was drawn from the remainder of members not already listed as MilHOP participants. This sample did not include those who were deceased or had specifically opted out of the Transition and Wellbeing Research Programme. Stratification was based on:

- Service – Navy, Army, or Air Force
- sex
- Rank Code (Officer/Enlistee)

The contact information and demographics for each of the sub-populations listed above – with the exception of individuals who opted out of the Study Roll – were then passed on to the CTSS researchers for recruitment and weighting purposes.

B.11.5 Phase 1: Distribution of self-report survey

Recruitment for the study was staggered across the entire data collection period, and online invitation packages were distributed to participants in batches. The first batch of invitation emails was rolled out to participants in June 2015. Each email contained a unique study ID number and token password, as well as a secure link to an online invitation package. This package contained the self-report survey and all associated study materials, including information sheets and consent forms. Invitation packs were uniquely tailored to participants' current serving status and eligibility criteria. Where email addresses were not available, or upon request, hard-copy versions of the invitation package were posted out to participants.

Follow-up with survey non-respondents

The researchers took a multifaceted approach to following up with survey non-respondents to maximise participation rates.

Reminder emails: A series of email reminders were sent out to all non-responders two, four and six weeks after the invitation package was sent out, and one month before the survey closed. Participants who preferred to complete a hard-copy version of the survey were directed to call or email the study team. This was specified in all reminder email correspondence.

SMS reminders: SMS reminders were sent to all non-responders concurrently, to remind them to check their emails. Recipients included members who had not yet commenced the survey, as well as individuals who had partially completed the survey.

Targeted telephone follow-up: Some high-priority participants belonging to the MHPWS CIDI cohort were targeted via a structured telephone follow-up process. It was important to maximise the response rate for this longitudinal cohort with existing data points, so the research team could map the trajectory of their disorders. The telephone follow-up also included participants without email addresses, those who had partially completed a survey and other target groups with low response rates, to help ensure a representative coverage of these groups. Specifically, this included:

- Transitioned ADF members who had a landline phone number but no email address or mobile phone number
- Transitioned ADF members with a landline phone number and Defence email address but no mobile phone number
- partial completers from all cohorts
- participants with bounced emails from sole non-Defence email addresses, and who had a landline phone number but no mobile number
- participants who nominated family members for the Family Study but did not provide contact details for those family members
- all other Transitioned ADF members and Ab initio Reservists who had not yet commenced the survey.

Trained research staff at CTSS conducted these phone calls following a structured script. They called at various times during the day and evening to maximise contact opportunities, making a maximum of 10 attempts to speak to each participant twice. Where no contact was made and a telephone message service was available, the researchers left a reminder message on only two of the 10 occasions, along with the study's toll-free phone number and email address.

Hard-copy letters: Hard-copy invitation letters containing the toll-free phone number, email address and URL for the online survey were sent to:

- all Transitioned ADF non-responders
- all Ab initio Reservist non-responders
- all 2015 Regular ADF non-responders who did not participate in MilHOP.

B.11.6 Phase 2: Diagnostic interview

Selection

Phase 2 involved targeting a sub-group of Transitioned ADF and Regular ADF members from eligible samples to participate in a one-hour telephone interview using the World Mental Health Survey Initiative version of the CIDI. To be eligible for recruitment,

potential interviewees must have completed the self-report measures, and have completed the Mental Health and Wellbeing Transition Study consent form, stating their consent to being contacted to participate in a telephone interview.

Phase 2 targeted:

- a stratified sample of ADF members who had transitioned from being current serving ADF members after 2010. Transitioned ADF survey responders were invited to complete the CIDI based on their scores on the PCL and AUDIT screening measures, and demographic characteristics were used to further preference participants to help the CIDI sample represented the entire cross-section of population characteristics as much as possible
- all MHPWS ADF members who were interviewed using the CIDI in 2010. This included individuals who met ICD-10 diagnostic criteria for a 12-month ICD-10 affective, anxiety or alcohol disorder in 2010, as well as individuals who were sub-syndromal or who had no disorder
- a sample of ADF members who participated in the MEAO Prospective Health Study between 2010 and 2012.

Recruitment

Recruitment calls were made by trained HRF interviewers who did not know how participants had scored on the self-report measures. The interviewers placed these calls at various times during the day and evening, taking into account participants' preferences, to maximise contact opportunities.

To ensure the interviewers had access to the most recent contact details, current phone numbers were obtained from PMKeyS immediately before the study commenced, and then intermittently throughout the interview period.

Participants' contact information:

- was provided by participants themselves, either online or in hard copy as part of Phase 1 of the Mental Health and Wellbeing Transition Study
- was provided by AIHW
- was downloaded from PMKeyS
- was provided by participants themselves, either online or in hard copy as part of the MilHOP suite of studies.

The interviewers first tried the primary phone number provided in the contact information sheet completed in Phase 1. In the absence of this information, they used a phone number obtained from one of the other sources listed above.

The interviewers made a maximum of 10 attempts to speak to the participant before removing them from the participant pool. If the interviewer failed to make contact, they left a reminder message on only two of the 10 occasions, along with the study's toll-free phone number and email address.

When they did make contact over the phone, the interviewer explained the aims, purpose and requirements of the interview, and if the participant agreed, arranged a time for the interview to take place.

Interview

At the beginning of each interview, the interviewer reminded the participant that participation was voluntary, that they could stop the interview at any point and that they could withdraw from the study at any time without any impact on their career or entitlements.

If the participant agreed to proceed with the interview, verbal consent was obtained and recorded, and the highly structured interview began.

At the end of the structured interview, participants allowed sufficient time to debrief, ask questions and give interview-related feedback.

If at any time the participant indicated that they were feeling distressed or suicidal, interviewers followed the relevant duty of care protocols.

B.12 Medicare and PBS/RPBS data links

As part of the broader research Programme, participants were invited to fill out a consent form authorising the researchers' access to complete Medicare, Pharmaceutical Benefit Scheme (PBS) and Repatriation Pharmaceutical Benefit Scheme (RPBS) data. The research team collected data for each consenting participant from the five-year period prior to their scheduled interview date, which included information about their medical visits, procedures, associated costs and prescription medications filled at pharmacies. Consent forms for this component of the research were sent securely to the Department of Human Services, which holds this information confidentially.

B.13 Statistical analysis

Analyses were conducted in Stata version 13.1 or SAS version 9.2, using weighted estimates of totals, means and proportions, except where specified otherwise. Standard errors were estimated using linearisation, except where specified otherwise.

Sub-group analyses were conducted on each of the 12-month ICD-10 mental disorders using the demographic and deployment history predictors of:

- sex (Male, Female)
- age (18–27, 28–37, 38–47, 48–57, 58+)
- 2015 Regular ADF Service, or Service at the time of transition (Navy, Army, Air Force)
- 2015 Regular ADF rank, or rank at the time of transition (Officer, Non-Commissioned Officer, Other Rank)
- years of regular service (<3 months, 3 months – 3.9 years, 4–7.9 years, 8–11.9 years, 12–15.9 years, 16–19.9 years, 20+ years)
- deployment status (ever deployed, never deployed).

For Transitioned ADF participants, the analyses also included the specific transition factors of:

- transition status (Ex-Serving, Inactive Reservist, Active Reservist)
- reason for discharge (medical discharge, other reason)
- years since transition (0, 1, 2, 3, 4, 5)
- DVA client status (DVA client, not a DVA client).

Comparisons between the prevalence of 12-month ICD-10 disorders among sub-groups were analysed using weighted logistic regressions. All regressions involved the variables of age, sex, Service and rank. Comparisons between the prevalence of 12-month ICD-10 disorder classes (affective disorders, anxiety disorders and alcohol disorders) among sub-groups were analysed using a weighted multinomial logistic regression, and the outcome was a number of disorder classes. The regression involved the covariates of age, sex, Service and rank. Comparisons between the prevalence of self-reported suicidal behaviour among sub-groups were analysed using weighted logistic regressions. All regressions included the covariates of age, sex, Service and rank.

For the self-report measures, the analysis looked at the proportion (n (%)) of ADF members in each sub-group. Comparisons between the mean total scores among sub-

groups were also analysed where appropriate, using weighted multiple linear regressions. All regressions included the covariates of age, sex, Service and rank. Comparisons between the prevalence of self-reported alcohol consumption and problems with drinking were analysed using weighted logistic regressions. A proportional odds model was considered for this analysis, but the main assumption of this approach was violated, so the ordinal response was dichotomised using several cut-offs. All regressions included the covariates of age, sex, Service and rank.

A direct numerical comparison was used to compare the mental health and wellbeing of 2015 Regular ADF members and 2010 Regular ADF members. This did not include standardisation or tests of statistical significance. As these two samples cannot be considered independent, differences between groups should be interpreted with caution, noting that some members of the 2015 Regular ADF sample are also represented in the 2010 Regular ADF sample. The issue of individual change in symptoms and disorders over time in this group will be addressed in the future Longitudinal Report.

To compare estimates in the Transitioned ADF cohort and the wider Australian Community, direct standardisation was applied to estimates within the 2014–2015 ABS National Health Survey (NHS). The NHS data were restricted to those aged 18–71 (consistent with the Programme's transition population), and was standardised by sex, employment status (employed or not) and age category (18–27, 28–37, 38–47, 48–57 and 58+). Standard errors for the NHS data were estimated using the replication weights provided in the NHS data file.

B.14 Ethical considerations

To combat potential risks and ensure that participation in the study was completely free from coercion, participants were made explicitly aware that their involvement in the study was voluntary and that they could decline to participate and/or were free to withdraw from the project at any time. This was emphasised in all study materials. Whether or not an individual had chosen to participate in the study was not communicated to senior staff in the ADF, nor were members directly asked by a uniformed Officer to participate in the study. This also helped ensure recruitment was free from coercion.

To manage potential risks to participants in both phases of the research, the research team established and strictly adhered to a duty of care protocol.

B.15 Ethical approvals

The study protocol was approved by the Department of Veterans' Affairs Human Research Ethics Committee (E014/018), and was mutually recognised by the Directorate, Defence Health Research and the University of Adelaide Human Research Ethics Committee. The study protocol was also submitted to the Australian Institute of Health and Welfare Ethics Committee and received the requisite approval (EO 2015/1/163).

Acronyms

ABS	Australian Bureau of Statistics
ADF	Australian Defence Force
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AUDIT	Alcohol Use Disorders Identification Test
BRS	Ohio State University Brief Resilience Scale
CI	Confidence interval
CIDI	World Mental Health Survey Initiative Version of the World Health Organization Composite International Diagnostic Interview – version 3
CRC	Cooperative Research Centre
CTSS	Centre for Traumatic Stress Studies
DAR-5	Dimensions of Anger Reactions Scale
DMAC	Data Management & Analysis Centre
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders – 4th edition
DVA	Department of Veterans' Affairs
ESO	Ex-service organisation
GAD	Generalised anxiety disorder
GAD-7	Generalised Anxiety Disorder 7-item Scale
HILDA	Household, Income and Labour Dynamics in Australia
HREC	Human Research Ethics Committee
HRF	Hunter Research Foundation
ICD-10	International Statistical Classification of Diseases and Related Health Problems – 10th Revision
K10	Kessler Psychological Distress Scale

KCMHR (ASMMH)	King's Centre for Military Health Research (Academic Department of Military Mental Health)
MEAO	Middle East Area of Operations
MEC	Medical Employment Classification
MECRB	Medical Employment Classification Review Board
MHPWS	Mental Health Prevalence and Wellbeing Study
MilHOP	Military Health Outcomes Program
mTBI	Mild traumatic brain injury
NCO	Non-Commissioned Officer
NDI	National Death Index
NHMRC	National Health and Medical Research Council
NHS	National Health Survey
OCD	Obsessive-compulsive disorder
OFFICER	commissioned officer
OR	Odds ratio
OR	Other Ranks
OSU TBI-ID	Ohio State University Traumatic Brain Injury Identification Method
PBS	Pharmaceutical Benefits Scheme
PCL-C	Posttraumatic Stress Disorder Checklist – civilian version
PCS	Post-Concussion Syndrome Checklist
PGSI	Problem Gambling Severity Index
PHQ-9	Patient Health Questionnaire
PMKeyS	Personnel Management Key Solution
PTSD	Posttraumatic stress disorder
RPBS	Repatriation Pharmaceutical Benefits Scheme
SAC	Scientific Advisory Committee
SE	Standard error
TBI	Traumatic brain injury
UA	University of Adelaide

Glossary of terms

12-month prevalence – Meeting diagnostic criteria for a lifetime ICD-10 mental disorder and then having reported symptoms in the 12 months prior to the interview.

Affective disorders – Affective disorders is a class of mental disorders. The Mental Health and Wellbeing Transition Study examined three types of Affective Disorder: Depressive episodes, Dysthymia and Bipolar Affective Disorder. A key feature of these mental disorders is mood disturbance.

Agoraphobia – Marked fear or avoidance of situations such as crowds, public places, travelling alone, or travelling away from home, which is accompanied by palpitations, sweating, shaking, or dry mouth as well as other anxiety symptoms such as chest pain, choking sensations, dizziness, and sometimes feelings of unreality, fear of dying, losing control, or going mad.

Alcohol dependence – Characterised by an increased prioritisation of alcohol in a person's life. The defining feature of alcohol dependence is a strong, overwhelming desire to use alcohol despite experiencing a number of associated problems. A diagnosis was given if the person reported three or more of the following symptoms in the previous 12-months:

- strong and irresistible urge to consume alcohol
- a tolerance to the effects of alcohol
- inability to stop or reduce alcohol consumption
- withdrawal symptoms upon cessation or reduction of alcohol intake
- continuing to drink despite it causing emotional or physical problems
- reduction in important activities because of or in order to drink.

Alcohol harmful use – Diagnosis not only requires high levels of alcohol consumption, but that the alcohol use is damaging to the person's physical or mental health. Each participant was initially asked if they consumed 12 or more standard alcoholic drinks in a 12-month period. If so, they were then asked a series of questions about their level of consumption. A diagnosis of Alcohol Harmful Use was applied if the alcohol interfered with either work or other responsibilities; caused arguments with their family or friends; was consumed in a situation where the person could get hurt; resulted in being stopped or arrested by police; or if the participant continued to consume alcohol despite experiencing social or interpersonal problems as a

consequence of their drinking during the previous 12-months. A person could not meet criteria for Alcohol Harmful Use if they met criteria for Alcohol Dependence.

Alcohol Use Disorders Identification Test (AUDIT) – Alcohol consumption and problem drinking was examined using the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993), a brief self-report screening instrument developed by the World Health Organization. This instrument consists of 10 questions to examine the quantity and frequency of alcohol consumption, possible symptoms of dependence, and reactions or problems related to alcohol. The AUDIT is an instrument that is widely used in epidemiological and clinical practice for defining at-risk patterns of drinking.

Anxiety disorders – Anxiety disorder is a class of mental disorder. This class of disorder involves the experience of intense and debilitating anxiety. The anxiety disorders covered in the survey were panic attacks, panic disorder, social phobia, specific phobia, agoraphobia, generalized anxiety disorder (GAD), posttraumatic stress disorder (PTSD) and obsessive-compulsive disorder (OCD).

Australian Bureau of Statistics (ABS) – The ABS is Australia's national statistical agency, providing trusted official statistics on a wide range of economic, social, population and environmental matters of importance to Australia. To enable comparison of estimates in the Transitioned ADF with an Australian community population, direct standardisation was applied to estimates within the 2014-2015 ABS National Health Survey (NHS) data. The NHS is the most recent in a series of Australia-wide ABS health surveys, assessing various aspects of the health of Australians, including long-term health conditions, health risk factors, and health service use.

Australian Defence Force (ADF) – The Australian Defence Force (ADF) is constituted under the Defence Act 1903, its mission is to defend Australia and its National interests. In fulfilling this mission, Defence serves the Government of the day and is accountable to the Commonwealth Parliament which represents the Australian people to efficiently and effectively carry out the Government's defence policy. The current programme of research aims to examine the mental, physical and social health of serving and Ex-Serving Australian Defence Force (ADF) members, and their families. It builds upon previous research to inform effective and evidence based health service provision for contemporary service members and veterans.

Australian Institute of Family Studies (AIFS) – AIFS is the Australian Government's key research body in the area of family wellbeing. AIFS conducts original research to increase understanding of Australian families and the issues that affect them. The current research was conducted by a consortium of Australia's leading research institutions led by the Centre for Traumatic Stress Studies (CTSS) at the University of Adelaide and the Australian Institute of Family Studies (AIFS)

Australian Institute of Health and Welfare (AIHW) – Australia's national agency for health and welfare statistics and information. AIHW was utilised in the current programme of research to develop a Study Roll by integrating contact information from various sources/databases.

Bipolar affective disorder – associated with fluctuations of mood that are significantly disturbed. These fluctuations of mood are markedly elevated on some occasions (hypomania or mania) and can be markedly lowered on other occasions (Depressive Episodes). A diagnosis of Bipolar Affective Disorder was applied in this study if the individuals met criteria for mania or hypomania in the previous 12-months

Centre for Traumatic Stress Studies (CTSS) – The Centre for Traumatic Stress Studies seeks to improve evidence-based practice by informing and applying scientific knowledge in the field of trauma, mental disorder and wellbeing in at-risk populations. The current programme of research was conducted by a consortium of Australia's leading research institutions led by the Centre for Traumatic Stress Studies (CTSS) at the University of Adelaide and the Australian Institute of Family Studies (AIFS)

Chain of Command – the line of authority and responsibility along which orders are passed within a military unit and between different units.

Class of mental disorder – Mental disorders are grouped into classes of disorder that share common features. Three classes of mental disorders were included in the survey. These were affective disorders, anxiety disorders and alcohol disorders.

Comorbidity – The occurrence of more than one disorder at the same time**.** Comorbidity was defined by grouping any alcohol disorders, any affective disorders, any anxiety disorders (excluding PTSD), and PTSD according to their co-occurrence. In addition to a breakdown of the individual patterns of co-occurrence, 5 categories were defined representing those with no mental disorder, and those with 1, 2, 3 or 4 disorder categories.

Composite International Diagnostic Interview (CIDI) – The World Mental Health Survey Initiative version of the World Health Organization's Composite International Diagnostic Interview, version 3 (WMH-CIDI 3.0)(Kessler & Ustun, 2004) provides an assessment of mental disorders based on the definitions and criteria of two classification systems: the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) and the World Health Organization International Classification of Diseases, 10th revision (ICD-10) (World Health Organisation, 1994). This instrument was utilised in phase 2 of the current research Programme.

Confidence interval – A confidence interval gives an estimated range of values which is likely to include an unknown population parameter, the estimated range being calculated from a given set of sample data

Department of Veterans Affairs (DVA) – The Department delivers government programs for war veterans, and members of the ADF and the Australian Federal Police and their dependants. In 2014, DVA, in collaboration with the Department of Defence, commissioned the Transition and Wellbeing Research Programme, one of the largest and most comprehensive military research projects undertaken in Australia.

Deployment status – In Mental Health and Wellbeing Transition Study, deployment status was based on survey responses, and defined accordingly:

- Never Deployed – Individuals who did not endorse any of the listed deployments in the self-report survey (Your Military Career: Deployments) and did not endorse any of the Deployment exposures (Your Military Career: Deployment Exposure).

- Deployed – Individuals who endorsed one or more of the listed deployments (Your Military Career: Deployments) OR endorsed one or more of the deployment exposures (Your Military Career: Deployment Exposure).

Depressive episodes – are a characteristic of a major depressive disorder and require that an individual has suffered from depressed mood lasting a minimum of two weeks, with associated symptoms or feelings of worthlessness, lack of appetite, difficulty with memory, reduction in energy, low self-esteem, concentration problems, and suicidal thoughts. Depressive episodes can be mild, moderate or severe. All three are included under the same heading. Hierarchy rules were applied to depressive episodes such that a person could not have met criteria for either a hypomanic or manic episode.

Diagnostic criteria – The survey was designed to estimate the prevalence of common mental disorders defined according to clinical diagnostic criteria, as directed by the International Classification of Diseases 10th Revision (ICD-10). Diagnostic criteria for a disorder usually involve specification of:

- the nature, number and combination of symptoms
- a time period over which the symptoms have been continuously experienced
- the level of distress or impairment experienced
- circumstances for exclusion of a diagnosis, such as it being due to a general medical condition or the symptoms being associated with another mental disorder.

Dimensions of Anger Reactions scale (DAR-5) –The DAR-5 is a concise measure of anger. It consists of five items that address anger frequency, intensity, duration, aggression, and interference with social functioning. Items are scored on a 5-point Likert scale generating a severity score ranging from 5 to 25 with higher scores indicative of worse symptomatology. This scale has been used previously to assess Australian Vietnam veterans, as well as US Afghanistan and Iraq veterans, and shows strong unidimensionality, and high levels of internal consistency and criterion validity.

DVA Client – The term 'DVA Client' was used during reporting when referring to DVA clients for the purpose of analyses.

In the construction of the DVA dataset for the study roll, DVA created an indicator of confidence against each veteran with respect to the level of interaction DVA had with each them for assessing how confident DVA was in the address accuracy. Each of the following groups were considered DVA client:

- High – where a veteran is in receipt of a fortnightly payment (such as income support or compensation pension) from DVA it was a sign of regular ongoing contact with the client and therefore DVA would have a high-level of confidence that their address would be up to date and correct.

- Medium – where a veteran only holds a treatment card (i.e., does not also have an ongoing payment) there is a lower level of ongoing contact with the Department and therefore the level of confidence that DVA can assign to the accuracy of the client's address is lower.

- Low – not all veterans who have their illness/injury liability claim accepted as service related by DVA automatically receive a treatment card or pension payment, however they would still be considered DVA clients.

For the purposes of this report, any individual in the study population, who met the criteria above, was flagged as a 'DVA Client'. Those with this flag were compared against those without this flag.

Dysthymia – is characterised as a chronic or pervasive disturbance of mood lasting several years that is not sufficiently severe or in which the depressive episodes are not sufficiently prolonged to warrant a diagnosis of a recurrent depressive disorder. Hierarchy rules were applied to dysthymia such that in order to have this disorder, a person could not have met criteria for either a hypomanic or manic episode and could not have reported episodes of severe or moderate depression within the first two years of dysthymia.

Ex Service Organisation (ESO) –ESO's provide assistance to current and former ADF members. Services can include but are not necessarily limited to: welfare support, assistance with DVA claims, and employment programs and social support.

Generalised anxiety disorder (GAD) – Generalised and persistent worry, anxiety or apprehension about everyday events and activities lasting a minimum of six months that is accompanied by anxiety symptoms as described in 'agoraphobia'. Other symptoms may include symptoms of tension, such as inability to relax and muscle tension, and other non-specific symptoms, such as irritability and difficulty in concentrating.

Generalised Anxiety Disorder 7-item Scale (GAD-7) – a brief 7-item screening measure based on the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV) criteria for Generalised Anxiety Disorder. Originally validated for used in primary care, the GAD-7 performs well in detecting probable cases of Generalised Anxiety Disorder with a sensitivity of 89% and a specificity of 82%.

Gold card – DVA health card 'for all conditions'. A Gold card entitles the holder to DVA funding for services for all clinically necessary health care needs, and all health conditions, whether they are related to war service or not. The card holder may be a veteran or the widow/widower or dependant of a veteran. Only the person named on the card is covered.

Help seeking latency – the delay in time between first becoming concerned for a health problem, and first seeking help for that problem. In order to assess help-seeking latency in the current study, participants were asked to indicate when they first sought help for their own mental health. Options included 'within 3 months of becoming concerned' or 'within 1 year of becoming concerned'. Alternatively, participants were able to specify the number of years since becoming concerned. This item was developed by researchers for use in the study

Hypomanic episodes – last at least four consecutive days and are considered abnormal to the individual. These episodes are characterised by increased activity, talkativeness, elevated mood, disrupted concentration, decreased need for sleep and disrupted judgment manifest as risk taking (for example, mild spending sprees). In a subgroup of people, these disorders are particularly characterised by irritability. To meet criteria for the 'with hierarchy' version, the person cannot have met criteria for an episode of mania.

Kessler Psychological Distress Scale (K10) – The K10 is a short 10-item screening questionnaire that yields a global measure of psychological distress based on symptoms of anxiety and depression experienced in the most recent 4-week period. Items are scored from 1 to 5 and are summed to give a total score between 10 and 50.

Various methods have been used to stratify the scores of the K10. The categories of low (10–15), moderate (16–21), high (22–29) and very high (30–50) that are used in this report are derived from the cut-offs of the K10 that were used in the 2007 ABS Australian National Mental Health and Wellbeing Survey (Slade et al., 2009).

Lifetime prevalence – Meeting diagnostic criteria for a mental disorder at any point in the respondent's lifetime.

Lifetime trauma – Self-report Lifetime Trauma exposure questions used in this section were drawn from the Posttraumatic Stress Disorder module of the CIDI 3.0 (Haro et al., 2006). Participants were asked to indicate whether or not they had experienced the following traumatic events: combat (military or organised non-military group); being a peacekeeper in a war zone or a place of ongoing terror; being an unarmed civilian in a place of war, revolution, military coup or invasion; living as a civilian in a place of ongoing terror for political, ethnic, religious or other reasons; being a refugee; being kidnapped or held captive; being exposed to a toxic chemical that could cause serious harm; being in a life-threatening automobile accident; being in any other life-threatening accident; being in a major natural disaster; being in a man-made disaster; having a life-threatening illness; being beaten by a spouse or romantic partner; being badly beaten by anyone else; being mugged, held up, or threatened with a weapon; being raped; being sexually assaulted; being stalked; having someone close to you die; having a child with a life-threatening illness or injury; witnessing serious physical fights at home as a child; having someone close experience a traumatic event; witnessing someone badly injured or killed or unexpectedly seeing a dead body; accidentally injuring or killing someone; purposefully injuring, torturing or killing someone; seeing atrocities or carnage such as mutilated bodies or mass killings; experiencing any other traumatic event

Mania – is similar to hypomania but is more severe in nature. Lasting slightly longer (a minimum of a week), these episodes often lead to severe interference with personal functioning. In addition to the symptoms outlined under hypomania, mania is often associated with feelings of grandiosity, marked sexual indiscretions and racing thoughts.

Medical Employment Classification (MEC): Medical Employment Classification (MEC) is an administrative process designed to monitor physical fitness and medical standards in the ADF. Medical Employment Classification was divided into four levels (either current or on discharge from Regular ADF service):

- **MEC 1** – Members who are medically fit for employment in a deployed or seagoing environment without restriction.

- **MEC 2** – Members who have medical conditions that require access to various levels of medical support or employment restrictions, however, they remain medically fit for duties in their occupation in a deployed or seagoing environment. In allocation of sub-classifications of MEC 2 access to the level of medical support will always take precedence over specified employment restrictions.

- **MEC 3** – Members who have medical conditions that make them medically unfit for duties in their occupation in a deployed or seagoing environment. The member so classified should be medically managed towards recovery and should be receiving active medical management with the intention of regaining MEC 1 or 2 within 12 months of allocation of MEC 3. After a maximum of 12 months their MEC is to be reviewed. If still medically unfit for military duties in any operational environment, they are to be downgraded to MEC 4 or, if appropriate, referred to a Medical Employment Classification Review Board (MECRB) for consideration of an extension to remain MEC 3.

- **MEC 4** – Members who are medically unfit for deployment or seagoing service in the long-term. Members who are classified as MEC 4 for their military occupation will be subject to review and confirmation of their classification by a MECRB.

Medical Fitness – Medical fitness was defined accordingly:

- **Fit** – Fit refers to those who are categorised as fully employable and deployable, or with restrictions. Participants were classified as 'Fit' if they fell into MEC 1 or 2 as described above OR were assigned a perturbed MEC value of Fit.

- **Unfit** – Unfit refers to those not fit for deployment, original occupation and/or further service. This can include those undergoing rehabilitation or transitioning to alternative return to work arrangements or in the process of medically separating from the ADF. Participants were classified as 'Unfit' if they fell into MEC 3 or 4 as described above OR were assigned a perturbed MEC value of Unfit.

Medical discharge – A 'Medical Discharge' is an involuntary termination of the client's employment by the ADF, on the grounds of permanent or at least long-term unfitness to serve, or unfitness for deployment to operational (warlike) service.

Mental health disorders – Mental health disorders are defined according to the detailed diagnostic criteria within the World Health Organisation International Classification of Diseases. This publication reports data for ICD-10 criteria.

Mental Health Prevalence and Wellbeing Study (MHPWS) – The 2010 ADF Mental Health Prevalence and Wellbeing Study, part of the Military Health Outcomes Program

(MilHOP), was the first comprehensive investigation of the mental health of an ADF serving population.

Middle East Area of Operations (MEAO) – Australia's military involvement in Afghanistan and Iraq is often referred to as the Middle East Area of Operations (MEAO). Thousands of members have deployed to the MEAO since 2001, with many completing multiple tours of duty. The Transition & Wellbeing Research Programme will build upon the Military Health Outcomes Program (MilHOP), which detailed the prevalence of mental disorder in current serving ADF members in 2010 as well as deployment-related health issues for those deployed to the Middle East Area of Operations (MEAO).

Military Health Outcomes Program (MilHOP) – The Military Health Outcomes Program (MilHOP) detailed the prevalence of mental disorder in current serving ADF members in 2010 as well as deployment-related health issues for those deployed to the Middle East Area of Operations (MEAO). The current Programme will address a number of gaps identified following MilHOP, including the mental health of Reservists, Ex-Serving members and ADF members in high risk roles, as well as the trajectory of disorder and pathways to care for individuals previously identified with a mental disorder in 2010.

National Death Index (NDI) – The NDI is a Commonwealth database that contains records of deaths registered in Australia since 1980. Data come from Registrars of Births, Deaths and Marriages in each jurisdiction, the National Coronial Information System and the Australian Bureau of Statistics. Prior to contacting participants, the study roll was cross-checked against the NDI to ensure that we did not approach deceased members.

National Health and Medical Research Council (NHMRC) – The NHMRC is Australia's peak funding body for medical research. Previous investigations undertaken by the Centre have received NHMRC funding.

National Health Survey (NHS) – 2014-2015 National Health Survey is the most recent in a series of Australia-wide ABS health surveys, assessing various aspects of the health of Australians, including long-term health conditions, health risk factors, and health service use.

Obsessive compulsive disorder (OCD) – A disorder characterised by obsessional thoughts (ideas, images, impulses) or compulsive acts (ritualised behaviour). These thoughts and acts are often distressing and typically cannot be avoided, despite the sufferer recognising their ineffectiveness.

Optimal epidemiological cut-off – Is the value that brings the number of false positives (mistaken identifications of disorder) and false negatives (missed identifications of

disorder) closest together, there by counterbalancing these sources of error most accurately. Therefore, this cut-off would give the closest estimate to the true prevalence of 30-day ICD-10 disorder as measured by the WMH-CIDI and should be used to monitor disorder trends.

Optimal screening cut-off – Is the value that maximizes the sum of the sensitivity and specificity (the proportion of those with and without the disease that are correctly classified). This cut-off can be used to identify individuals that might need care.

Panic attack – Sudden onset of extreme fear or anxiety, often accompanied by palpitations, chest pain, choking sensations, dizziness, and sometimes feelings of unreality, fear of dying, losing control, or going mad.

Panic disorder – Recurrent Panic attacks that are unpredictable in nature.

Patient Health Questionnaire (PHQ) – Self-reported depression was examined using the Patient Health Questionnaire – 9 (PHQ9). The 9 items of the PHQ9 are scored from 0-3 and summed to give a total score between 0 and 27. The PHQ9 provides various levels of diagnostic severity with higher scores indicating higher levels of depression symptoms.

Pharmaceutical Benefit Scheme (PBS) – The Pharmaceutical Benefits Scheme (PBS) began as a limited scheme in 1948, with free medicines for pensioners and a list of 139 'life-saving and disease preventing' medicines free of charge for others in the community. Today the PBS provides timely, reliable and affordable access to necessary medicines for Australians. The PBS is part of the Australian Government's broader National Medicines Policy. Health Care Utilization, Cost and Pharmaceutical Benefit Scheme data/ Repatriation Pharmaceutical Benefits Scheme data were obtained for consenting serving and Ex-Serving ADF members as part of the current programme of research.

Post-traumatic stress disorder (PTSD) – A stress reaction to an exceptionally threatening or traumatic event that would cause pervasive distress in almost anyone. Symptoms are categorised into three groups: re-experiencing symptoms such as memories or flashbacks, avoidance symptoms, and either hyperarousal symptoms (increased arousal and sensitivity to cues) or inability to recall important parts of the experience.

The Post Traumatic Stress Disorder Checklist – civilian version (PCL-C) – a 17 item self-report measure designed to assess the symptomatic criteria of PTSD according to the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV). The 17 questions of the PCL-C are scored from 1 to 5 and are summed to give a total symptom severity score of between 17 and 85. An additional 4 items from the newly released

PCL-5 were also included, giving researchers flexibility to also measure PTSD symptoms according to the most recent definitional criteria.

Personnel Management Key System (PMKeyS) – PMKeyS is an integrated human resource management system that provides the ADF with a single source of personnel management information. PMKeyS manages information about the entire Defence workforce – Navy, Army, RAAF.

Prevalence of mental disorders – The proportion of people in a given population who meet diagnostic criteria for any mental disorder in a given time frame.

See also 12-month prevalence and lifetime prevalence.

Probable mental (health) disorder – Where probable rates of mental disorder are presented, these are based on self-report epidemiological cut-offs.

Psychopathology – the scientific study of mental disorders.

Rank Status – Three levels of rank were utilized in the Mental Health and Wellbeing Transition Study:

- **Commissioned Officer (OFFR)** – consists of Senior Commissioned Officers (Commander (CMDR), Lieutenant Colonel (LTCOL), Wing Commander (WGCDR) and above) and Commissioned Officers (Lieutenant Commander (LCDR), Major (MAJ), Squadron Leader (SQNLDR) and below)

- **Non-Commissioned Officer (NCO)** – consists of Senior Non-Commissioned Officers (Petty Officer (PO), Sergeant (SGT) and above) and Junior Non-Commissioned Officers (Leading Seaman (LS), Corporal (CPL) and below)

- **Other Ranks –** consists of Able Seaman (AB), Seaman (SMN), Private (PTE), Leading Aircraftman (LAC), Aircraftman (AC) or equivalent

Reason for Discharge – reason for transitioning out of the ADF. In the current Programme of research, reason for discharge was derived from responses on the self-report survey, and classified accordingly:

- **Medical discharge** – A 'Medical Discharge' is an involuntary termination of the client's employment by the ADF, on the grounds of permanent or at least long-term unfitness to serve, or unfitness for deployment to operational (warlike) service.

- **Other** – all other types of discharge including: compulsory age retirement, resignation at own request, assessed as unsuitable for further training, end of

fixed period engagement, end of initial enlistment period/return of service obligation, end of limited tenure appointment, not offered re-engagement, accepted voluntary redundancy, compassionate grounds, and non-voluntary administrative discharge.

Repatriation Pharmaceutical Benefit Scheme (RPBS) – The benefits listed in this Schedule can only be prescribed to Department of Veterans' Affairs beneficiaries holding a Gold, White or Orange card. Health Care Utilization, Cost and Pharmaceutical Benefit Scheme data/ Repatriation Pharmaceutical Benefits Scheme data were obtained for consenting serving and Ex-Serving ADF members as part of the current programme of research.

Service Status – The ADF is comprised of the following three Services:

- **Australian Army** – The Australian Army is Australia's military land force. It is potent, versatile and modern Army which contributes to the security of Australia, protecting its interests and people.

- **Royal Australian Navy** – The Navy provides maritime forces that contribute to the ADF's capacity to defend Australia, contribute to regional security, support global interests, shape the strategic environment and protect national interests.

- **Royal Australian Air Force** – Air Force provides immediate and responsive military options across the spectrum of operations as part of a Whole of Government joint or coalition response, either from Australia or deployed overseas. They do this through the key air power roles – control of the air; precision strike; intelligence, surveillance and response; and air mobility – enabled by combat and operational support.

Social phobia – Marked fear or avoidance of being the centre of attention or being in situations where it is possible to behave in a humiliating or embarrassing way, accompanied by anxiety symptoms, as well as either blushing, fear of vomiting, or fear of defecation or micturition.

Specific phobia – Marked fear or avoidance of a specific object or situation such as animals, birds, insects, heights, thunder, flying, small enclosed spaces, sight of blood or injury, injections, dentists, or hospitals, accompanied by anxiety symptoms as described in 'Agoraphobia'.

Stratification – Refers to grouping of outcomes by variables of interest. In *Mental Health Prevalence Report*, 12-month diagnosable mental disorder and self-reported suicidality were stratified by age, sex, rank, service, years of Regular ADF service,

deployment status, transition status, years since transition, reason for transition and DVA client status.

Study roll – Participants' contact details and demographic information were obtained via the creation of a study roll by the Australian Institute of Health and Welfare (AIHW). This process involved integrating contact information from the following sources:

- Defence PMKeyS database
- DVA client databases
- National Death Index
- ComSuper member database
- Military Health Outcomes Program (MilHOP) dataset

Suicidal ideation – Suicidal ideation is defined as serious thoughts about taking one's own life.

Suicidality – The term suicidality covers suicidal ideation (serious thoughts about taking one's own life), suicide plans and suicide attempts.

Subsyndromal disorder – Characterized by or exhibiting symptoms that are not severe enough for diagnosis as a clinically recognized syndrome

Transitioned ADF/ADF members – The term transition(ed) ADF is used to denote military service leavers. For the purpose of the current study, this included all ADF members who transitioned from Regular ADF service between 2010 and 2014, including those who transitioned into the Active and Inactive Reserves.

Transitioned status – Transitioned ADF members were grouped into three groups which broadly represented their level of continued association and contact with Defence as well as their potential access to support services provided within Defence:

- **Ex serving** – individuals who were a Regular ADF member prior to 2010, who have transitioned from the Regular ADF since 2010 and who no longer remain engaged with Defence in a reservist role. These individuals are classified as discharged from Defence;

- **Inactive Reservist** – individuals who were a Regular ADF member prior to 2010 but who have now transitioned into an Inactive Reservist role.

- **Active Reservist** – individuals who were a Regular ADF member prior to 2010 but who have now transitioned into an Active Reservist role

Two-phase design-A well accepted epidemiological approach to the investigation of the prevalence of mental disorders. In the first phase, participants completed a screening questionnaire, which is generally economical in terms of time and resources. Based on the results of this screening and demographic information, certain participants were selected for a more accurate but costly formal diagnostic interview.

Veterans' Health Cards – The health card arrangements are the main way the Department of Veterans' Affairs (DVA), on behalf of the Australian Government, provides convenient access to health and other care services for veterans, war widows and eligible dependents. Arrangements are based on providing access to clinically appropriate and required treatment, which is evidence-based. There are 3 categories of DVA health cards. They include Gold, White and Orange.

Weighting – Weighting allowed for the inference of results for the entire population. This involved the allocation of a representative value or 'weight' to the data for each responder, based on key variables. This weight indicated how many individuals in the entire population were represented by each actual responder. Weighting was applied for the following purposes:

1. to correct for differential non-response

2. to adjust for any systematic biases in the responders (e.g., oversampling of high scorers for CIDI)

White card – DVA health card for specific conditions. A White card entitles the holder to care and treatment for:

- accepted injuries or conditions that are war caused or service related;
- malignant cancer, pulmonary tuberculosis, posttraumatic stress disorder, anxiety and/or depression whether war caused or not; and
- the symptoms of unidentifiable conditions that arise within 15 years of service (other than peacetime service).

Services covered by a White card are the same as those for a Gold card but must be for treatment of war caused or service related accepted conditions.

Years since transition –. For Transitioned ADF only, in order to ascertain the number of years since transition from Regular Service, participants were asked to indicate what year they transitioned to Active Reserves, Inactive/Standby Reserves or discharged out of the Service (Ex-Serving). Options included: 0, 1, 2, 3, 4, 5 years

Years of Regular Service – The following categories were used in the Mental Health and Wellbeing Transition Study to define the number of years of Regular Service: 3 months – 3.9 years, 4-7.9 years, 8-11.9 years, 12-15.9 years, 16-19.9 years, 20+ years

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