Phoenix
AUSTRALIA

Wellness Action Through Checking Health

WATCH Project Report
Command Addendum

Acknowledgements

Phoenix Australia acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of Country throughout Australia and pays respect to all Elders, past and present. We acknowledge the continuing connection of Aboriginal and Torres Strait Islander peoples to land, water and communities – places of age-old ceremonies, of celebration and renewal – and their unique contribution in the life of these lands. We are committed to fostering an environment in which the relationship between Aboriginal and Torres Strait Islander peoples and their fellow Australians is characterised by a deep mutual respect, leading to positive change in our nation's culture and capacity.

We would like to acknowledge Joint Health Command and the Department of Defence for funding the WATCH Project. We recognise the Uniformed Supervisors who volunteered their time to help us better understand health behaviours in members of the Australian Defence Force. The WATCH Project was conducted in collaboration with the Department of Defence.

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Citation

Dell, L., Madden, K. & Sbisa, A. (2022). Wellness Action Through Checking Health: WATCH Project Report – Command Addendum. Report prepared for Department of Defence. Melbourne: Phoenix Australia – Centre for Posttraumatic Mental Health.

Disclaimer

This report is based on qualitative research and the results may therefore not truly reflect the whole Defence workforce population. Numerical data presented in this report is solely based on frequency and does not indicate statistical significance. The views and recommendations stated in this report are solely those of Phoenix Australia and do not reflect those of the Department of Defence or the Australian Government.

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Chapter 1
Introduction

Brief overview of the WATCH Project

Phoenix Australia has partnered with the Department of Defence (Defence) to undertake the Wellness Action Through Checking Health (WATCH) Project. The WATCH Project is a multi-component project that broadly aims to increase understanding of subthreshold symptoms in current serving Australian Defence Force (ADF) members. The first component of the project involved conducting interviews and focus groups with Health Service Providers (HSPs) and current serving ADF members. Focus groups were conducted with family members of current serving ADF members in the second component of the project. Findings from these components of the WATCH Project indicated that Defence members with staff under their command may be well placed to help identify early changes in members' mental health. Thus, the scope of the WATCH Project was expanded to include interviews with Uniformed Supervisors who have ADF members under their command. 'The WATCH Report' and 'The WATCH Report – Families Addendum' are available separate to this addendum. The WATCH Report (main report) includes detailed information on the design and scope of the study (Dell, Madden, Jones, & Sbisa, 2021).

Ultimately, the WATCH Project aims to uncover ways in which Defence health processes can be bolstered to better manage ADF members experiencing changes in their mental health and how Defence can better support ADF members in managing their mental health. Better management of these subthreshold symptoms may contribute to reducing progression to full-threshold mental health diagnoses within ADF members and improve outcomes in work, home and social life.

Overview of the literature

The risk of developing diagnosable mental health disorders in former and current serving military personnel is well established (Bergman, Mackay, Smith & Pell, 2016). While evidence-based treatments for diagnosed disorders such as posttraumatic stress disorder (PTSD), depression and anxiety exist, an emerging body of research suggests that subthreshold symptoms of mental health disorders may also warrant intervention due to their similarly detrimental impacts on individuals' functioning and wellbeing (Judd et al., 1996; Karsten et al., 2013; Marshall et al., 2001; Pietrzak et al., 2009). Results of the Longitudinal ADF Study Evaluating Resilience (LASER-Resilience): Patterns and Predictors of Wellbeing study and the Transition and Wellbeing Research Programme (the Programme) suggest that there is a considerable proportion of ADF members who may be experiencing subthreshold symptoms of mental health problems. For example, up to 31% of current serving ADF members were found to be experiencing subthreshold symptoms of distress (Dell et al., 2019), and once transitioned, subthreshold symptoms increased. Further, 34% of transitioned members have reportedly experienced subthreshold symptoms of depression (Bryant et al., 2019).

Although less severe than symptoms of clinically diagnosable disorders, subthreshold symptoms are associated with a range of negative outcomes for military personnel (Garber et al., 2012; Sampasa-Kanyinga et al., 2018). In addition, several research studies have associated subthreshold symptoms of PTSD with symptoms of depression and suicidal ideation (Cukor et al., 2010; Marshall et al., 2001), increased alcohol use (Adams et al., 2006), anger and aggression (Jakupcak et al., 2007), work-loss days and increased healthcare use (Breslau et al., 2004).

The findings of the LASER-Resilience study and the Programme suggested that there is a considerable proportion of ADF members experiencing symptoms of mental health problems that are not severe enough to meet clinical or diagnostic criteria but may be at a level that is causing the individual a level of distress or concern. As the experience of subthreshold symptoms is associated with a high level of impairment, ADF members who are experiencing such symptoms must be routinely identified, monitored and supported.

When mental health symptoms are at early low levels, members are less likely to seek support independently, and research has shown that even when symptoms become severe, help-seeking behaviour is still relatively low. Several studies explored this phenomenon and have reported that there are barriers to help-seeking and access to care for military personnel: adverse beliefs about mental health treatment (e.g., distrust in the military healthcare system) (Fikretoglu et al., 2008; H. Zinzow et al., 2012); anticipated stigma from admitting psychological problems (e.g., being perceived as 'weak', being treated differently by unit leadership) (Sharp et al., 2015; H. Zinzow et al., 2012); self-stigma (e.g., where the individual with the condition internalises stereotypical negative attitudes about mental illness and help-seeking) (Blais & Renshaw, 2013); and practical or logistical barriers to accessing care (e.g., demanding work schedules, inability to get time off work, reduced deployability) (McFarlane, 2017; Ramchand, Rudavsky, Grant, Tanielian & Jaycox, 2015).

International research

In a comparative analysis study of North Atlantic Treaty Organisation (NATO) and allied International Security Assistance (ISAF) partners, all participants agreed that a comprehensive approach to mental health training across the deployment life cycle and integrated into operational practices is essential to ensure that mental health 'fitness', like physical fitness, becomes part of daily military operations. The NATO and allied ISAF partners reported that leaders had a primary role of ensuring that members know how to access support during operations and promoting a culture where members are encouraged to access support and give support to colleagues (Vermetten et al., 2014).

Similarly, in a qualitative study of US military personnel, participants reported that positive messaging around help-seeking from senior-level leadership was important to add credibility to messaging (Clark-Hitt et al., 2012). Hearing high-ranking officers describe their experiences with seeking help for early symptoms of PTSD was reported as highly persuasive for members of all ranks. Additionally, participants expressed an added encouragement when help-seeking messaging came from individuals a member respects, such as members they regard as 'warriors' (Clark-Hitt et al., 2012).

The results of a study of 2678 deploying US soldiers reinforced the importance of leadership support for help-seeking. 47% of participants felt

that reminders from their direct supervisors regarding the importance of seeking care would facilitate greater help-seeking, and 46% agreed that communication from senior leadership regarding help-seeking not harming their military career would encourage them to seek help (Warner, Appenzeller, Mullen, Warner & Grieger, 2008). The most frequently reported barrier to help-seeking identified by participants was concern that leadership may treat them differently, followed by difficulties regarding time permitted from work.

In another qualitative study, active duty US Army leaders and junior enlisted personnel reported that leaders often perceive members seeking mental health treatment as 'slackers' or malingerers (Zinzow et al., 2013). Members reported that they had difficulty trusting their leaders enough to go to them with mental health problems, thought leaders were too busy to be supportive and were concerned about a lack of confidentiality. Additionally, leaders themselves reported that they were sometimes unclear about treatment ramifications, such as the amount of time off the member would need to take or what duties they could and could not assign to the member (Zinzow et al., 2013). In line with these leadership-related barriers to help-seeking, once again, themes of supportive leadership were frequently reported as facilitators to help-seeking, including identification of problems by leadership, role modelling of help-seeking by leaders and leadership approval of help-seeking (Zinzow et al., 2013). Interestingly, those in leadership positions were more likely than junior members to report low mental health literacy (e.g., lack of information about how, when and where to get treatment) and a belief that nothing is wrong (e.g., 'I can deal with it on my own', 'I've been through worse') (Zinzow et al., 2013).

Taken together, these research findings suggest that Command have the potential to be more effective at recognising the signs of early mental health symptoms compared to other strategies, such as post-deployment screening. Education targeted to Command may help those in leadership roles more easily identify early symptoms, understand how to support the member, and assess and manage the workforce implications, which may encourage earlier help-seeking and greater support uptake by members to deal with the emergence of mental health symptoms.

A final note

It is important to acknowledge that ADF members are likely to experience various responses to potentially stressful events, such as training, transitions, deployments and postings, and that within this range, there is a 'normal' or anticipated response. This project's focus is understanding a more pervasive response that has begun to impact an individual's ability to function optimally and is sustained beyond what would be considered a reasonable time after exposure to a stressful event. The research questions and interview questions are intended to be taken in this context, that is, subthreshold symptoms of mental health disorders that are not explained by a 'normal' response to stressful events.

The further expansion of the WATCH project to include Uniformed Supervisors with ADF members under their command (herein referred to as Command) is the final component of the WATCH Project. Taken together, the Health Service Provider (HSP), current serving members, families of current serving members and Command components provide a holistic overview of several perspectives. Findings from each component of the WATCH Project are available as separate reports.

Aims

This component of the WATCH Project aims to understand the perspectives of Command, identify their capability to recognise and support members experiencing emerging mental health symptoms, and determine optimal ways to identify and manage subthreshold symptoms in ADF personnel. Four research questions were formulated to address this aim:

1. What are the early behaviours that Command observe when ADF members are having challenges with their mental health?
2. What actions do Command take if they notice ADF members experiencing these challenges?
3. What resources are Command aware of for members experiencing subthreshold symptoms and which do they recommend to members?
4. What barriers do Command personnel experience when trying to support members experiencing early changes in their mental health? What are the enablers?

Chapter 2
Method

Design

A qualitative research design was used throughout all components of the WATCH Project. Qualitative data was collected through audio recorded interviews with Command (*n* = 28). Demographic information was collected via an online survey.

An inductive approach was taken during data analysis, whereby thematic analysis methodology was used (Braun & Clarke, 2006). Specifically, the following steps were taken: 1) the WATCH project team member familiarised themselves with the data by reading through transcripts; 2) initial descriptive codes were generated for commonly reported responses, and data were categorised to each code; 3) codes were grouped based on similarity of concepts to produce themes; 4) themes were discussed with a second and third member of the project team for oversight; 5) themes were refined, defined and named. Themes were continuously contrasted against initial codes throughout the thematic analysis process to ensure they accurately represented the data.

Participants

The Command component of the WATCH Project recruited Uniformed Supervisors with ADF members under their command. It was important to be able to determine the impact that length of time in a Command role had on the study outcomes; therefore, participants were asked to self-identify as either junior-, middle- or senior-level Command. These categories were developed during the co-design phase of the project and were meaningful to those participating. Rank options included:

Commissioned Officer ranks:

- FLGOFF, LEUT and below
- all Commissioned Officer ranks between
- SQLDR, CAPT (Navy), LTCOL and above

Non-Commissioned Officer ranks:

- LS, CPL and below
- all Non-Commissioned Officer ranks between
- WOFF, WO, WO1

Inclusion criteria for Command are outlined in Figure 1.

Inclusion

- A Uniformed Supervisor with ADF members under your Command
- Aged over 18
- A permanent member of the ADF (current SERCAT 6 or 7)

COMMAND

Figure 1. Inclusion criteria for Command

An important note

It should be noted that the Command personnel who elected to participate in the WATCH Project were more likely to be engaged with, and have an interest in, mental health within the ADF. Thus, the perceptions presented in this report may not be generalisable to all Command and outcomes should be considered with this in mind.

Procedure

Ethics approval

An application for quality assurance and evaluation activity was submitted to the Departments of Defence and Veterans' Affairs Human Research Ethics Committee to expand the recruitment of the WATCH Project to include Command. Ethics approval was granted on 8 February 2022 (protocol number 402-21).

Recruitment

Command from across Australia were recruited via the means listed in Figure 2. Interested participants were directed to an electronic REDCap expression of interest survey.

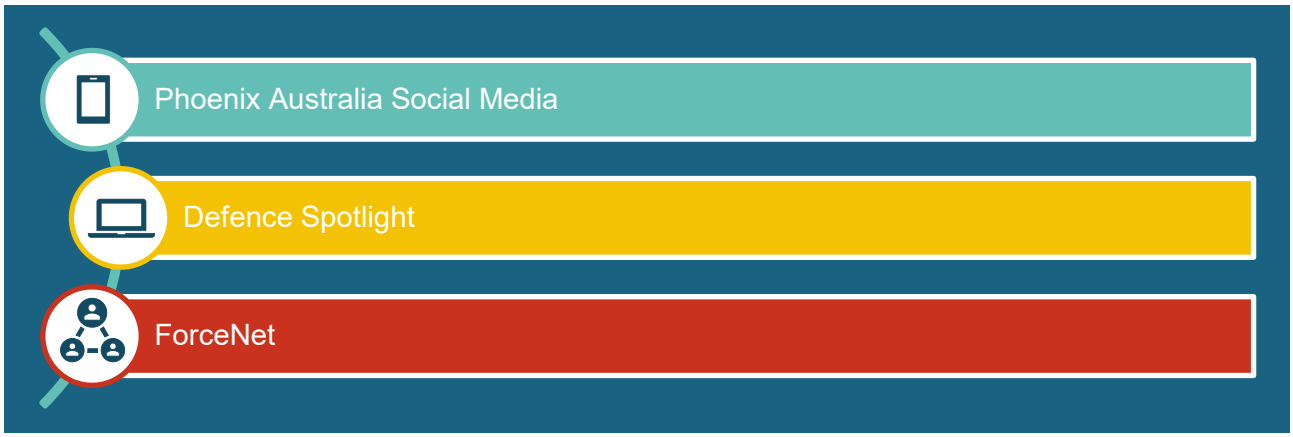


Figure 2. Command recruitment channels

Data collection

Internal Defence communication via Spotlight, ForceNet and emails directed interested Command personnel to the WATCH Project – Command landing page, which contained a link to the expression of interest survey, delivered through the REDCap online survey platform. The expression of interest survey collected basic demographic (e.g., gender, age), service (e.g., length of service, rank, perceived level of leadership) and contact information. Interested participants were contacted to arrange a one-on-one interview via Zoom or Microsoft Teams (see Figure 3 for Command recruitment process). Interviews with Command lasted up to 30 minutes and were audio recorded. Transcripts produced by Zoom or Microsoft Teams supported the data analysis.

Data

Perceived level of leadership was used to group participants as junior, middle, or senior leaders. The final dataset included transcripts of 28 interviews with Command (see Figure 4). Analysis of demographic information was used to identify sample characteristics.

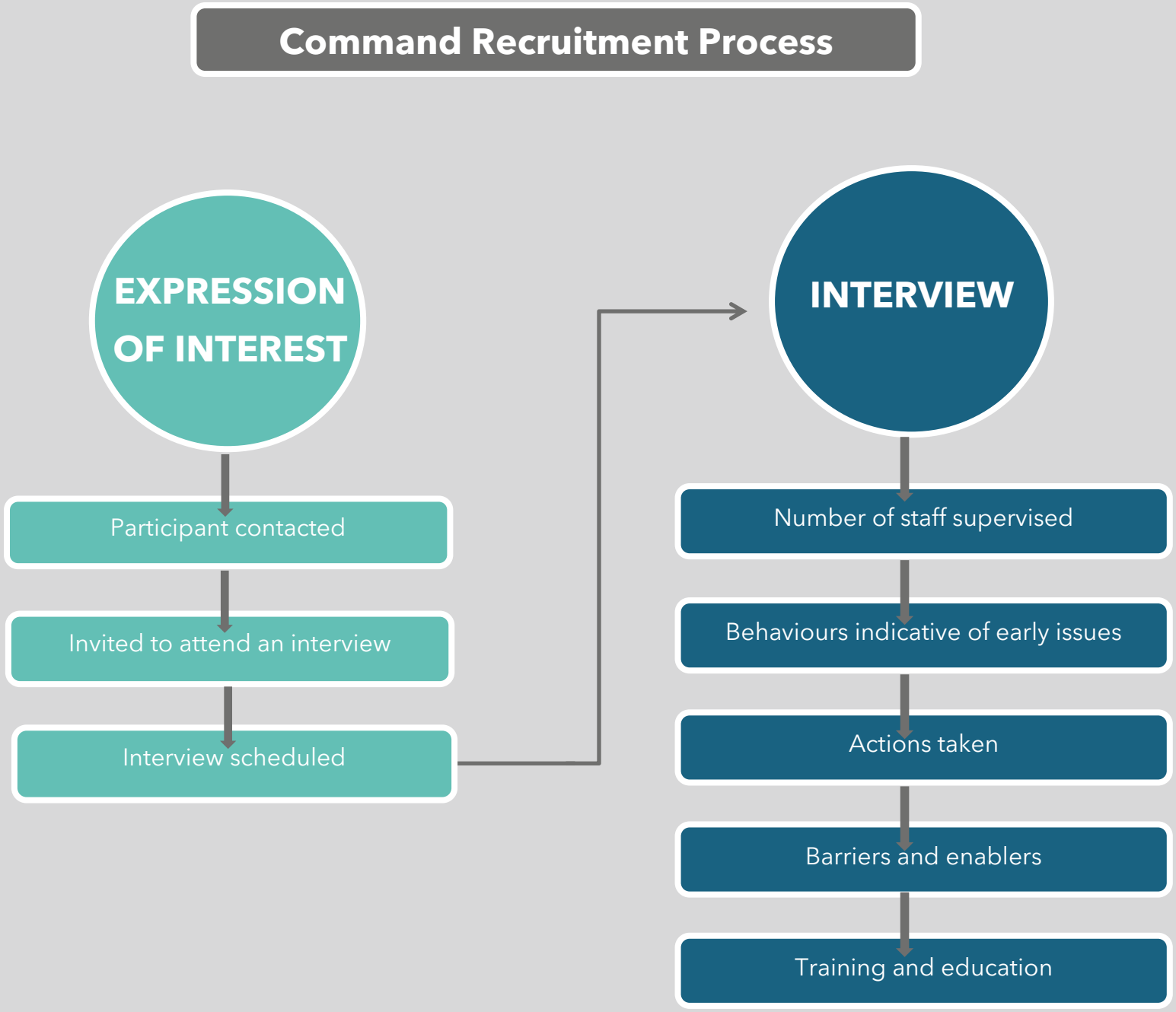


Figure 3. Command recruitment process

Command Interview Questions

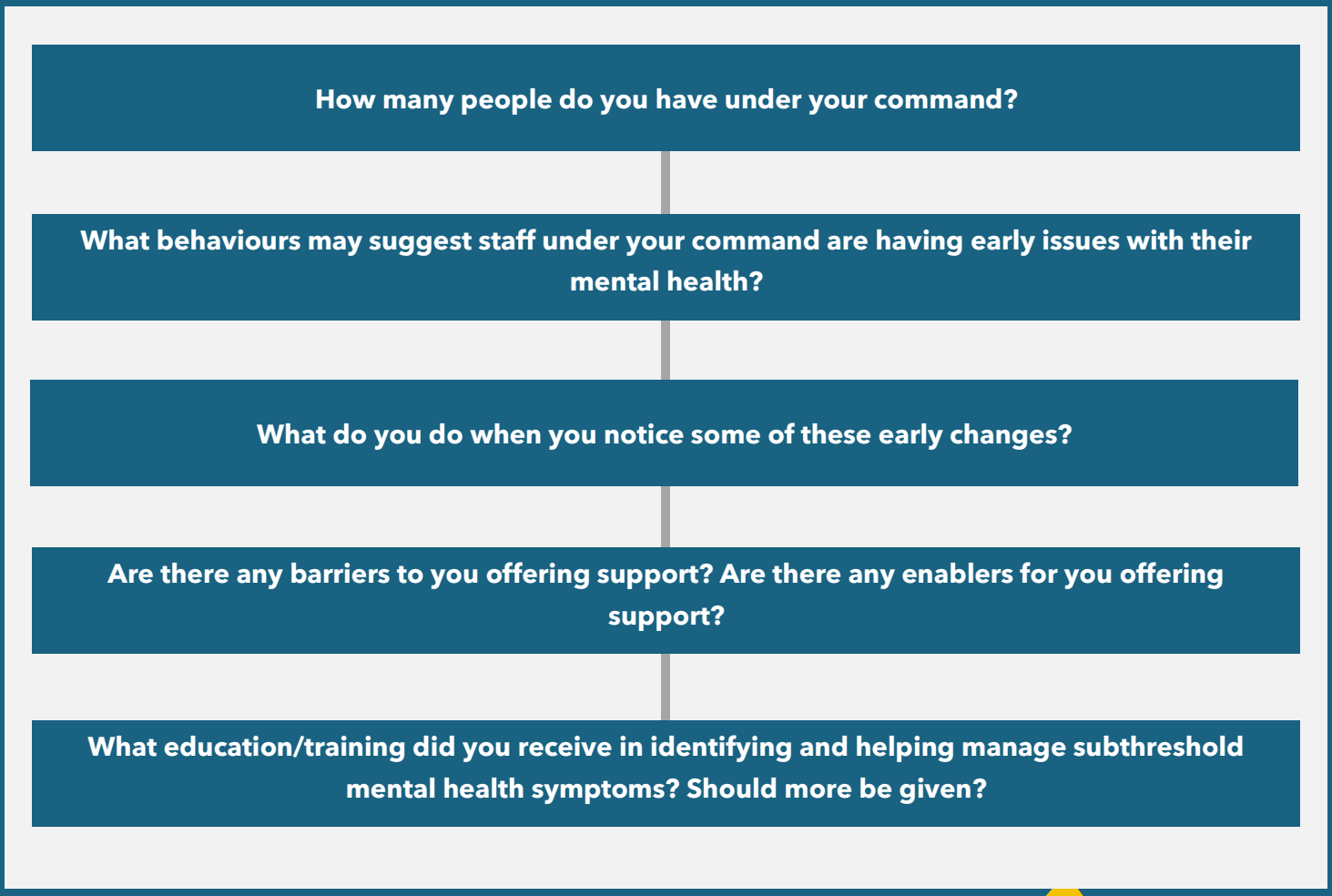


Figure 4. Command interview questions

How to read this report

This report includes several graphics and visual prompts to improve readability. The following information has been provided to assist with orienting the reader to the style of this report.

Tree plots are used throughout the report to visually endorse themes that emerged from the focus groups/interviews (see Figure 5). The size of the boxes within the tree plots corresponds to the proportion of participants who endorsed each theme (e.g., the number of participants who mentioned a specific barrier).

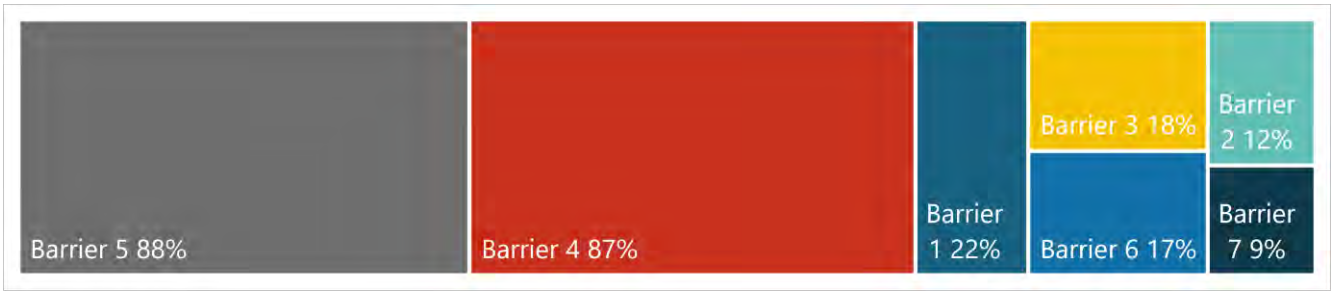


Figure 5. Example tree plot – mock data

As participants could mention more than one theme in response to a question, the data in these plots do not always total 100%. These plots are descriptive only and do not represent a statistical test of differences between responses.

Quotes from participants

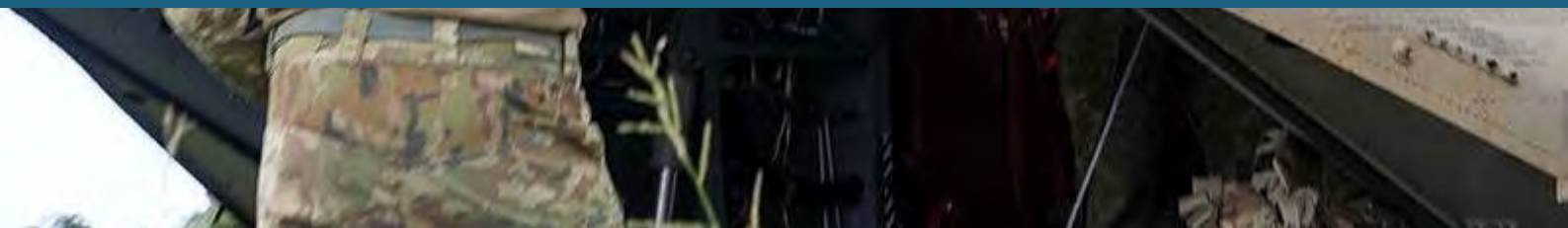
"Quotes presented like this."

Disclaimer: quotes in this report solely reflect the views and opinions of those who participated. Individuals who have an interest in, or personal experience with, mental health challenges may have been more likely to participate, which may introduce selection bias.

Interview questions

Interview questions are presented in boxes like this.

Chapter 3
Command outcomes

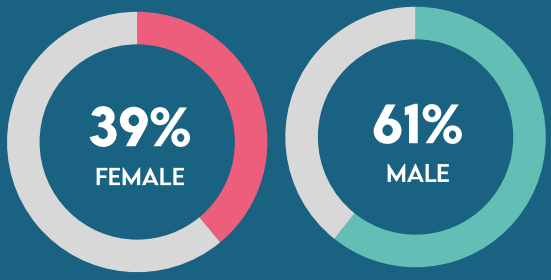


Phoenix AUSTRALIA

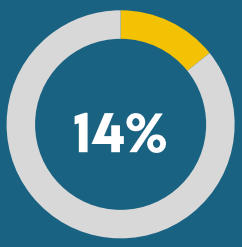
COMMAND DEMOGRAPHICS

9 JUNIOR-, 11 MIDDLE- AND 8 SENIOR-LEVEL COMMAND WERE RECRUITED.

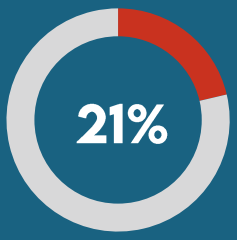
36% NAVY
32% AIR FORCE
32% ARMY



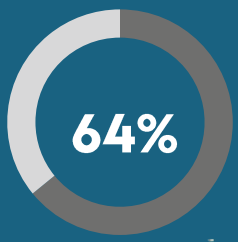
LENGTH OF SERVICE



LESS THAN 8 YEARS

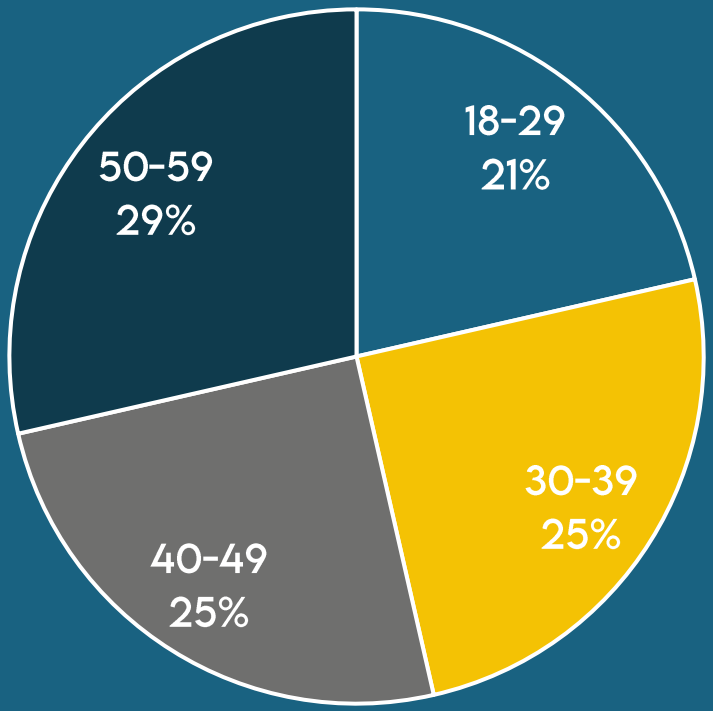


8 TO 15 YEARS



16+ YEARS

AGES



Leadership level

Leadership was self-determined by asking Command, "Do you consider yourself junior (see Figure 6), middle (see Figure 7), or senior leadership (see Figure 8)?" The categories for the levels of leadership (junior, middle and senior) were selected through consultation with the Defence project team and confirmed with representatives from each of the services to be appropriate and meaningful categories. However, it is important to note that the level of leadership that individuals self-selected may not precisely align with the Defence leadership structure.

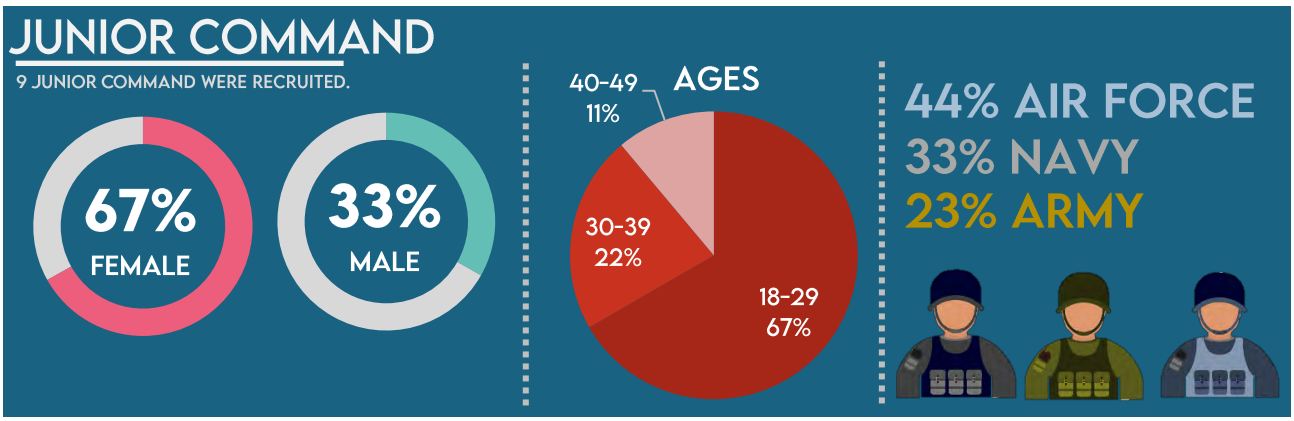


Figure 6. Junior-level Command demographics

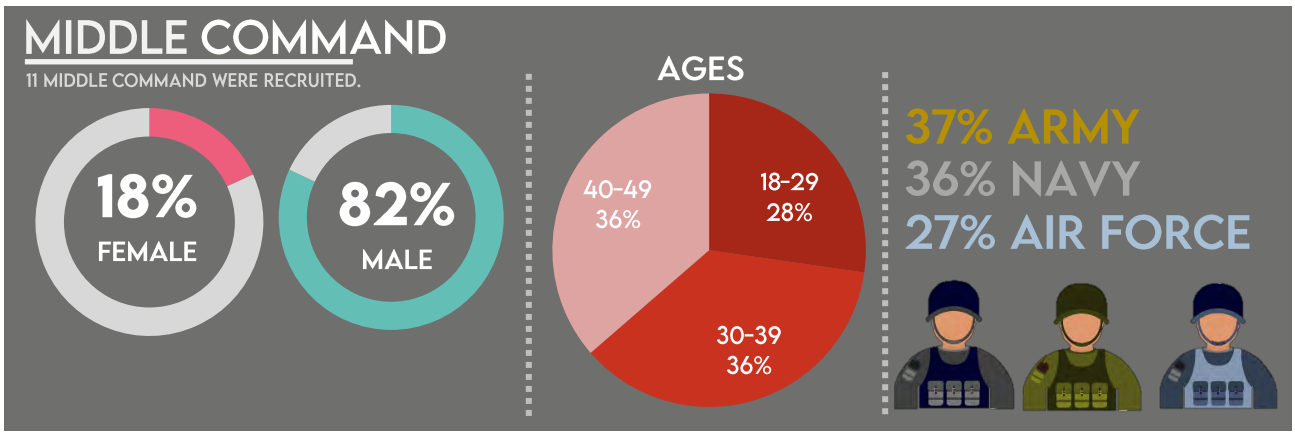


Figure 7. Middle-level Command demographics

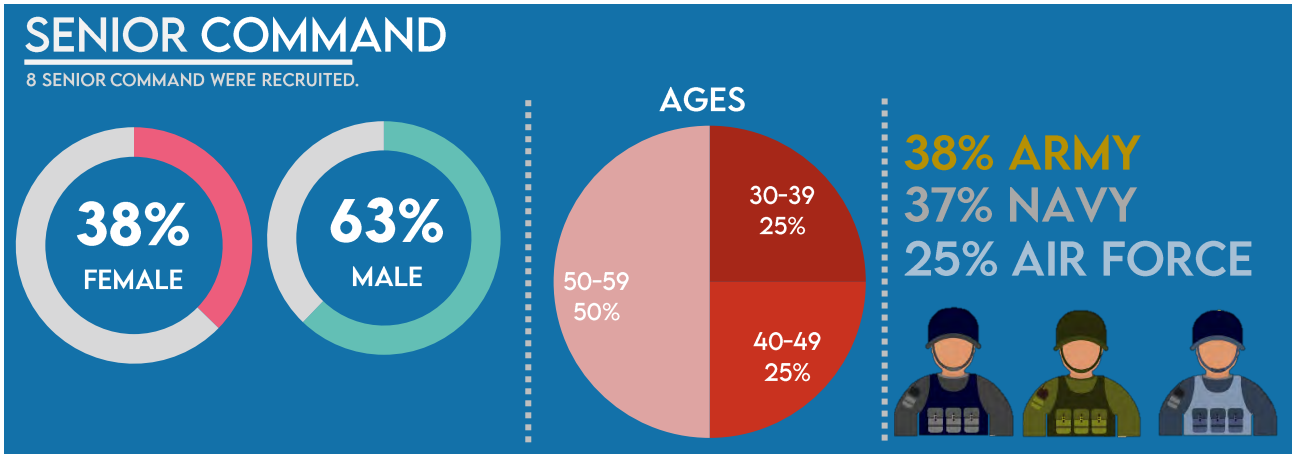


Figure 8. Senior-level Command demographics

Results

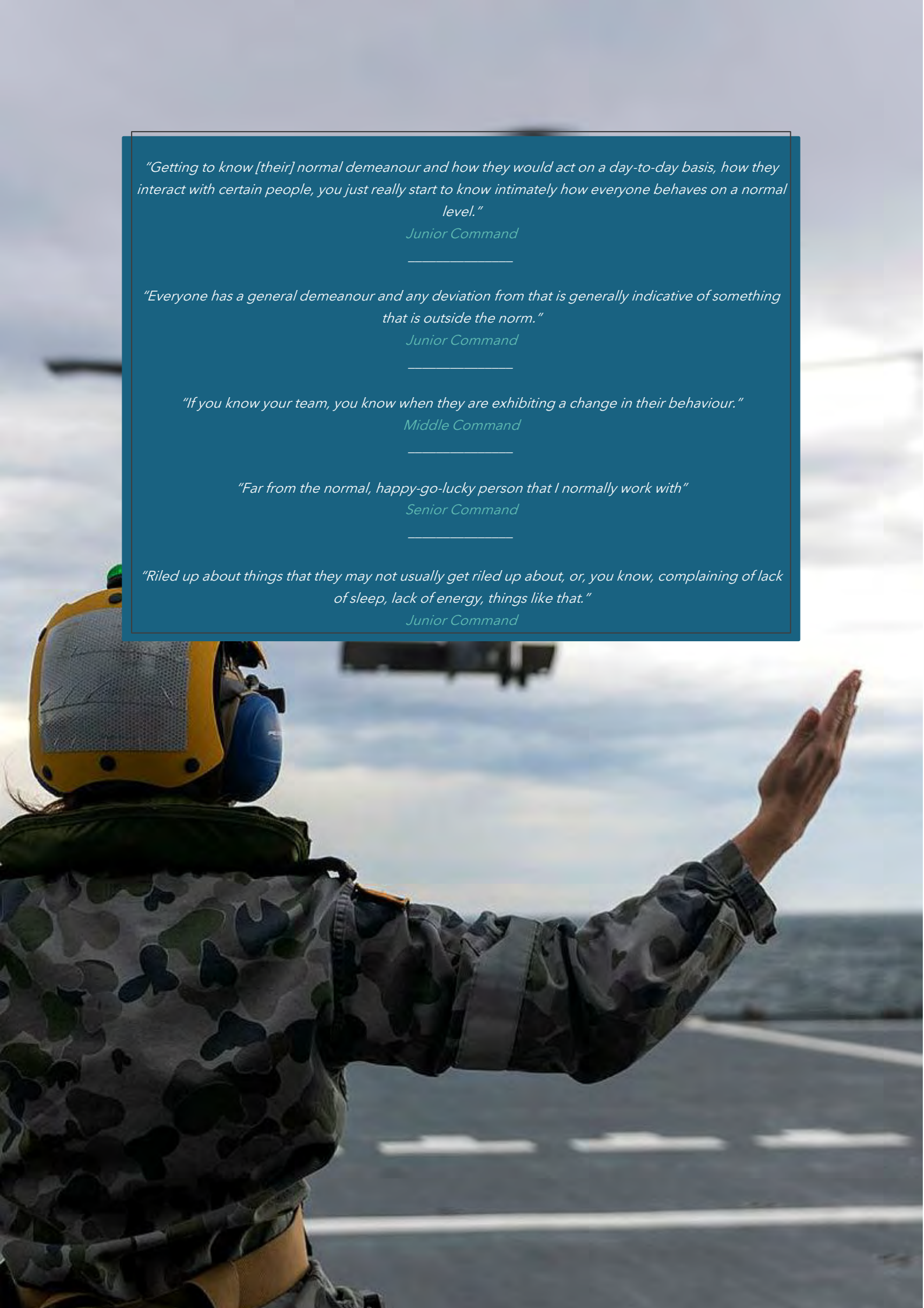
Early indicators

What behaviours may suggest staff under your command are having early issues with their mental health?

Command personnel identified several behaviours that they felt represented early changes in mental health for those under their command (see Figure 9). Seeming different from one's usual self (82%) was the most consistently reported early indicator across all levels of Command. This included noticing a "behaviour change", noticing their member speaking differently or less than usual, changing mood, getting a feeling that "something is not right", and observing a change in appearance or personality. Withdrawal (54%) was also commonly reported as an early indicator, and included noticing members "don't want to get involved" in activities they would usually enjoy, "not engaging", "distancing themselves", and not engaging in conversation by having "monosyllabic responses".

While those with less experience in a position of Command recognised irritability as an indicator (44% junior; 27% middle), such as "being quick to anger", "lashing out a little bit more than usual", being "more agitated" or "snappy", more experienced Command personnel noticed performance-based indicators, such as reduced work performance (36% middle; 38% senior) and increased absenteeism (38% senior). This was reported as "turning up late", having "frequent absences from work", "not contributing as they normally would", having a "dip in performance", "lack of motivation", or their work being "not at a standard that it usually is". Some Command also experienced members either complaining of lack of sleep or noticed members appearing tired (33% junior; 38% senior). For example, being "very tired at work" or telling their Command that they are "not sleeping".

Figure 9. Early indicators of mental health challenges



"Getting to know [their] normal demeanour and how they would act on a day-to-day basis, how they interact with certain people, you just really start to know intimately how everyone behaves on a normal level."

Junior Command

"Everyone has a general demeanour and any deviation from that is generally indicative of something that is outside the norm."

Junior Command

"If you know your team, you know when they are exhibiting a change in their behaviour."

Middle Command

"Far from the normal, happy-go-lucky person that I normally work with"

Senior Command

"Riled up about things that they may not usually get riled up about, or, you know, complaining of lack of sleep, lack of energy, things like that."

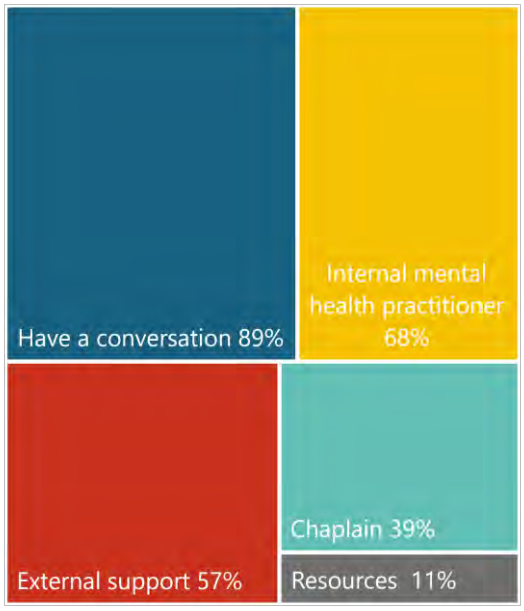
Junior Command

Offering support

What do you do when you notice some of these early changes? Do members proactively approach you? How has this gone in the past when you have offered support?

Upon recognising early indicators (see Figure 10) and suspecting that a member may be having some challenges with their mental health, Command personnel were most likely to approach the member and start a conversation (89%) by asking questions such as "are you okay?", "how are you doing?" and/or "do you want to have a chat?" Command often emphasised that they would take steps to ensure the conversation was private and that the member felt safe. For example, ensuring they approach the member "in a private location away from the rest of the team", inviting the member to chat "in a discreet way", waiting until the member is "in a relaxed environment", or asking the member to "go for coffee and getting them out of the workplace". All levels of Command had experienced members proactively approaching them about the early changes they were experiencing in their mental health (50%). When members did approach Command, the members were commonly open about what was happening in their lives (95%), with fewer members being "reluctant" to share too much information or acting "closed off" (30%). Under a quarter (21%) of Command believed that having other Command share experiences more often would encourage members to come forward and seek support earlier.

All levels of Command used a variety of resources (82%) to support members under their command, including mental health practitioners (MHPs; 68%) such as psychologists, mental health nurses, or medical officers, as well as external providers (57%) such as Open Arms, Mates4Mates and Beyond Blue. Junior- and middle-level Command reported that they would recommend members see a chaplain (67% junior; 36% middle), whereas senior-level Command did not mention referring members to chaplains. Other Command personnel reported using resources such as the "leaders toolkit" and "Fighting Fit".



"I would approach them and have a really honest, genuine conversation with them in regards to how they're feeling, their mental health and what's going on in their life."
Junior Command

"We've got our mental health providers in all our health facilities.
Senior Command

"Open Arms or Beyond Blue, some of the, I guess, just more general civilian organisations, though some of them are pretty well aligned to support Defence members."
Middle Command

Figure 10. Supports offered to members exhibiting early signs of mental health challenges

"I just try and pull them aside, personally I try and create that safe space for people as well, so that they can come and talk, and a lot of them do seek me out. I've had a couple where I asked them and they go 'yeah, yeah, I'm fine' and then they'll come and find me later and go 'oh, actually, I'm not okay'."

Junior Command

"I try to take anyone that I think [is struggling] away from the work environment. I don't wear a uniform to try and put it in the most relaxed atmosphere for them and just sit down and have a coffee and chat and ask them about what's going on."

Middle Command

"It's a pretty close-knit team. Usually it's just a matter of asking if they're okay. It doesn't usually take much more than that. If someone's pretty stressed out, they just wanna have a chat or, you know, sometimes it goes to the point of closing the door and bringing them in. But usually it's just a quick chat and you know they keep going."

Senior Command

Barriers

Are there any barriers to you offering support?

Command personnel identified several barriers to offering support to those under their command (see Figure 11), with the most commonly reported barrier being stigma, that is, member behaviour due to their beliefs about seeking help for mental health problems (54%). This included stigma from the way individuals talk about those experiencing challenges with mental health, such as "there's nothing wrong with him", as well as self-stigma, whereby individuals think they are weak if they take a sick day or that it is commendable to have never had a sick day. Command also mentioned machoism, toughness and a macho bravado as common attitudes among members that contribute to mental health stigma. It was noted that attitudes towards mental health continue to improve among members, such that stigma is "progressively being whittled away" (18%).

Just under one-third of all Command felt that limited resources (29%) was a barrier to offering support. This primarily referred to their teams being "stretched very thin" and feeling "understaffed", which could potentially be exacerbated when people take time off to seek support, and the capacity of MHPs (specifically their wait times).

Command also perceived that some members have a fear that seeking help may impact their career (25%), which included "career stalling or career termination", being "medically downgraded", or "discharged from the military".

"Some feel that [if you] take sick leave, there's a weakness and I've heard colleagues say, 'I've never taken a sick day', and that's a, you know, a badge of honour."
Junior Command

"Mental health professionals reside within Garrison Health Centres and that sort of thing. I just wonder, do we, as an organisation, have ready enough access to those people? Are there enough of them?"
Middle Command

"I think there's this stigma from a military perspective that you're worried it's going to impact on your career. You know, [seeking help] might mean I can't go on deployment, it might mean I'll lose my security clearance."
Senior Command

"It's all about that culture shift, which I really feel like, I know, I've seen it in in my career, it gets better every year."
Senior Command

Figure 11. Reported barriers

Enablers

Are there any enablers for you offering support?

Over two-thirds of Command personnel (71%) believed rapport was vital for offering support, facilitating members approaching Command for help and identifying early signs of mental health challenges (see Figure 12). This was reported as having a "really good working relationship" with personnel, getting to "know people on a more personal level", working to "build up a relationship with members", being a "good listener", making an effort to "talk to the guys" and having "a real connection to your people".

Just over one-third of Command reported that knowing a member's baseline of wellbeing (36%) helps them recognise when members are different from their usual selves. As well as getting to know members while developing rapport, Command personnel use many strategies to understand members' baseline. These include the "Platoon Commander's interview", "making the time" to get to know members and taking "notes" on members' "usual demeanour" and "keeping [the notes] private".

Having strong leadership skills (29%) was identified as another enabler to offering support, which included empathy, emotional intelligence, having an "open door policy", being a good listener and "social mastery". Middle Command emphasised leadership skills more than other levels.

"I've sort of managed to get that really good working relationship where I can, you know, either give them less duties that aren't as taxing, or [say] 'let's just take it a little bit easier today'."

Junior Command

"If you've got the emotional intelligence to look at a situation, stand back and kind of see it from other people's perspectives, then you can pick up what's happening and what needs to occur to help that individual."

Middle Command

"Sometimes you can't pick up some of the behaviours within the workplace unless you've got a real connection to your people. As a Commander, if you don't have that professional relationship, it is sometimes hard to pick up signs."

Senior Command

"I'm a very good listener, very good talker and [I have a] very, very good relationship with most people in my work community, so they feel comfortable talking to me. That might be different if I was a different type of leader or Commander."

Senior Command

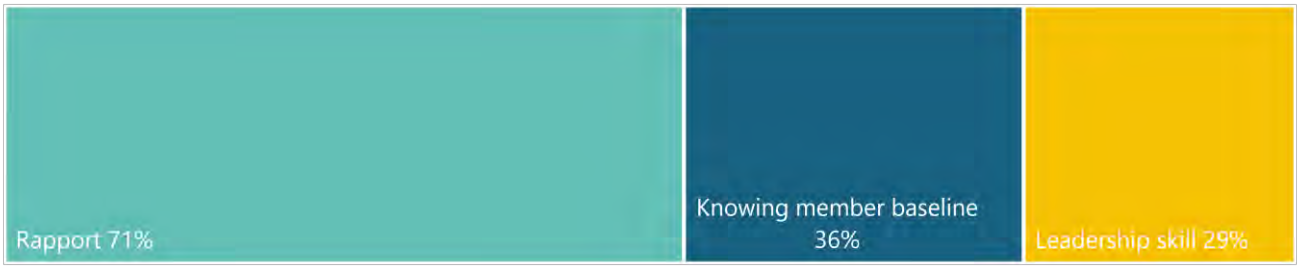


Figure 12. Reported enablers

Training and Education

What education/training did you receive in identifying and helping manage subthreshold mental health symptoms? Should more be given?

Internally run Defence training was the most commonly reported source of education for mental health across all levels of Command (81%). This included the Applied Suicide Intervention Skills Training program; Critical Incident Mental Health Support course; Alcohol, Tobacco and Other Drugs Program; Keep Your Mates Safe program; BattleSMART (Self-Management and Resilience Training) training; and other general leadership programs. Just under one-third of Command had undertaken Mental Health First Aid (30%), which was sometimes recommended for them to do as part of their role and other times completed as a non-mandatory training. Fewer Command had completed other external or tertiary training (26%) in mental health, such as undergraduate or postgraduate training (Diploma through to PhD level) or courses offered by Full Stop Australia and Lifeline (see Figure 13).

"What I would like to see in that training is a real focus on not just the mental health side, but the practical skills and the application of empathy, of critical thinking, of actually removing your own views from a situation."
Junior Command

"I think [training] should be more [about] those little red flags, a little bit more in depth and 'if you see this, this is what we need to do – these are your steps [to follow]'."
Middle Command

"I went through my own mental health struggles and I feel that I've got more of an awareness. Whether that just comes naturally as such, or whether I just can pick up the telltale signs a little bit easier."
Senior Command

Under half of Command reported that their own lived experience (44%) was an important source of education for learning to recognise early indicators, understanding the process of seeking help from a MHP and having greater empathy. Command reported drawing on their personal experience with mental health challenges and experiences with colleagues or family, such as a spouse, going through challenging periods. Junior- and middle-level Command were most likely to draw on lived experience.

Over two-thirds (67%) of members across all levels of Command believed there was a need for further training to be introduced and that there is a capacity for such training. Skills-based training (37%) was the most reported training type that Command thought would be useful. This was described as training on "how you actually look after your people"; practical skills that give "the tools to handle these sorts of issues"; training that presents a situation and then asks, "how would you react?"; and learning to identify "red flags" in members.

Figure 13. Reported sources of education

Chapter 4

Addressing the research questions

Research Question 1: What are the early behaviours that Command observe when ADF members are having challenges with their mental health?

Command personnel recognise several early indicators that suggest members under their command may be experiencing mental health challenges. Above all else, Command personnel recognised a change from an individual's usual wellbeing baseline, such as a change in personality, usual demeanour, appearance, or seeming different from their usual self. Other signs recognised by Command were withdrawal, reduced work performance, increased absenteeism, irritability and lack of sleep (reported by members themselves or by Command noticing members appearing tired at work). Some differences emerged between levels of Command regarding what they most commonly noticed. For example, irritability was recognised by junior- and middle-level Command, whereas junior- and senior-level Command recognised lack of sleep more often. Reduced work performance was more likely to be noticed by middle- and senior-level Command.

Research Question 2: What actions do Command take if they notice ADF members experiencing these challenges?

The data indicated that Command are quick to initiate conversations when they recognise early signs that members may be struggling. Command personnel emphasised the importance of privacy so that members feel safe to open up about the challenges they are experiencing. Most Command had experiences with members proactively approaching them for support and reported that these conversations often went well, with members being candid about the challenges they were facing. There were some instances where members were reluctant to share information when they were approached, though this was the exception rather than the norm.

Research Questions 3: What resources are Command aware of for members experiencing subthreshold symptoms and which do they recommend to members?

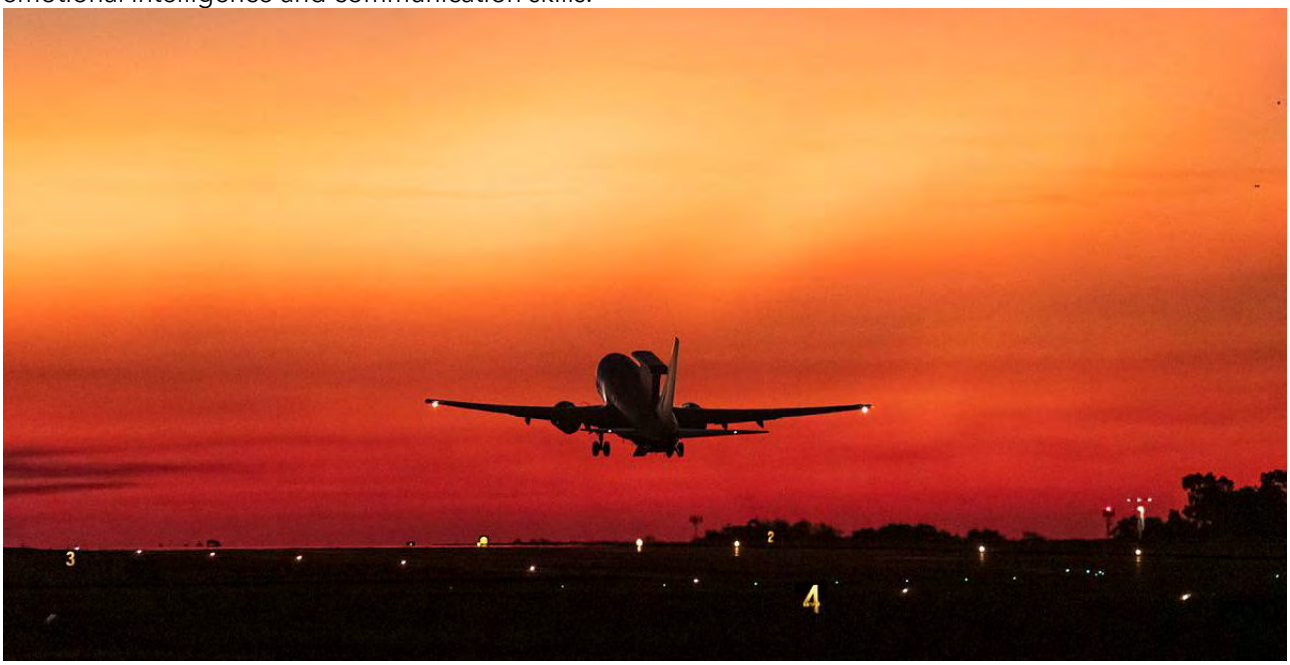
Command personnel are aware of and use several resources when supporting members experiencing subthreshold symptoms. Resources and supports used included recommending members seek support from internal mental health supports (e.g., medical officers and psychologists) and external supports (e.g., Open Arms). Few Command personnel reported using non-service resources, such as the leader's toolkit, which suggests Command could benefit from reminders that such resources exist and are helpful resources to refer to when supporting members. One small difference between the levels of Command was that junior

and middle Command also referred members to chaplains, whereas senior Command did not mention referring members to chaplains.

Research Question 4: What barriers do Command personnel experience when trying to support members experiencing early changes in their mental health? What are the enablers?

Stigma was a common barrier reported by Command across all levels and included broad stigma and self-stigma, which impacts the extent to which members are open to speaking about mental health and seeking support. Command also reported that members' fear of the impact on their career is a barrier that hinders members from seeking help or opening up about challenges they may be facing. Limited resources (time and capacity) among Command and MHPs was perceived as a barrier to offering support. Using learnings from Defence mental health training and lived experience was identified as useful for all levels of Command. Indeed, it was felt that more training could further reduce barriers by equipping Command personnel with the skills to identify subthreshold symptoms and knowledge on how to approach such situations.

Command personnel focussed more on enablers to support members under their command than barriers. Developing and maintaining rapport with members was identified as critical to offering support, facilitating members approaching Command for help, and picking up on early signs of mental health challenges. By developing rapport, Command personnel understand members' wellbeing baseline, which helps facilitate identifying a change from their baseline. Having leadership skills, while most identified among middle-level Command, was another important factor for recognising subthreshold symptoms among members and supporting those experiencing early symptoms. The most important leadership skills included empathy, emotional intelligence and communication skills.



Chapter 5
Implications

This chapter outlines the key implications of the Command component of the WATCH Project. The following implications represent the opinions of the authors of this addendum and have been developed based on the data and consultation with key stakeholders within Defence. Prior to considering implementation, further stakeholder liaison should be undertaken by Defence to establish practical and realistic ways in which these can occur.

Boosting Command's knowledge of the support options for members

Most Command personnel could identify early indicators of mental health change among members and, upon recognising these early indicators, were quick to initiate conversation with members. While Command personnel identified several resources they refer members to when members are experiencing these changes, increasing Command's knowledge of information and resources to support members would be beneficial. This could include tips for self-management strategies (and helping members to recognise when to move from self-management to a health professional) and encouraging reaching out to family and friends for support (with a sound understanding of the impact this may have on those groups and how best to navigate these conversations). Given the ADF member data highlighted a preference for self-management in the early stages of mental health changes, a focus for Command personnel on understanding and supporting this preference is important.

Availability of skills-based training to further build on the information learned during annual training emerged from the data. Command personnel felt they would benefit from further education to understand the functional impacts of subthreshold symptoms on members and how to appropriately communicate this to members to facilitate management of these symptoms. Command personnel also indicated they would value training on how to approach members who are showing symptoms of subthreshold mental health problems. This may include, for example, discussing with members how to manage and address their symptoms early to provide the best opportunity for recovery and that addressing symptoms early may reduce the potential for impact on career.

The strength of Command as a support for members

Most Command personnel in this project could identify members who may be struggling, approached them to provide support, and were willing to direct them towards appropriate support and resources. Most Command recognised the importance and value of getting to know members under their command, developing rapport, and understanding members' baseline (usual) demeanour and wellbeing. This knowledge helped Command to identify when members were behaving differently to their usual selves and provided an opportunity for Command to reach out and have a conversation with members about wellbeing.

The interviews with Command personnel highlighted that this group are well placed and willing to support members experiencing mental health challenges; however, capacity within their roles can be a barrier to Command offering support. It is important to ensure that Command personnel are supported in making time to address issues among members under their command.

Results from the ADF member component of the WATCH Project demonstrated that members may under-recognise and under-use the support that Command personnel can provide. It is important for Command personnel to recognise this attitude and behaviour in members and to ensure they regularly engage and reach out to members with appropriate advice and support around optimising mental health and wellbeing.

Finally, Command personnel identified that lived experience was an advantage for recognising early indicators, giving them a greater knowledge of the help-seeking process via a MHP and allowing for greater empathy. Command personnel reported drawing on these personal experiences often in their approach to and conversations with members under their command. Through sharing stories of lived experience, Command personnel may also indirectly encourage others to seek support, which could contribute to reducing the barrier of stigma around help-seeking.

Abbreviations

ADF	Australian Defence Force
Command	Uniformed Supervisors with members under their command
Defence	Department of Defence
MHP	Mental Health Practitioner
NATO	North Atlantic Treaty Organisation
PTSD	Posttraumatic stress disorder
ISAF	allied International Security Assistance

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