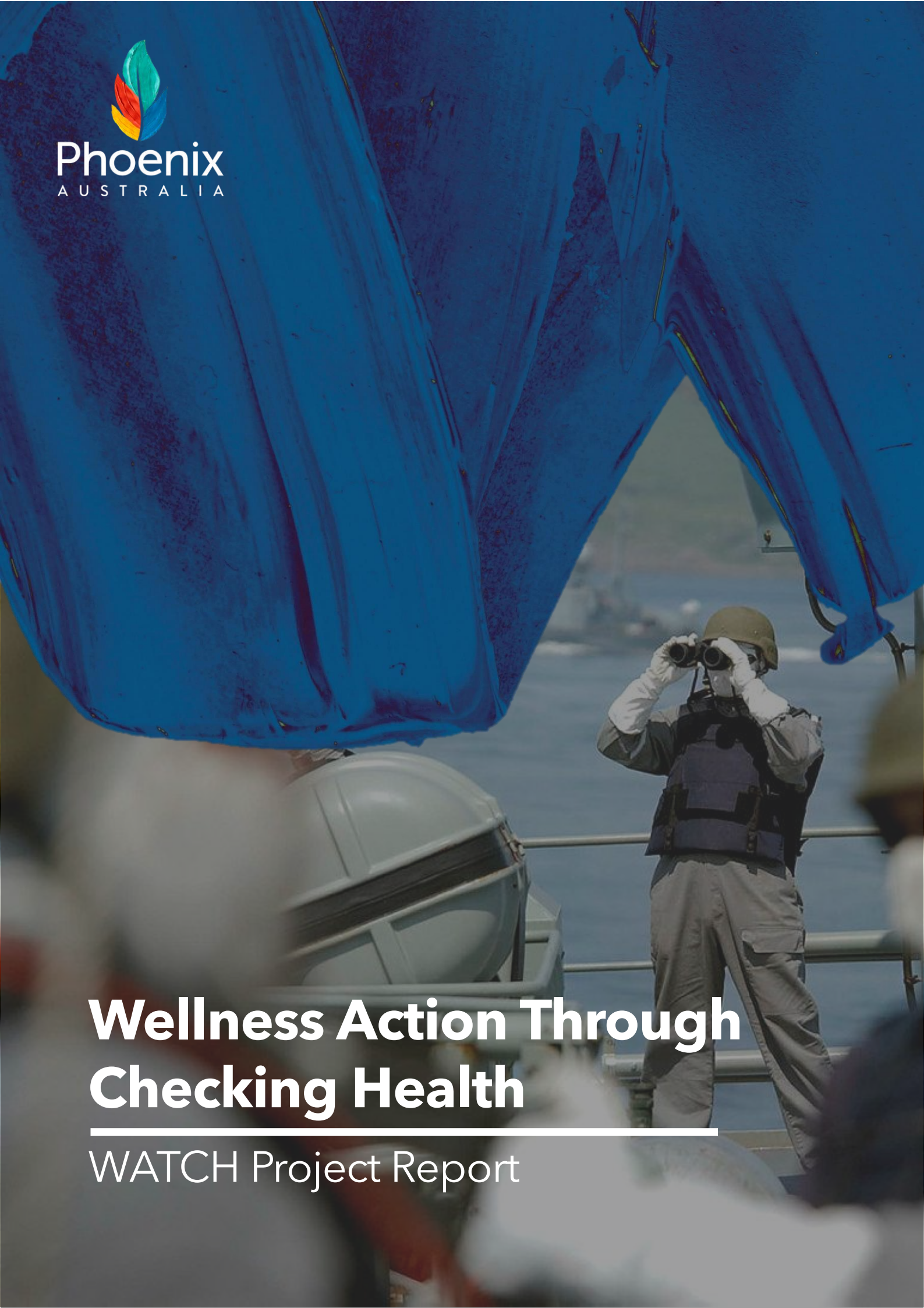
Phoenix
AUSTRALIA



Wellness Action Through Checking Health

WATCH Project Report

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 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 current serving members and health service practitioners that 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.

Key investigators:

Phoenix Australia

A/Professor Dr Lisa Dell
Dr Kim Jones
Ms Kelsey Madden

Specialist input:

Professor David Forbes
Dr Ellie Lawrence-Wood
Ms Nicole Sadler

Department of Defence

Dr Helen Benassi
Ms Carolina Casetta
Ms Kanny Tait (Project Manager)

All images in this report are sourced from images.defence.gov.au/assets.

Citation

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

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.

For enquiries:

A/Professor Lisa Dell | Director Military Mental Health
Phoenix Australia| Centre for Posttraumatic Mental Health
Department of Psychiatry | The University of Melbourne
Level 3, Alan Gilbert Building, 161 Barry Street, Carlton VIC 3053
lisa.dell@unimelb.edu.au | www.phoenixaustralia.org

Contents

Executive summary

Identifying ways to promote resilience and prevent mental illness as a means to optimise the mental health and fitness of the workforce continues to be an important goal of the Australian Defence Force (ADF). Indeed, the ADF's commitment to understanding and researching factors that strengthen resilience, address stigma and barriers and improve prevention and early intervention is clearly articulated in the Defence Mental Health and Wellbeing Strategy 2018–2023.

Subthreshold mental health symptoms (i.e., symptoms that do not meet diagnostic criteria but cause functional impairment) can be a precursor to the development of more severe mental health symptoms in the future. Even in the absence of disorders, subthreshold symptoms are associated with negative effects and outcomes. In the absence of a clinical diagnosis, individuals experiencing subthreshold symptoms may find their symptoms remain unrecognised by health-service providers (HSPs) and thus go untreated, allowing the symptoms to continue to affect individuals' wellbeing and potentially worsen over time (Mitchell et al., 2011; Rodríguez et al., 2012). Additionally, understanding the effects of subthreshold symptoms on wellbeing and functionality may be under-recognised by current serving ADF members (members) and those around them, and could affect the likelihood of individuals seeking support early and addressing symptoms before they worsen. Intervening early to target those with emerging symptoms of disorders is one clear way to mitigate the risk of symptom escalation.

Two of the largest Australian military mental health projects, the Longitudinal ADF Study Evaluating Resilience (LASER-Resilience) and the Transition and Wellbeing Research Programme (The Programme), identified key factors contributing to the emergence and progression of subthreshold symptoms. From these important programs of work, and in partnership with Joint Health Command, the Phoenix Australia–Centre for Posttraumatic Mental Health conducted the Wellness Action Through Checking Health (WATCH) Project. The WATCH Project was unique in that it used, for the first time, a qualitative methodology of interviews and focus groups to understand how subthreshold symptoms are experienced by members, how these symptoms present to others and whether they are being recognised. The WATCH Project identified how subthreshold symptoms are being addressed by different groups within the ADF with the aim of identifying how current Defence health systems could be bolstered to support the earlier identification of subthreshold mental health symptoms.

The WATCH project sought to identify which early symptoms are displayed by ADF members when they experience changes in their mental health and how Defence can better support ADF members to take charge and manage their own mental health. Initially, the project was designed to interview ADF members and HSPs, including psychologists, physiotherapists, rehabilitation officers, nurses, general practitioners, psychiatrists and chaplains; however, through these consultations, the importance of family members and Command (i.e., Uniformed Supervisors with ADF members under their command) in the early identification of symptoms and provision of support became apparent, and the project was expanded to include these groups. Ultimately, the WATCH Project explored the thoughts, experiences and attitudes of the following four groups: HSPs; ADF members, family members of current serving ADF members (family members); Command.

Those who participated in the interviews or focus groups included 36 HSPs, 40 ADF members with early, middle, and long career lengths, 22 family members, and 28 junior, middle and senior level Command personnel (who self-identified their level of leadership). It should be noted that the participants who elected to participate in the WATCH Project may be more likely to be engaged with and have an interest in mental health within the ADF than those who did not volunteer to participate.

Detailed findings on each of the cohorts interviewed (ADF members and HSPs) can be found in this report and in the two attached addendums (family members of current serving ADF members and Command).

Identifying symptoms

Family, Command and HSPs are well placed to observe early symptoms. Each cohort reported several early indicators of change commonly observed in ADF members (see Figure 1).

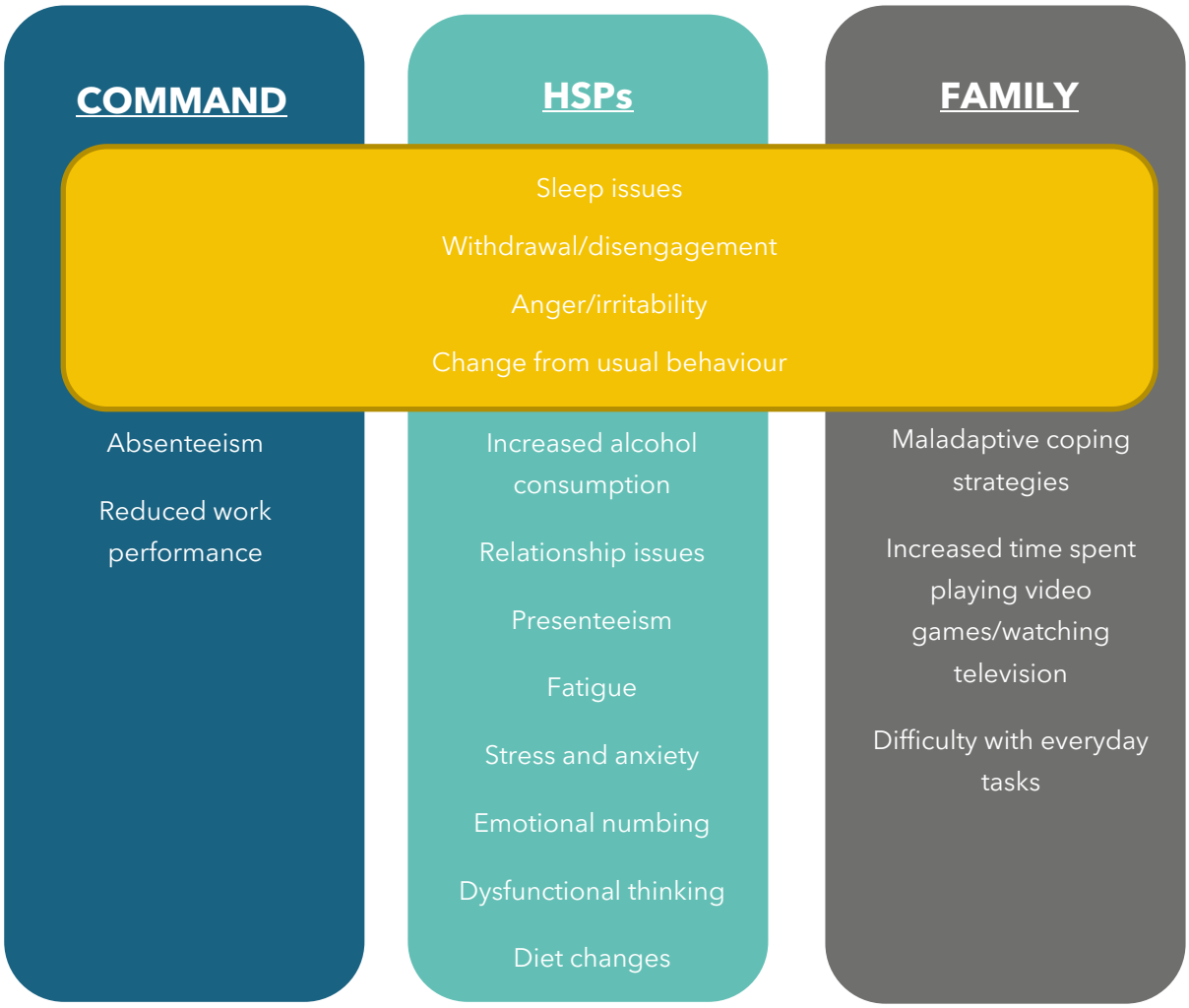


Figure 1. Symptoms identified across the cohorts.

Figure 1 shows the early indicators of changes in mental health reported by Command, HSPs and family members. There were several unique changes identified by each cohort; however, there was significant overlap in the main areas identified.

Barriers and facilitators to seeking help or offering support

As Figure 2 shows, ADF members, family members, HSPs and Command noted several barriers to members seeking support for early mental health changes. The majority of participants agreed that ADF members do not recognise the early signs in themselves and, if they do, feared seeking help due to the potential effect on their career. Conversely, Command noted several other factors which facilitated seeking help, including developing rapport, knowing a member's wellbeing baseline and having strong leadership skills that enabled them to offer support to members in their team. HSPs, family members and Command all noted that members sometimes do not recognise the signs that they may be experiencing mental health challenges. This highlights the importance of ensuring members are aware of how to self-identify symptoms as they first emerge to prevent mental health decline and significant functional impairment.

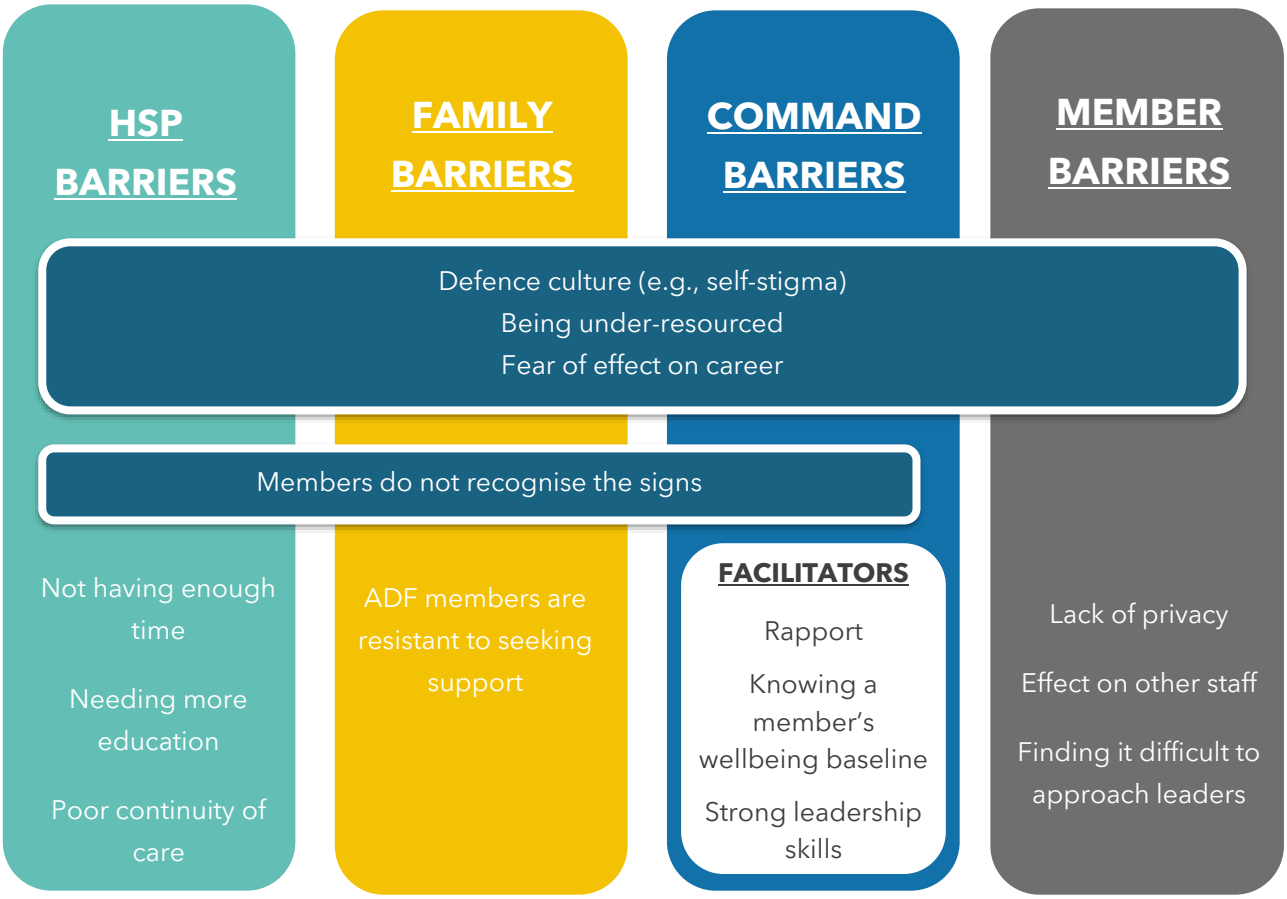


Figure 2. Barriers to help-seeking or offering support as identified by each cohort.

Bolstering current processes

Increasing knowledge of available supports for members to identify and self-manage early symptoms

It is vital for members to self-identify early indicators of mental health challenges and make themselves aware of the supports available to aid the self-management of symptoms. All cohorts, except for the members themselves, indicated that members often do not self-recognise the early signs and symptoms of mental health change in themselves. Increasing awareness of self-management strategies, such as exercise, listening to music/podcasts, re-engaging in enjoyable activities and using NewAccess or accessing applications (e.g., Headstrength or High Res), will likely enhance members' ability to recognise early changes through education and know what steps to take if they do recognise early indicators.

Boosting HSPs' knowledge and access to information

Knowledge about the importance of these early symptoms and how they may present differently in different career cohorts could be strengthened. There should be a focus on educating HSPs about the importance of these early features and subsequent mental health trajectories and the manner in which, while appearing innocuous, they can affect functioning, performance and capability. Further, the results of the WATCH project will help to educate HSPs as to the kinds of symptoms and behaviours that may emerge at each career stage and how to identify and intervene early with members throughout their life with Defence.

The strength of Command as a support for members

Command personnel are well placed and willing to support members experiencing mental health challenges and could potentially play a critical role in the early identification of members who may be struggling. The key attributes for Command in being able to do this effectively were getting to know the members under their command, being able to develop a strong rapport with members and understanding each members' mental health and wellbeing baselines to be able to detect early changes in mental health. Ensuring Command personnel are engaging in these conversations with those under their command will help to facilitate a culture of early identification and assist in the management of mental health issues.

Increasing knowledge of already available supports to family members

There is strong evidence that social support is a protective factor against symptoms of poor mental health. Similarly, social support can be a protective factor for the wellbeing of those who are supporting someone with mental health challenges. Family members in the WATCH project spoke of the importance of connecting with other Defence families and having like-minded support networks. Several sources of

support are available to family members of current ADF members; however, the family members were not always aware of the wide range of support options available to them. Increasing family members' knowledge of the support available to them and their serving members has the potential to enhance the utilisation of already available resources (e.g., Open Arms). Family members who seek support for themselves are more likely to be in a better position to support their serving member. Additionally, having knowledge of the specific resources that their serving member can access to seek support will provide family members with an opportunity to encourage their member to seek assistance from specific individuals or organisations (e.g., Command, Defence Member and Family Support).

Initial triaging into the Defence health service system

Ensuring that specific HSPs, such as nurses and medics, are able to work at the highest level within their scope of practice may represent an opportunity to alleviate some of the pressure on other primary healthcare practitioners, such as Medical Officers. For example, staff could perform a range of medical triage activities, including querying and exploring symptoms known to be related to early mental health issues in all members presenting for care. This could be as simple as running through a checklist with a member.

Educating members on the pathways to care and the processes and timing for appointments and treatment, particularly for those in their early career who may be less familiar with the Defence health system, would be beneficial. There is information in the community more generally about the Australian health system (provided by the Department of Health); however, it may be beneficial for members to have easy access to information specific to the Defence health system.

Mental health screening—An already embedded opportunity

A clear opportunity exists to identify members who are scoring in the subthreshold zone on particular mental health screening measures that are already well embedded in the Defence health system. Resourcing is critical to consider; however, a subthreshold screening triage system might be an effective way to identify early challenges and educate members on what their scores mean, what they need to be mindful of and how to access support for their specific symptoms. Such a system would serve to educate and empower members and allow them to take charge of their own mental health and wellbeing, to 'tune in' to their symptoms more clearly and to take proactive action to monitor and seek help when needed.

Routine follow-up

Checking in, following up and recalling members who have sought care for a significant health issue is part of routine clinical practice and governance. A potential gap in the health service system exists in the follow-up of those who have presented with lower-level mental health challenges. HSPs were not always knowledgeable of the outcomes of their recommendations or treatments, and feedback loops for members presenting with subthreshold symptoms were not always enacted. The e-health system has reminders built in for practitioners to follow up with members. Thus, this system has the potential to be used for those members who are actively managing subthreshold symptoms. Resourcing implications

need to be considered; however, time spent arranging follow-up is likely to be offset by the benefit of early intervention (thereby preventing the likely progression to more significant problems).

Conclusion

The WATCH Project provides a valuable contribution to optimising the performance of ADF members by increasing the recognition of the importance of the identification and appropriate management of those factors at the right level to prevent mental health symptoms from progressing. Each cohort (Command, HSPs and family members) has a role in identifying and addressing members' challenges with their mental health and wellbeing, and this network of support surrounding members should be maximised to ensure optimal wellbeing and functioning across the Defence life of the member.

Critically, a change from baseline or usual behaviours was reported by every cohort as meaningful. Such observations should serve as a key indicator that a member could benefit from extra mental health support. The members themselves may not realise the importance of quickly addressing emerging symptoms, and this is where the network of support from peers, leadership, HSPs and family members is critical to ensuring optimal health and wellbeing.

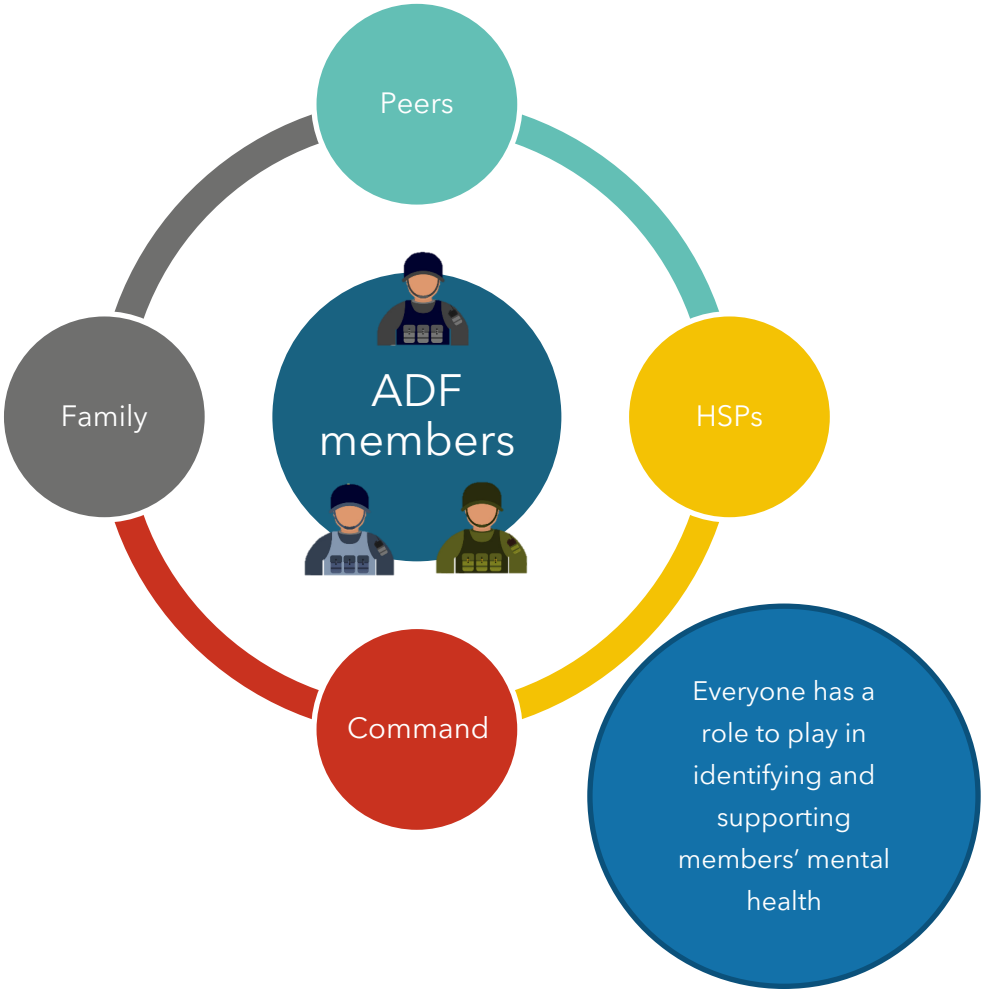


Figure 3. Conglomerate of support.

Chapter 1
Introduction to WATCH

Background

Mental health and wellbeing are critical to an effective and capable workforce. Poor mental health is associated with lower job satisfaction, lower resilience to stressors, higher rates of work absenteeism and presenteeism, and subsequent reduction in work performance and productivity (Bartone, 2012; Sanchez, Bray, Vincus, & Bann, 2004). Improving the mental health and wellbeing of a workforce reduces both personal and organisational costs (Hassard, Teoh, Thomson, & Blake, 2021) and serves to increase capability. Improvement of mental health and wellbeing is an essential focus of the Australian Defence Force (ADF) and central to its approach, as outlined in the Defence health strategy (Department of Defence, 2017).

Prevalence rates of affective disorder are higher in the ADF (9.5%) than in the general population (5.9%) (McFarlane, Hodson, Van Hooff, & Davies, 2011). Similarly, more ADF members are diagnosed with posttraumatic stress disorder (PTSD) in a 12-month period than others in the Australian community (8.3% vs 5.2% respectively) (McFarlane, Hodson, Van Hooff, & Davies, 2011). Therefore, identifying ways to promote resilience and prevent mental illness continues to be an important goal of the ADF. One clear way of preventing the development of psychiatric disorders is to intervene early, targeting those with emerging symptoms of disorder.

We know that subthreshold symptoms can signal development of more severe mental health symptoms in the future, but subthreshold symptoms are in themselves associated with negative outcomes. Additionally, individuals experiencing subthreshold symptoms may find their symptoms remain unrecognised in the absence of a clinical diagnosis. These individuals may go untreated, allowing symptoms to continue to impact individuals' wellbeing and potentially worsen over time (Mitchell, Rao, & Vaze, 2011; Rodríguez, Nuevo, Chatterji, & Ayuso-Mateos, 2012). It is of course, important to note that stress and distress symptoms are a part of everyday life and that not everyone experiencing stress will need intervention.

There has been much discussion in the literature about how we can identify when early symptoms might become problematic (Cuijpers et al., 2014; Kearns, Ressler, Zatzick, & Rothbaum, 2012) and as yet we still do not have a consensus. What we do know, however, is that terminology is important. The literature has used a number of terms to capture when stress or distress symptoms are starting to look problematic. Terminology has included subthreshold disorder, subclinical disorder or subsyndromal symptoms, and generally this terminology identifies that **a number of symptoms are present and the symptoms do not meet diagnostic criteria but they are causing functional impairment**. The field is still evolving and there is work to be done to reach an understanding on when early symptoms become problematic (Biella et al., 2019; Breslau, Lucia, & Davis, 2004; Cukor, Wyka, Jayasinghe, & Difede, 2010; Rodríguez et al., 2012).

Defence has long recognised the importance of identifying personnel with subthreshold symptoms, as can be seen in two of the largest Australian military research projects commissioned in the past decade: the Longitudinal ADF Study Evaluating Resilience (LASER-Resilience) and the Transition and Wellbeing Research Programme (the Programme). Together the two Defence research programs provided us with an understanding of subthreshold presentations and the factors that contribute to their emergence and progression. A summary of these studies has been provided in Appendix I.

While we know that the large majority of members maintain their mental wellness over the course of their military career, there is a proportion of members for whom subthreshold symptoms will emerge (Bryant et al., 2019; Dell et al., 2019). We can see from these studies that these symptoms may begin to emerge as early as within a couple of years of joining the military, to as late as at the transition point after a long career, which speaks to the value and investment in a whole-of-career approach to routine mental health checks and support. Importantly, these studies show that a substantial proportion of those with subthreshold presentations will accumulate symptoms and progress to mental health disorders. These results further highlight the seriousness of early intervention, to prevent the worsening of symptoms from subthreshold to probable disorder over time and to maintain a mentally fit workforce. The scientific literature is clear that chronic mental health problems are typically much harder to treat (Kaplan & Klinetob, 2000; Kim, Bagalman, & Goetzel, 2010; Rodriguez, Holowka, & Marx, 2012; Zepinic, 2015), and therefore an early intervention approach targeted to those who are experiencing subthreshold symptoms, not just those with disorder, is prudent. This may circumvent the development to clinical disorder or at least allow issues to be identified at a point where the symptoms are most amenable to treatment.

Risk factors for accumulation of symptoms

Reflecting on the course of the development of subthreshold symptoms, it is essential to understand why these symptoms worsen over time. We know that not all individuals with subthreshold symptoms progress to disorder but we also know that many do, and many maintain their subthreshold status for years. The LASER-Resilience study provided unique insights into these groups and identified the key factors that predicted the membership of these groups (see Figure 1).

The primary modifiable predictors of those who were experiencing subthreshold distress and posttraumatic stress symptoms were:

- poor social support
- use of maladaptive coping strategies
- sleep impairment
- high anger.

Similar modifiable predictors of the progression from subthreshold disorder in 2010 to probable disorder in 2015 were found in the Mental Health Prevalence and Wellbeing Study (MHPWS) longitudinal cohort.

Figure 1. Modifiable predictors of subthreshold and increasing psychological distress and PTSD symptom classes in the LASER-Resilience study

We know from the data that there are groups of personnel who are consistently staying in an unhealthy subthreshold symptom zone and we also know that some will continue to deteriorate and progress to psychological disorder (Bryant et al., 2019). Bryant et al. identified that of the ADF members who had subsyndromal symptoms of psychological distress in 2010, 32.5% still had subsyndromal symptoms five years later (in 2015), and 17.5% had symptom levels suggestive of probable disorder. Similarly, of those ADF members with subsyndromal PTSD symptoms in 2010, 39.5% still had this level of symptom severity in 2015. This research identified a number of predictors of 'maintaining' subsyndromal status or progressing to probable disorder, namely: greater amount of lifetime trauma exposure, anger, suicidality, and not being an Officer.

These risk factors provide us with valuable information about who these personnel may be and who is at risk. Using the results of the LASER-Resilience study we can identify people who are at risk of an escalation in their symptoms and intervene early. The next challenge, to be addressed by the current study, is how to identify these individuals and pinpoint the challenges to early intervention that need to be addressed to support successful implementation of any such intervention.

International research

International research has shown that the experience of psychological distress, which refers to non-specific depression and anxiety symptoms, is associated with impaired functional status and disability (Blanc, Zamorski, Ivey, McCuaig Edge, & Hill, 2014; Sampasa-Kanyinga, Zamorski, & Colman, 2018). Further, studies have demonstrated that subthreshold levels of PTSD and other mental health disorders are associated with significant health and psychosocial impairment and accordingly can impact on wellbeing to the same degree as symptoms associated with diagnosable disorders (Judd, Paulus, Wells, & Rapaport, 1996; Karsten, Penninx, Verboom, Nolen, & Hartman, 2013; Marshall et al., 2001; Pietrzak, Goldstein, Malley, Johnson, & Southwick, 2009). Additionally, it has been shown that many individuals with subthreshold symptoms improve without treatment but that this is often accompanied by reduced quality of life in the longer term (Sareen et al., 2013).

Subthreshold PTSD can take a chronic course with an average duration of up to 10 years (Pietrzak, Goldstein, Southwick, & Grant, 2011), and it is associated with increased incidence of psychiatric comorbidity, problematic alcohol use, reduced quality of life, functional impairment, and suicide (Chen et al., 2020; Cukor et al., 2010; Jakupcak et al., 2011; Marshall et al., 2001; Zlotnick, Franklin, & Zimmerman, 2002). Risk of full PTSD is also increased when subthreshold symptoms are present (Fink et al., 2018; Goodwin et al., 2012; Smid, Mooren, van der Mast, Gersons, & Kleber, 2009; Utzon-Frank et al., 2014). Similarly, subthreshold depression is associated with increased clinical comorbidity, functional decline, higher healthcare service use and increased mortality (Gilbody et al., 2017). Further, presence of subthreshold depression symptoms is highly predictive of development of major depressive disorder (MDD) (Klein, Schwartz, Rose, & Leader, 2000). Rates of progression to MDD vary due to differences in definition but range from 10 per cent to 41 per cent (Biella et al., 2019; Gilbody et al., 2017).

An important body of research evidence is that composed of studies that have looked at the course, or progression, of subthreshold symptoms over time. These studies help us understand what happens to people who are experiencing subthreshold symptoms across the course of many years. For example, Eekhout and colleagues (2016) found that the proportion of Dutch military personnel deployed to Afghanistan with above threshold PTSD symptoms continued to increase over five years post-deployment (4% at pre-deployment to 13% at five years post-deployment). Further, 9% of personnel experienced delayed onset PTSD symptoms that progressed from moderate at pre-deployment to high at five years (Eekhout, Reijnen, Vermetten, & Geuze, 2016). Collectively, the literature points to the need to focus our attention on those with subthreshold symptoms, as the functional impairment they are experiencing may be similar to those with diagnosed disorder. For some, subthreshold symptoms may naturally remit over time, however clinical judgement is important during this period given there are decisions to be made regarding how best to manage symptoms, whether clinically or via other methods. For others, the impacts will continue and may even worsen, thus it is important to ensure there are mechanisms to identify and support these individuals.

A final note

Early identification of mental health problems is not just an ADF or military issue. In the general community it is well documented that individuals will delay seeking help for numerous reasons. However, Defence has a unique opportunity through the Wellness Action Through Checking Health (WATCH) Project to examine the issues surrounding early identification and intervention. The project provides an opportunity to identify and assess potential strategies to improve early intervention, particularly given that Defence also provides the health services accessed by members. Defence's investment into early identification and intervention may potentially lead to better mental health of members, improved capability and functioning of the workforce, and reduced burden on the health service system in the future. The expansion of the WATCH Project to include the perspectives of families and command personnel will further aid understanding of how subthreshold symptoms present in ADF members and help to identify strategies which may increase early identification. Findings from families and command components of the WATCH Project are available as separate addendums to this report.

Wellness **A**ction **T**hrough **C**hecking **H**ealth (**WATCH**) Project

Phoenix Australia has partnered with the Department of Defence (Defence) to undertake the WATCH Project. The WATCH Project is about understanding how subthreshold symptoms present and whether these presentations are being recognised. It is about finding ways that 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 manage their own mental health. Better management of these changes in mental health can contribute to a reduction in the impact of disorder and improved outcomes in work, home and social life.

Aims

The overarching aim of this project is to inform how Defence Health Service Providers (HSPs), family members and Command identify and manage members with subthreshold mental health concerns, and how members themselves manage these symptoms. Five key research questions that address multiple components of this aim are:

1. Are members with subthreshold symptoms seeking help for low-level mental health concerns and what are the drivers for help-seeking?
2. How are subthreshold symptoms presenting and are these presentations recognised by health service providers, family members, Command and by members themselves?
3. How are subthreshold presentations currently being addressed?
4. What interventions are being implemented (and how), and are these interventions appropriate and effective?
5. How may existing management processes be improved?

Chapter 2
Methodology

Design

The WATCH Project used a qualitative research design. Qualitative data was collected through interviews and focus groups with HSPs (*n* = 36) and ADF members (*n* = 40), and survey data was collected from ADF members. The qualitative data was collected via audio recordings of participant interviews and focus groups. In conducting the qualitative data collection, we were guided by the concept of saturation. *Saturation is met when no new salient information is obtained from conducting further interviews*. Thus, interviews were conducted until saturation was reached for each question and within each career stage cohort (see below participants – ADF member). Recordings of the interviews and focus groups were transcribed and data analysis used the inductive approach known as thematic analysis and followed the guidelines developed by Braun and Clarke (2006). In brief, 1) a WATCH Project team member familiarised themselves with the data by reading through the transcripts; 2) initial descriptive codes were generated and the data was categorised to each code; 3) codes were collated into themes; 4) themes were reviewed and discussed in relation to codes and the entire dataset; 5) themes were refined, defined and named. These themes were continually checked against initial code and transcript as the database and analysis progressed to ensure they were representative within the context of the larger dataset.

While other research exists that provides valuable insight into the prevalence of subthreshold symptoms, the aims of the WATCH Project required a level of richness to uncover each participant's thoughts, experiences and attitudes to the experience, identification and management of mental health and wellbeing subthreshold symptoms. In order to contextualise the findings from this project, these two sets of qualitative data (HSPs and ADF members) were triangulated with the evidence from previous ADF reports (detailed in Appendix I), to identify key findings and implications from these findings.

In addition, a co-design working group was developed to ensure that internal Defence stakeholders were engaged throughout the entire project (see Appendix II for membership). Six co-design consultation meetings, along with out of session correspondence, were held during the project design, recruitment and data collection phases. In consultation with the co-design group, interview questions were refined, recruitment and engagement strategies were optimised, and relevance of all aspects of the project design to Defence was assured.

Participants

Health service providers (HSPs)

The WATCH Project recruited a range of HSPs including: psychologists, psychiatrists, medical officers, chaplains, physiotherapists and nurses. All HSPs who work directly with ADF members were eligible to participate. Interviews continued until saturation was reached.

ADF members

As previous ADF studies have highlighted differences in the experience of mental health symptoms across length of service in the ADF, comparable numbers of participants were sought from each of the three career

stages. 'Early career' was classified as less than eight years, 'mid-career' as eight to 15 years and 'long career' as over 16 years of service. Inclusion and exclusion criteria for ADF members is outlined in Figure 2.

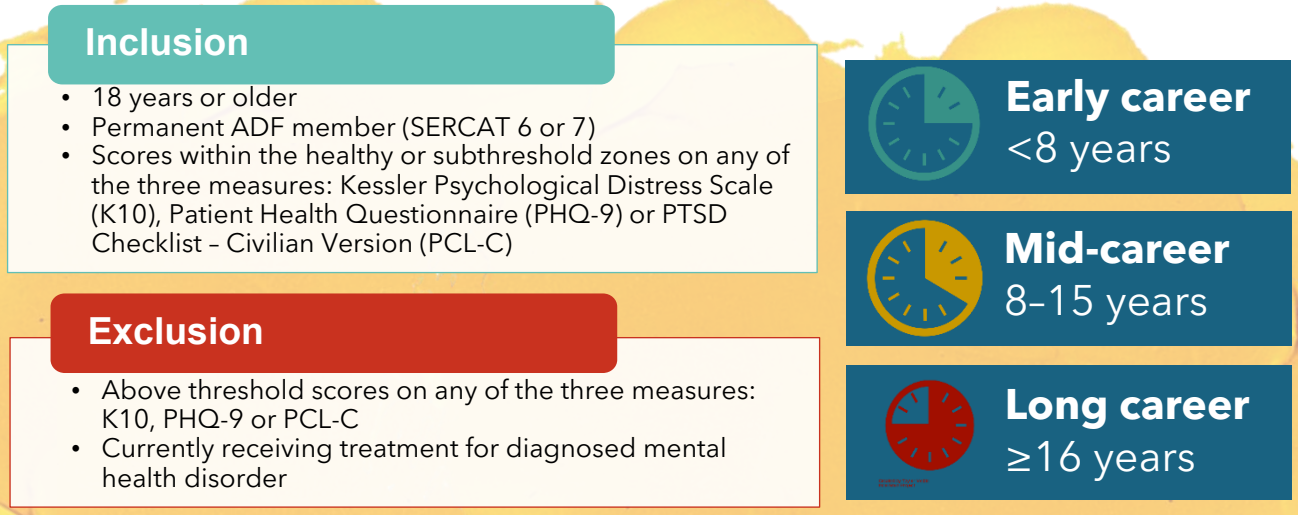


Figure 2. Inclusion and exclusion criteria for current ADF members

Procedure

Ethics approval

A submission was made to Departments of Defence and Veterans' Affairs Human Research Ethics Committee (DDVA HREC) for ethics approval for the WATCH Project. Ethics was approved on 21 September 2020 for ADF members and 6 October 2020 for HSP interviews and focus groups (protocol number 227-20).

Recruitment

Health service providers

Briefing emails were sent to Defence Member and Family Services (DMFS; formerly Defence Community Organisation (DCO)), 1st Psychology Unit, Navy Psychology, Air Force Psychology, Army Psychology and Open Arms – Veterans & Families Counselling, and verbal briefings were conducted with 1st Psychology Unit and Open Arms outlining the project and informing them of the recruitment targets. Representatives from each of these areas distributed emails containing the recruitment flyer for service providers. These flyers requested that interested participants contact Phoenix Australia directly. Reminder emails were sent to the sample, targeting particular task groups that were not represented in the sample obtained in the early stages of recruitment.

ADF members

ADF members were identified and recruited via five channels, shown in Figure 3 and described in more detail below.

Figure 3. Recruitment channels for ADF members

WATCH Project flyers were displayed in and distributed to potential participants at Defence health centres when checking in for an appointment. Garrison Health agreed to use Joint Health Unit – Northern New South Wales and Joint Health Unit – Central New South Wales (JHU-NNSW and JHC-CNSW) for recruiting participants. Health Clerks at these centres handed out flyers, and recruitment posters were displayed. Recruitment flyers were also distributed to ADF members by staff experienced in mental health following regular ADF Centre for Mental Health training sessions.

ADF members were also recruited via social media and Defence communication platforms. Social media promotions and advertisements were conducted through Phoenix Australia Facebook and LinkedIn accounts. Defence platforms used to facilitate recruitment were: service newspaper articles, Spotlight and ForceNet. All advertisements contained a link to the WATCH Project landing page on the Phoenix Australia website.

Finally, a targeted email campaign was used; a list of all ADF members was sourced from Directorate of Workforce Information (DWI). Using basic demographics (service, rank etc.), a random sample was selected to receive an email invitation (and two reminders) to participate in the WATCH Project. Emails were distributed through Survey Manager and this was repeated with a new random sample every two to four weeks, depending upon recruitment progress. Five rounds of email invitations were completed in total.

Data collection

Health service providers

HSPs expressed interest in attending an interview or focus group via email. After making initial contact, HSPs were requested to complete demographic questions and return responses via email. Once demographic information was obtained, HSPs were invited to attend either a one-on-one phone interview or a focus group comprising up to six providers and one facilitator via Microsoft Teams lasting approximately 45 minutes to one hour.

ADF members

Flyers, promotional posts and email invitations contained direct links to the WATCH intake questionnaire delivered via the REDCap online survey platform. Participants provided online consent and a screening questionnaire, and to confirm that participants were not experiencing symptoms of probable diagnosable mental health disorder, screening measures included assessments for psychological distress (K10), depression (PHQ-9) and PTSD (PCL-C).

Participants who did not score above threshold (i.e. healthy or subthreshold) on any of the self-report questionnaires were offered the opportunity to attend a phone interview. Interviews with ADF members lasted approximately 45 minutes to one hour and were audio recorded and later transcribed. Participants were waitlisted if the target had been reached in their service length group.

Self-report survey

Health service providers

Demographic details collected from HSPs identified a range of professionals for inclusion.

ADF members

Quantitative data was collected via REDCap. Demographics (i.e. personal details, service characteristics) were collected via responses to screening measures (see Figure 4). Participants scoring above threshold on any of the three screening measures were contacted by a trial clinician from Phoenix Australia and triaged according to level of risk as outlined in Appendix III. See Figure 5 for ADF member recruitment process.

Data

The final dataset included transcripts from five focus groups (comprising 21 HSPs), 15 interviews with HSPs (Figure 6) and 40 interviews with ADF members (Figure 7). Analysis of demographic information was used to identify sample characteristics.

Kessler Psychological Distress Scale (K10)

K10 is a 10-item self-report measure of psychological distress. How often participants have experienced each emotional state within the past four weeks is scored on a scale of 1 to 5 (1 = 'None of the time', 2 = 'A little of the time', 3 = 'Some of the time', 4 = 'Most of the time', 5 = 'All of the time'). Responses are summed to produce a total summed score between 10 and 50 that indicates symptom severity. Participants are categorised into one of three categories based on symptom severity: healthy (summed score of between 10 and 16), subthreshold (summed score between 17 and 25) and above threshold indicating probable disorder (summed score between 26 and 50).

Patient Health Questionnaire-9 (PHQ-9)

PHQ is a 9-item self-report screening tool for depression. Participants rate how often they have been bothered by symptoms within the past two weeks. Responses are ranked on a scale of 0 to 3 (0 = 'Not at all', 1 = 'Several days', 2 = 'More than half the days', 3 = 'Nearly every day'). Responses are summed to produce a total summed score ranging from 0 – 27 which indicates symptom severity. Participants are categorised into one of three categories based on symptom severity, these are: healthy (summed score of between 0 and 5), subthreshold (summed score between 6 and 10) and above threshold indicating probable disorder (summed score between 10 and 27).

PTSD Checklist – Civilian Version (PCL-C)

PCL-C is a 17-item self-report measure of PTSD. Respondents indicate how often they have experienced symptoms over the past month on a scale of 1 to 5 (1 = 'Not at all', 2 = 'A little bit', 3 = 'Moderately', 4 = 'Quite a bit', 5 = 'Extremely'). Total summed scores range from 17 to 85 and indicate symptom severity ranging from healthy (summed score of between 17 and 28), subthreshold (summed score between 29 to 53) and above threshold indicating probable disorder (summed score between 54 to 85).

Figure 4. Screening measures

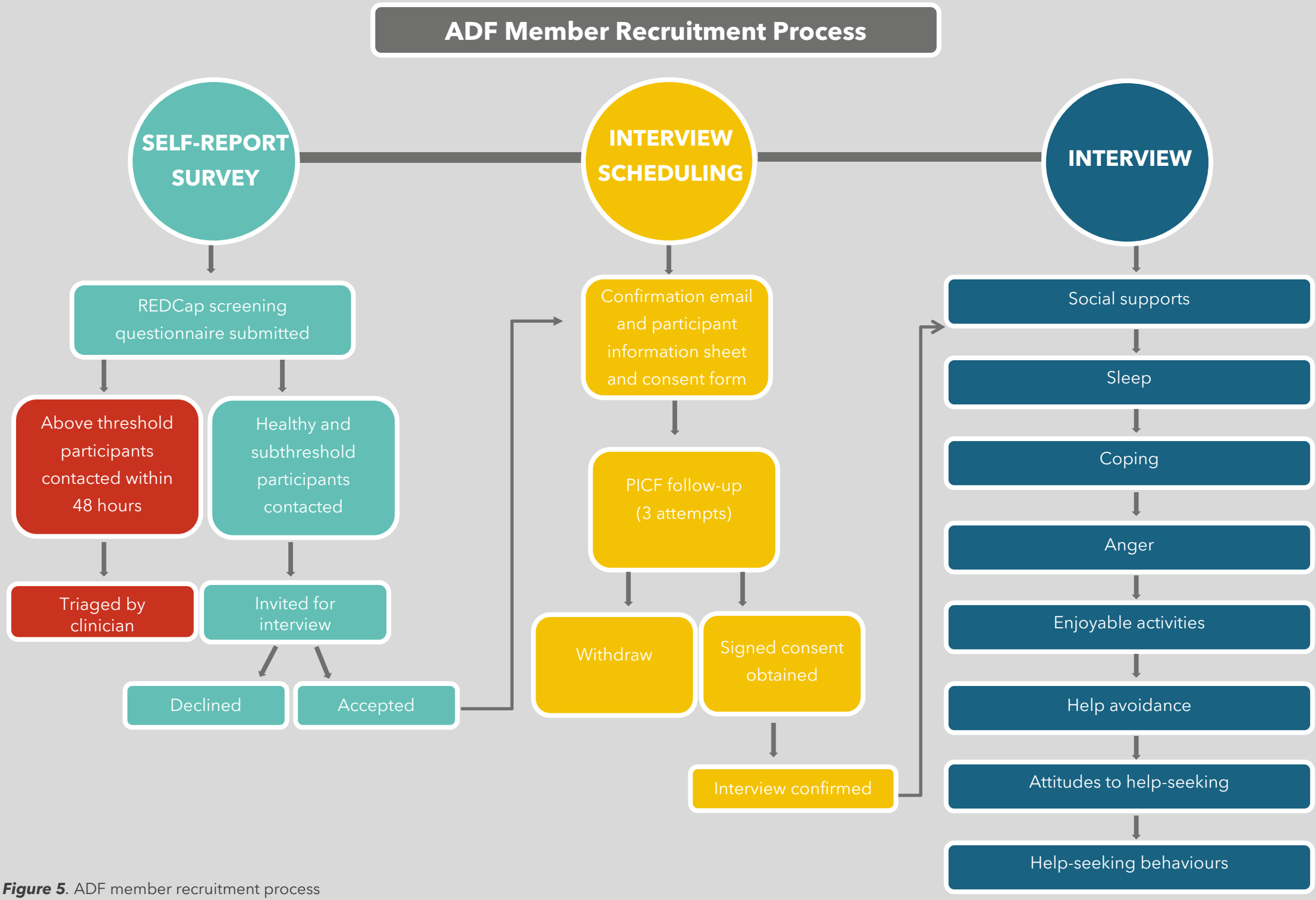


Figure 5. ADF member recruitment process

HSP Interview Questions

- What do you think of when you hear the term 'subthreshold symptoms'?
- Who do you think is best placed to identify people experiencing subthreshold symptoms?
- Do these people/groups have the information they need to respond appropriately when they identify issues?
- What barriers exist to the timely identification of subthreshold symptoms?
- Do you have any suggestions on how these barriers might be minimized or addressed?
- What intervention or treatment or support would you consider in the absence of a diagnosed disorder but in the presence of subthreshold symptoms?
- How useful do you think these interventions are? Do you think patients use them as they are intended to be used?
- Are there any systems issues that present barriers to implementation of these interventions?
- Are subthreshold symptoms identified by current screening processes and how is this information used?
- Do you think current recruitment processes should or do identify those who are experiencing subthreshold symptoms?

Figure 6. HSP interview questions

ADF Member Interview Questions

Tell me what sort of social supports you have. Who would you reach out to if you wanted to talk about something personal?

Have you ever had trouble with sleep?
(such as finding it hard to get to sleep or having trouble staying asleep)

Yes — What help did you seek? How useful dud you find this help? How long did you let it go before you sought help?

No — If your sleep did start to become a problem for you, what kinds of things would you do to sort that out?

When something happens at work that doesn't go your way, how do you manage that situation? What kinds of things do you do to be able to cope with the situation?

Do you find that you get or feel angry at people or situations quite a lot of the time?

Yes — What kinds of things do you do to manage that?

No

Have you ever had a period during your time with Defence where you stopped doing things that you enjoy?

Yes — What helped you get back on track?

No

Have you ever had health issues that impacted on your wellbeing that you didn't seek help for?

Yes — How did you manage? What types of strategies and/or resources did you use? Do you think that worked or could you have done something differently? What stopped you seeking professional help?

No — (I had a problem but I sought help): When did you seek help, what advice were you given? Were you satisfied with the outcome? Were you asked to go back in for follow up appointments to check how you were going?

How would you feel about yourself if you needed to seek care? What do you think would help you overcome those concerns? What do you think needs to be done to change this?

Do you think that when health issues arise, mental or physical, that the first port of call should be to go and see a health service provider (in Defence or external) or are there other ways you think that people could manage their health? Do you think there are any barriers to members seeking help for these issues?

Figure 7. ADF member interview questions

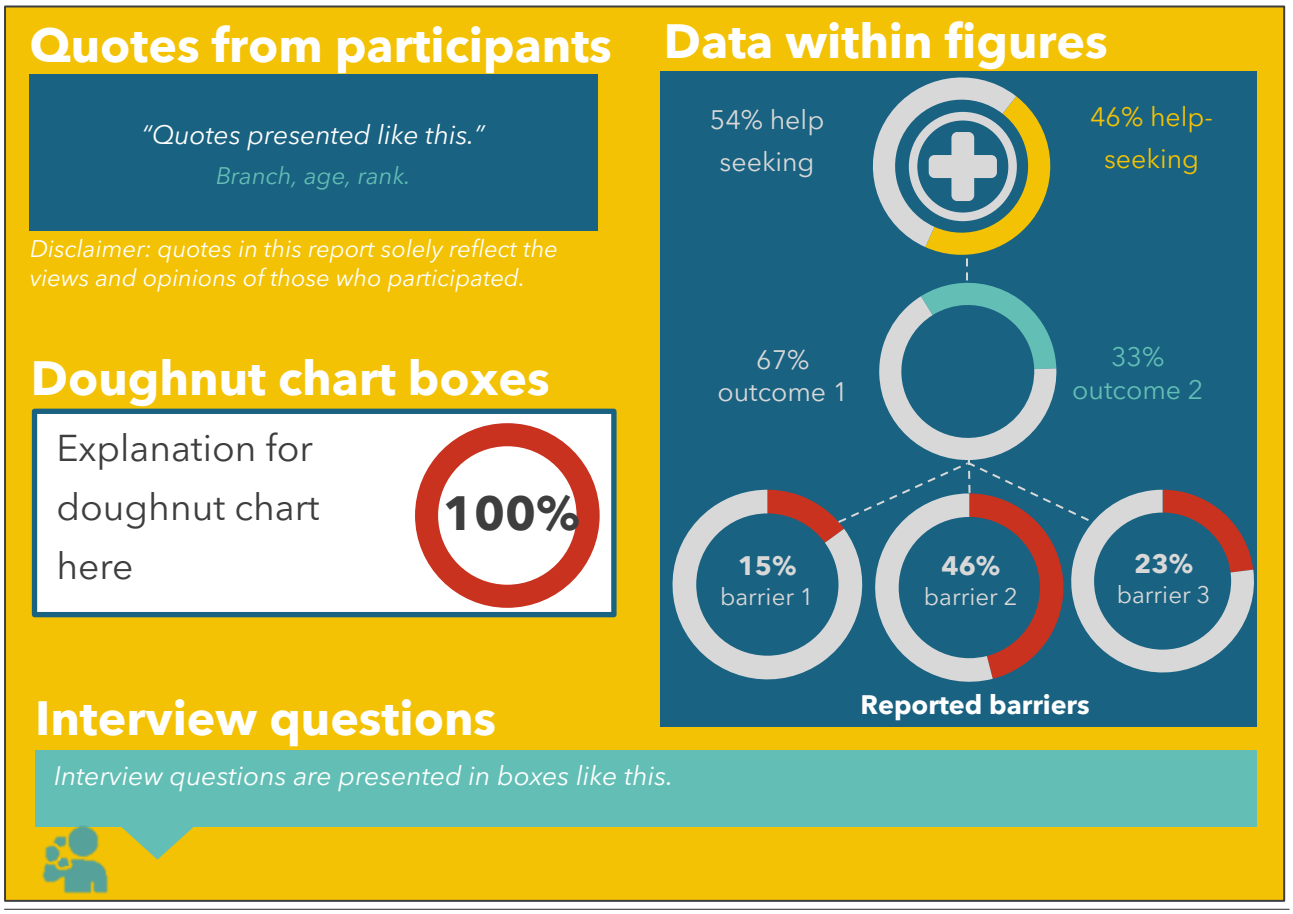
How to read this report

There are a number of graphics and visual prompts to aid in the readability of this report. The following information has been provided to assist with orienting the reader to the style of this report.

Figure 8. Example tree plot – mock data

Tree plots are used throughout the report to visualise endorsement of themes that emerged from the focus groups/interviews (see example Figure). The size of the boxes within the tree plots are meaningful and corresponds to the proportion of participants who endorsed each theme e.g. the number of participants who mentioned a specific barrier. As participants could mention more than one theme in response to a question, the data in these plots does not always total 100%. These plots are descriptive only and do not represent a statistical test of differences between responses.

Other report elements include quote boxes, question boxes, figures and doughnut charts within boxes. Throughout the report, you will find these presented as per the examples below:



Chapter 3

Health service provider outcomes

Demographics

A total 36 HSPs participated: 15 were interviewed one-on-one and 21 participated in one of five focus groups. Nine professions were represented as detailed in Figure 9. The majority of HSPs were employed on a full-time basis (*n* = 25) and were civilians/private contractors (*n* = 24). The experience of HSPs varied broadly, with the shortest career being two years to the longest at 35 years. The average length of career for HSPs was 14 years. Most HSPs interviewed were from either Queensland (QLD; *n* = 9), Victoria (VIC; *n* = 9) or New South Wales (NSW; *n* = 9) with two from each of Northern Territory (NT), South Australia (SA), Australian Capital Territory (ACT), and Tasmania (TAS), and one participant from Western Australia (WA).

Figure 9. Health service provider demographics

**Open Arms staff included community and peer advisers, counsellors and psychologists.*

Subthreshold symptoms

HSPs were asked what they think of when they hear the term subthreshold symptoms and to what degree they think they should be targeted with interventions.

Figure 10 shows that **sleep problems** were the most commonly mentioned issue that the term subthreshold brought to mind, with three quarters of HSPs mentioning this symptom. Over half of HSPs reported **anger or irritability**. **Alcohol problems, relationship issues, changes in behaviour** and a range of other symptoms shown in Figure 10 were reported by less than half of the HSPs interviewed. All HSPs felt that any subthreshold issues should be targeted with interventions or support.

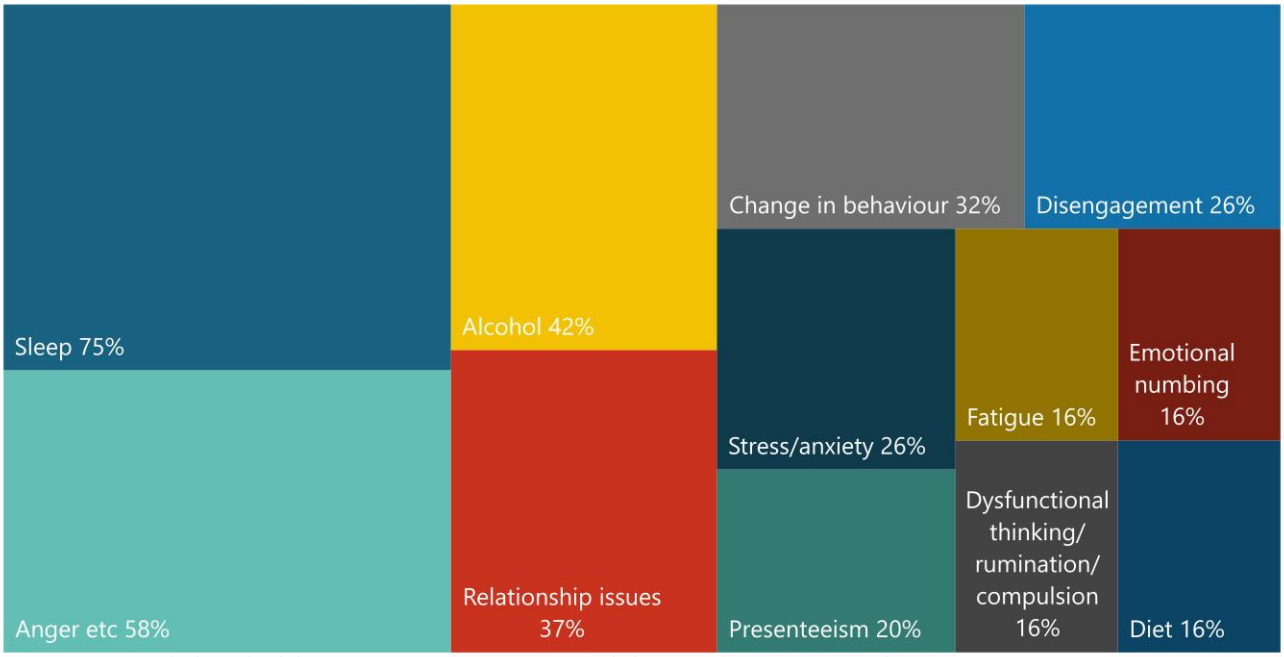
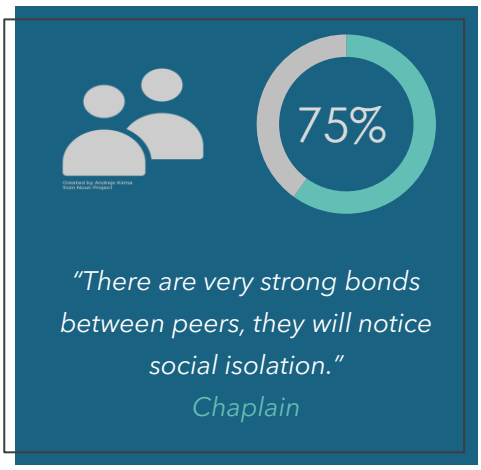


Figure 10. Subthreshold symptoms HSPs reported they see in ADF members

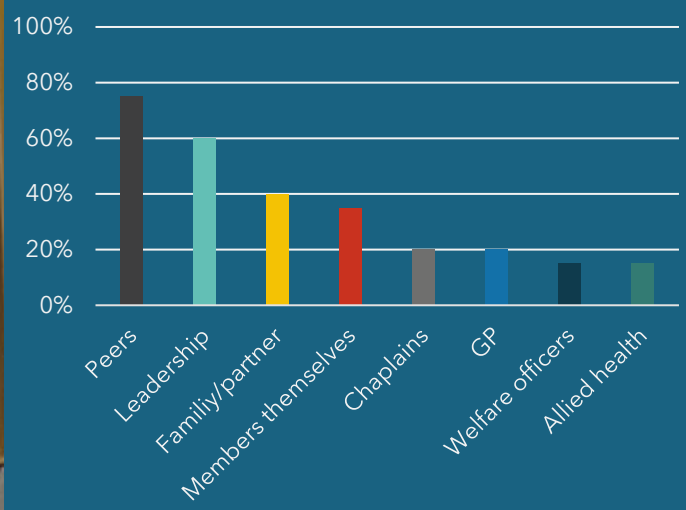
Identification of subthreshold symptoms

HSPs were asked how they think people with subthreshold symptoms could be identified. The majority of HSPs reported that ADF members' peers (75%) or leadership (60%, including Command, supervisor, junior leadership) are best placed to pick up on subthreshold symptoms. HSPs described close peer bonds as part of Defence culture that enables these groups to identify early behaviour changes. Members themselves and their family members or partners (40%) were the next most frequent responses. Chaplains, GPs, welfare officers and allied health professionals (e.g. rehabilitation consultants) were mentioned by fewer HSPs, but those HSPs who did mention them thought that they were well placed to pick up on early changes.



"A lot of time people come in through family and spouses. Sometimes a spouse will comment… too angry, drinking too much, not sleeping… you need to go get help."

Senior mental health adviser



"Commanding officers may recognise [early signs of mental health changes] but [it is] variable – this is where you would get the greatest impact – invest here."

Psychologist

"If you notice a change in your team, reach out, check in, ask the question. You know them better than anyone."

Psychologist

"It's on the ground that people see it – by the time they self-refer, or they are referred to us for training issues, they are often a long way down the track."

Psychologist

"Those higher up need to get out of the office and get to know members. By the time an issue is brought up at a MDT meeting the ship has sailed."

Chaplain

"Allied health see loads of members with subthreshold [symptoms], they need to know what to look for and what to do."

Rehabilitation Officer

"In theory the [welfare officers] should pick up on minor changes, but they are not always good [at it] and not everyone has good relationships with their Divisional Officer."

Psychologist

"We get people identified through chaplaincy [and] welfare officers."

Mental health Adviser

"GPs [are well placed to pick up on symptoms] if they come in for this, but there is usually no time to scan for these symptoms."

Medical Officer

HSPs felt that screening was one place where subthreshold symptoms could be identified but suggested that adding the assessment of life stressors might help signal when a member is at higher risk of some symptoms. Additionally, many HSPs suggested that while subthreshold symptoms may be identified on screens, most members hide their symptoms, limiting HSPs ability to detect symptoms; furthermore, when subthreshold symptoms are detected, HSPs often are limited by time constraints in following these up.

Another method HSPs highlighted to help identify those with subthreshold symptoms was by having conversations. HSPs suggested that team leadership should be educated in how to have conversations where they ask members how they are going if they notice changes in their behaviours, attitude or engagement. Many HSPs mentioned that 'knowing your people' was essential to identifying subthreshold symptoms. So that while junior leadership or supervisors are well placed to identify low-level symptoms and behaviour change, this requires really knowing your team members and having the skills required to ask members how they are going and responding appropriately.

Do they have the required information?

After identifying who HSPs thought were best placed to identify subthreshold symptoms, they were asked if they thought these people had the information required to do so. Sixty per cent of participants responded that education was required on identifying such symptoms (see Figure 11).

Figure 11. Proportion of HSPs who suggested education for different groups

Of these, almost half felt that members themselves need more information about what symptoms to look out for and the same proportion felt that Command or leadership required further education about identifying symptoms. Some participants mentioned education of padres, and another two considered that peers required education about early symptoms to look out for where intervention may be useful. Other participants highlighted that while education and information is needed, sometimes people can identify issues in others but are unsure how to actually talk to the individual about the symptom, particularly when symptoms are low level.

"Educating at all levels is critical. Those who move into leadership should be trained to pick up on issues and trained about how to talk to the team about them."

Psychologist

"There is scope for education (of members) on subthreshold symptoms and what to do if they are experiencing any."

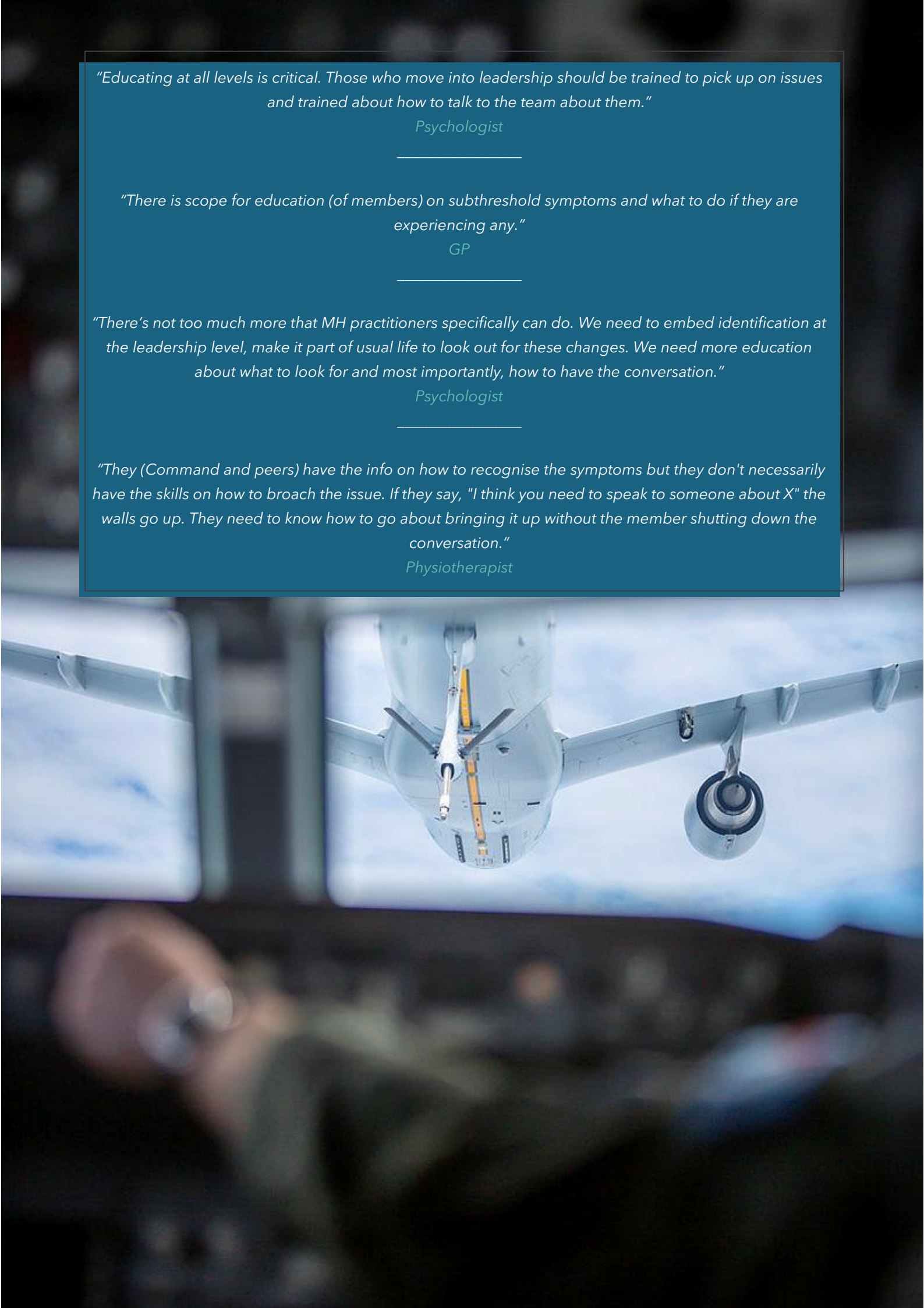
GP

"There's not too much more that MH practitioners specifically can do. We need to embed identification at the leadership level, make it part of usual life to look out for these changes. We need more education about what to look for and most importantly, how to have the conversation."

Psychologist

"They (Command and peers) have the info on how to recognise the symptoms but they don't necessarily have the skills on how to broach the issue. If they say, "I think you need to speak to someone about X" the walls go up. They need to know how to go about bringing it up without the member shutting down the conversation."

Physiotherapist



Barriers to early identification

HSPs were asked if they could identify any barriers to the timely identification of subthreshold symptoms. Figure 12 shows the main themes that emerged from HSP responses.

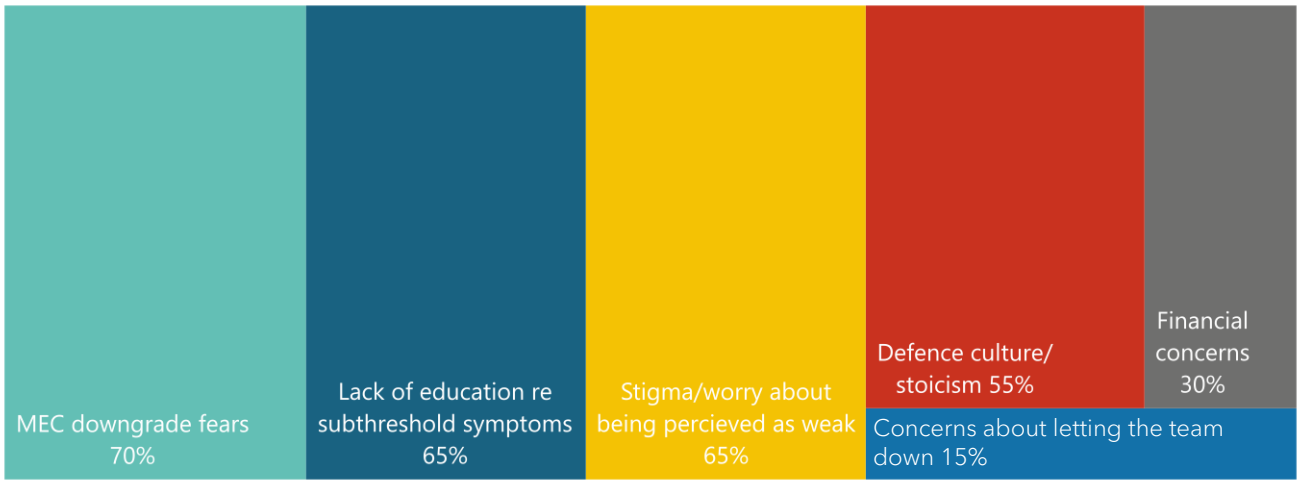


Figure 12. HSP identified barriers to early identification of subthreshold symptoms

Military Employment Classification (MEC) downgrade

The most frequently cited perceived barrier to early identification was fear of MEC downgrade. HSPs described the fear of being MEC downgraded was a strong driving factor for members avoiding help-seeking. Most HSPs who reported this barrier felt that some fears were warranted, as some members do receive a MEC downgrade that may be disproportionate in relation to the severity and impact of their symptoms. However, there was also a perception that there were a lot of myths among serving members about how MEC downgrades are applied. They often described an inconsistency in the application of downgrades as contributing to members' fears and the perpetuation of myths.

"There are myths around [that] if you see psych for more 4 or 6 appointments you will be MEC'd. There are lots of myths. I don't think we communicate [about the MEC system] well to reduce this barrier."
Psychologist

"MEC downgrading is variable there are some with hard touch, others with soft touch. It's meant to be standardised."
Psychiatrist

"Members are afraid of career implications [and] MEC downgrades, so they keep quiet."
Focus group member

"They don't realise they are not even at risk of a downgrade if they get help early."
GP

Lack of education

The next most frequently cited barriers were lack of education about subthreshold symptoms, and self-stigma or worry about being perceived as weak. Reported lack of education referred mostly to the education of members themselves. HSPs felt that members were uninformed about interactions between symptoms like sleep and anger and mental health decline. HSPs reported that members may not recognise these symptoms/issues as early signals that they

may need some support. It was felt that members do not have the knowledge to relate these types of issues to mental health more generally, and therefore they would be unlikely to seek help with a view to preventing further problems later on. HSPs felt that many members would not understand that they could receive help for these types of symptoms early on and that this would likely benefit them in the long run. They expressed that education about the benefits of 'processing and dealing with emotions' would reduce some barriers. Some HSPs felt that poor mental health literacy and members feeling that their low-level struggles with mental health lack validity need to be addressed to overcome barriers to early help-seeking. Some HSPs felt that lack of education of Command or service providers was also a barrier, with some HSPs not identifying early symptoms due to low awareness of the impacts of these symptoms.

> *"Many members have little education about the interaction between mental and physical health and how things like sleep and anger can be early signs of mental health decline."*
> *Physiotherapist*
>
> *"Members don't realise they can be helped with these sorts of symptoms."*
> *GP*

Self-stigma

The HSPs interviewed commonly described self-stigma related barriers to help-seeking in members. This was related to a fear of being judged by colleagues as being weak if they sought help for mental-health related symptoms or as not being strong enough to cope with the demands of the job if they sought help for something like sleep issues.

> *"Stigma is a barrier, they try to tough it out and don't seek help unless it's really bad."*
> *Open Arms member*
>
> *"There is a cultural problem where by members don't want to be seen as weak, they don't want team members to know they are struggling."*
> *Psychologist*

Defence culture/stoicism

Defence culture and issues related to a culture of stoicism emerged as a separate theme to self-stigma. HSPs described self-stigma as a barrier due to fear of being judged, whereas a culture of strength and stoicism was described as a barrier to members admitting to themselves that they may need help with an issue and choosing to 'soldier on' when experiencing symptoms such as sleep problems, difficult coping, or flat mood.

> *"the culture is don't show weakness."*
> *GP*
>
> *"need to be strong and tough and never show any weakness."*
> *Focus group member*
>
> *"There is a culture of stoicism, no-one likes to be broken, people won't admit to others or to them self and will hide issues due to stoicism."*
> *Chaplain*

Financial concerns

Financial concerns were identified as a significant barrier, mainly for Navy members, though concerns were applicable across all three Services, particularly for certain trades and specialisations, where additional allowances are provided. HSPs described a common fear of Navy members was the consequence of a MEC downgrade due to reporting mental health issues and missing out on

seagoing pay. HSPs explained that for many members this would be a critical issue as they depend on this extra pay and therefore will 'feel they need to keep going' because they cannot manage without it. Additionally, it was felt that the financial issues associated with downgrade and being unable to go to sea may exacerbate other issues such as stress and relationship issues, putting further pressure on individuals.

Letting the team down

A smaller but notable number of HSPs mentioned that concerns they would be 'letting the team down' pushed members to continue to work when they were struggling, or that they would avoid seeking help due to a fear they would be MEC downgraded and leave their team short. HSPs felt this was often a well-founded fear in terms of those with significant symptoms, but that if educated to seek help when issues were low level, this could be avoided. This issue was related to the culture of stoicism many HSPs described, with members feeling that if other team members were coping, they did not want to be seen as the 'weak link'. Having fewer resources could also place pressure on staff who work during times when staff absences are high.

Interventions to support members experiencing subthreshold symptoms

When asked what kinds of intervention, advice or support they would offer a member who was presenting with subthreshold symptoms, most HSPs reported that they would use psychoeducation and referral to a general practitioner (GP) or military medical officer (MO), mental health or other specialist, or to Open Arms. A number of HSPs mentioned recommending targeted apps; other self-help strategies such as education around healthy expression of emotions, encouragement of hobbies, letting go of rituals, writing down stressors, 'wash the day away', 'self-care' education; or encouraging the member to use their own social support networks (Figure 13). HSPs reported variable success with these interventions, and would use multiple strategies to support the member (e.g. engage in psychoeducation, self help and apps first and then referral if positive results were not seen).

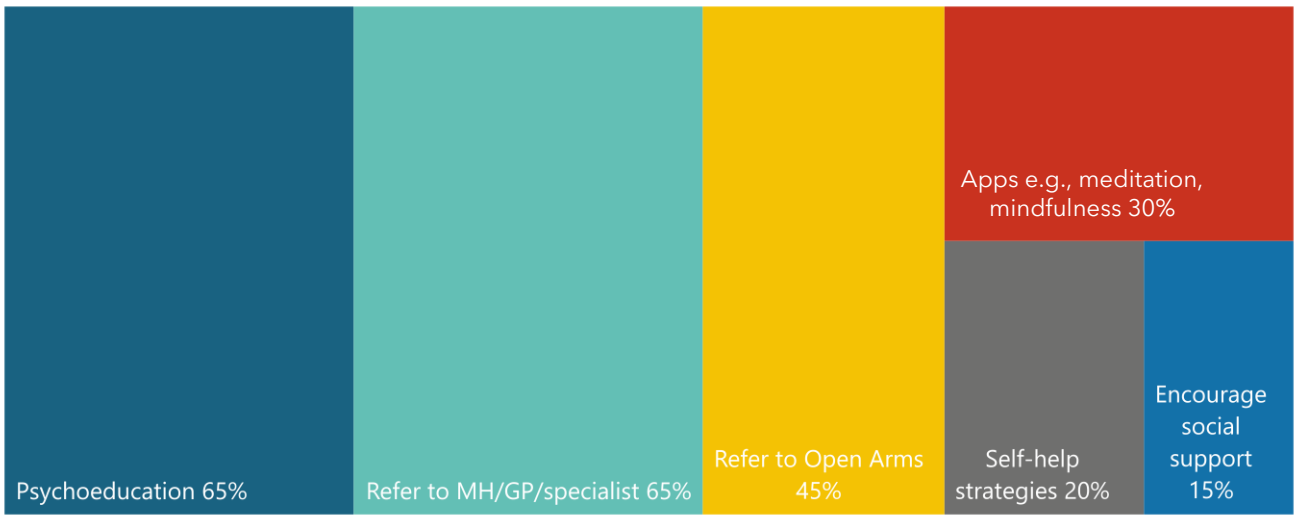


Figure 13. HSP-identified interventions for subthreshold symptoms

Psychoeducation

Most HSPs reported using education as their initial approach where symptoms were low level. This included education about topics such as sleep hygiene, healthy eating, benefits of exercise, emotional processing, balancing workload, and coping strategies. Most HSPs reported that these strategies work some of the time, but not always. Where symptoms do not improve or get worse (and members are either followed up or self-present for further support), HSPs reported that they then refer members on to a specialist, the mental health team, or GP/MO depending on the symptoms.

Referral to GP/MO, specialist or mental health practitioner

HSPs reported using referral to GPs/MOs, specialists such as sleep specialists, or mental health practitioners (e.g. mental health adviser, counsellor) where symptoms did not improve after initial psychoeducational strategies were tried.

Referral to Open Arms

HSPs reported referring members to Open Arms. They reported referring for issues such as stress, coping or anger issues and referred members to both counselling and specific courses such as anger, sleep and transition programs. HSPs reported that they felt that because Open Arms is external to Defence, members are more open to accessing support there. Most HSPs reported that they had not sought feedback from members on the usefulness of courses after referring. Two HSPs who had received feedback reported that members had found the courses 'OK' with no further feedback provided.

Apps, self-help strategies, social support

A number of HSPs said that they recommend specific phone apps such as relaxation or sleep apps. Two HSPs had sought feedback on the usefulness of apps and reported that the members did not actually use them (despite the recommendation to). Some HSPs reported recommending general (non-app based) relaxation or mindfulness strategies but none had sought feedback on the usefulness of these. A small number of HSPs reported that they encourage members to seek social support and encourage greater social interaction when members present with low-level mental health concerns.

"Where people are having issues coping I recommend apps in mindfulness or relaxation. If these do not work, I refer onto the psychologist. I usually emphasise that they require practical help with coping strategies as most are reluctant to engage with psychs as they don't want to talk about their past etc. So coping strategies and relaxation skills are the focus."

Physiotherapist

"Some members don't know how to deal with frustration and it builds up. I give them basic life coaching, suggestions such as vent in the boxing room, punch a pillow, and I refer onto anger workshops."

Chaplain

Barriers to implementation of support strategies

HSPs were asked whether they could identify any barriers to the implementation of effective strategies to address subthreshold symptoms (Figure 14). The most commonly reported barriers were inadequate time and resources, followed by Defence culture, a lack of education and poor continuity of care. These are explored further below.

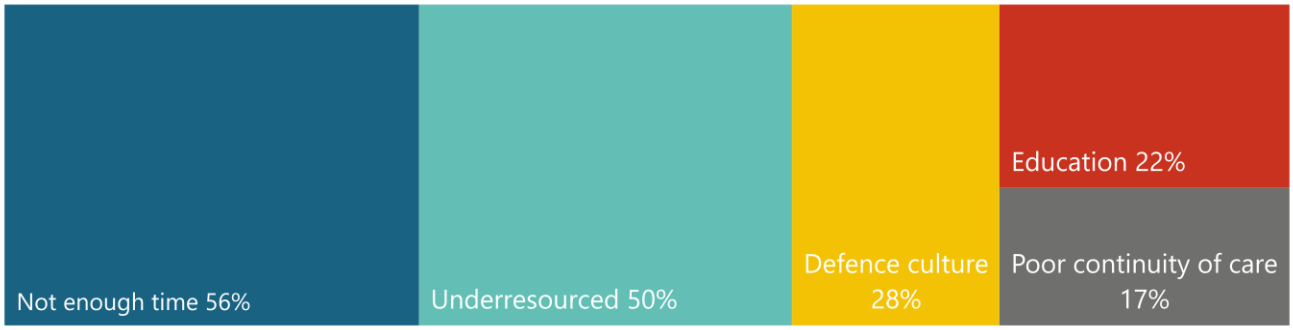


Figure 14. HSP-reported barriers to implementing effective strategies to address subthreshold symptoms

Time constraints

Just over half of the HSPs reported that implementation of effective strategies to identify and combat subthreshold symptoms was impacted by the limited time they have with members. HSPs reported that short appointment times prevented them from completing everything they need to complete, and that there was rarely time to explore how members were coping, sleeping, feeling etc. Also noted as a barrier was the time imposition on members themselves to go to appointments, as well as long wait times to get appointments, resulting in some members avoiding help-seeking completely.

Resource constraints

Half of the HSPs felt that a lack of resources was a barrier to effective implementation of strategies to address subthreshold symptoms. HSPs described a lack of staff, staff being spread too thin and inadequate funding for mental health. Civilian mental health practitioners described caseloads of 200 members per practitioner, and chaplains reported covering up to 1000 members each. HSPs felt that the continuity of care was often a challenge and that locum staff impacts the ability to build trust.

"We are very under resourced. Wait times are up to four months for a GP appointment."
Medical Officer

"[We] need more time and more people. If they had two hours up-front this would be enough for most people, then they could do a follow up and refer out if ongoing support was required."
Psychologist

"On base mental health professionals are way too thin on the ground so they refer people out to private contracted practitioners. There is a deficit there."
Psychologist

"Time is a major barrier."
GP

"Long wait times [are a barrier], if someone has subthreshold symptoms this could lead to someone not following through."
GP

Culture

HSPs described a culture within Defence where strength and resilience are lauded but weakness is unaccepted. They felt that members were encouraged by their superiors to push through rather than admit when they need help and that this can lead to members being 'broken' due to waiting so long to reach out for help.

"Alcohol is a massive issue with the culture,[it's] very very hard to change. Defence are trying but it is a big part of the culture."
Open Arms counsellor

The use of alcohol was noted by many and described as a concern.

HSPs shared examples to describe the diminution of a community culture, such as the fact that unit sports had significantly declined and Defence housing was perceived to be profit driven. Additionally, several HSPs mentioned that the use of a top-down approach thwarted cultural change and that using a bottom-up approach would help overcome barriers to help-seeking; examples could include investing in educating mental health champions or further developing the peer support system.

Education

Many HSPs felt that a lack of investment into the education of both members and Command was a barrier to implementation of effective strategies to tackle subthreshold symptoms. HSPs felt that members received a lot of useful education around more serious mental health issues such as suicidality. However, subthreshold symptoms would be frequently thought of as 'part of the job', something that would not benefit from intervention or would resolve on its own. HSPs felt that members would benefit from education on what early signs could be addressed through seeking help. Within the HSP population it was noted that some mental health professionals may resist education based on new research as they 'may feel like they already know everything about mental health'. The perceived lack of investment in education of chaplains in subthreshold symptom interventions was also a significant barrier to early identification within this group. The chaplains and many of the HSPs felt that members were not properly informed about the role that chaplains play and the support they can provide for subthreshold issues.

'The ones who are hard workers, it's eyes on the prize, they're doing their job. They're the ones that are perpetuating this culture of 'suck it up and do your job,' unless you're completely broken."
Medical Officer

"I more often see a negative culture of 'no, you keep working.'"
Medical Officer

"We are pushing our people to breaking point. We're not managing the subthreshold level at all. When they're broken there is such a stigma around it and it's really hard then."
Medical Officer

Suggested solutions

A number of HSPs offered suggestions for ways to overcome the barriers to effective implementation of strategies to manage emerging symptoms. These suggestions are of great importance for translation of research findings and will be addressed through the Directorate of Health Research Translation and Knowledge to Action Framework.

Shorter wait times to get appointments and more time for appointments were identified as critical which, it was noted, would require increased staff to share workloads. HSPs suggested that having more mental health professionals on base and increased appointment times would be helpful, as many members found the retelling of their story to multiple HSPs difficult. Many HSPs felt that with longer appointment times, low-level issues could be resolved in one to two sessions, before they evolved into a bigger issue, and that external referral might often not be necessary.

Education was commonly suggested as a helpful strategy to overcome barriers to the effective identification and/or management of subthreshold symptoms. HSPs felt that members would benefit from education around what mental health professionals do and also what types of supports chaplains provide. HSPs suggested that simple fact sheets and posters that highlight what types of symptoms could become problematic, and that provide contacts and resources, would be useful. They suggested that members often do not realise the risk associated with not addressing subthreshold symptoms and that if members felt that the risk was sufficient, they would be more motivated to address issues early. Some HSPs felt that members need education around the interaction between physical health and mental health to help them understand that improving mental health would also impact physical wellbeing. It was suggested that this would be particularly useful at the initial stages of a member's training to set an expectation that mental health is something they need to maintain just like physical fitness. Allied health professionals, such as rehabilitation consultants, felt that increased education in their field on how to identify symptoms and where to refer members to when symptoms were identified would be very useful.

Promotion of more general mental health wellbeing and prevention activities such as yoga, Pilates and meditation were suggested as potential strategies to help reduce self-stigma and improving wellbeing. Several HSPs suggested that incorporating these into Defence life like physical training (PT), where they are conducted as part of work, would be useful. They suggested these activities be incentivised by ensuring people could go during work hours, as with physical training, and that this would also help normalise wellbeing activities as part of keeping fit and optimising performance. It was suggested that having guidelines for mental health, like there are for physical health, would help highlight the importance of mental health and wellbeing.

"Privacy is an issue in smaller units. If you go to see someone, everyone knows. Telehealth could be a great solution here."
Rehabilitation Officer

"Prevention and wellness activities. [We] could easily leverage off established systems such as PT."
GP

"It is critical to consider how engagements for these issues are recorded to avoid this [fear of MEC downgrade] barrier."
Psychologist

"Packaging this as performance rather than mental health issues will help overcome barriers."
Medical Officer

Some HSPs suggested using telehealth to overcome resourcing and accessibility issues as well as provide increased privacy for members help-seeking, thereby addressing some confidentiality concerns.

Opinions on screening

HSPs were asked to share their thoughts on the usefulness of current screening processes to identify subthreshold symptoms. It is important to note that not all HSPs interviewed had a good understanding of screening practices and processes. Of those who did, a large majority felt that members know how to answer screening questionnaires and will frequently hide symptoms until they are ready to seek treatment. HSPs reported that members had expressed that this reluctance to report symptoms was to avoid the consequences of having mental health issues identified, due to the same barriers to help-seeking mentioned earlier (e.g. self-stigma, fear of career implications). HSPs mentioned that post-deployment screening was not followed up at times, leaving subthreshold symptoms unaddressed. Additionally, they reported that some members are dishonest on in-country and post-deployment screens due to a desire to get home as quickly as possible and because members feel that once they are home the symptoms will likely resolve. It was felt that if high scorers are not followed up, often they will just live with the symptoms for many years until they reach levels that are having a significant impact on wellbeing and functioning. When asked about the periodic mental health screen (PMHS), those HSPs who had used it felt that it would be better implemented as a paper questionnaire due to difficulties with the online version. HSPs commented on difficulties finding and reviewing previous screening scores and service history (related to deployments specifically), which undermined the ability to use previous health information in tracking members' mental health and wellbeing. GPs/MOs described not having enough time to complete the PMHS and that, due to time constraints, they do not look for subthreshold symptoms. They suggested that a traffic light alerts system would be useful so they could easily identify those who scored in the subthreshold zone, but as it is, they find it difficult to even find the scores and then interpret them. A small number of HSPs suggested that it would be useful to add a scale of life stressors to screening in order to pick up on those at higher risk of emerging mental health issues.

> *"[With post-deployment screens] people have told me they have come back from deployment feeling terrible but they were told that if anyone records high they will have to wait and they all just want to get out so they just 'tick and flick'."*
> *Psychiatrist*
>
> ---
>
> *"Screening is overused and most members lie. They are sick of screening they don't take it seriously."*
> *Open Arms*
>
> ---
>
> *"I haven't heard one member who says that they are honest on those screening assessments - they tell them what they want to hear."*
> *Open Arms counsellor*
>
> ---
>
> *"K10, PCL etc. it's very obvious on how you should answer it. People administering it don't know what it means, nurses and doctors need more education on thresholds."*
> *Focus group member*
>
> ---
>
> *"The PMHS is absolutely terrible…far too resource intensive. People didn't know how or when to do it. The doctors just didn't know how to use it, if it was a paper questionnaire it would work."*
> *Psychologist*

"PMHS is good when someone follows up on the results but this is not well done."

Mental Health Nurse

"Members 'tick and flick' - particularly [RTAPS] - they want to go home, they are tired and want to see their families. Then symptoms emerge later and they ignore them, learn to hide them and live with them, sometimes for over 10 years. They think they will be okay when they get home."

Mental Health Nurse

"If people have a high amount of trust that the info will be used well, they will be honest. But people are fearful of what will happen if they are honest. People divulge to me that they lie on screening."

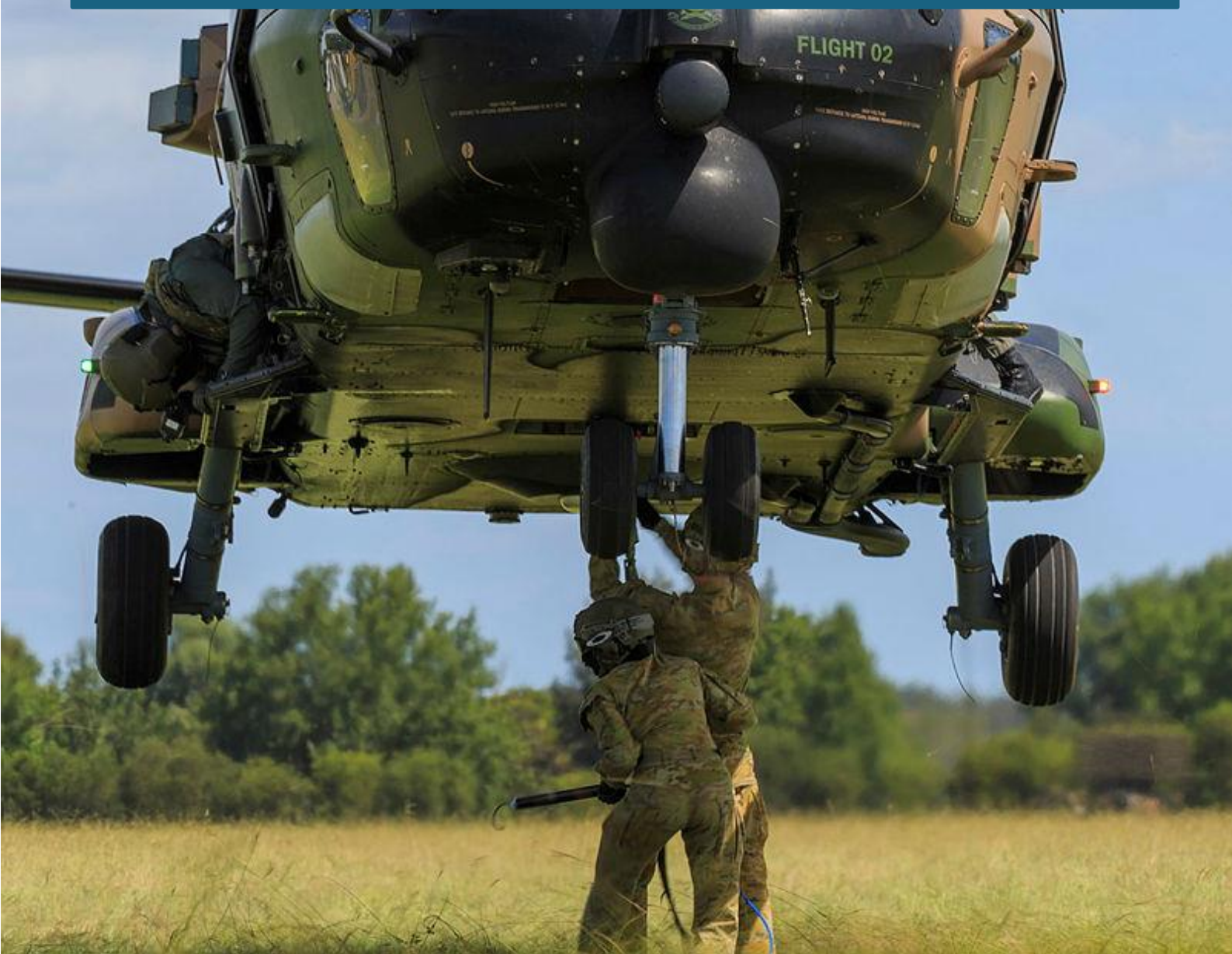
Chaplain

"Screening is useful but doesn't always pick up subthreshold [symptoms]. It's all about how clinicians use the results, the K10, PCL-C and AUDIT are overused."

Psychologist

"The people doing screening don't care and they hate doing it. The members are so tested they are so sick of it. The whole process diminishes the usefulness of psychometrics. Are there better tools? Could they look at quality of life? Could they identify what each individual's major stressors are and work with them on those issues?"

Open Arms counsellor



Chapter 4

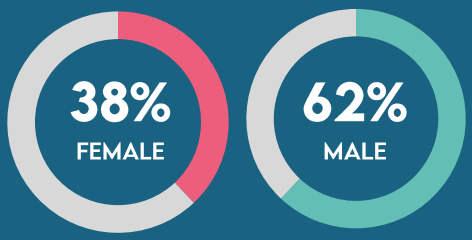
Early career member outcomes

EARLY CAREER DEMOGRAPHICS

Phoenix AUSTRALIA

13 EARLY CAREER MEMBERS WERE RECRUITED.

38% AIR FORCE
39% ARMY
23% NAVY

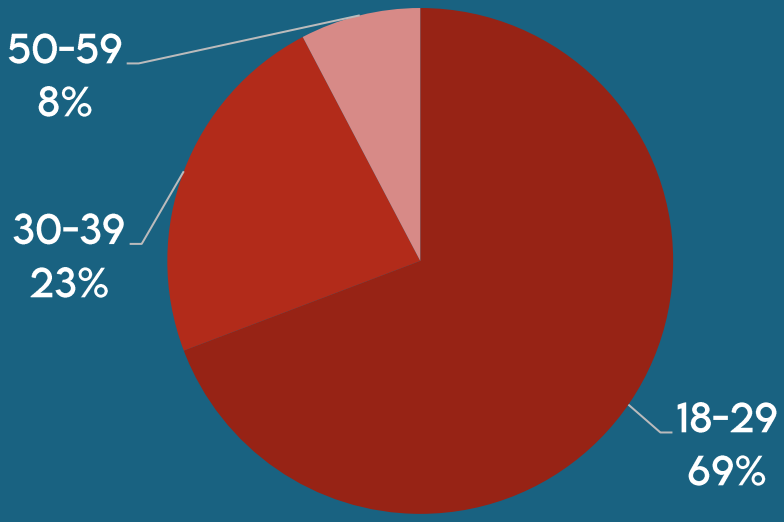


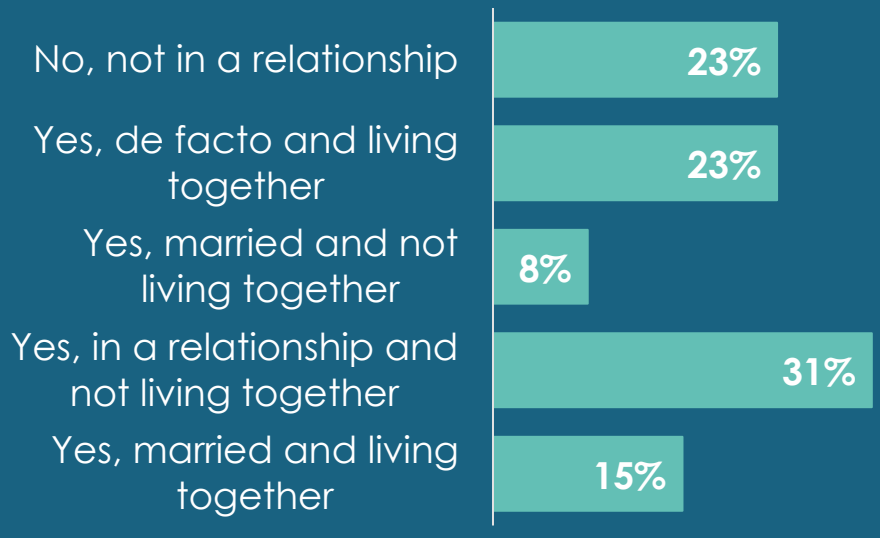
0% SENIOR COMMISSIONED OFFICER
0% SENIOR NON-COMMISSIONED OFFICER
16% JUNIOR NON-COMMISSIONED OFFICER
38% OTHER RANKS
46% COMMISSIONED OFFICER

46%
HEALTHY

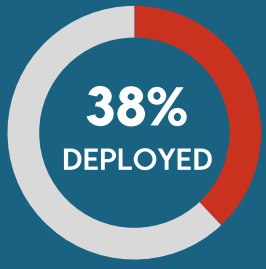
54%
SUBTHRESHOLD

AGES





DEPLOYMENT



Early career members

Members were categorised as early career if they had served for less than eight years, with a total of 13 members interviewed to reach saturation.

The majority of early career members were male (62%), aged between 18-29 years (69%) and had not been deployed (62%). Just over half were experiencing subthreshold symptoms at the time of participating (54%). Additional demographics, including rank and relationship status, are shown on page 35.

Social support

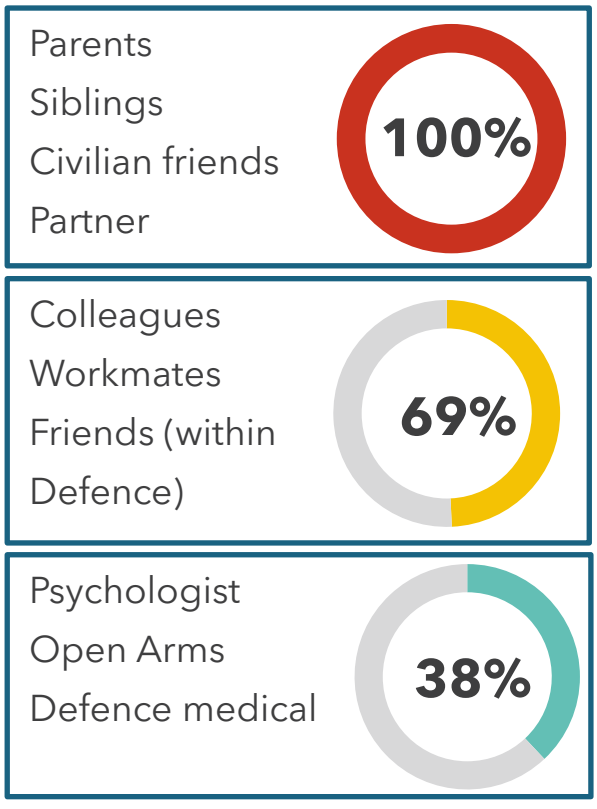
Tell me what sort of social supports you have. Who would you reach out to if you wanted to talk about something personal?

All early career members reported that their primary source of social supports were informal. These included direct and extended family members, civilian friends, partners and pets.

The second most commonly reported source of social support were colleagues. These were described as friends within Defence, colleagues, people of 'same rank level' and workmates. Early career members also reported seeking support for personal issues from health practitioners. Here members referred to presenting at the medical centre for sick parade or seeing a psychologist or counsellor both within and external to Defence.

"I don't really have many civilian friends because you move around a lot, you post a lot, it's difficult to maintain those relationships. Inside Defence I have friends just about all over Australia."
Army, 18-29, years Junior Non-Commissioned Officer

"I can talk to my friends without any shame or fear of being judged because we've all experienced the same things. It's actively 'are you okay?' or 'I've noticed this' people are more observant of the welfare of their brothers and sisters in that space. In Defence it is a brother and sisterhood of people who are like minded, who share experiences. It adds a level of comfort, because you're all in it together. That bonded mateship is so strong."
Army, 18-29 years, other ranks.

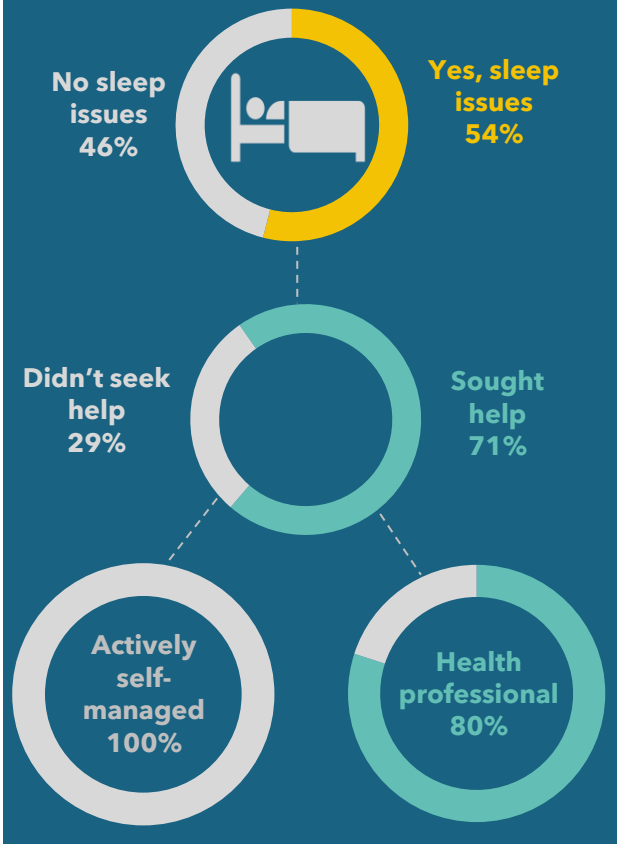


Sleep

Have you ever had trouble with sleep, such as finding it hard to get to sleep or falling asleep? Have you sought help?

Just over half of all early career members interviewed reported that they have had trouble with sleep (Figure 15). Of those members who reported sleep issues, over two-thirds said they had sought help. All of these members sought help from a health practitioner. The early career members who reported that they had experienced sleep issues but had *not* sought help for this, reported that they chose to actively self-manage. Active self-management involved using sleep hygiene strategies such as staying away from blue light-emitting technology before bed, diet, exercise, and meditation. Early career members also reported seeking help from 'medical', mental health nurses, psychologists and Open Arms.

Figure 15: Early career sleep outcomes



"No, not really. If I notice if I'm staying up late because I'm not particularly tired, I'll try and tire myself out throughout the day. So maybe I'll go for a longer run or go to the gym or something like that to fatigue me more. Or [I'll] go see some friends."
Air Force, 18-29 years old, Commissioned Officer

"Sleep is not an issue for me. [If it did start to become a problem] I am aware of tool like meditation, making sure the bedroom is a good environment for sleeping and that sort of thing."
Air Force, 30-39 years, other ranks.

"Yes, I have had sleep issues, I've been given tips and tricks on sleep hygiene [from a psychologist]."
Army, 30-39 years, Commissioned Officer.

"Not outside of work. In a seagoing environment, yes. I'm very self-aware and know when I'm coping and when I'm not coping"
Navy, 18-29 years, Commissioned Officer

"The nature of my job and doing watchkeeping throws it out a bit, so I kind of put it down to that."
Navy, 18-29 years, Junior Non-Commissioned Officer

Coping

When something happens at work that doesn't go your way, how do you manage that? What kinds of things do you do to be able to cope with the situation?

The majority of early career members reported that they would use active self-management strategies to cope with these events (Figure 16). Active self-management strategies included: positive self-talk e.g. "treat it like water off a duck's back", "that's just life"; dealing with the problem through communication strategies e.g. "seek clarification", "try to impact a change", "work through things"; or immersive distractors/diversions e.g. cooking. Other members described trying to remain calm, venting or doing activities to 'switch off'.

Over a third of the early career members endorsed speaking with leadership when things do not go their way at work. This included when they are feeling extremely angry and can't control it. For example, early career members reported that they "may go to executive squadron leader" or would start low level and "if I'm stuck on things I'll go higher". Early career members also endorsed getting professional support (i.e. psychologist, MO, Open Arms) and seeking informal support, while just under a third reported using exercise to cope when things do not go their way.

"I do tend to get a bit flustered. I will reflect on it myself. I try and remain calm. I do tend to reach out to people at work."
Air Force, 30-39 years, other ranks

"I guess venting to friends as much as I can. Working it out and training is a big thing for blowing off steam or just doing something where I don't have to switch on."
Navy, 18-29 years, Junior Non-Commissioned Officer

"I definitely partake in a number of sports. That really helps me deal with whatever is going on with work and just forget about it."
Navy, 18-29 years, other ranks.

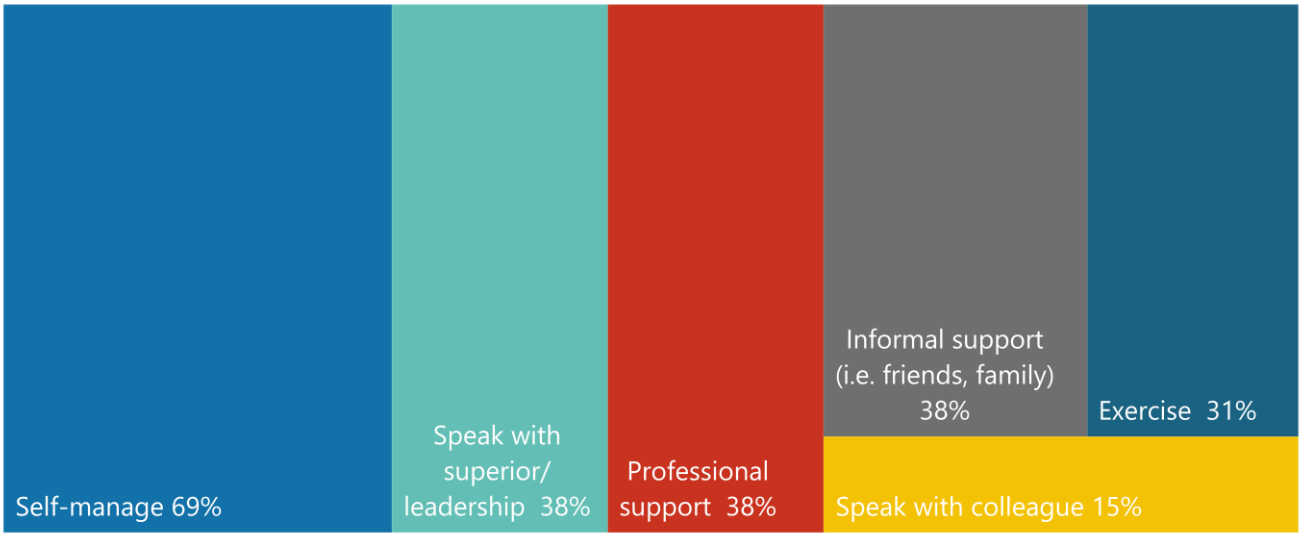
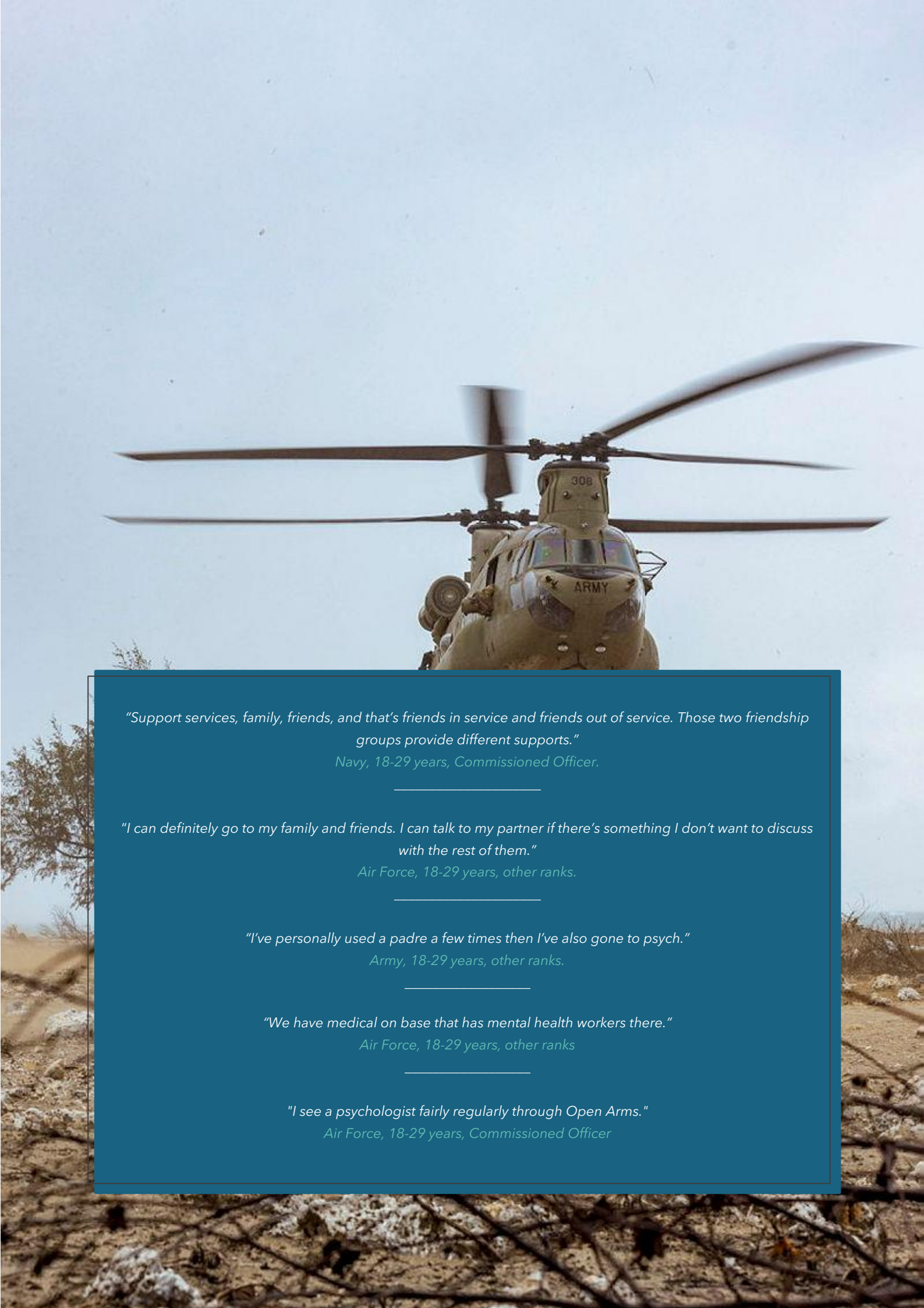


Figure 16. Early career group coping strategies



"Support services, family, friends, and that's friends in service and friends out of service. Those two friendship groups provide different supports."

Navy, 18-29 years, Commissioned Officer.

"I can definitely go to my family and friends. I can talk to my partner if there's something I don't want to discuss with the rest of them."

Air Force, 18-29 years, other ranks.

"I've personally used a padre a few times then I've also gone to psych."

Army, 18-29 years, other ranks.

"We have medical on base that has mental health workers there."

Air Force, 18-29 years, other ranks

"I see a psychologist fairly regularly through Open Arms."

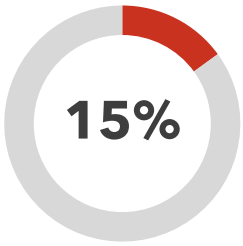
Air Force, 18-29 years, Commissioned Officer

Anger

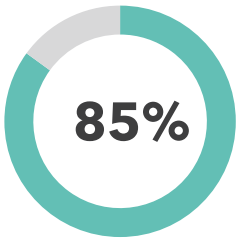
Do you find that you get or you feel angry at people or situations quite a lot of the time? What kinds of things do you do to manage that?

Most early career participants reported not feeling angry at people or situations quite a lot of the time. Those who did report feelings of anger quite a lot said they had experienced these feelings previously but not recently. No participants reported having any recent experiences with feeling angry frequently. Some participants reported experiencing frustration and annoyance but did not equate this to feelings of anger. To cope with feelings of frustration and annoyance, members used exercise, such as running, going to the gym, and playing sports; talking to friends and family; and active self-management strategies such as breathing exercises, removing themselves from the situation and considering other's perspectives.

Previously had times where they feel angry quite a lot of the time



Do not feel angry quite a lot of the time

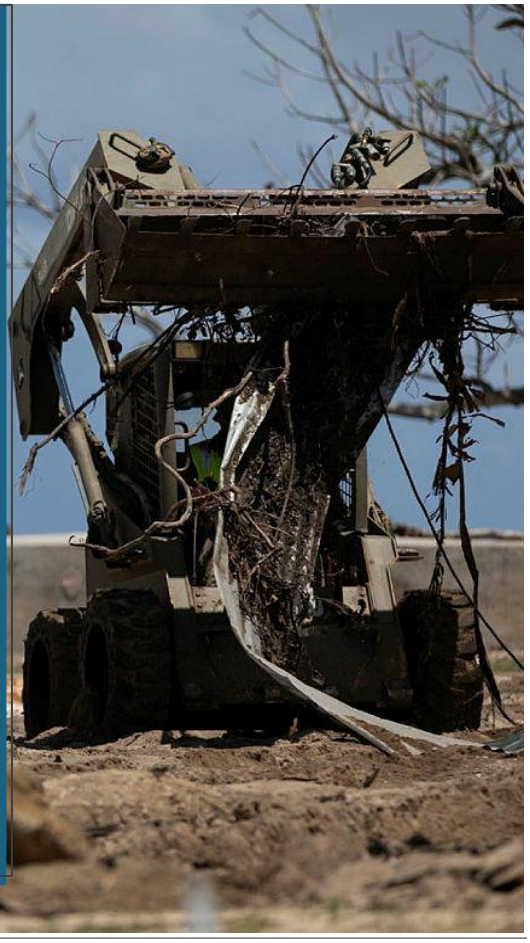


"Not angry, more annoyed. Sports, running, talking to my mum [helps]."
Navy, 18-29 years, other ranks.

"Less so as I've gotten older and I've worked in lots of different locations and with lots of different people and I've done more in my job role. Obviously when you're 18 its quite hard to manage your anger if you're just getting screamed all day every day and you can't retaliate but that changes a lot, comparative to when you're 26 and you're the adult of the situation and you understand why this is occurring."
Army, 18-29 years, Junior Non-Commissioned Officer

"Anger is not really an emotion that I get too much. My Sargent can get irate. I can definitely see it more in the older generation of soldiers around here."
Army, 30-39 years, Commissioned Officer

"No, I don't get angry. I have a pretty relaxed personality, it takes a lot for someone to annoy me."
Army, 18-29 years, other ranks.

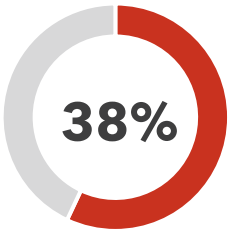


Doing enjoyable activities

Have you ever had a period during your time with Defence where you stopped doing things that you enjoy? What helped you get back on track?

Just over a third of early career participants reported never having a time where they stopped doing things they enjoy. Where members did report having a period of time where they stopped doing things they enjoy, this was noted to be either due to their personal wellbeing (that is, due to deterioration in their own wellbeing and mental health) or due to the demands of the job.

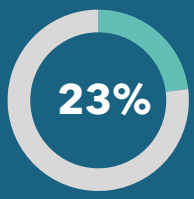
Have NOT had a time where they stopped doing things they enjoy



Some early career participants reported having a period of time where they stopped doing things they enjoy, due to demands of the job. Some said they were unable to play sport during training as they weren't "allowed due to guidelines at the time" or that having periods of not doing things you enjoy is "just part of the stressors of Defence". Of note, some early career members highlighted that the period where they stopped doing things they enjoy due to demands of the job was when they first started in Defence or during their training.

Just under a third of early career participants reported having a period of time where they stopped doing things they enjoy due to personal wellbeing. These participants reported drinking more, that their family noticed a change from their regular self or that they self-recognised that they weren't doing things that they would normally.

Not doing things you enjoy due to demands of the job



"At sea yes, but that's purely because of the fact that I haven't had time. I've never been in a position where I have had time but I haven't been able to do things I enjoy."

Navy, 18-29 years, Commissioned Officer

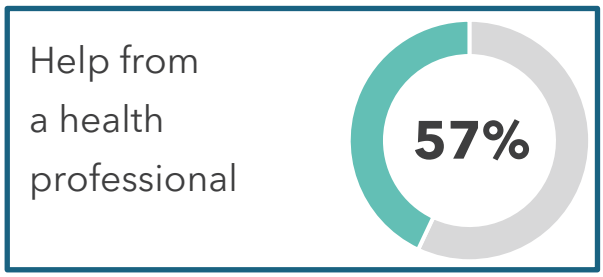
"Yes. During initial training. The tempo of training is so demanding. [I] gave up on exercise which I really loved. I could have fit it in so I'm not really sure why I gave it up."

Air Force, 18-29 years, Commissioned Officer

"Yes, I'm still not back on track to be honest with you. It's a long process. Changing jobs definitely helped and changing location definitely helped. I think it's just part of the stressors of Defence where you drop the things you enjoyed beforehand and you've just got to re-fine ways to integrate them healthily."

Army, 18-29 years, Junior Non-Commissioned Officer

Participants who did have a time where they stopped doing things they enjoy (either due to personal wellbeing or demands of the job) were asked what helped them get back on track. Seeking professional help was the most commonly reported method of getting back on track.



For members who did not seek help from a health professional, they either passively self-managed and did not try to make any change, started "leaning on others" once they realised they were "all in the same boat" or are still trying to find ways to get back on track.

Help avoidance

Have you ever had health issues that impacted on your wellbeing but you didn't seek help for? How did you manage?

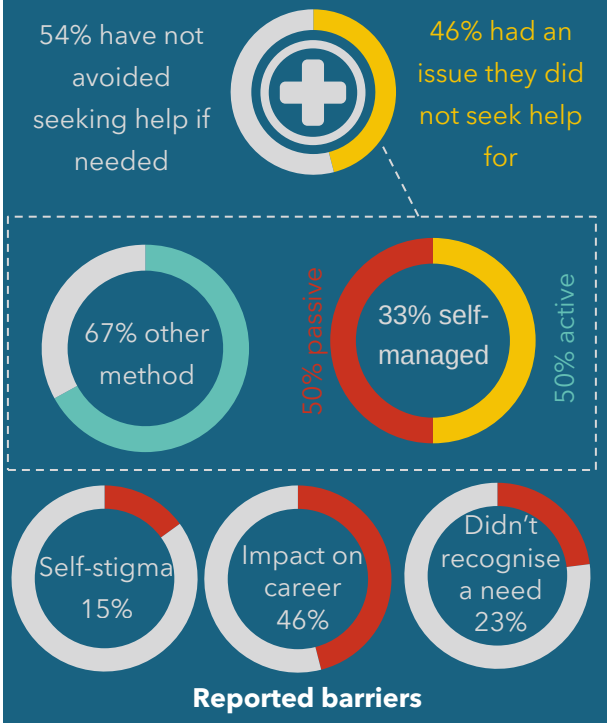
With this question we aimed to explore what activities members used to relieve symptoms, if they had previously not sought professional help for symptoms of poor mental health, and to identify barriers that early career members experience. This is in contrast to the following question on attitudes to help-seeking where the aim was to gather members' thoughts relating to self-stigma, to determine whether help avoidance was ever related to feelings of shame or unworthiness/failure. It should be noted that members' comments did not always align in these responses, with some members reporting that they had avoided help-seeking due to self-stigma, while at the same time responding that they would not feel negatively about themselves if they did need to seek help and this would not be a barrier to care.

Just under half of early career participants had an issue that was impacting their wellbeing that they did not seek help for. Of those who reported having an issue that they did not seek help for, a third self-managed. Of the proportion of participants who self-managed, half actively self-managed by talking to friends for example, and half passively self-managed (did not do anything). However, self-management methods were rare within the early career group.

Participants were also asked why they themselves did not seek help when they had a health issue that was impacting on their wellbeing, or the reasons they see others not seeking help. The most commonly reported barriers to help-seeking were impact on career, self-stigma, or because they themselves or others do not recognise when help is needed (Figure 17).

> *"To be [in this job] you have to have a certain medical classification. So a lot of people are not as willing to go forward and seek help under the fear that they will be removed from that job and lose the financial incentives."*
>
> *Navy, 18-29 years, Commissioned Officer*
>
> *"It's almost like you seek help and then you get punished for it."*
>
> *Air Force, 18-29, other ranks*

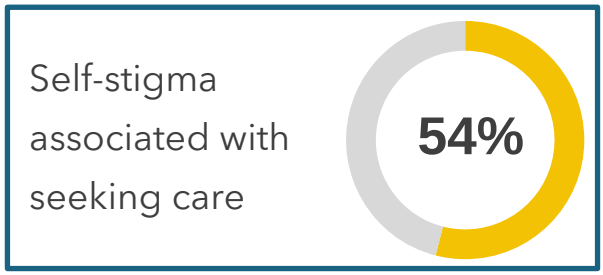
Figure 17. Early career help-seeking



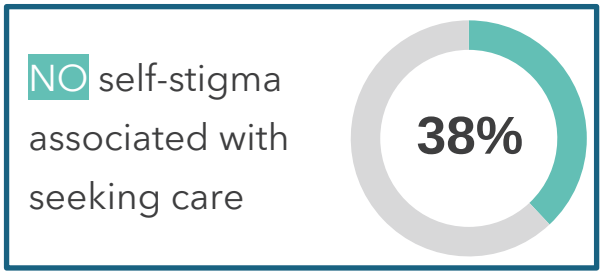
Attitudes to help-seeking

How would you feel about yourself if you needed to seek care? What do you think would help you overcome those concerns? What do you think needs to be done to change this?

The majority of early career participants reported that they would have difficulties seeking care and/or would experience self-stigma if they needed to seek care (e.g. would fell they are 'messed up' if they needed to seek care). Fewer participants reported that they would be comfortable seeking care (i.e. would not experience self-stigma) and/or would not feel negative towards themselves.



When asked what can be done to change things, participants said decreasing wait time for appointments would be useful. Some participants raised the issue of difficulty getting medical attention, saying that it takes "hours to see a doctor in the sick parade" and that "it's easier to soldier on and hope the injury goes away".



It was also highlighted that people need to be educated on what health issues can be managed at home versus those that need treatment because some members seek help for injuries that "are not that bad".

Other early career members also reported that having exemplars or evidence of where help-seeking has had positive impacts would be helpful. For example, participants said they would like to see more people seek help and have no negative repercussions in order to increase help-seeking behaviours.

Increased education was also endorsed as a means of improving issues with how members feel about themselves if they needed to seek help. This included education around how to seek help, what supports are available, as well as how it will be reported and recorded in Defence systems. Importantly, there was recognition that general attitudes toward help-seeking are improving within Defence.

"I think the old stereotype is that you're messed up if you need help. But I think that's going away."
Air Force, 18-29, Commissioned Officer

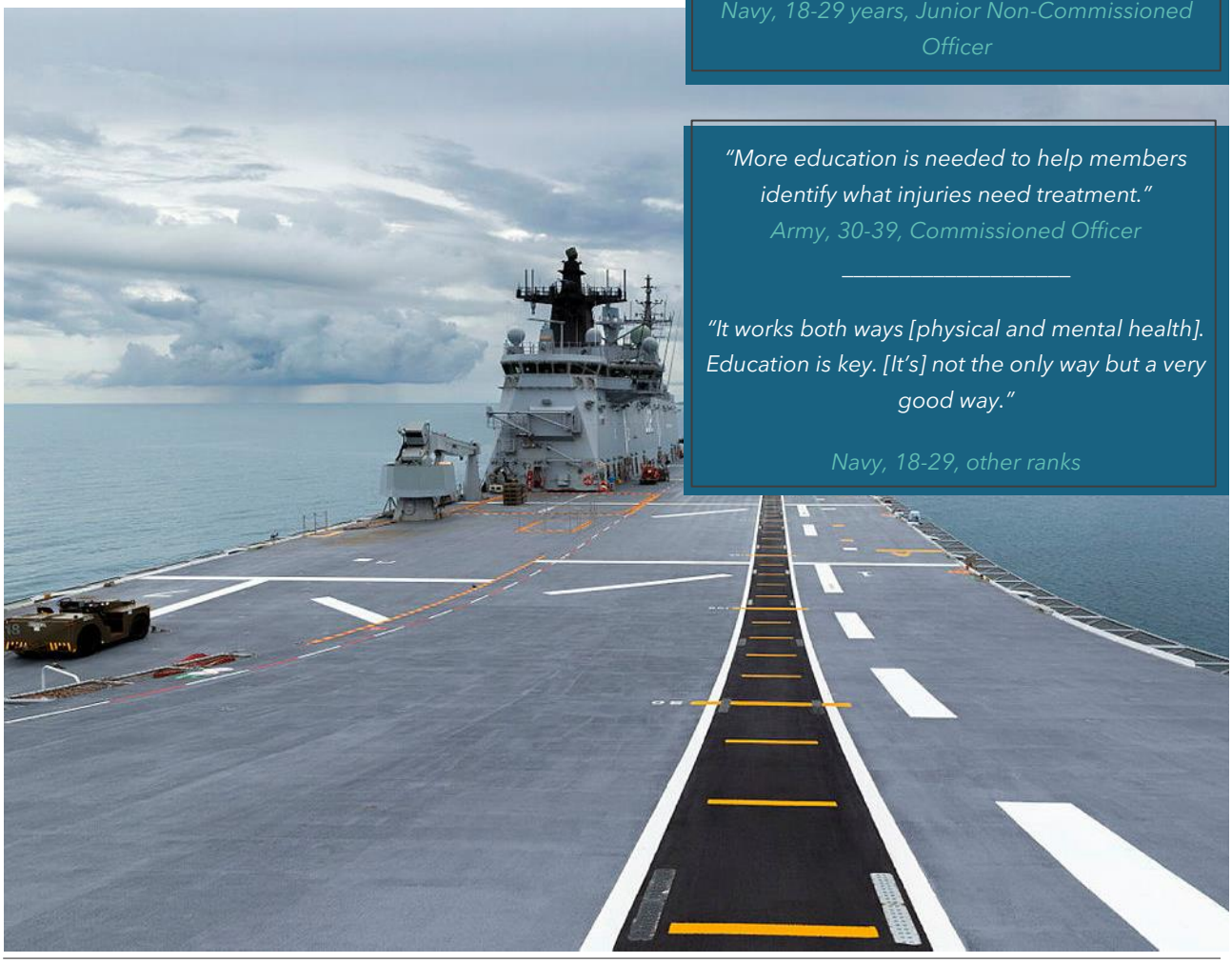
"Don't let your soldiers see you feeling anything other than confident and on top of everything."
Army, 30-39, Commissioned Officer

"It is difficult to think that you need help. No one wants to be that person that needs help."
Air Force, 18-29, Commissioned Officer

"I guess it would be difficult. It's hard to admit to yourself that you need help. It's easier to access assistance through Defence for a physical issue. Wait times for psychological services can be quite long."
Navy, 18-29 years, Junior Non-Commissioned Officer

"More education is needed to help members identify what injuries need treatment."
Army, 30-39, Commissioned Officer

"It works both ways [physical and mental health]. Education is key. [It's] not the only way but a very good way."
Navy, 18-29, other ranks



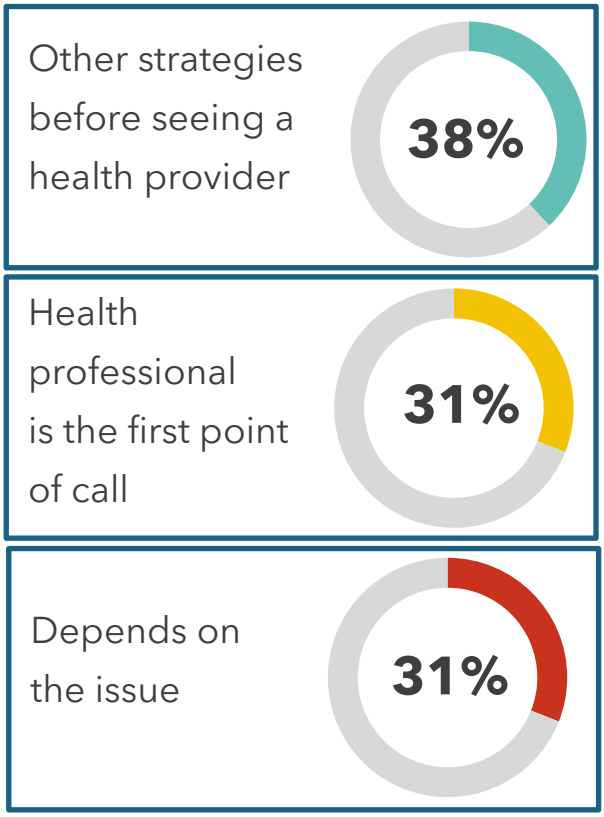
Help-seeking behaviours

Do you think that when health issues arise, mental or physical, that the first port of call should be to go and see a health provider or are there other ways you think that people could manage their health? Do you think there are any barriers to members seeking help for these issues?

Over a third of early career participants reported that other strategies should be used first. Other strategies that could be used were talking to informal supports, such as friends and family, as well as self-managing. Self-managing included calling free help lines, meditation, yoga and exercise.

Equal proportions of participants believed seeking help from a health professional should be the first port of call or that it depends on the issue.

Participants reporting that it depends on the issue mostly said that it depended on whether it was an issue with physical or mental health as well as the type of illness or injury. Some of these members noted that trying to self-manage is a good starting point, as well as talking to friends or seeking advice from a supervisor in some instances.



"I go to defence supports for physical. For mental health I'd be more inclined to go to non-Defence ones"
Air Force, 18-29, Commissioned Officer

"If people have a problem they should be more than welcome to speak to a professional."
Army, 18-29, other ranks.

"It all depends on the nature of the injury, of the illness, I think there could be other ways, it comes down to, if you're injured, can you fix yourself."
Air Force, 50-59, Commissioned Officer

"You can always reach out to other people around you."
Navy, 18-29 years, Junior Non-Commissioned Officer

I know a lot of people when they first have health concerns, they'll bring it up to their friends more often than anything. They'll [say] 'hey my knee has been driving me nuts for 6 months but I don't want to go and seek medical help.'"
Army, 18-29 years, Junior Non-Commissioned Officer

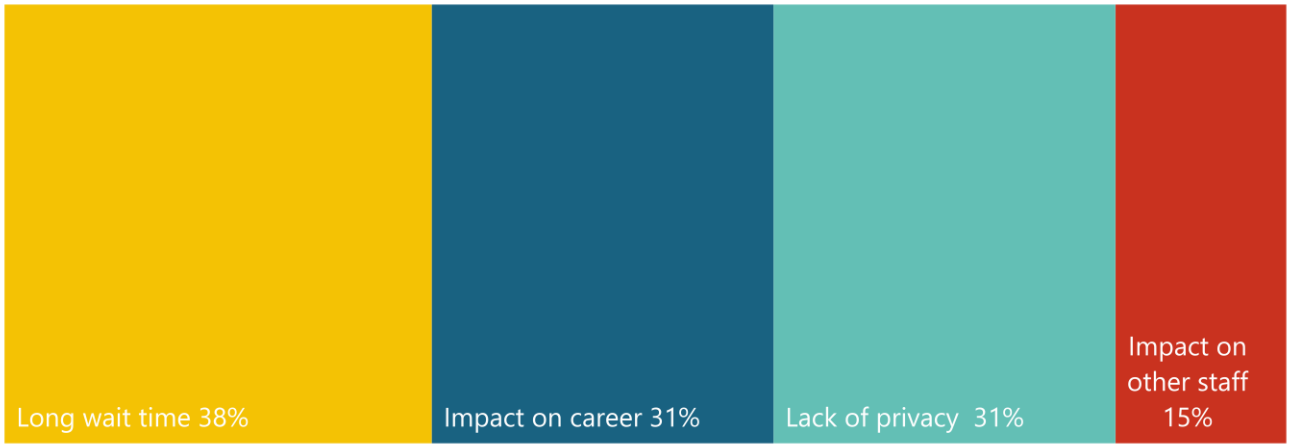


Figure 18. Early career reported barriers to help-seeking

Long wait times

Early career participants were asked about perceived barriers to help-seeking (Figure 18) and reported that there is "not enough medical staff", people have "difficulty getting appointments", and there is a "time delay in being able to access services". This causes members to "wait it out" and see if they get better. Members reported that they are aware that facilities are not available so they "don't bother seeking help. What's the point?"

"Current system to see a psych is slow and drawn out."
Army, 30-39, Commissioned Officer

"Medical are under the pump."
Air Force, 30-39, other ranks

"If you are in a remote location you may wait 6 months to get a specialist appointment and injury deteriorates further.
Army, 18-29, Junior Non-Commissioned Officer

Impact on career

The second most commonly reported barrier was impact on career. Early career participants reported that seeking help could impact their clearance, their ability to be deployed and promotions. Interestingly, some participants noted that this fear is an "incorrect perception" saying they have known "other people that have not had a negative impact from seeking help, but there is still a level of fear there."

"People can be quite scared of reaching out for mental health services that may have an impact on their clearance.
Navy, 18-29, Junior Non-Commissioned Officer

"It takes courage to put your hand up for support and it is very unhelpful when that support ends up causing problems for you in your career."
Army, 30-39, Commissioned Officer

Lack of privacy

Lack of privacy was also reported as a barrier to seeking professional help among early career members. Gossip among colleagues such as "blah hasn't been himself" and "seen him at medical" stops people from seeking help.

Impact on other staff

Impact on other staff was the last barrier identified by the early career group. Participants reported that rosters do not have much flexibility and that the job is prioritised over individual needs.

Reducing barriers

Participants endorsed an informal support service as a solution to reduce barriers to help-seeking. Participants reported that it would be helpful to have a location where you could have an initial "chat" with a mental health practitioner that would be "more casual than going through psych" or a service that could help members determine whether they need to seek help or not.

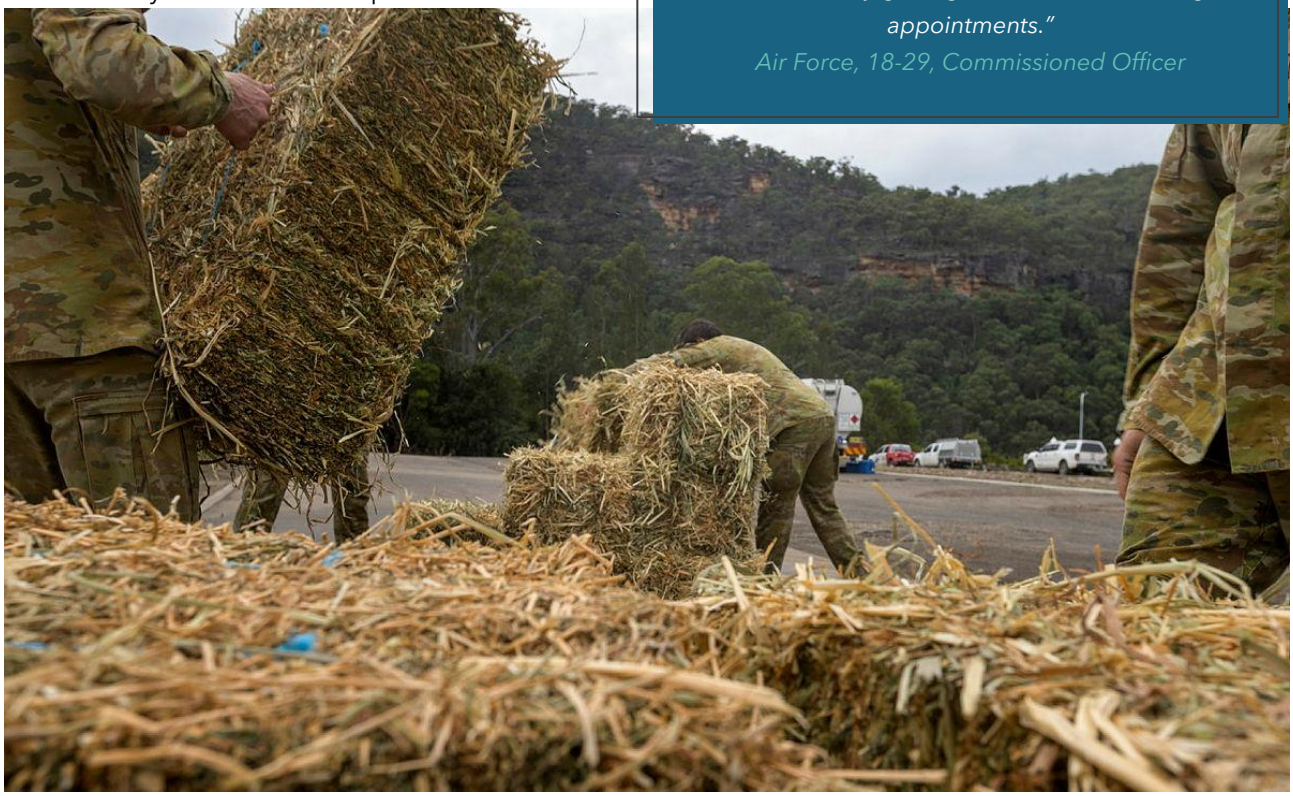
"There's no hard barrier, the support is there. It's the hidden stuff, like gossip."
Air Force, 18-29, Commissioned Officer.

"People get weird about going to medical and seeing people they know."
Air Force, 30-39, other ranks.

"I know one person in particular in defence who went to a leader to say I'm having a problem with this, and you know, they said in a meeting previously if you ever want to come and talk to me it's just between you and me. Straight away after the person talked to their supervisor, the supervisor ran straight to the manager and told them. What's the point if people are going to do that."
Navy, 18-29, other ranks.

"Program of what the unit is doing is sometimes put before what the member needs."
Navy, 18-29 years, Junior Non-Commissioned Officer

"There's difficulty getting time off the roster to go to appointments."
Air Force, 18-29, Commissioned Officer



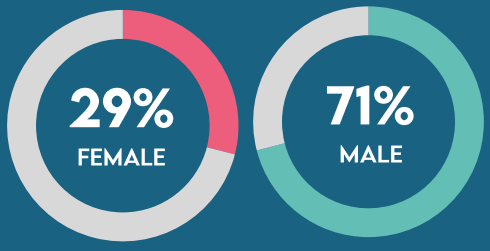
Chapter 5
Mid-career member outcomes

MID-CAREER DEMOGRAPHICS

Phoenix AUSTRALIA

14 MID-CAREER MEMBERS WERE RECRUITED.

21% AIR FORCE
36% ARMY
43% NAVY

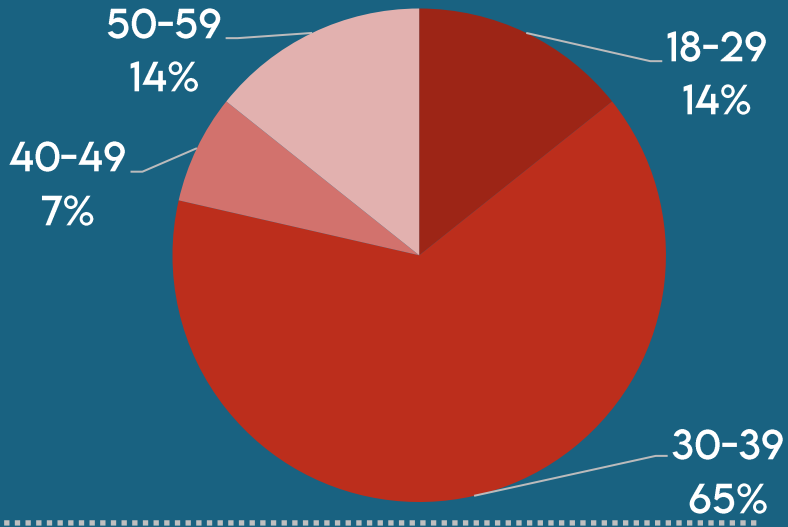


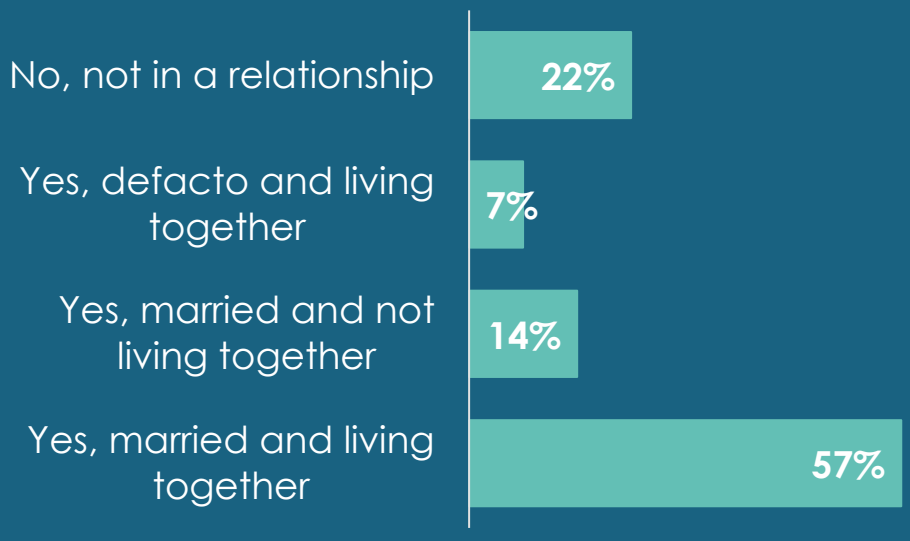
7% SENIOR COMMISSIONED OFFICER
7% OTHER RANKS
7% SENIOR NON-COMMISSIONED OFFICER
29% JUNIOR NON-COMMISSIONED OFFICER
50% COMMISSIONED OFFICER

36% HEALTHY

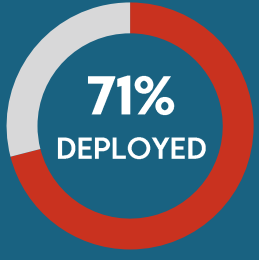
64% SUBTHRESHOLD

AGES





DEPLOYMENT



Mid-career members

Members were categorised as mid-career if they had served for eight to fifteen years. Fourteen members were in this category. The majority were male (71%), aged between 30 and 39 years (65%) and had been deployed (71%). Over half were experiencing subthreshold symptoms (64%). Additional demographics, including rank and relationship status, are shown on page 49.

Social support

Tell me what sort of social supports you have. Who would you reach out to if you wanted to talk about something personal?

All participants reported reaching out to informal supports to talk about something personal (Figure 19). This included family, friends and partners. Over a third of participants reported going to a health professional. These included psychologists, GPs, Open Arms, DVA, and "the medical system" more generally. Almost a quarter noted that they would seek help from the chain of command; this was described as "senior leaders," the "divisional system" and "supervisors" and "managers." Colleagues were also reported as a means of social support for just under a quarter of the participants; these were referred to as "colleagues" and "friends within Defence" by mid-career members.

"In Navy, there is a divisional system, I'm less inclined to reach out in that aspect because of negative consequence."
Navy, 50-59, Commissioned Officer

"Mostly family and friends. Depending on the nature of it, in the last few years I go to Department of Veteran Affairs and talk to one of the counsellors there".
Army, 30-39, Junior Non-Commissioned Officer

Figure 19. Mid-career social support sources

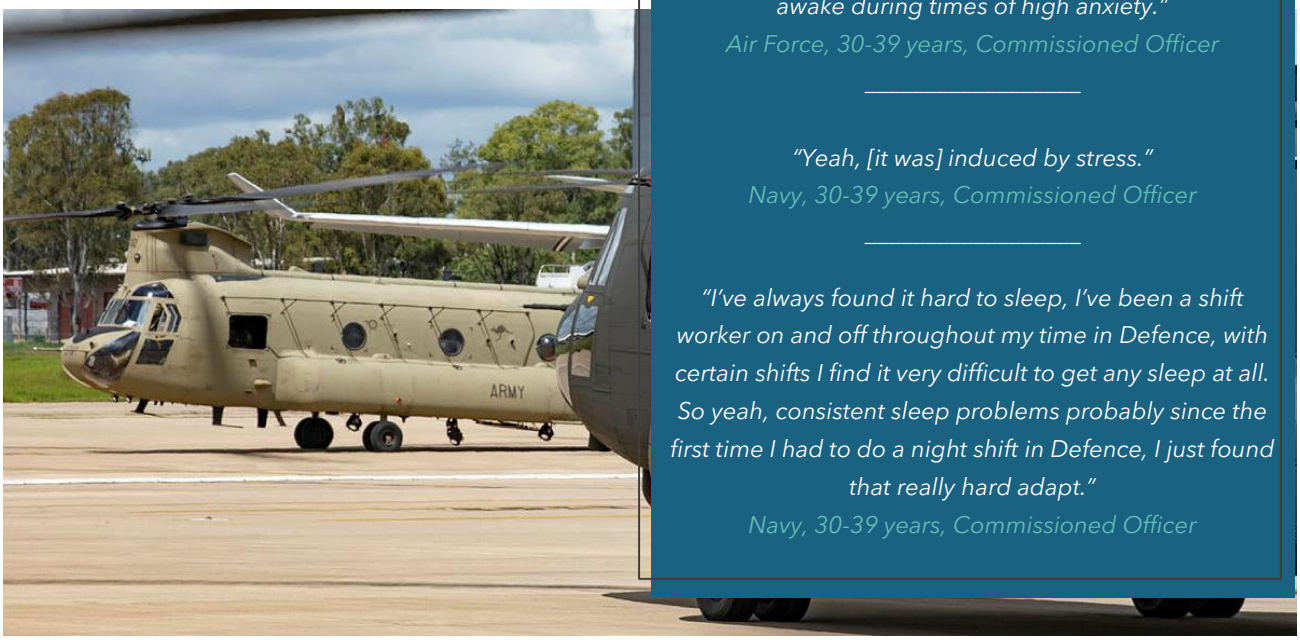
Sleep

Have you ever had trouble with sleep, such as finding it hard to get to sleep or falling asleep? Have you sought help?

The majority of mid-career participants reported having problems with sleep, and most had sought help for these sleep issues (Figure 20). Some members reported that the advice they received was "useful at the time" and that seeing a psychologist was "helpful". At times, delays in getting an appointment with a provider resulted in passive self-management strategies and an incomplete resolution of the problem. All members who did seek help sought that help from a health practitioner. Health practitioners were identified as psychologists, Open Arms and other counsellors, GPs and psychiatrists. Members either self-referred to these services or were referred by another health practitioner.

Figure 20: Mid-career sleep outcomes

There was a mixture of members who sought help internal and external to Defence. Of the small proportion of participants who did not seek help, the majority self-managed (passively and actively) because the "rudimentary tools I use to manage is sufficient".



"Yes, I have in the past. Majority of the time its triggered from nerves and anxiety. Thought patterns keep me awake during times of high anxiety."
Air Force, 30-39 years, Commissioned Officer

"Yeah, [it was] induced by stress."
Navy, 30-39 years, Commissioned Officer

"I've always found it hard to sleep, I've been a shift worker on and off throughout my time in Defence, with certain shifts I find it very difficult to get any sleep at all. So yeah, consistent sleep problems probably since the first time I had to do a night shift in Defence, I just found that really hard adapt."
Navy, 30-39 years, Commissioned Officer

Coping

When something happens at work that doesn't go your way, how do you manage that? What kinds of things do you do to be able to cope with the situation?

Three themes emerged within the mid-career group (Figure 21). The majority of members either actively or passively self-managed. Active self-management strategies included "problem solving", removing themselves from the situation to "calm down", "think through the situation", engaging in enjoyable activities, breathing exercises and maintaining a healthy routine. Passive self-management strategies included "letting things go", moving on and accepting the situation, "switching off" and not taking work issues too personally. After self-management, the second most common strategy was speaking with informal support networks such as family, friends and partners. Finally, over a third reported that they would speak with the chain of command.

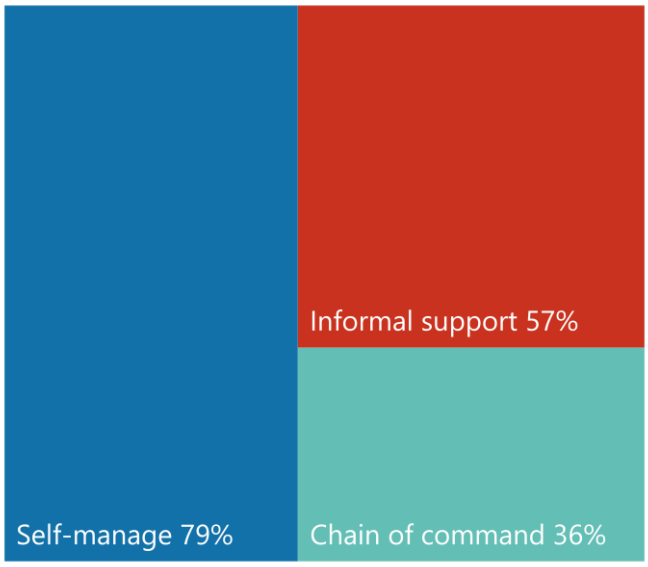
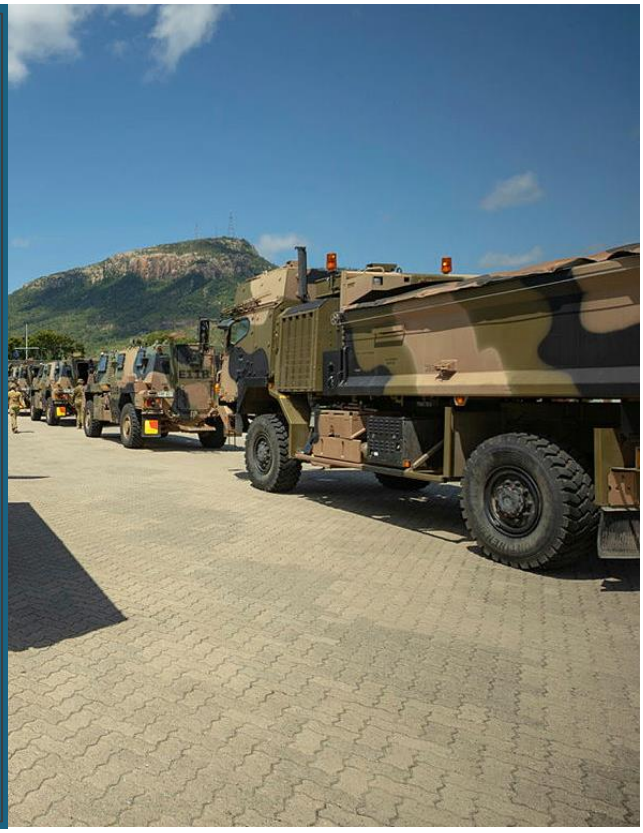


Figure 21. Mid-career group coping strategies

"I'd probably look at it from a proportionate perspective. I would say now I'm less likely to have a knee jerk reaction and I'll think about things for longer and certainly discuss with my spouse in more detail now."
Navy, 50-59 years, Commissioned Officer

"I like to self-reflect. If there's a problem I like to isolate myself from the problem, get thoughts in order, think about the scenario, what next action [could] resolve or improve it and then form a plan to improve the situation."
Air Force, 30-39 years, Commissioned Officer

"In the first instance I would probably try and approach someone at work that I have a good personal relationship with and talk the issue out and see if there's a problem resolution there. Failing that I would probably stress a lot."
Navy, 18-29 years, other ranks



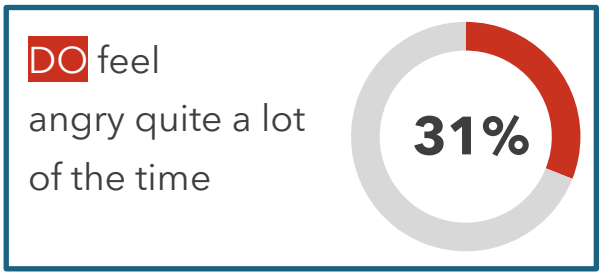
Anger

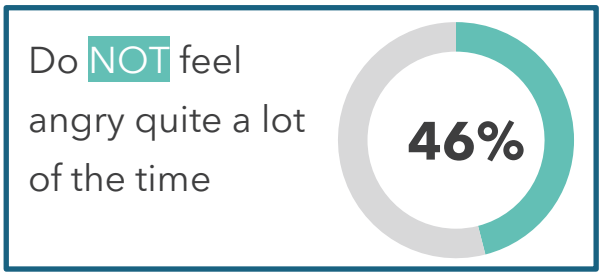
Do you find that you get or you feel angry at people or situations quite a lot of the time? What kinds of things do you do to manage that?

Some mid-career members reported that they were actively experiencing anger quite a lot of the time (and others said they have previously gone through periods where they have experienced anger).

The other half of this group reported that they had never gone through a period of experiencing anger quite a lot of the time.

Mid-career members most often reported that they manage their anger by seeking help from a professional. Just under half of participants reported using both active and passive self-management strategies. Passive self-management strategies included trying to "ride it out" and tolerate the anxiety, tuning out or walking away. Active self-management strategies included sharing opinions, trying to change the situation or actively venting frustrations. Other members reported that exercise such as running, martial arts, swimming, or squash helps them manage their anger.





"I don't think so. My emotional regulation has gotten better as I have gotten older. I am less impatient than I used to be, I'm less quick to feel frustrated and I let a lot more things go than I used to."
Navy, 30-39 years, Commissioned Officer

"I just try and separate myself from the issue."
Navy, 30-39 years, Commissioned Officer

"Historically there's been periods where I've been quite angry over a number of things, now, I can put it best as subdued anger"
Navy, 50-59 years, Commissioned Officer

Not quite a lot of the time. It does happen. Not the person to get angry quickly. If it has time to build then there is the chance.
Navy, 18-29 years, Junior Non-Commissioned Officer

Doing enjoyable activities

Have you ever had a period during your time with Defence where you stopped doing things that you enjoy? What helped you get back on track?

Mid-career members commonly reported that they had previously had a time where they stopped doing things they enjoy and this was related to personal wellbeing (that is, due to issues with their own wellbeing and mental health) rather than demands of the job (Figure 22). Almost half of these members reported seeking professional help to get back on track. Professional supports included psychologists, counsellors and the Defence medical system. Members also used their informal support network and self-management strategies to get back on track. Self-management strategies included removing themselves from the situation, reflecting on the situation and passive self-management (i.e. not engaging in self-management strategies that require physical or mental effort).

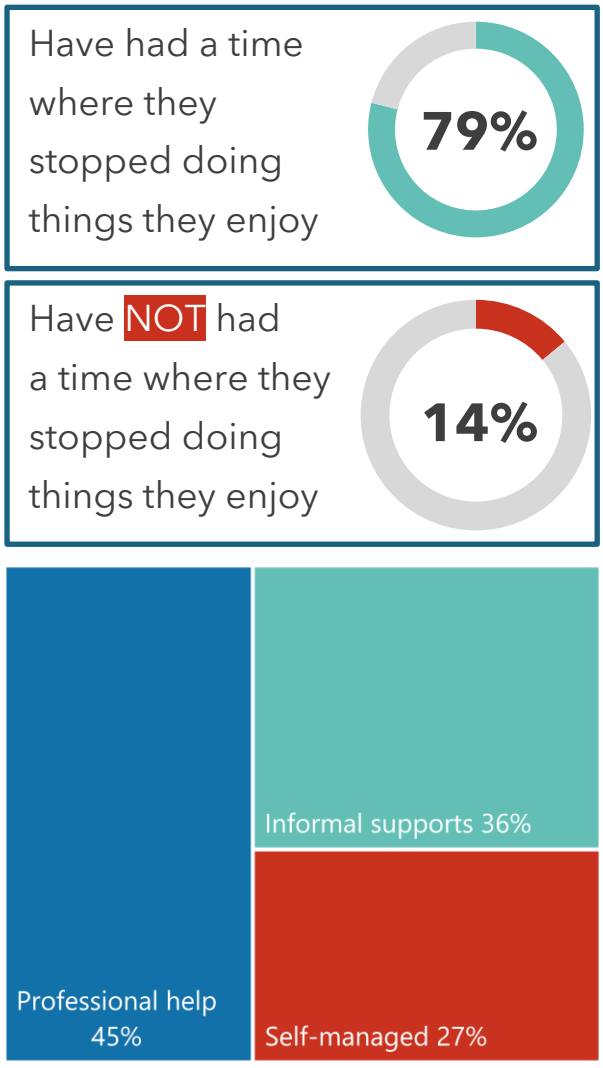


Figure 22. Mid-career groups methods for getting back on track

"Yes. People did bad things and it impacted me significantly to the extent that I could no longer continue on in that situation and I took big steps to get away."

Navy, 50-59 years, Commissioned Officer

"Oh yeah, absolutely. When I got back from my deployment in 2008 I was feeling a bit lost, like what's next in my career, you know, I've sort of gone and done my job for real and everything sort of felt like a let down from there, so for a while there I just sort of felt a little bit lost."

Navy, 30-39 years, Commissioned Officer

Yes. That led to previous episodes. I pulled away from social interaction and church. Not in a mindset to talk to people. Once I went back to the activity you realise you enjoy them again which triggers you to keep going back. You feel like you won't enjoy it but that feeling isn't valid.

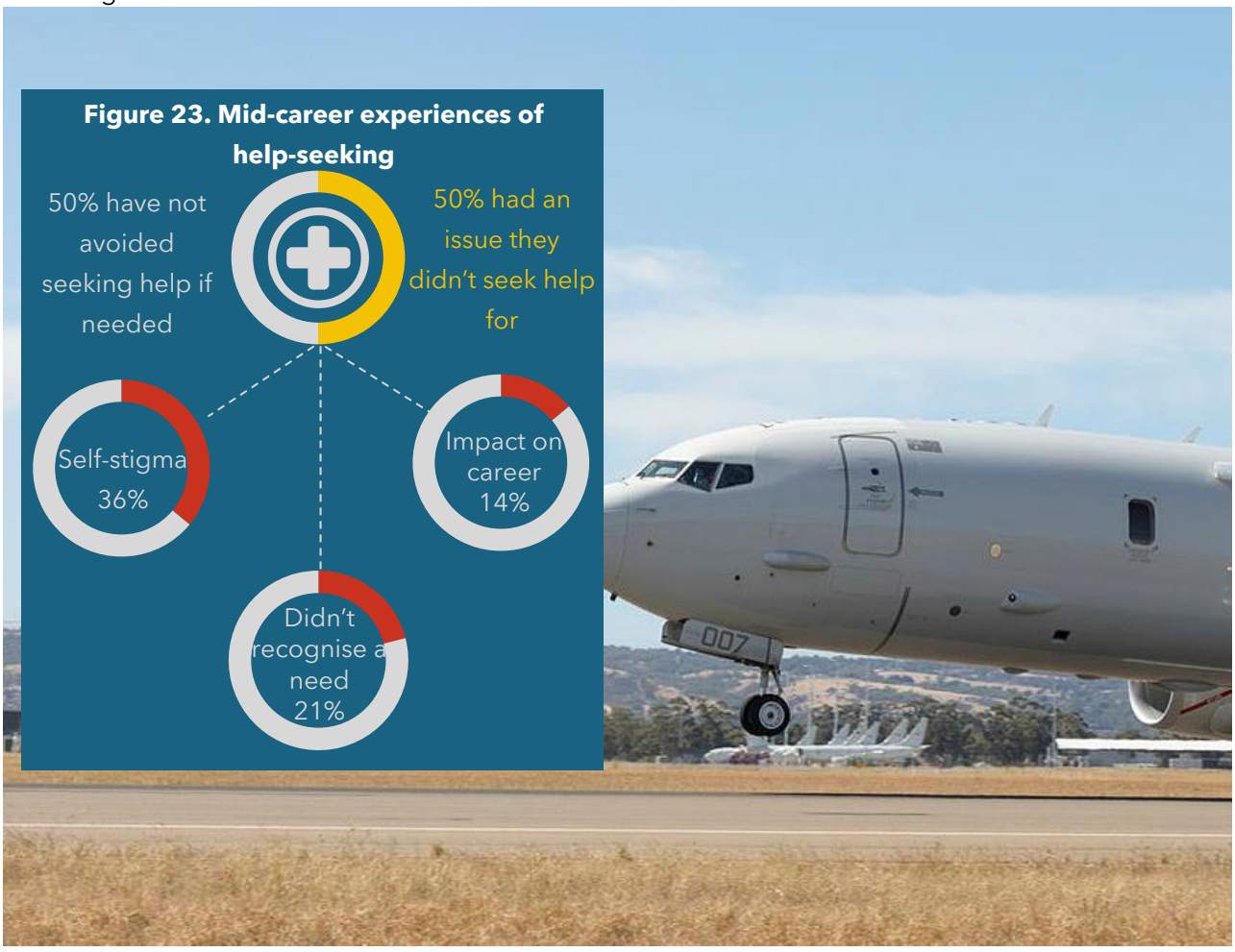
Air Force, 30-39 years, Commissioned Officer

Help avoidance

Have you ever had health issues that impacted on your wellbeing but you didn't seek help for? How did you manage?

Half of mid-career members had never had an issue impacting their wellbeing that they did not seek help for (Figure 23). This was because they either always sought help if it was needed, or they had never experienced an issue that impacted wellbeing. These members were asked whether they had seen other members avoiding seeking help and reasons why they believe some members avoid seeking help.

The other half of mid-career members had experienced a health issue that they did not seek help for. The most common reason reported by mid-career members for not seeking help themselves, or reasons they believe others do not seek help, was feelings of self-stigma. Members reported not wanting to be seen as unable to cope, or as trying to dodge work. Some members reported impact on career as a reason for not seeking help, such as the potential for being medically downgraded, and less opportunity for promotion and deployments. Mid-career members also reported that some members do not seek help because they are unable to recognise that help is needed. For example, it was reported that members do not realise they need to take control of their mental health and "manage it" as well as not being "fully aware" of their mental wellbeing.



Attitudes to help-seeking

How would you feel about yourself if you needed to seek care? What do you think would help you overcome those concerns? What do you think needs to be done to change this?

All participants in the mid-career group indicated that they would be comfortable seeking care and/or would not have negative attitudes towards themselves (Figure 24). A proportion of mid-career group members said they had seen others or they themselves had previously felt inwardly negative about seeking care (43%) but that this seemed to have shifted as their time in Defence increased.

When asked what could be done to support more members help-seeking, participants suggested having exemplars or evidence of where help-seeking has had positive impacts would be helpful. Some also suggested that increased education would help people overcome concerns towards seeking care. This includes more 'Corps members' doing mental health first aid and suicide prevention courses. It was noted, however, that "more education can be helpful but can also be off putting if there is too much".

Finally, members reflected that some are not aware that Open Arms is an option for support. Importantly, there was a recognition among almost a third of this group that people's attitudes towards seeking care have improved over time.

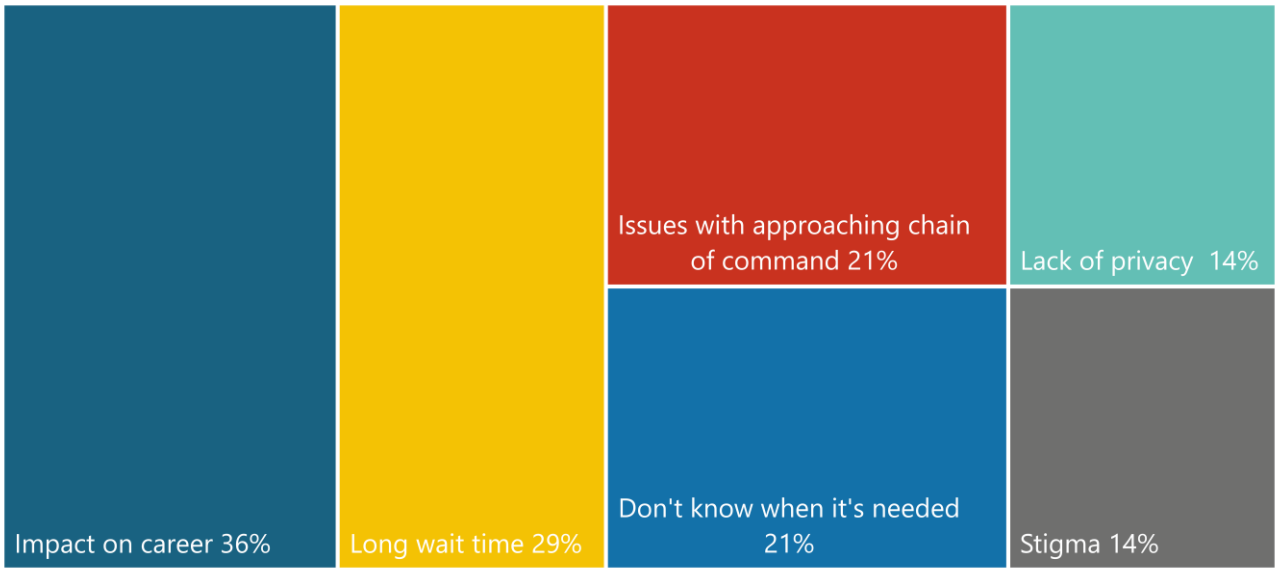
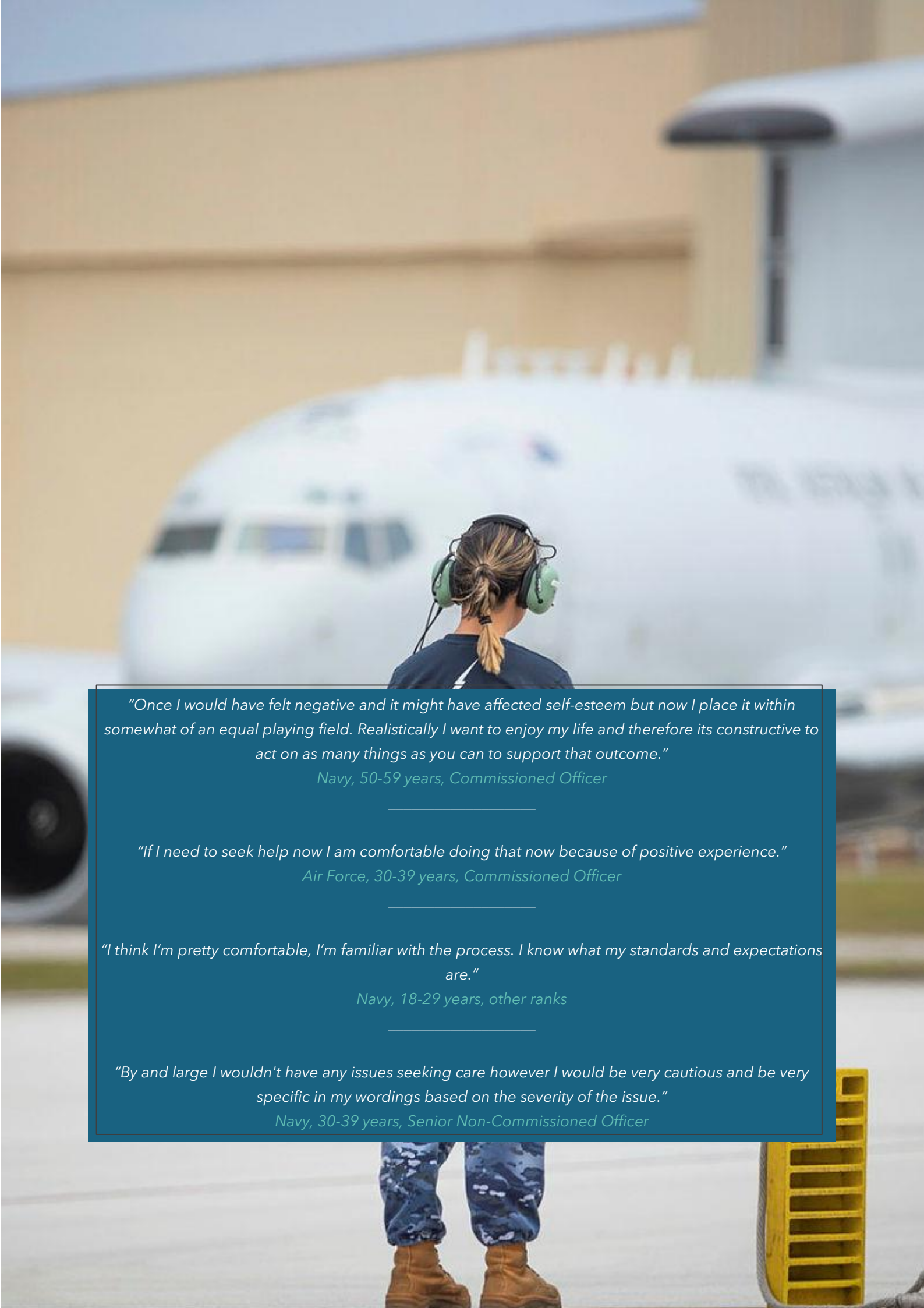


Figure 24. Mid-career group perceived barriers to seeking care



"Once I would have felt negative and it might have affected self-esteem but now I place it within somewhat of an equal playing field. Realistically I want to enjoy my life and therefore its constructive to act on as many things as you can to support that outcome."

Navy, 50-59 years, Commissioned Officer

"If I need to seek help now I am comfortable doing that now because of positive experience."

Air Force, 30-39 years, Commissioned Officer

"I think I'm pretty comfortable, I'm familiar with the process. I know what my standards and expectations are."

Navy, 18-29 years, other ranks

"By and large I wouldn't have any issues seeking care however I would be very cautious and be very specific in my wordings based on the severity of the issue."

Navy, 30-39 years, Senior Non-Commissioned Officer

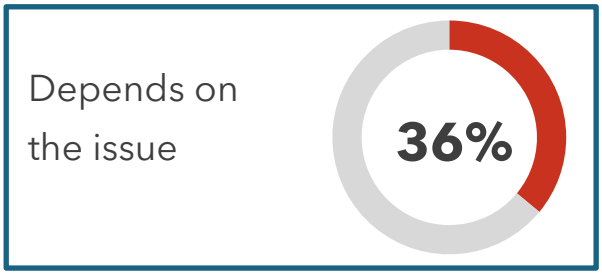
Help-seeking behaviours

Do you think that when health issues arise, mental or physical, that the first port of call should be to go and see a health provider or are there other ways you think that people could manage their health? Do you think there are any barriers to members seeking help for these issues?

Just over a third of mid-career members reported that other strategies should be used before seeing a health practitioner. Members were asked what alternative strategies people could use to manage health issues and they most commonly reported that self-managing should be the first port of call. This includes diet, exercise, sleep and accessing resources such as 1800IMSICK or Lifeline. A number of mid-career members reported they would only seek help from resources external to Defence such as Open Arms because it is "more private".

Some mid-career members reported that when and where they seek help depends on the issue, on the type of injury or illness, and the severity. Most participants who said that it depends on the issue endorsed that health service providers are a good first port of call for physical issues and that for mental health issues, self-management strategies such as more sleep "can be a good place to start".

The remaining mid-career members reported that a health provider should be the first port of call regardless of whether the issue is physical or mental.



"Physical stuff has a clearer path for resolution. E.g. hurt knee, rest, ice etc. mental health everyone is different. There are definitely things people could try at home to see what works. Difficult thing is awareness of when it's not working and the next step is needed."

Air Force, 30-39 years, Commissioned Officer

"There's definitely other ways, especially in the mental space."

Air Force, 30-39 years, Commissioned Officer

Impact on career

Mid-career members were asked whether they believe there are any barriers to help-seeking. Impact on career was the most commonly perceived barrier among mid-career group members. This included the impact that help-seeking may have on deployment opportunities, the "potential of medical downgrading" and that a "psych discharge will also impact career opportunities outside of Defence" in other frontline services such as the police.

Long wait times

Mid-career group members noted that there can be long delays in getting appointments, that scheduled appointments often get "reassigned" and that it "would be good to have more appointments available".

Approaching chain of command

Members reported that the core issue may be their chain of command or they may struggle to approach their chain of command. This impacts member's ability to use their chain of command as a source of support.

Recognising issues

Participants reported that members do not know when help-seeking is necessary and that they hope their issues might resolve naturally. For example, some members believe the issue "isn't that bad and hope that it goes away".

"The potential impact on your career is a big one."
Navy, 30-39 years, Commissioned Officer

"Stigma is very real. it exists and I don't think it's warranted nor actual but there's a perceived risk for impact on career [and] next deployment."
Air Force, 30-39 years, Commissioned Officer

"There are some constraints e.g. having to wait for an appointment. I'd make a dozen appointments because I'd find that my appointment's been reassigned."
Navy, 50-59 years, Commissioned Officer

"Sometimes chain of command is the actual problem."
Navy, 50-59 years, Commissioned Officer

"Bringing it up through chain of command is an issue as well because chain of command might be the issue."
Army, 30-39 years, Junior Non-Commissioned Officer

"If you're young you might be intimidated approaching a chaplain or going to someone up the chain."
Navy, 30-39 years, Commissioned Officer

"People don't really understand what mental health issues look like and when to seek help."
Army, 30-39 years, Junior Non-Commissioned Officer

Self-stigma

Mid-career members reported that self-stigma was also a barrier to seeking help because of a fear that members perceive them as "crazy" if they are referred to a psychologist or that others may believe they are attempting to get out of work if they seek help. These perceptions were thought to "prevent hardworking people from seeking help".

Lack of privacy

Lack of privacy was also endorsed as a barrier to help-seeking. This included other members finding out if a member is seeking help because "everyone knows what everyone is up to". Mid-career members also reported that seeking help external to Defence, such as through Open Arms, is "more private".

Reducing barriers

Importantly, a portion of participants suggested a solution to reduce barriers to help-seeking, in the form of an informal support service. For example, members recommended a service that is more informal than "going to medical", that will not be logged on a member's records and serve as a "first port of call", such as counsellors and mental health specialists "with ready access on each base". It was recommended that this support should "mirror the chaplaincy program" in terms of the access and confidentiality of the service.

"Some of it will get out through various networks."
Air Force, 30-39 years, Commissioned Officer

"[There is] stigma that someone is crazy if they get referred to psychology."
Navy, 30-39 years, Commissioned Officer

"Everyone knows what everyone is up to so people hide it because of that lack of privacy."
Navy, 30-39 years, Commissioned Officer

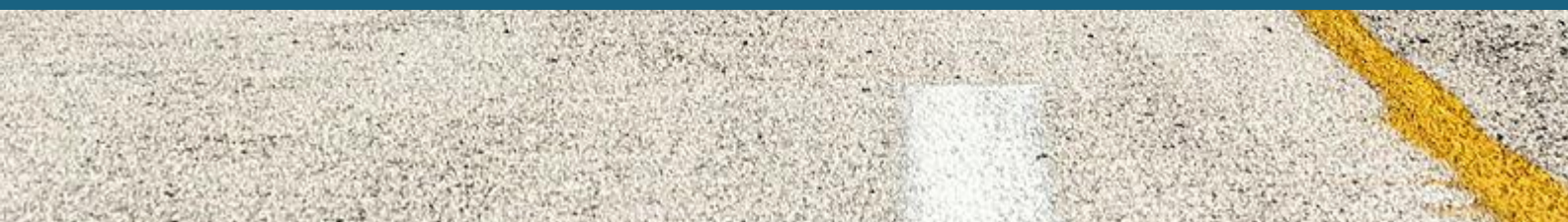
"Needs something more informal that you can go to firstly that isn't going to go on your record."
Navy, 30-39 years, Commissioned Officer

"A service where people can go and receive support in a non-clinical setting would be very beneficial as a first port of call."
Army, 40-49 years, Commissioned Officer

"There's enough out there for you to get the advice and help that you need."
Navy, 50-59 years, Commissioned Officer

"Comes down to talking about it more. In our regular mandatory training psychological help is not a focus. It's more OH&S... Suicide training is great to talk about the worst outcome but there's a whole bunch of stuff that you can do prior to that to catch a whole bunch of other issues before suicide."
Air Force, 30-39 years, Commissioned Officer

Chapter 6
Long career member outcomes

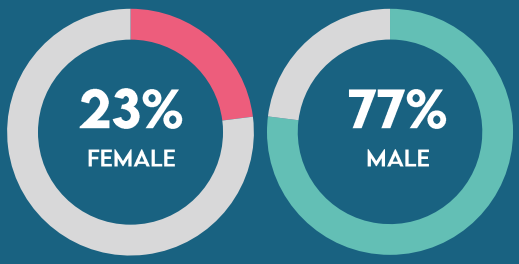


LONG CAREER DEMOGRAPHICS

Phoenix AUSTRALIA

13 LONG CAREER MEMBERS WERE RECRUITED.

46% AIR FORCE
31% ARMY
23% NAVY

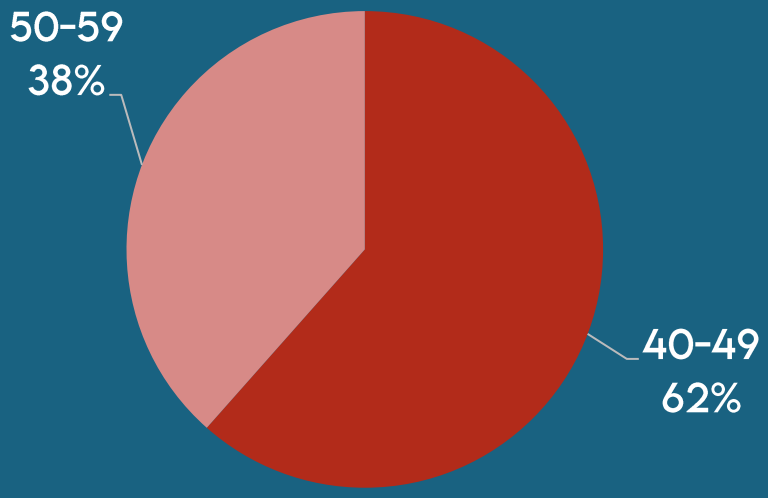


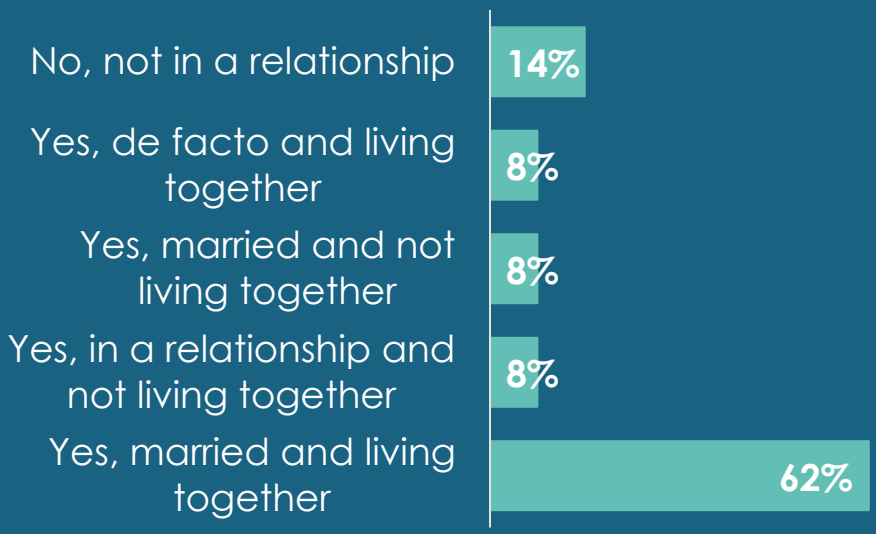
8% SENIOR COMMISSIONED OFFICER
54% SENIOR NON-COMMISSIONED OFFICER
15% JUNIOR NON-COMMISSIONED OFFICER
23% COMMISSIONED OFFICER

38%
HEALTHY

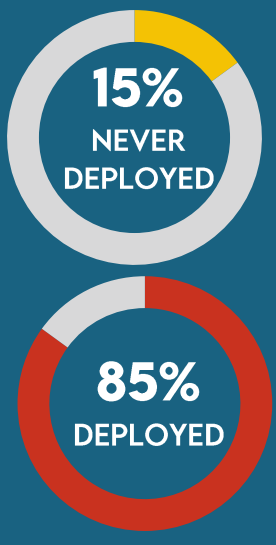
62%
SUBTHRESHOLD

AGES





DEPLOYMENT



Long career members

Members were categorised in the long career group if they had served for 16 years or more. Thirteen members were in this category.

The majority were male (77%), aged between 40-49 years (62%) and had been deployed (85%). Over half were experiencing subthreshold symptoms (62%). Additional demographics, including rank and relationship status, are shown on page 62.

Social support

Tell me what sort of social supports you have. Who would you reach out to if you wanted to talk about something personal?

A broad range of supports were identified along with some challenges associated with support networks, such as those that arise from frequent postings (Figure 25). All long career participants reported using informal supports to talk about something personal. There was also endorsement for accessing health practitioners for support, including psychologists, MOs, general "medical", and psychiatrists. Long career group members also reported going to colleagues as a source of social support, as well as chain of command/supervisors.

"I have social support networks from within my branch 'cause we're a small branch and so we tend to know each other reasonably well."
Navy, 40-49 years, Senior Commissioned Officer

"It always feels like you go through a cycle when you move to a new location. It takes it takes a while to get to know people and you start getting know people, you start to build friendships, and then towards the end of your posting you make really good friends. After 7 or 8 moves you get to a point where you're just like, I won't bother making friends 'cause we're just going to post again and it's all gonna be too hard to say goodbye and then start again.
Air Force, 40-49 years, Senior Non-Commissioned Officer

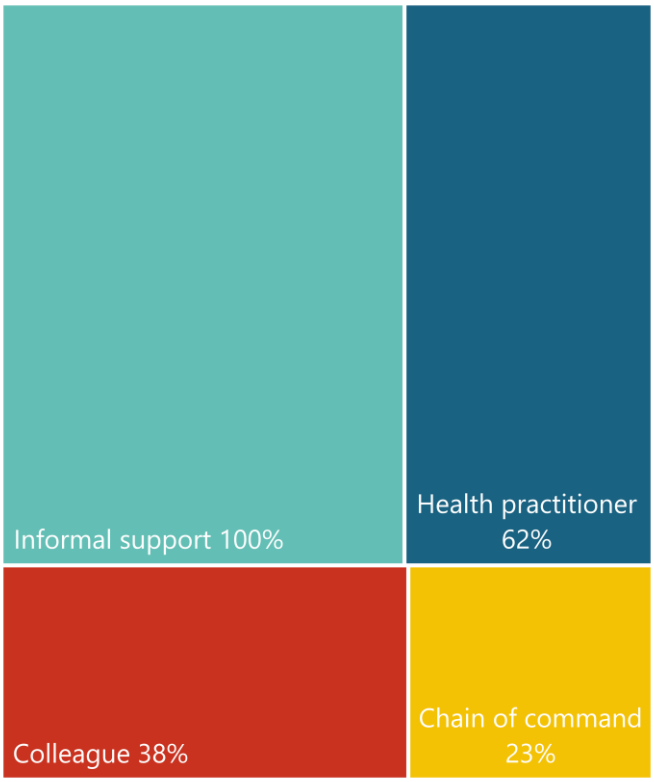


Figure 25. Long career group social supports

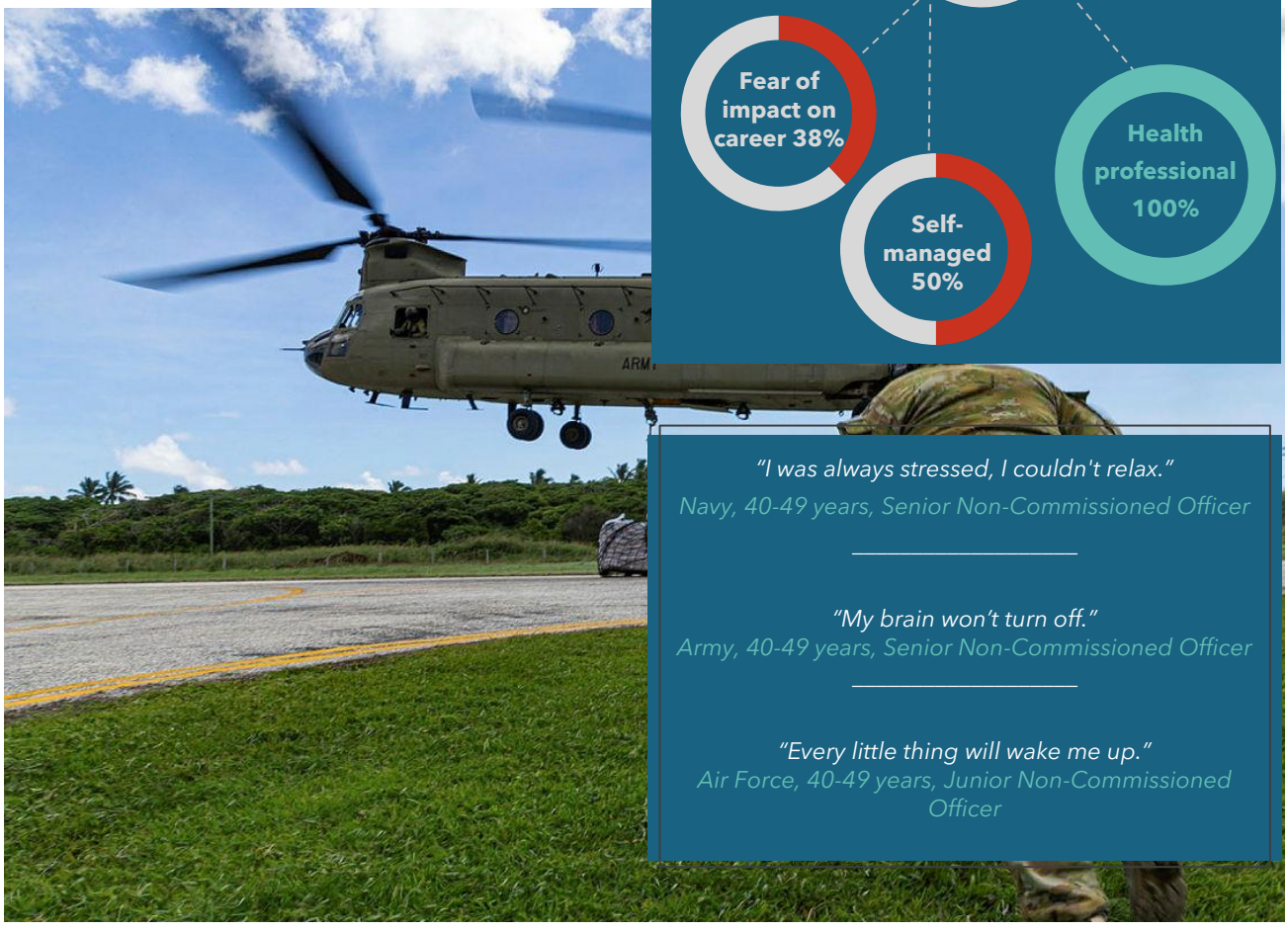
Sleep

Have you ever had trouble with sleep, such as finding it hard to get to sleep or falling asleep? Have you sought help?

All long career participants reported having an issue with sleep at some point (Figure 26). Under half of members sought help and, for those who did, it was always sourced from a health practitioner.

Over half of participants did not seek help for their sleep issues due to impact on career and a preference to self-manage being the most common. The self-management strategies were both active and passive in nature and included journaling, meditation, herbal supplements, exercise, sleep hygiene, relaxation techniques and mundane activities like puzzles to "try and disengage".

Figure 26: Long career sleep outcomes



"I was always stressed, I couldn't relax."
Navy, 40-49 years, Senior Non-Commissioned Officer

"My brain won't turn off."
Army, 40-49 years, Senior Non-Commissioned Officer

"Every little thing will wake me up."
Air Force, 40-49 years, Junior Non-Commissioned Officer

Coping

When something happens at work that doesn't go your way, how do you manage that? What kinds of things do you do to be able to cope with the situation?

Long career participants were asked what they do to manage when something doesn't go their way at work (Figure 27). Numerous coping strategies emerged as themes within the long career group. The most commonly reported strategies were active (54%) and passive (15%) self-management. Active self-management strategies included meditation, engaging with enjoyable activities, breathing exercises, listening to music/podcasts, journaling, venting frustrations by speaking with others and addressing the issue directly. Examples of passive self-management strategies were "let it go" and letting the issue "resolve itself".

Speaking with command was the next most common strategy employed by long career members.

Over a third reported that exercise helped them cope when things do not go their way at work. For example, getting out for a walk or regular training. Just under a third of members reported that speaking with colleagues, support from a health professional, including psychologists, medical doctors, Open Arms, civilian doctors, psychiatrists, and counsellors, as well as support from informal support networks such as friends and family, helped them deal with these issues.

"My emotional intelligence is enough that I know that I'm stressed."
Navy, 40-49 years, Senior Commissioned Officer

"Depending what it is I might discuss with colleague or supervisor. If it's possible to discuss it with the other person involved, talk to them. If its organisational there's not much you can do about it."
Air Force, 50-59 years, Senior Non-Commissioned Officer

It depends on what it is. Sometimes it's just a case of going and having a quick walk outside [and] just removing yourself.
Army, 50-59 years, Senior Non-Commissioned Officer

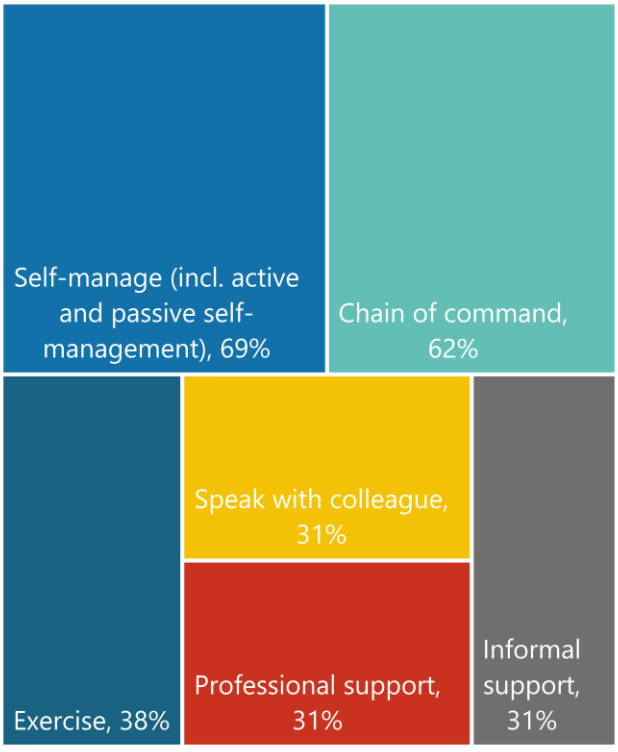


Figure 27. Long career members' coping resources

Anger

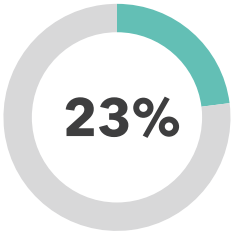
Do you find that you get or you feel angry at people or situations quite a lot of the time? What kinds of things do you do to manage that?

Long career participants were asked whether they find that they feel angry quite a lot of the time and what kinds of things they do to manage that (Figure 28). Almost a quarter reported that they do not experience anger quite a lot of the time

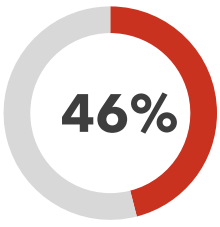
Just under half of long career members said they do experience anger quite a lot of the time. For those that had experienced frequent anger, they mostly reported active and passive self-management strategies to deal with this. Active self-management strategies included things such as relaxation and breathing exercises, venting to others, maintaining healthy behaviours such as adequate sleep, diet and exercise. Passive self-management strategies involved walking away from the situation causing the anger, having the urge to go home, using alcohol and trying to "let the anger go". While some of these examples refer to strategies that are active in nature as they require some effort to engage in the behaviour, passive strategies have here been defined as those that are either maladaptive or require no level of engagement.

Exercise, seeking help from a health professional (e.g. psychologist) and speaking with leadership were all equally endorsed strategies that have or would be used by long career participants to manage frequent anger.

Do NOT feel angry quite a lot of the time



DO feel angry quite a lot of the time



"[You] have to suss out what is going wrong i.e. individual, environment, personality clash etc. subordinates come to me quite often."
Air Force, 30-39 years, Junior Non-Commissioned Officer

"I think I'm being more direct with people than what I would normally be because I'm a little bit short tempered at the moment. If it's something that's completely out of my ability to be able to deal with and I need to bump it up, I will go and see one of my supervisors to basically push that up. I work in such a dynamic place that you know I've gotta let go of it fairly quickly because the next issue is actually popping up within 5 minutes."
Army, 50-59 years, Senior Non-Commissioned Officer

"[I] just accept the ridiculousness of a lot of the situations I find myself wanting to get angry in and just move on."
Air Force, 40-49 years, Senior Non-Commissioned Officer

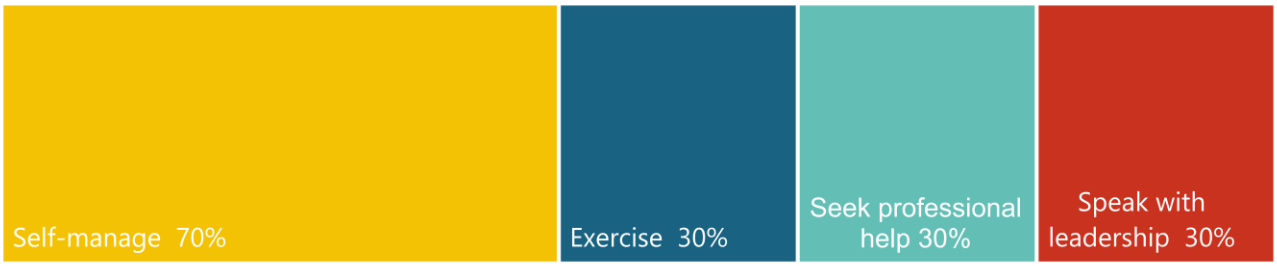


Figure 28. Long career group strategies for coping with anger

Doing enjoyable activities

Have you ever had a period during your time with Defence where you stopped doing things that you enjoy? What helped you get back on track?

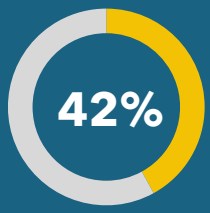
Just under half of the long career participants reported that they had previously had a time where they stopped doing things they enjoy due to personal wellbeing (that is, due to issues with their own wellbeing and mental health).

Others reported that they had previously had a time where they stopped doing things they enjoy but that this was due to the demands of the job. Importantly, there was recognition in this group that individuals may need to find alternative enjoyable activities at times that fit in with work demands.

Remaining participants stopped doing things they enjoy for other reasons, such as medical issues and lack of enjoyment with their current Defence role leading to them stopping doing things they enjoy more broadly.

Of those members who did have a period of time where they stopped doing things they enjoy for either personal wellbeing or demands of the job, informal support networks were most often what helped get them back on track and some also sought professional help from psychologists or other allied health professionals. The members who did not use informal supports or professional help reported using a range of other active and passive methods to help get back on track such as speaking with colleagues; the ADF Arts for Recovery, Resilience, Teamwork and Skills (ARRTS) program; "getting on with it"; mindfulness; and exercise.

Not doing things you enjoy due to personal wellbeing

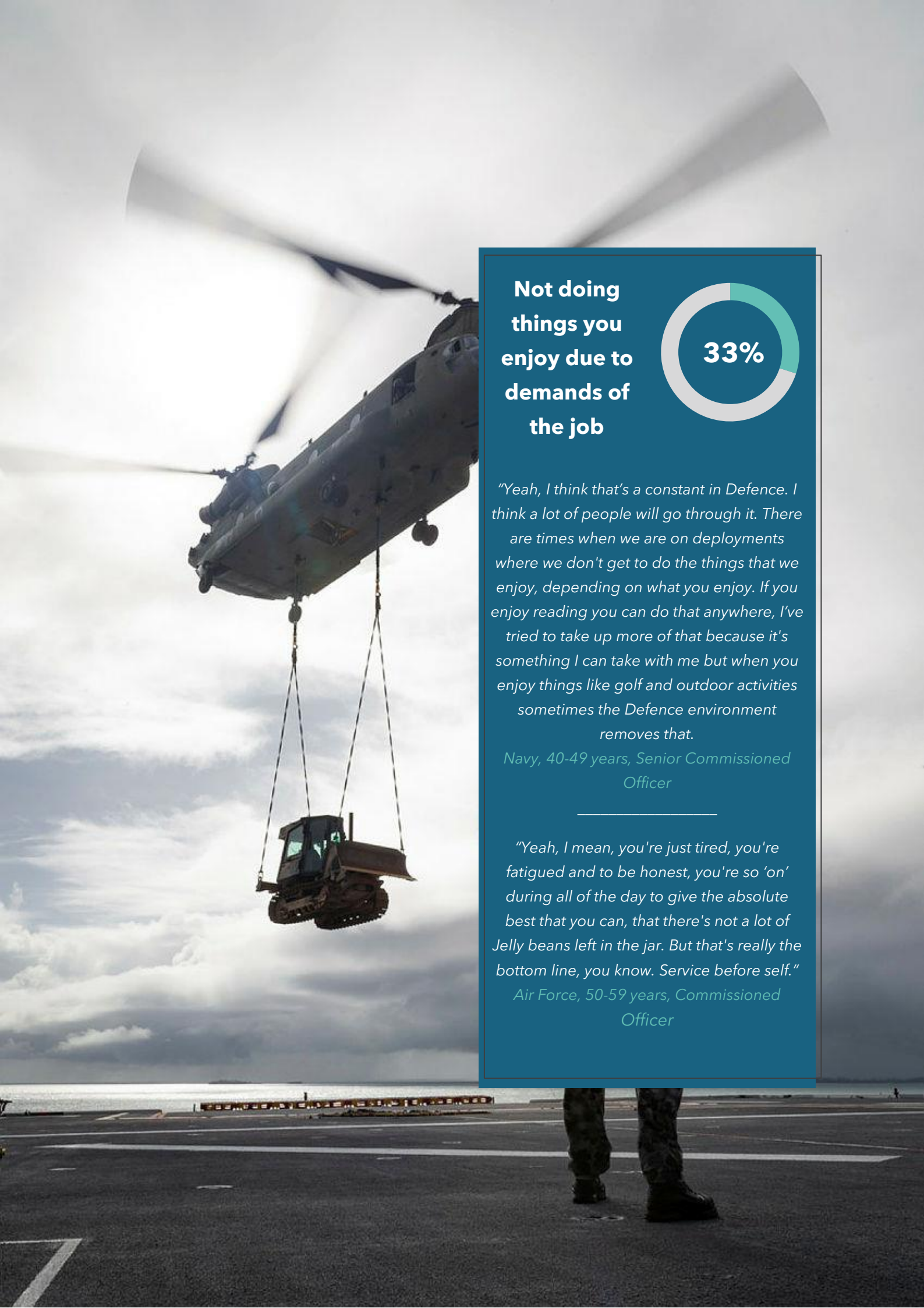


"He pulled me aside and said what's going on mate, you don't look right, are you okay? Upon reflection, the 8-12 month lead up to that was a whole bunch of key indicators that I wasn't okay, including not doing things that I normally would do."

Air Force, 40-49 years, Senior Non-Commissioned Officer

"Yeah when I had depression, I basically shut myself down into a little ball. I wouldn't go out, I wouldn't see people, I'd rather be at home where I thought I was in a safe place. Someone that I was working with at the time took me to the medics because they could see how bad [it was], they knew me before it all happened."

Navy, 40-49 years, Senior Non-Commissioned Officer



Not doing things you enjoy due to demands of the job

"Yeah, I think that's a constant in Defence. I think a lot of people will go through it. There are times when we are on deployments where we don't get to do the things that we enjoy, depending on what you enjoy. If you enjoy reading you can do that anywhere, I've tried to take up more of that because it's something I can take with me but when you enjoy things like golf and outdoor activities sometimes the Defence environment removes that.

Navy, 40-49 years, Senior Commissioned Officer

"Yeah, I mean, you're just tired, you're fatigued and to be honest, you're so 'on' during all of the day to give the absolute best that you can, that there's not a lot of Jelly beans left in the jar. But that's really the bottom line, you know. Service before self."

Air Force, 50-59 years, Commissioned Officer

Help avoidance

Have you ever had health issues that impacted on your wellbeing but you didn't seek help for? How did you manage?

Over half of long career participants reported that they had avoided seeking help for an issue (Figure 29). Of those, over half reported active and passive self-management strategies. For example, members who passively self-managed reported "I normalised it all" and "I put up with it". Active self-management strategies included avoiding going to the shops during peak times after realising the noise levels were triggering during the period after returning from deployment, and venting with others. Members who reported that they had avoided seeking help for an issue, and did not self-manage the issue, reported that they did not recognise the issue at the time.

Just over a third of long career members reported that they have never had an issue that was impacting their wellbeing that they avoided seeking help for. These members either never had an issue that they needed to seek help for, or (more frequently) they sought help from a health practitioner (i.e. psychologists and "medical") when it was required.

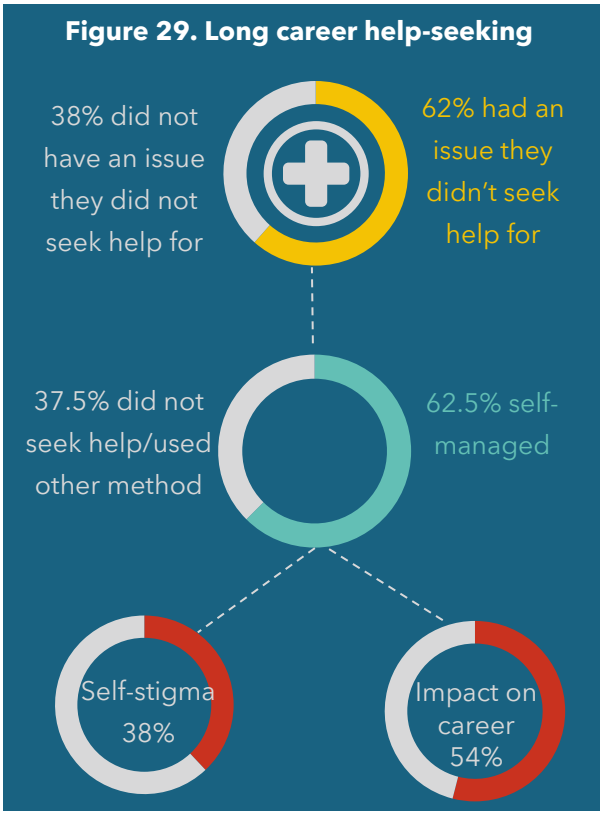
Long career members who had resisted seeking help reported that the impact it may have on career was a barrier. Some members reported that they believed others avoided help-seeking for the same reason. Self-stigma was the other reason that was commonly reported as a potential barrier to help-seeking with members noting that pride, shame and guilt related to help-seeking prevented some members from accessing supports.

"If I had not had the panic attack I don't know where I would be now."
Navy, 50-59 years, Commissioned Officer

"We'll try and hide it, not talk about it, because that's what you do, so there's a bit of a culture around not really admitting that there's even a problem."
Air Force, 40-49 years, Senior Non-Commissioned Officer

"I hurt my back a few times and managed it myself. In a high tempo unit with a lot of deployments happening, you didn't want to risk not getting a deployment. I was the sort of person who didn't got to the medical centre - only if I really needed to."
Army, 40-49 years, Senior Non-Commissioned Officer

Figure 29. Long career help-seeking



Attitudes to help-seeking

How would you feel about yourself if you needed to seek care? What do you think would help you overcome those concerns? What do you think needs to be done to change this?

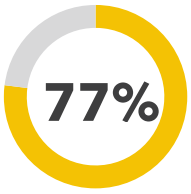
Most participants in the long career group indicated that they would be comfortable seeking care and/or would not have negative attitudes towards themselves. Some members that reported this may have previously had an issue they didn't seek help for (reported in the previous question), reflecting that some long career members are now more open to seeking help than they were in the past. While members claim to be more open to seeking help, many still do not seek help when it is needed.

Fewer long career members reported that they would feel negative about themselves if they were to seek care. A small portion of long career members reported seeing others having issues with seeking care.

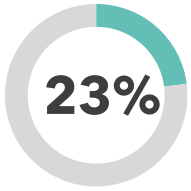
When asked what can be done to change things, long career participants reported more education around seeking help and mental health was important. They suggested, as an example, that greater awareness around the "white card" would be beneficial as "a lot of people are unaware of it".

A portion of long career participants also reported that decreasing the wait time for appointments would be helpful in assisting members to overcome barriers to seeking help, highlighting that sometimes it can take so long that the issue "becomes the new normal". A small proportion noted that things are improving in Defence in regard to people proactively seeking help for mental health concerns.

No issues seeking care



Would feel negative about seeking care



"I would rather go and see someone and say I am struggling than leave it to fester for a while. It doesn't help, it just makes your life even worse."
Navy, 40-49 years, Senior Non-Commissioned Officer

"Seeking help identifies to yourself and others that you are not as strong as you think."
Air Force, 40-49 years, Commissioned Officer

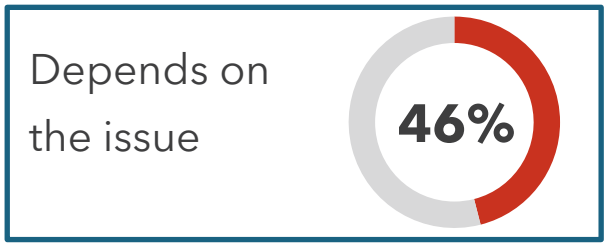
"I was reluctant to go and see the doctor, it was time away from work. I have to go to sick parade and sit there and wait for hours to see somebody. I've got so much going on, so much work to do, and I know logically that I need to look after myself to then better support the organisation, but then pride takes over and I want to clear my workload."
Army, 40-49 years, Senior Non-Commissioned Officer

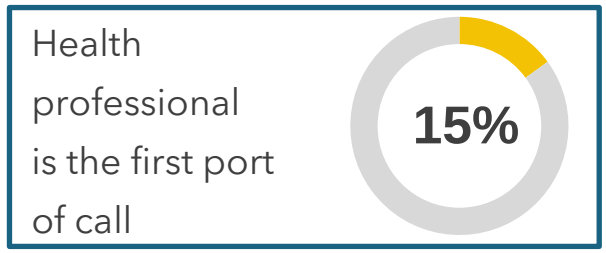
Help-seeking behaviours

Do you think that when health issues arise, mental or physical, that the first port of call should be to go and see a health provider or are there other ways you think that people could manage their health? Do you think there are any barriers to members seeking help for these issues?

Just under half of long career members said that it really depends on the issue. These members reported that "sometimes medical is a given" and that it depends on the type of issue, such as whether it is mental or physical and the severity. Over a third of members reported that other strategies should be used before seeking professional help from a health provider. These "other" strategies included both active and passive strategies, such as speaking with the chain of command first, to "take accountability for themselves" and self-manage, speak with friends and family "unless things are at that point where they really, really need Defence to step in".

A small percentage of long career members believed that medical should always be the first port of call. Some long career members reported that talking to informal supports is an alternative way to manage issues. No other alternative strategies emerged as themes within the long career group.





"If it is physical issues then you should definitely go to medical. If it is mental health issues there needs to be a confidential service available, like Open Arms, that is widely encouraged and people are aware of. Open Arms is somewhat discouraged."
Navy, 40-49 years, Senior Non-Commissioned Officer

"If [you've] got a sore toe then yeah, go and talk to the doctor. If you're having troubles dealing with work, you should come and talk to me as your supervisor"
Air Force, 50-59 years, Commissioned Officer

"Physical absolutely, go to a doctor or medic. Mental there's some flexibility for us to test the waters in different ways before you need to escalate it."
Navy, 40-49 years, Senior Commissioned Officer

"First port of call should be to talk to supervisor, or you can take yourself to the medical centre to seek support."
Navy, 50-59 years, Commissioned Officer

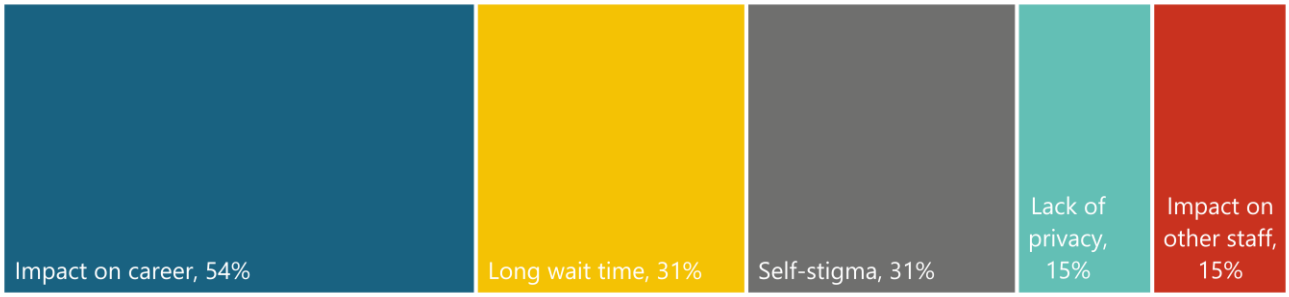


Figure 30. Long career group reported barriers to help-seeking

Impact on career

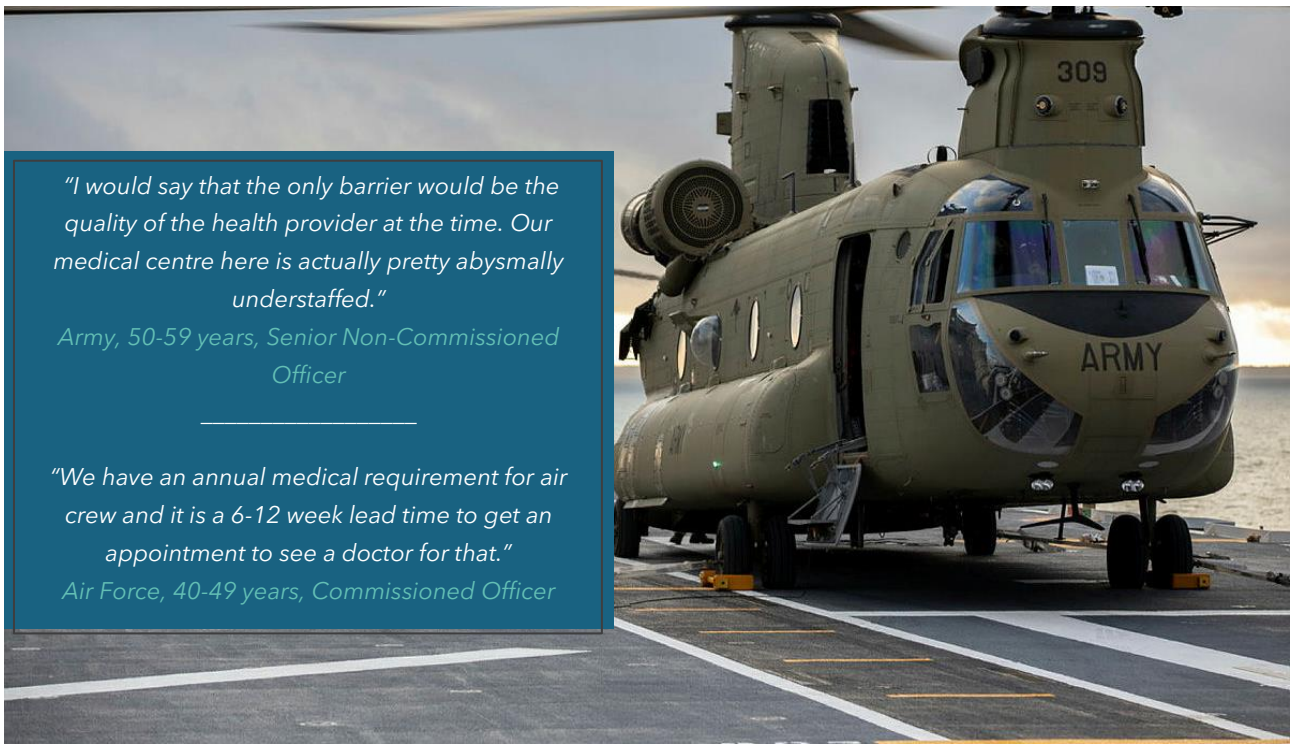
Participants were asked whether there are any barriers to help-seeking (Figure 30). Over half of long career members reported that they avoid help-seeking or believe others avoid help-seeking due to the potential impact on their career. These members described feeling afraid that they might be downgraded, terminated or discharged, that eligibility for promotion will be affected or (for Navy members) that they might be removed from the ship.

"In the Navy especially, people get concerned about being removed from their ship. If that wasn't the case more people might seek help earlier."
Navy, 40-49 years, Senior Non-Commissioned Officer

"The process is that no matter what it will be highlighted to Commander and have an effect on career."
Air Force, 50-59 years, Senior Non-Commissioned Officer

Long wait times

Long career participants also reported that long wait times for appointments are also a barrier to help-seeking.



"I would say that the only barrier would be the quality of the health provider at the time. Our medical centre here is actually pretty abysmally understaffed."
Army, 50-59 years, Senior Non-Commissioned Officer

"We have an annual medical requirement for air crew and it is a 6-12 week lead time to get an appointment to see a doctor for that."
Air Force, 40-49 years, Commissioned Officer

Self-stigma

Self-stigma was also reported as a barrier to help-seeking by just under a third of long career members. This was described as members experiencing shame or feeling weak for seeking help, particularly if the outcome is a diagnosis or prescribed medication. Others made comments such as "there is a stigma about mental health".

Lack of privacy

Lack of privacy was reported as a barrier for long career members. For example, members believed there "should be a system that is de-identified" and supports on offer with "guaranteed privacy".

Impact on other staff

Impact on other staff was another perceived barrier reported by the long career group. For example, members reported that their teams are "understaffed and under resourced", that members "don't want to burden others with having time off".

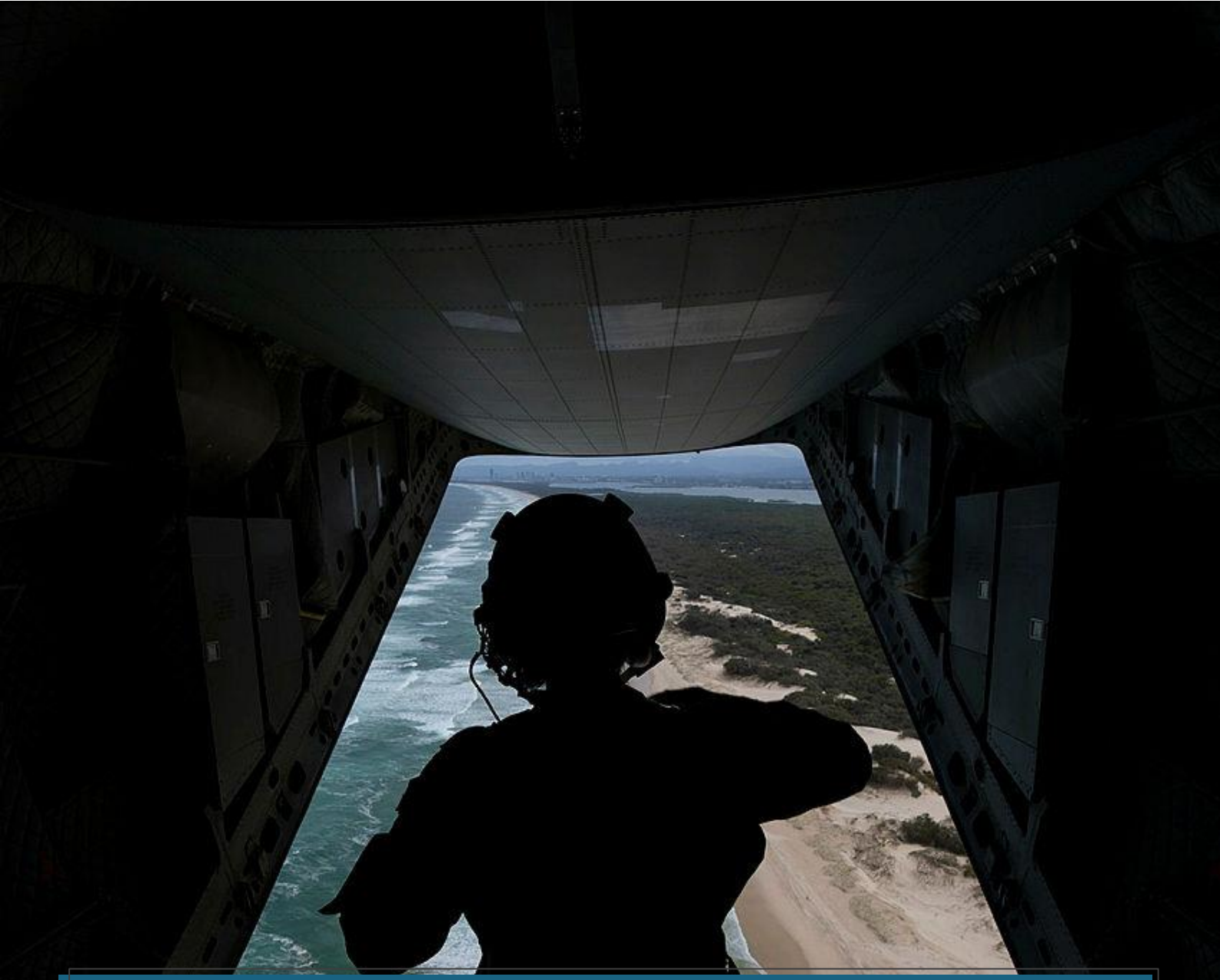
"I can't go to medical because I have so much important work to do. People push their selves to exhaustion because of the impact on the team, you're seen to be slacking off, being told you have to do it or people will die."
Air Force, 40-49 years, Senior Non-Commissioned Officer

"Pride, shame, guilt that I've let the team down, when younger there was a lot of reasons that might stop me stepping forward."
Navy, 40-49 years, Senior Commissioned Officer

"It's still there [stigma], they're alpha males, dominating people, they are pack animals. you'll be considered weaker than the others."
Air Force, 40-49 years, Junior Non-Commissioned Officer

"I think it's up to the senior people within Defence force to sit there and say hey, it's quite normal for people to seek help. You shouldn't be judging someone because they've decided to take their own health seriously."
Navy, 40-49 years, Senior Non-Commissioned Officer

"Oh yeah [people still have concerns about seeking help], maybe older generations but also some of the other people. More education [would help], we just need to keep banging the drum. I think we are at a state now where it's part of the rhetoric."
Navy, 50-59 years, Commissioned Officer



"The way Defence managed my various episodes was more positive than I anticipated it to be. While I initially had concerns about how it might affect my career, I've had a pretty good career … regardless. I haven't been able to do a couple of the things that I would have liked to do, specifically because of what was on my medical record, but I've still had the opportunity to be a positive provider to Defence capability. They made every effort to look after me and maintain my capability and I think that has worked."

Army, 40-49 years, Senior Non-Commissioned Officer

"It's not as bad as what it used to be. I think it's pretty good actually. The last 12 years have seen an improvement. New Generation Navy really changed who we are and our culture."

Navy, 40-49 years, Senior Commissioned Officer

"If you had relationship with your medical team whether it be regular appearances from them at morning brief, and they were giving weekly updates in various fields of enhancement or dealing with sleep problems then you develop a rapport and people are more likely to talk with them."

Air Force, 40-49 years, Commissioned Officer

"The mindset change within defence has been quite unique."

Army, 50-59 years, Senior Non-Commissioned Officer

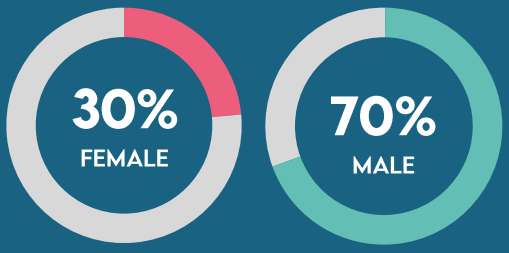
Chapter 7
Summary of findings

ADF MEMBER DEMOGRAPHICS

Phoenix AUSTRALIA

40 ADF MEMBERS WERE RECRUITED IN TOTAL.

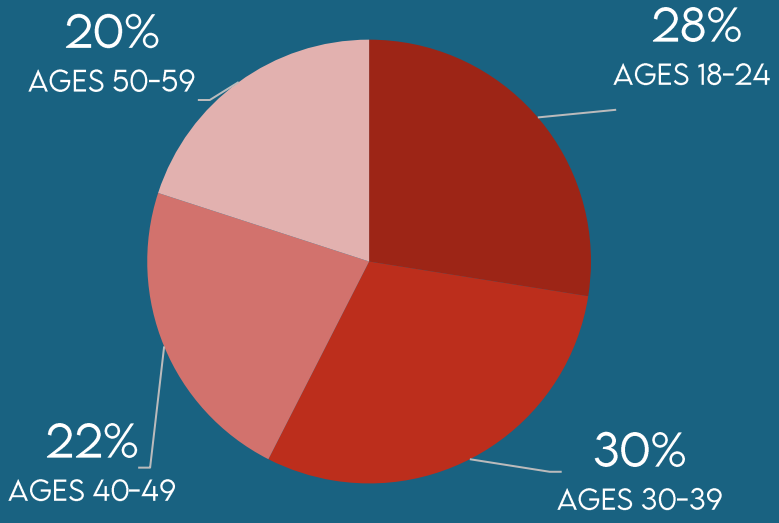
35% AIR FORCE
35% ARMY
30% NAVY

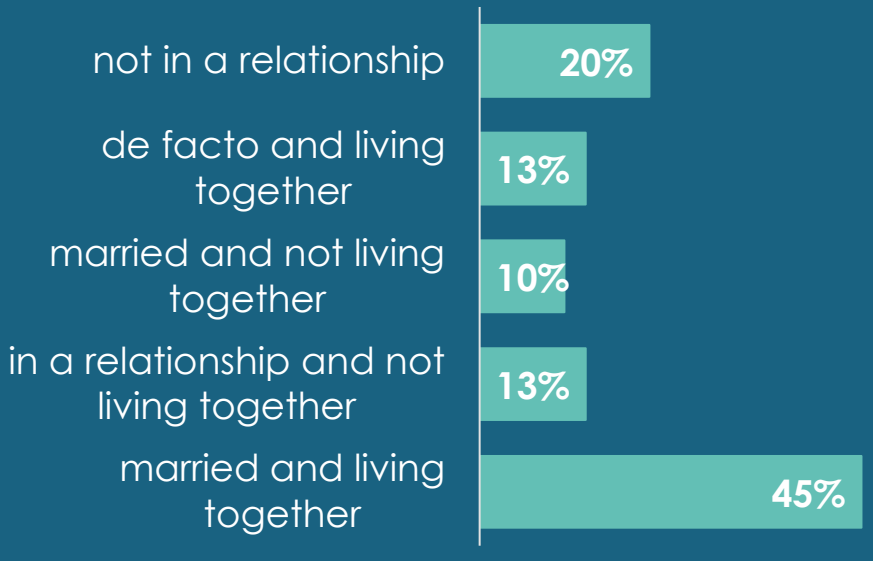


5% SENIOR COMMISSIONED OFFICER
15% OTHER RANKS
20% SENIOR NON-COMMISSIONED OFFICER
20% JUNIOR NON-COMMISSIONED OFFICER
40% COMMISSIONED OFFICER

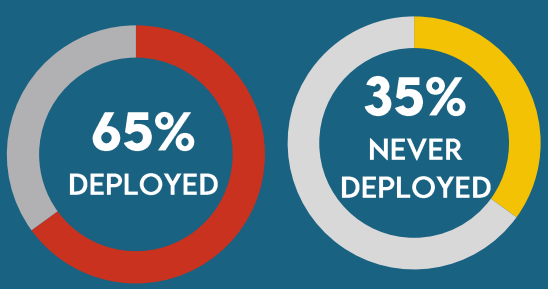
CAREER LENGTH

32.5% < 8 YEARS
35% 8 TO 15 YEARS
32.5% > 16 YEARS





40% HEALTHY
60% SUBTHRESHOLD



SIMILARITIES AND DIFFERENCES BETWEEN CAREER STAGES

EARLY CAREER

- Mostly use informal supports
- Talk to colleagues about personal issues
- Less comfortable with HSPs for reduced desire to do enjoyable activities
- Few sleep issues
- No anger issues
- Strongest self-stigma
- Worried about career impacts and privacy if seeking help
- Get back on track through professional help

MID-CAREER

- Variety of supports used
- Prefer to self-manage or use informal supports when not coping
- Some sleep issues
- Some anger issues will self-manage or see HSP
- Developed a range of strategies to get back on track
- Perceived stigma higher than self-stigma
- Concerns about seeking help via chain of command

LONG CAREER

- Accessing many different social supports
- Prefer to self-manage or speak to superior when not coping
- Sleep issues common
- Most have experienced anger, prefer self-management
- Prefer to use informal supports to get back on track
- Less likely to use HSPs for any health issue
- Worried about self-stigma & career impacts if seeking help

COMMON TO ALL MEMBERS

- Informal supports to talk about issues
- Seek help from HSP for sleep issues
- Self-manage when things do not go their way
- 37% of members from all cohorts would use other strategies before HSPs for any health issue
- Avoid help-seeking due to fears about impact on career & self-stigma
- All think education is needed
- Main barriers to help-seeking are worry about career impacts, privacy concerns & long wait times

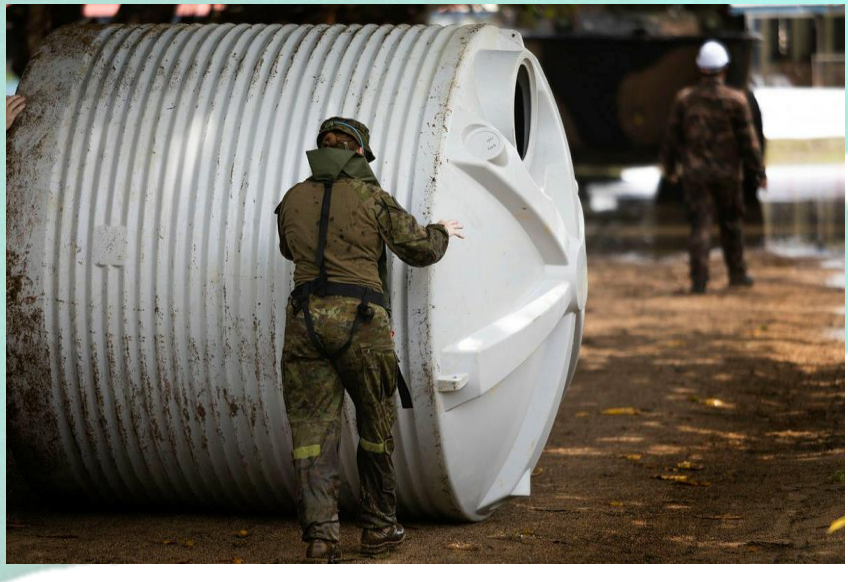
Research Question 1: Are ADF members with subthreshold symptoms seeking help and what are the drivers for help-seeking?

The ADF member data suggests that while some members are engaging with HSPs for help with subthreshold symptoms, most are using a variety of other supports while others do not recognise a need for help or understand its value when symptoms are low level. While some HSPs reported that members do present with subthreshold issues, many present for other issues and subthreshold symptoms are detected through discussion with the member. This suggests that while the data here shows that help-seeking behaviours appear to increase as time in Defence increases, it may be a result of increased screening opportunities or medical appointments due to longer years in service. That is, while the longer career members were more likely to have engaged with HSPs, this may be due to opportunity rather than self-initiated help-seeking.

The people who HSPs felt were best placed to detect subthreshold symptoms were somewhat in contrast to the supports that ADF members reported using when they need to talk about something personal or when they seek help for low-level symptoms. While the majority of HSPs felt that colleagues and leadership were best placed to recognise the emergence of early symptoms, ADF members did not report using them as supports very often. All members of all career stages reported that they go to informal supports first (e.g. civilian friends, family, partner).

Interestingly, all cohorts recognised the broad range of social support networks available to reach out to about personal issues. The likelihood of using other supports (e.g. health practitioners, chain of command), rather than informal supports, increased as length of time in Defence increased. This could be due to knowledge about or comfort with these alternative supports.

HSPs felt strongly that line managers/supervisors/junior leadership were very well placed to identify early changes in behaviour. By virtue of their everyday contact and knowledge about their teams, all levels of leadership are an excellent resource for identifying early issues and should be able to provide a pathway to assistance for members.



There was substantial variability among members viewing leadership as a source of support. Members who had a longer career length were more likely to reach out to leadership for support. In contrast, but perhaps not

surprising, the more junior (by virtue of career length) members were, the less likely they were to access leadership as a preferred source of support.

Members who were experiencing challenges coping when things at work did not go their way, or who were not able to do previously enjoyable things due to the demands of the job, used a variety of help-seeking strategies. For support in coping, there was a preference to self-manage (both actively and passively) in all cohorts; however, there was also the likelihood that some members would reach out to leadership to help cope with the situation. When it came to getting back on track and engaging in enjoyable activities again, seeking support from health professionals or passive self-management were the two most likely help-seeking strategies employed by all members. The high degree of concern about the impact on career that help-seeking may have, helps to explain why there is variable endorsement for help-seeking strategies. The relatively common use of leadership for the management of some subthreshold issues is notable and cause for consideration as to whether this group is adequately equipped to detect low-level symptoms. Indeed, almost half of HSPs reported that there was a pressing need for education of leadership on how to identify these symptoms and triage to appropriate supports.

HSPs reported that others were better placed to identify symptoms than members themselves. In line with this, it was reported by a proportion of mid- and early career members that they themselves did not know help was needed at times when they had experienced subthreshold symptoms. This suggests that, in the case of low-level behaviour change, it may sometimes be easier for those who are closest to an individual (such as colleagues, family, leaders) to notice early subtle behaviour changes and support them in seeking help, rather than these individuals just 'getting by' and waiting until symptoms progress into more substantial problems.

Chaplains were also identified by HSPs as being well placed to detect symptoms. While this was endorsed by only a small proportion of the overall sample of members, it is important to note, as it is critical to have choices when help-seeking. The data in this report demonstrates that personal preference influences help-seeking behaviour and the more options that members have to access, the greater the likelihood that they will use one.

Drivers for help-seeking

Very few members were able to describe the reasons why they sought help. However, for those who did, they described being encouraged by their supervisor or family members, or that their symptoms got to a level where they were less manageable and self-management strategies were no longer working. Likewise, HSPs reported that members frequently present after their supervisors request that they seek help or after a partner has expressed concern.

Barriers to early identification

Fear of downgrade

HSPs reported that the biggest issue preventing members from seeking help for subthreshold symptoms was the fear of MEC downgrade. This was supported by the ADF member data. Long career members were

particularly concerned about the career impacts of reporting health issues, even at low levels. This fear was also reported by about a third of mid- and early career members. The data suggests that there is a high level of misinformation and/or a lack of clarity among members as to how MEC downgrades are applied. Additionally, HSPs perceived that the application of downgrades was highly variable across units, with some being quicker to downgrade than others, which may be more likely during busy periods when HSPs are in high demand.

Lack of education

Most HSPs felt that a lack of knowledge about subthreshold symptoms contributed to members avoiding seeking help as early as they could. This finding aligns with the high levels of self-stigma being reported as a barrier to help-seeking by members. It was suggested by HSPs that self-stigma prevents people seeking help as they do not want to be seen to be 'weak' or 'not coping'. Members need to be educated that seeking help early is actually contributing to improved mental health and wellbeing which is a 'strength' rather than 'weakness' and shows positive coping strategies rather than a failure to cope. It was suggested by HSPs that many members do not understand that symptoms such as sleep and anger issues can be effectively managed, nor do they understand that these types of symptoms can be precursors to later more serious mental health issues.

Culture

Related to education and self-stigma is the commonly cited cultural barrier whereby Defence was described as promoting a culture where strength and resilience is valued and weakness is unwelcome. While some members stressed that this was changing, many felt there was still a way to go in creating a culture where members felt supported to admit they were struggling. This was seen most strongly in early career members where they reported higher levels of feelings of negativity towards themselves if they needed to seek help.

Financial concerns

Many HSPs and some ADF members described financial concerns as an important barrier to help-seeking. This was specifically mentioned in relation to the allowances, such as the seagoing allowance for Navy members. HSPs explained that many members depend on these extra allowances

to survive, and when temporarily or permanently withdrawn from positions with associated allowances, due to a medical issue, that can be detrimental to the members' financial security. Therefore, reporting symptoms may be avoided and low-level symptoms left to worsen.

Letting the team down

Another barrier to members seeking help is a strong drive to avoid letting the team down. In most cases, it was reported that, if a member is not at work due to a medical issue, this will impact the rest of the team. In some cases, members and HSPs described that team members who were on medical leave or restrictions would be considered to be dodging work duties and ostracised due to their failure to put the team's needs before their own.

Research Question 2: How are subthreshold symptoms presenting clinically and are these presentations recognised by service providers?

HSPs reported a good level of awareness of different subthreshold symptoms, and data indicated that those interviewed were capable of identifying subthreshold symptoms. It should be noted that as HSPs self-selected into the project, this data may reflect a level of self-selection bias whereby those HSPs who are more adept at subthreshold symptom management opted to participate. HSPs were asked if they thought other HSPs they knew commonly enquired about subthreshold symptoms; most reported that they thought there was a varied awareness and openness to addressing these issues but that, overall, due to resourcing and time constraints (rather than skill or proficiency), HSPs were less likely to identify symptoms unless members actually presented for these issues.

Most HSPs reported that members will often present with a physical, fatigue or poor work performance issue rather than mental health symptoms, and through discussion and probing, it will become apparent that there is an underlying subthreshold issue.

Some HSPs (i.e. rehabilitation officers/consultants, physiotherapists) were thought to be more likely to notice early symptoms due to the extended time they spend with members during appointments, the rapport that is built due to the type and frequency of

treatment and, interestingly, due to the fact that members are often not physically sitting face-to-face with the service provider.

The opportunity that screening presents for early identification was noted by a number of HSPs. Screening was thought to be a useful activity and it was largely felt that it helped identify people with early challenges who might otherwise not be picked up elsewhere. However, HSPs acknowledged that there were challenges with the truthfulness (or not) of screening data and, many suggested that members 'know' how to answer screening questionnaires in order to avoid follow-up. A second challenge about screening stemmed from perceived issues with Defence health systems. The difficulty of finding information on deployments, previous screenings undertaken, and health service usage was frequently cited as a barrier to supporting members presenting for health care. It was noted that, during the PMHS exams for example, it was almost impossible to triangulate all this information in the time available; therefore, opportunities to track mental health and wellbeing over time were severely hampered.

Research Questions 3 & 4: How are subthreshold presentations currently being addressed? And what interventions are being implemented and are these interventions tolerated and perceived as useful?

The HSPs who were interviewed indicated that they primarily use psychoeducation when members present with subthreshold symptoms. This includes education about topics such as sleep hygiene, healthy eating, benefits of exercise, emotional processing, balancing workload, and coping strategies. Most HSPs reported that these strategies work some of the time but not always and none were able to report on any systematic assessment of the usefulness of these strategies. Where symptoms do not improve or get worse, HSPs report that they then refer members on to a specialist, the mental health team, or MO depending on the symptoms.

HSPs also reported frequently referring members to Open Arms for issues such as stress, coping, and anger issues. They reported referring members to both one-on-one counselling and specific courses such as anger, sleep and transition programs. HSPs reported that, because Open Arms is external to Defence, they felt members were more open to accessing support there. Almost all of the HSPs reported that they had not sought feedback from members on the usefulness of courses after referring. The two psychologists who had received feedback reported that members had found the courses 'okay' with no further feedback provided.

A small proportion of HSPs noted that they recommended specific phone apps such as relaxation or sleep apps. Two had sought feedback on the usefulness of apps and both reported that the members that they advised to use them did not do so. A number of HSPs mentioned that members do not generally use apps after the initial download and first try. Some HSPs reported recommending general (non-app based) relaxation or mindfulness strategies but none had sought feedback on the usefulness of these. A small number of HSPs reported that they encourage members to seek social support and encourage greater social interaction when members present with low-level mental health concerns.

Research Question 5: How may existing management processes be improved?

Education on identifying symptoms early

Education of members on what symptoms could benefit from what types of support and interventions while at low levels would be useful and was suggested by almost half of the HSPs interviewed. HSPs felt that educating members in how the use of strategies to manage low-level symptoms will actually avoid the development of mental health problems and prevent impacts on career is crucial. This would include education about the interplay between mental and physical health. They suggested that members need to be educated on how common symptoms like poor sleep or frequent anger can be treated. This could help avoid mental health problems later, as many members would not know about the links between these issues.

It was thought that packaging this education as mental fitness and likening it to physical fitness and the prevention of injury would help overcome self-stigma related to help-seeking and motivate members to make improvements in management of early symptoms. Due to the higher levels of self-stigma reported in the early career cohort, it was suggested that promoting that the management of subthreshold symptoms is similar to maintaining physical fitness would help overcome cultural barriers in this cohort to some degree. It is important to note, however, that the ability to make this of interest during early career when few symptoms have emerged, and the longer term consequences are less likely to be understood or thought of as relevant, is challenging.

HSPs suggested that colleagues were not well enough educated in subthreshold presentations to recognise early symptoms as they emerge. Education on how to recognise subthreshold symptoms, on what is healthy and what might indicate someone is starting to have issues would be useful. The other part to this education that was highlighted in the data, is how to have a conversation about these types of issues. HSPs commented that while members had received training on how to talk about more serious mental health issues, talking about low-level symptoms could be difficult as they are not commonly discussed as requiring intervention. Members experiencing these subthreshold symptoms may not think they are problematic or worth seeking support from a health professional for.

The finding that 100% of members used informal supports, such as partners and friends, suggested that education of family members may be useful. Further information on whether informal supports are equipped with the knowledge required to identify early symptoms of mental health decline will be facilitated by the families component of the WATCH Project. In the families component, partners and parents will elucidate whether they feel they have the skills and resources to identify when their family member presents with subthreshold symptoms, and any gaps in education or resources.

Some HSPs and the chaplains who participated felt that increased education of chaplains on the identification and management of subthreshold symptoms would be useful. Some felt that chaplains were an underused resource, as they have a unique role whereby they have time to discuss low-level issues, and are easier to secure a time with than other HSPs. It was felt that many members would benefit from being educated on the role chaplains play and that they offer non-religious support.

Education on MEC system

Most HSPs felt that members needed clearer information about the MEC system process, including that there are no hard and fast rules such as a threshold number of appointments with a mental health practitioner (i.e. that a MEC change will not be made purely on the number of appointments an individual has had). More standardisation of the system was suggested as a potential improvement but with the ability for flexibility and individualisation built in.

Chapter 8
Implications

This chapter provides a summary of the implications that have emerged from the data collected during the initial phase of the WATCH Project. Findings of the families and command components of the WATCH Project are available as separate addendums to this report. The following implications represent the opinions of the authors of this report and have been developed based on the data and consultation with key stakeholders within Defence. Prior to implementation, further stakeholder liaison by Defence should be undertaken to establish practical and realistic ways in which these can occur. The capacity to address these implications must also be considered alongside resourcing in the Defence health system. Finally, it is important to note that some of the gaps identified as a result of the data collected in the WATCH Project are not unique to the ADF health system, many of these are present in international military organisations and the community more generally, such as limited availability of resources.

Identifying subthreshold symptoms and early changes in mental health

Change from usual baseline of wellbeing

Early changes in mental health and wellbeing are most easily identified by individuals who know the member well. Data from the WATCH Project demonstrates that the earliest changes in mental health vary between individuals – for some it may be changes in sleep, for others it might be withdrawal from social support networks or a shift to maladaptive coping strategies. The data also demonstrated that some of these changes tend to emerge as time in career progresses (such as sleep and anger issues), but that other changes may occur as early as the first few years of service (such as maladaptive coping strategies). It is therefore critical to recognise that early mental health changes can present differently for everyone, and can emerge at different times throughout an individual's career.

In considering who is best placed to identify these unique changes across the life course of a member's career, both the ADF members and HSPs endorsed the belief that peers are able to identify when an individual has a shift or a change from their usual baseline of wellbeing, as well as leadership and family members. The frequency of contact and knowledge of the individual on a day-to-day basis make these groups well placed to identify early and nuanced change in mental health. Some differences related to the most frequently used sources of support were found between the member career cohorts, and it was identified that as time in service progressed, the social support network that member's felt willing to access broaden substantially. These differences are useful to be aware of and represent an opportunity for a more proactive 'reach in' from the social support network to the member (for example, leadership reaching in more to early career members). Similarly, there is an opportunity to educate members about 'reaching out' (member seeking support from others). For instance, early and mid-career members would benefit from understanding the importance of accessing HSPs and leadership as a form of support whereas long career members would benefit from education around more frequently accessing leadership as a source of support.

For reaching out and reaching in to occur in a meaningful way, there needs to be awareness concerning how and when to do this. Educating members, leaders, and HSPs that this is part of their role should be a

continual component of messaging regarding health and wellbeing. Clear guidance with regards to the early changes to look for, what to do when they are identified, and when to act, will be needed to ensure the whole social support system surrounding a member is informed and able to intervene early when needed.

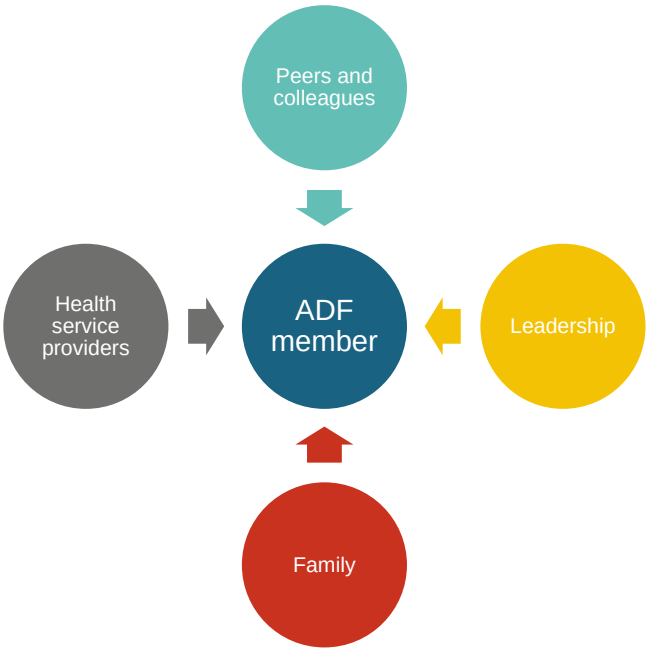


Figure 31. Supports who are well-placed to identify when an individual has a shift or a change from their usual baseline of wellbeing.

Enhancing the capacity for early identification in the health service system

Initial triaging into the Defence health service system

The ADF health service system conducts over 50,000 health appointments in any given month. Despite this extremely high volume of service there was still substantial feedback regarding wait times and access to more specialised services from both HSPs and members. Moreover, the high caseloads of those in primary health care were reported to impact the ability of practitioners to explore issues other than the ones the member has presented with.

Ensuring that health staff such as nurses and medics are able to work at the highest level within their scope of practice may represent an opportunity to alleviate some of the pressure on primary health care practitioners. These staff could perform a range of medical triage activities including querying and exploring subthreshold symptom presentation in members presenting for care. Increasing education for nurses and medics on early symptom emergence (signs and symptoms to look for, potentially in the form of easy to reference algorithms/flow charts) and pathways to further support members experiencing initial

changes in their mental health would be an important first step. Undertaking this could result in enhanced access to doctors, as well as increasing the opportunity to identify those with subthreshold symptoms. This may in turn activate earlier access to support and treatment, resulting in better outcomes for the member.

It may also be useful to have a resource available to members that clearly identifies pathways to care, and the processes and timing for appointments and treatment, particularly for those in their early career who will likely be less familiar with the Defence health system. Whilst there is information in the community more generally about the Australian health system (provided by the Department of Health), it may be beneficial for members to have information specific to the Defence health system. This may serve to help members with understanding usual processes and thereby reduce their frustration when engaging with the Defence health system.

Boosting health service provider's knowledge and access to information

This project demonstrated that there is a very good level of knowledge among HSPs about subthreshold symptoms and how to identify them. However, knowledge about the importance of these early symptoms and how they may present differently for different career cohorts could be further enhanced (particularly for allied health professionals). There should be a focus on educating HSPs about the importance of these early features in subsequent mental health trajectories and the manner in which, while appearing innocuous, they can impact on functioning, performance and capability.

Additionally, this study has provided, for the first time, new information about symptoms across the three career cohorts. While the numbers in this study are small, the themes that emerged were consistent enough to suggest that these differences would likely exist across the broader population. Building in this new information about what kinds of symptoms and behaviours may emerge at each career stage is important in building knowledge within the health system about how to identify and intervene early with members who are experiencing challenges with their mental health and wellbeing.

A second opportunity to boost knowledge and access to information for HSPs emerged from this project. There was substantial variability in HSPs' knowledge and use of online and digital products to support the health and wellbeing of current serving members, including variability in the quality of online apps and tools being suggested to members. Defence currently has a substantial amount of work in this area underway.

Mental health screening – an opportunity already embedded

Mental health screening was clearly identified by HSPs as a valuable process within Defence. However, many raised both implementation and systems issues with current screening practices, all of which are already known challenges. A number of these issues may be mitigated by the introduction of the new e-health system in 2023 (such as having easier access to historical screening records and linking up screening events for an individual to detect trajectories). However, the challenges with screening are not only systemic in nature.

A clear opportunity exists to identify members who are scoring in the subthreshold zone on particular screens that are already well embedded (such as the Post Operational Psychological Screen or the Periodic Mental Health Screen). While needing to consider the implications of this from a resourcing perspective, a subthreshold screening triage system might be an effective way to identify early challenges and educate members on what their scores mean, what they need to be mindful of and how to access support for their specific symptoms. Such a system would serve to educate and empower members (rather than pathologise them), allow them to take charge of their own mental health and wellbeing, to 'tune in' to their symptoms more clearly and to take proactive action to monitor and seek help when needed. With this education and empowerment, it is likely that members will experience a reduction in symptoms (and their consequential functional impacts), and this may serve to redirect their trajectory towards further ill health.

Facilitating help-seeking behaviour

Education through lived experience

Across the three career cohorts, the idea of hearing stories from others was thought to be an effective strategy to encourage help-seeking in members. Two types of stories were suggested: hearing from members who had noticed early changes in their mental health but who did not seek help, resulting in a progression of symptoms and a more substantial treatment and recovery process; and hearing from members who sought help early, when changes in their mental health first s tarted to emerge.

Lived experience education campaigns can be very powerful and an effective way to break down barriers to help-seeking through real-world examples of seeing how the system 'works'.

Checking back in on early symptoms

Routine follow-up

Checking in, following up and recall with members who have sought care for a significant health issue is part of routine clinical practice and governance. A potential gap in the system exists in the follow up of those who have presented with lower level mental health challenges. HSPs shared that they are not always knowledgeable of the outcomes of their recommendations or treatment and that feedback loops for members presenting with subthreshold symptoms are not always enacted. The e-health system has reminders built in for practitioners to follow up with members, so this system could be used for those members who are actively managing subthreshold symptoms. Whilst it is important to recognise that the mental health and wellbeing of members can fluctuate over time, and that the experience of subthreshold symptoms can remit naturally for some, this is not the case for all. As such, it is critical to ensure there is a system in place to identify and support those experiencing subthreshold symptoms which are not remitting naturally with time. The mechanism of routine follow-up would ensure that members who haven't bounced back to their usual baseline of wellbeing are identified and further supported.

It is important to ensure that such a process does not further burden GPs, so the follow-up for subthreshold symptom management and treatment could rest with nurses and medics. Following up with members

experiencing early symptoms of mental health problems would assist in determining whether the member would benefit from further support and management.

Additional considerations

A number of additional implications, some of which are already being addressed by Defence, emerged from the WATCH Project that are important to note. These are listed here to be considered in conjunction with those above.

Area	Gaps and opportunities
Military Employment Classification	• Perceived inconsistencies in the way the MEC system is being applied. • The perceived impact of a "downgrade" (change in classification) is a barrier to help seeking. • Much work is being done within Defence around MEC, and it is recognised that the system is large and complex, but an evaluation of the MEC system and its application could be considered • Using the lived experience voice may be a powerful way to educate members about the process of MEC • Education about the MEC system and how the system is designed to allow time for recovery should be further explored.
Resources and education	• Very few members or HSPs recalled the large number of resources that Defence already have (such as Access and RESET) • HSPs would benefit from more frequent and tailored ongoing professional development, particularly with regards to keeping on top of advancements in research and treatment modalities • ADF members have some knowledge on how to manage early mental health changes (particularly of areas such as sleep hygiene). It would be useful to consider building member knowledge of subthreshold symptoms (and their management) in opportunities that are already present, such as using presentations relating to sleep as an opportunity to address other issues. • It may be useful to have increased advertisements and accessibility to active and accessible list of all mental health resources that Defence have developed (or routinely use) to encourage uptake • Whilst opportunities such as the MH30+30 forums exist to allow for upskilling and exposure to current research, it would be useful to identify other opportunities for professional development for HSPs, such as further training on the early identification of subthreshold symptoms, and ensure that HSPs are engaging in these activities
Continuity of care	• A lack of continuity of care (due to HSP turnover over or seeing someone new every time a member presents) can be a barrier for members who feel that they are constantly having to retell their 'story' • Handover practices when staff post out of health centres could be reviewed to ensure client handover is thorough

Help seeking behaviour	• ADF members may benefit from less formalised pathways to care • Opportunities to have initial, informal chats about changes in mental health may be useful for members. Whilst we have explored alternate triage pathways into care in detail in the above section, there may be further opportunity to provide a less formal first step into care – a graded way to access help. Consideration into the Chaplains role in these initial, informal chats may be useful for maximising the important role they have in these initial chats.
Keeping the conversations going	• Important to normalise mental health and wellbeing, promote activities as part of keeping fit. • Members suggested that lived experience campaigns and testimonials showing how help seeking works would be beneficial • Consider guidelines for how to keep mentally fit (sitting alongside those that focus on physical fitness) • The voice of exemplars could be a powerful voice for members to hear, mid-career members may be well places to fill such a role given their attitude shift across their career. Whether mid-career members could see themselves filing this role would require further enquiry.

Abbreviations

ADF	Australian Defence Force
Defence	Department of Defence
GP	general practitioner
HSP	health service provider
K10	Kessler Psychological Distress Scale
MO	Military Medical Officer
MEC	Military Employment Classification
MHPWS	Mental Health Prevalence and Wellbeing Study
PCL-C	PTSD Checklist – Civilian Version
PHQ-9	Patient Health Questionnaire-9
PTSD	posttraumatic stress disorder

References

Bartone, P. (2012). Social and organizational influences on psychological hardiness: How leaders can increase stress resilience. *Security Informatics, 1*(1), 21.

Biella, M., Borges, M., Strauss, J., Mauer, S., Martinelli, J., & Aprahamian, I. (2019). Subthreshold Depression Needs A Prime Time In Old Age Psychiatry? A Narrative Review Of Current Evidence. *Neuropsychiatric disease and treatment, 15*, 2763-2772. doi:10.2147/NDT.S223640

Blanc, S., Zamorski, M., Ivey, G., McCuaig Edge, H., & Hill, K. (2014). How much distress is too much on deployed operations? Validation of the Kessler Psychological Distress Scale (K10) for application in military operational settings. *Military Psychology, 26*(2), 88-100.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Breslau, N., Lucia, V. C., & Davis, G. C. (2004). Partial PTSD versus full PTSD: an empirical examination of associated impairment. *Psychol Med, 34*(7), 1205-1214.

Bryant, R., Lawrence-Wood, E., Baur, J., McFarlane, A., Hodson, S., Sadler, N., . . . Van Hooff, M. (2019). *Mental Health Changes Over Time: a Longitudinal Perspective: Mental Health and Wellbeing Transition Study*. Canberra: Department of Defence and Department of Veterans' Affairs.

Chen, C., Salim, R., Rodriguez, J., Singh, R., Schechter, C., Dasaro, C., . . . Feder, A. (2020). The Burden of Subthreshold Posttraumatic Stress Disorder in World Trade Center Responders in the Second Decade After 9/11. *J Clin Psychiatry, 81*(1). doi:10.4088/JCP.19m12881

Cuijpers, P., Koole, S. L., van Dijke, A., Roca, M., Li, J., & Reynolds, C. F., 3rd. (2014). Psychotherapy for subclinical depression: meta-analysis. *The British journal of psychiatry : the journal of mental science, 205*(4), 268-274. doi:10.1192/bjp.bp.113.138784

Cukor, J., Wyka, K., Jayasinghe, N., & Difede, J. (2010). The nature and course of subthreshold PTSD. *J Anxiety Disord, 24*(8), 918-923. doi:https://doi.org/10.1016/j.janxdis.2010.06.017

Dell, L., Fredrickson, J., Cowlishaw, S., Sadler, N., Crane, M., Lewis, V., . . . Forbes, D. (2019). *LASER-Resilience: Patterns and Predictors of Wellbeing.* Report prepared for the Australian Government Department of Defence. Phoenix Australia: Melbourne.

Department of Defence. (2017). *Defence Mental Health and Wellbeing Strategy 2018-2023*. Retrieved from https://www.defence.gov.au/sites/default/files/2020-09/Defence_Mental_Health_Wellbeing_Strategy_2018-2023_0.PDF

Eekhout, I., Reijnen, A., Vermetten, E., & Geuze, E. (2016). Post-traumatic stress symptoms 5 years after military deployment to Afghanistan: an observational cohort study. *Lancet Psychiatry, 3*(1), 58-64. doi:10.1016/S2215-0366(15)00368-5

Fink, D., Gradus, J., Keyes, K., Calabrese, J., Liberzon, I., Tamburrino, M., . . . Galea, S. (2018). Subthreshold PTSD and PTSD in a prospective-longitudinal cohort of military personnel: Potential targets for preventive interventions. *Depress Anxiety, 35*(11), 1048-1055. doi:10.1002/da.22819

Gilbody, S., Lewis, H., Adamson, J., Atherton, K., Bailey, D., Birtwistle, J., . . . McMillan, D. (2017). Effect of Collaborative Care vs Usual Care on Depressive Symptoms in Older Adults With Subthreshold Depression: The CASPER Randomized Clinical Trial. *Jama, 317*(7), 728-737. doi:10.1001/jama.2017.0130

Goodwin, L., Jones, M., Rona, R., Sundin, J., Wessely, S., & Fear, N. (2012). Prevalence of delayed-onset posttraumatic stress disorder in military personnel: is there evidence for this disorder?: Results of a prospective UK cohort study. *J Nerv Ment Dis, 200*(5), 429-437. doi:10.1097/NMD.0b013e31825322fe

Hassard, J., Teoh, K., Thomson, L., & Blake, H. (2021). Understanding the cost of mental health at work: An integrative framework. *The SAGE Handbook of Organizational Wellbeing*, 9.

Jakupcak, M., Hoerster, K., Varra, A., Vannoy, S., Felker, B., & Hunt, S. (2011). Hopelessness and suicidal ideation in Iraq and Afghanistan War Veterans reporting subthreshold and threshold posttraumatic stress disorder. *J Nerv Ment Dis, 199*(4), 272-275. doi:10.1097/NMD.0b013e3182124604

Judd, L., Paulus, M., Wells, K., & Rapaport, M. (1996). Socioeconomic burden of subsyndromal depressive symptoms and major depression in a sample of the general population. *Am J Psychiatry, 153*(11), 1411-1417. doi:10.1176/ajp.153.11.1411

Kaplan, M. J., & Klinetob, N. A. (2000). Childhood emotional trauma and chronic posttraumatic stress disorder in adult outpatients with treatment-resistant depression. *J Nerv Ment Dis, 188*(9), 596-601.

Karsten, J., Penninx, B., Verboom, C., Nolen, W., & Hartman, C. (2013). Course and risk factors of functional impairment in subthreshold depression and anxiety. *Depress Anxiety, 30*(4), 386-394. doi:10.1002/da.22021

Kearns, M. C., Ressler, K. J., Zatzick, D., & Rothbaum, B. O. (2012). Early interventions for PTSD: a review. *Depress Anxiety, 29*(10), 833-842. doi:10.1002/da.21997

Kim, E., Bagalman, J., & Goetzel, R. (2010). Cost burden of treatment resistance in patients with depression. *Am J Manag Care, 16*(5), 370-377.

Klein, D., Schwartz, J., Rose, S., & Leader, J. (2000). Five-Year Course and Outcome of Dysthymic Disorder: A Prospective, Naturalistic Follow-Up Study. *American Journal of Psychiatry, 157*(6), 931-939. doi:10.1176/appi.ajp.157.6.931

Marshall, R., Olfson, M., Hellman, F., Blanco, C., Guardino, M., & Struening, E. (2001). Comorbidity, impairment, and suicidality in subthreshold PTSD. *Am J Psychiatry, 158*(9), 1467-1473. doi:10.1176/appi.ajp.158.9.1467

McFarlane, A., Hodson, S., Van Hooff, M., & Davies, C. (2011). *Mental health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study: Full Report*. Department of Defence: Canberra.

McFarlane, A., Hodson, S., Van Hooff, M., & Davies, C. (2011). *Mental health in the Australian Defence Force: 2010 ADF mental health prevalence and wellbeing study: Full report. Canberra: Department of Defence*: Department of Defence.

Mitchell, A. J., Rao, S., & Vaze, A. (2011). Can general practitioners identify people with distress and mild depression? A meta-analysis of clinical accuracy. *J Affect Disord, 130*(1), 26-36. doi:https://doi.org/10.1016/j.jad.2010.07.028

Pietrzak, R., Goldstein, M., Malley, J., Johnson, D., & Southwick, S. (2009). Subsyndromal posttraumatic stress disorder is associated with health and psychosocial difficulties in veterans of Operations Enduring Freedom and Iraqi Freedom. *Depress Anxiety, 26*(8), 739-744. doi:10.1002/da.20574

Pietrzak, R., Goldstein, R., Southwick, S., & Grant, B. (2011). Prevalence and Axis I comorbidity of full and partial posttraumatic stress disorder in the United States: results from Wave 2 of the National Epidemiologic Survey on Alcohol and Related Conditions. *J Anxiety Disord, 25*(3), 456-465. doi:10.1016/j.janxdis.2010.11.010

Rodríguez, M. R., Nuevo, R., Chatterji, S., & Ayuso-Mateos, J. L. (2012). Definitions and factors associated with subthreshold depressive conditions: a systematic review. *BMC Psychiatry, 12*(1), 181. doi:10.1186/1471-244X-12-181

Rodriguez, P., Holowka, D. W., & Marx, B. P. (2012). Assessment of posttraumatic stress disorder-related functional impairment: A review. *Journal of Rehabilitation Research and Development, 49*(5), 649-666.

Sampasa-Kanyinga, H., Zamorski, M., & Colman, I. (2018). Mental Disorder, Psychological Distress, and Functional Status in Canadian Military Personnel. *The Canadian Journal of Psychiatry, 63*(9), 620-628.

Sanchez, R., Bray, R., Vincus, A., & Bann, C. (2004). Predictors of Job Satisfaction Among Active Duty and Reserve/Guard Personnel in the U.S. Military. *Military Psychology, 16*(1), 19-35. doi:10.1207/s15327876mp1601_2

Sareen, J., Henriksen, C., Stein, M., Afifi, T., Lix, L., & Enns, M. (2013). Common mental disorder diagnosis and need for treatment are not the same: findings from a population-based longitudinal survey. *Psychol Med, 43*(9), 1941.

Smid, G., Mooren, T., van der Mast, R., Gersons, B., & Kleber, R. (2009). Delayed posttraumatic stress disorder: systematic review, meta-analysis, and meta-regression analysis of prospective studies. *J Clin Psychiatry, 70*(11), 1572-1582. doi:10.4088/JCP.08r04484

Utzon-Frank, N., Breinegaard, N., Bertelsen, M., Borritz, M., Eller, N., Nordentoft, M., . . . Bonde, J. (2014). Occurrence of delayed-onset post-traumatic stress disorder: a systematic review and meta-analysis of prospective studies. *Scand J Work Environ Health, 40*(3), 215-229. doi:10.5271/sjweh.3420

Zepinic, V. (2015). Treatment resistant symptoms of complex PTSD caused by torture during war. *Canadian Social Science, 11*(9), 26-32.

Zlotnick, C., Franklin, C., & Zimmerman, M. (2002). Does "subthreshold" posttraumatic stress disorder have any clinical relevance? *Comprehensive Psychiatry, 43*(6), 413-419. doi:https://doi.org/10.1053/comp.2002.35900

Wellness Action Through Checking Health

WATCH Project Appendices

Appendix I

Previous studies

LASER-Resilience

The LASER-Resilience program was the first Australian longitudinal study that examined wellbeing during the initial years of service. It surveyed participants at five time points, beginning at enlistment/appointment and continuing through the early years of their military career and up to four years post-enlistment/appointment. Two reports from the study are of interest to the current discussion: Patterns and Predictors of Wellbeing (Dell, Fredrickson, Cowlishaw, et al., 2019) and the LASER-Resilience Summary Report (Dell, Fredrickson, Sadler, et al., 2019).

The Patterns and Predictors of Wellbeing report is of particular importance in this current investigation. This report not only examined subthreshold distress and posttraumatic stress symptoms but it followed these symptoms in personnel over a period of three to four years (by modelling the trajectories of symptom progression), allowing us to plot who progressed to disorder and who remained mentally well.

The Programme

The Programme examined the impact of military service on the mental, physical and social health of serving and ex-serving ADF members, including those who had deployed in contemporary conflicts, and their families. It was the first attempt in Australia to establish the prevalence of mental disorders in a representative cohort of ADF members who transitioned out of the Regular ADF between 2010 and 2014, compared to a sample of permanent, full-time serving ADF personnel in 2015. Two reports from The Programme are of relevance to this study: the Impact of Combat Study (Lawrence-Wood et al., 2019) and The Mental Health Changes Over Time: a Longitudinal Perspective Report (Bryant et al., 2019). Both these reports provide a snapshot of the rates of personnel with subthreshold distress, posttraumatic stress symptoms and depression.

Subthreshold distress

Prevalence of subthreshold psychological distress, measured by the Kessler Psychological Distress Scale (K10), was examined in both the LASER-Resilience study and the Programme (Figure 1). The LASER-Resilience Study found that proportions of members with subthreshold psychological distress generally increased over time from enlistment to four years post-enlistment/appointment: 11.8% at baseline (enlistment or first weeks of training), 28.1% at the end of initial training (or after one year of service for those undertaking longer periods of initial training), 24.5% one year later, 29.3% a further one year later, and 30.8% a further one year later (Dell, Fredrickson, Cowlishaw, et al., 2019). In the Impact of Combat cohort, subthreshold psychological distress increased from 12.0% at pre-deployment to 16.7% at post-deployment and remained steady 16.4% at Time 3, three to four years later (Lawrence-Wood et al., 2019). In the MHPWS longitudinal cohort, a quarter of the Transitioned ADF (25.2%) and just under that for Regular ADF members (21.4%) had subthreshold psychological distress in 2010 (Bryant et al., 2019). Both

of these figures decreased by a similar proportion in 2015 (Transitioned ADF 21.1%, Regular ADF 17.4%). This report also examined symptom progression in more detail, looking at the proportion of those with subthreshold disorder in 2010 that then had no disorder, subthreshold disorder or probable disorder in 2015. The results showed that approximately a third of both the Transitioned and Regular ADF that reported subthreshold symptoms in 2010 retained their subthreshold status in 2015 (32.7% vs 32.5%), with 25.2% of Transitioned ADF and 17.5% of Regular ADF progressing to probable disorder in 2015.

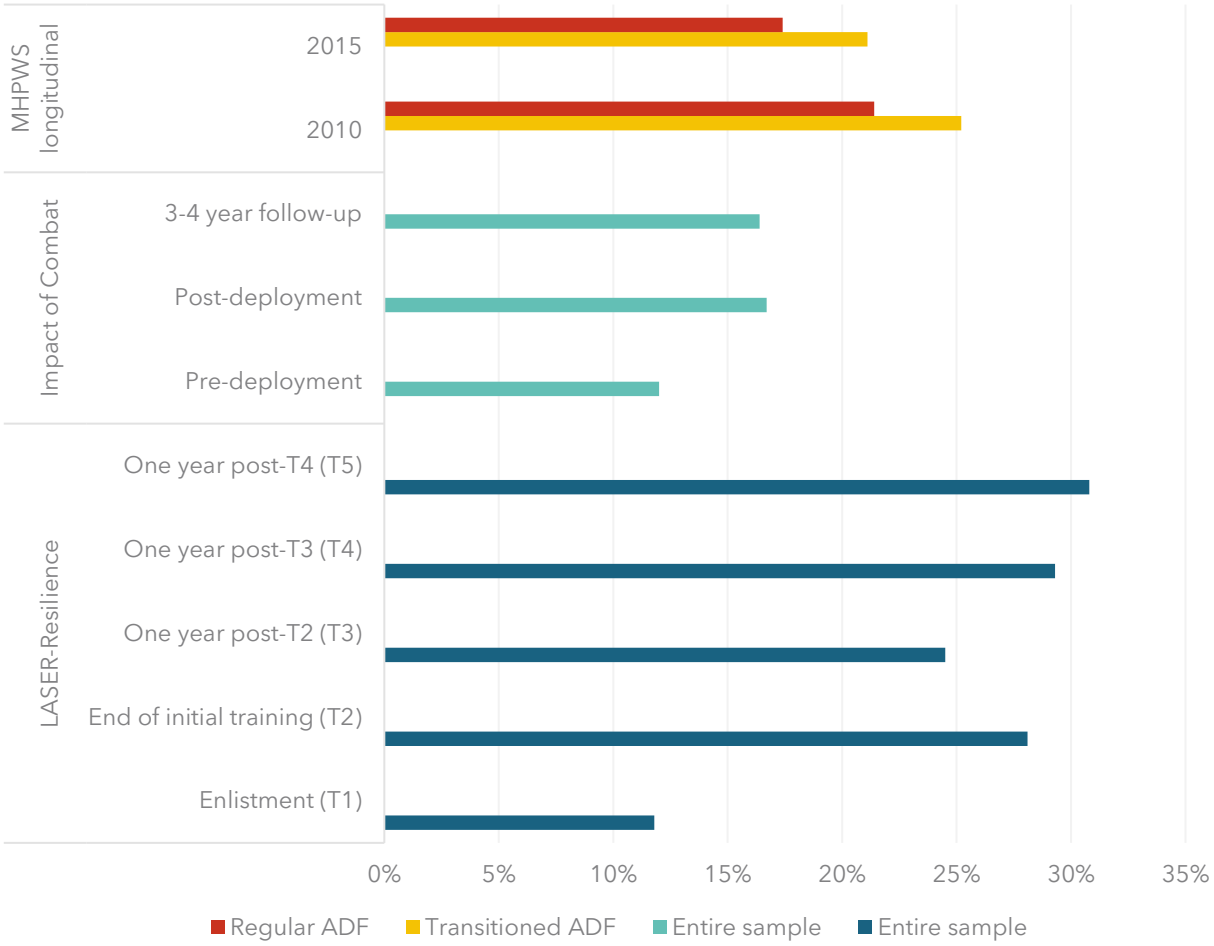


Figure 1. Prevalence of subthreshold psychological distress in the three Defence cohorts

Subthreshold posttraumatic stress symptoms

Prevalence of subthreshold PTSD symptoms (using the Patient Health Questionnaire (PCL-C)) were measured in the two Programme cohorts (Figure 2). In the Impact of Combat cohort, 7.1% reported subthreshold PTSD symptoms at pre-deployment, increasing to 13.4% at post-deployment and further to 21.7% at the most recent time point (Lawrence-Wood et al., 2019). In the MHPWS longitudinal cohort, 19.6% of Transitioned ADF and 14.9% of Regular ADF reported subthreshold posttraumatic stress symptoms in 2010 (Bryant et al., 2019). Both groups had an increased prevalence at five-year follow-up

(Transitioned ADF 25.0%, Regular ADF 17.1%). Of those with subthreshold posttraumatic stress symptoms in 2010, 42.0% of Transitioned ADF and 39.5% of Regular ADF maintained their subthreshold status in 2015. A further 23.4% of Transitioned ADF and 9.9% of Regular ADF members progressed from subthreshold disorder in 2010 into probable disorder in 2015.

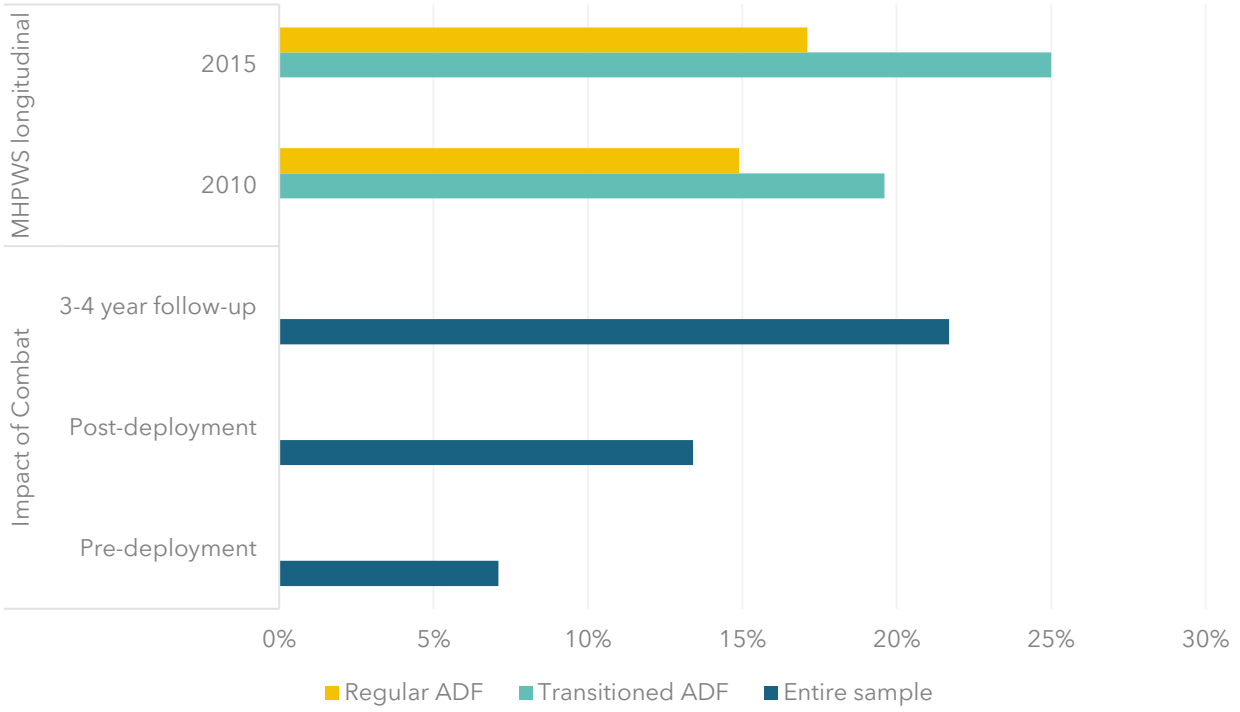


Figure 2. Prevalence of subthreshold posttraumatic stress symptoms in the Programme cohorts

Subthreshold depressive symptoms

Prevalence of subthreshold depressive symptoms was measured in the two Programme cohorts using the Patient Health Questionnaire (PHQ-9) (Figure 3). In the Impact of Combat cohort, 7.7% reported symptoms consistent with subthreshold depression at pre-deployment, increasing to 12.4% at post-deployment, which then more than doubled at the most recent time point (27.9%) (Lawrence-Wood et al., 2019). In the MHPWS longitudinal cohort, 23.6% of Transitioned ADF and 16.1% or Regular ADF reported subthreshold depressive symptoms in 2010 (Bryant et al., 2019). The prevalence increased for both groups in 2015, with 33.6% of Transitioned ADF and 29.6% of Regular ADF meeting cut-off at five-year follow-up. Of those with subthreshold depressive symptoms in 2010, over half retained their subthreshold status in 2015 (Transitioned ADF 51.9%, Regular ADF 57.3%). A further quarter of Transitioned ADF (23.1%) and 9.2% of Regular ADF members worsened to probable disorder in 2015.

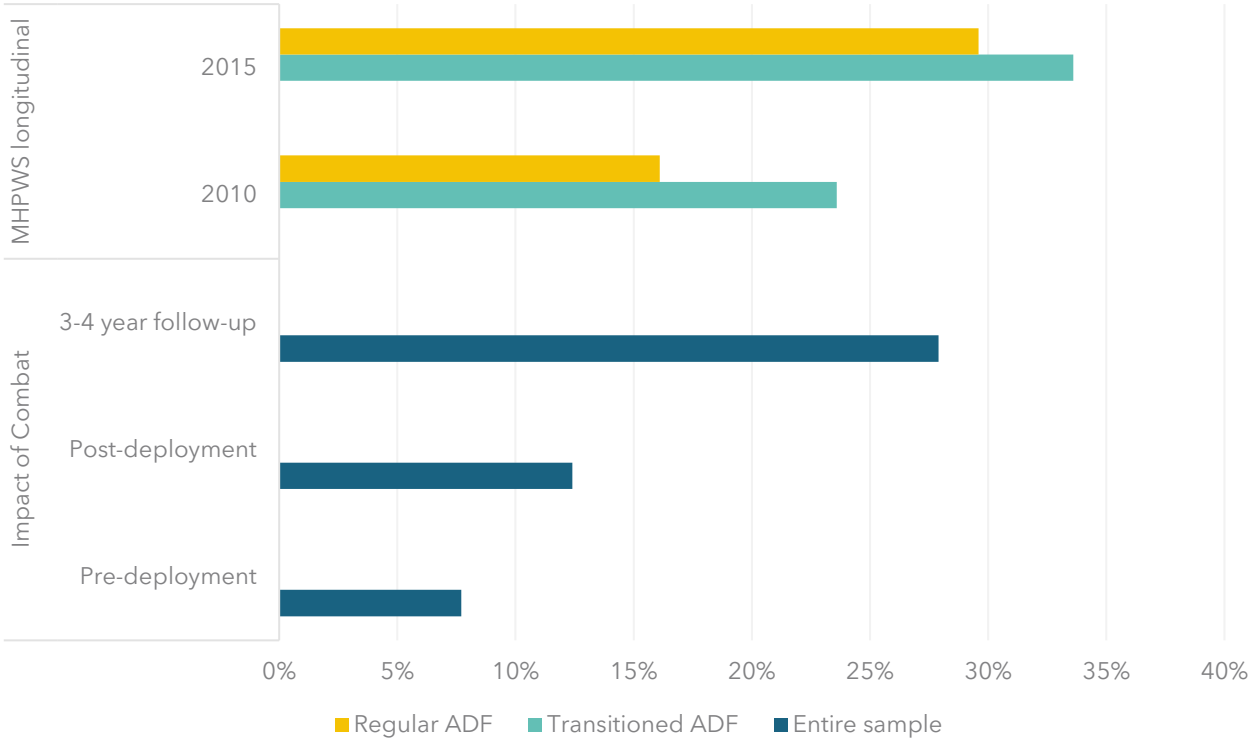


Figure 3. Prevalence of subthreshold depressive symptoms in the Programme cohorts

The emergence and course of subthreshold presentations

The Patterns and Predictors of Wellbeing report from the LASER-Resilience study examined sub-groups of personnel that experienced different mental health trajectories across time. These sub-groups are presented in Figure 4 below. As shown by the red circle in the graph, there are two groups of personnel reporting subthreshold distress. The green line shows a group of individuals who were experiencing subthreshold symptoms at just above cut-off at the end of initial training (T2) which increased into probable clinical disorder range after training (T3) and remained there across transfer to a unit, base or ship and possible deployment (T4 and T5). The yellow line represents a group of individuals who were experiencing symptoms of probable disorder at the end of initial training (T2) which reduced after training (T3) but remained at subthreshold level throughout the study and showed evidence of increasing by transfer to a unit, base or ship and possible deployment (T4 and T5). Both of these groups would likely benefit from interventions targeted at the resolution of subthreshold symptoms of distress.

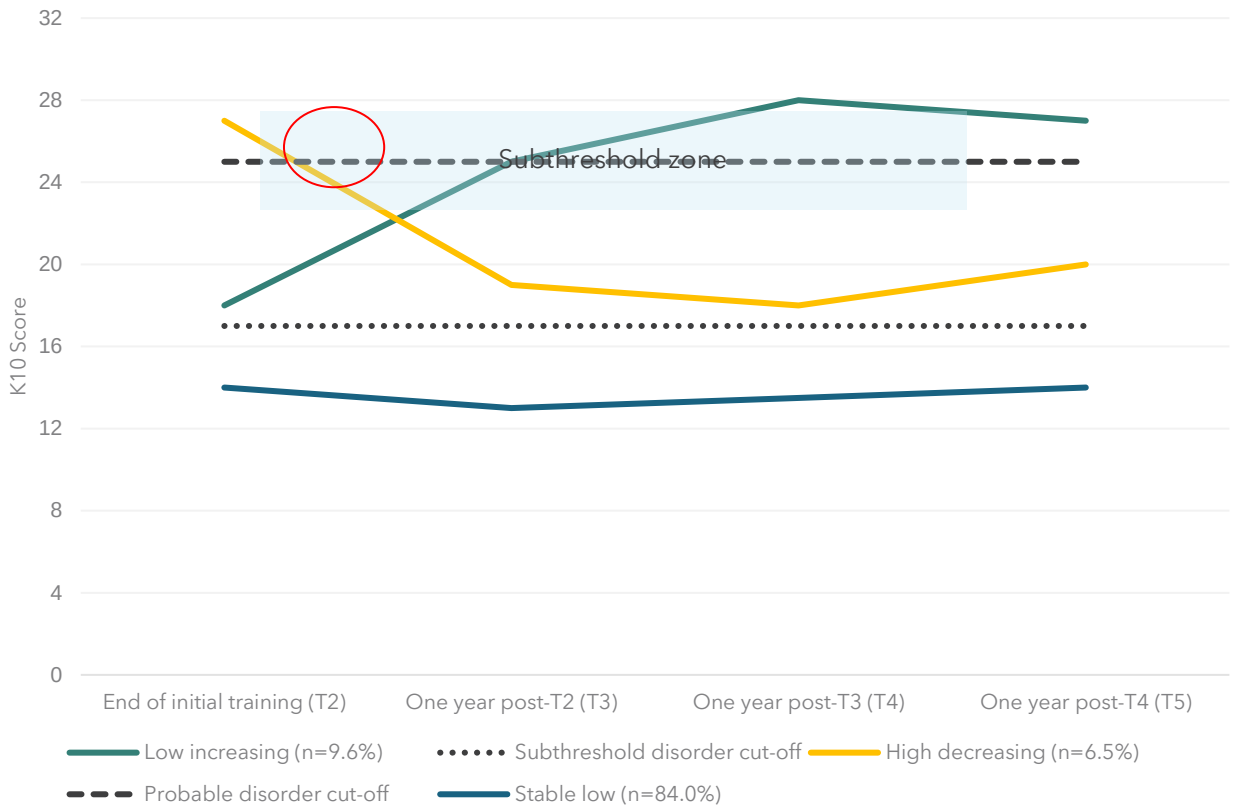


Figure 4. Trajectories of K10 score across time in the LASER-Resilience study (Dell, Fredrickson, Cowlishaw, et al., 2019)

The Patterns and Predictors of Wellbeing report also identified four sub-groups as best suiting the trajectories of posttraumatic stress symptom scores, two of which are of interest here.

Figure 5 shows a group of individuals who were experiencing low levels of PTSD symptoms at the end of initial training (T2) which had increased to probable disorder post training (T3) and continued to increase and remain high across transfer to a unit, base or ship and possible deployment (T4 and T5). The yellow line indicated a group of individuals who were experiencing mild PTSD at the end of initial training (T2) whose symptoms reduced to subthreshold level by post training (T3) but remained in the subthreshold range throughout the study. Both of these groups are of interest in the current study as the group represented by the green line may benefit from early intervention to prevent progression to disorder, while interventions targeting subthreshold symptoms may help resolve persistent symptoms experienced by the group represented by the yellow line.

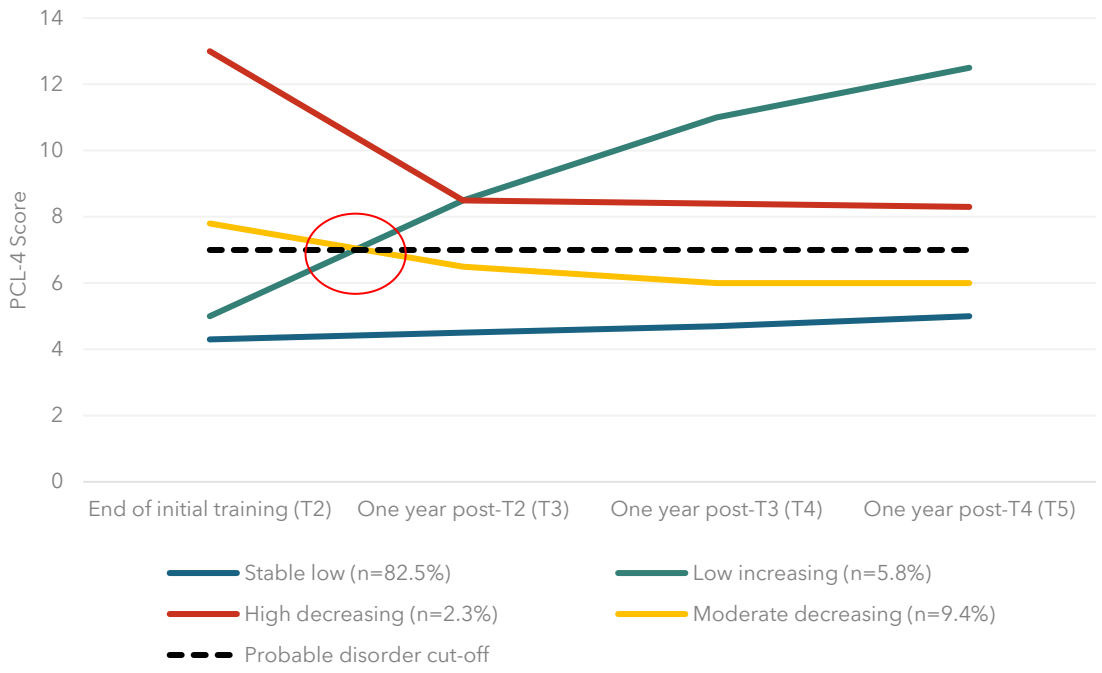


Figure 5. Trajectories of PCL-4 score across time in the LASER-Resilience study (Dell, Fredrickson, Cowlishaw, et al., 2019)

The Impact of Combat Study allowed for the examination of the impact of deployment on mental health and found increases emerged in subthreshold psychological distress, depressive and posttraumatic stress symptoms from pre to post deployment. These subthreshold symptoms were still present three to four years on, with an even great prevalence and with some members progressing to probable disorder.

The MHPWS longitudinal cohort examined subthreshold symptoms specific to Transitioned personnel. Personnel who had transitioned in 2015 reported higher levels of subthreshold symptoms compared to those that remained Regular ADF members between 2010 and 2015, both while they were still in current service in 2010 and once they had transitioned. The prevalence of those meeting subthreshold cut-offs for posttraumatic stress and depressive symptoms increased over time. Further, higher proportions of Transitioned ADF with subthreshold disorder progressed onto probable disorder after transition compared to those that remained in regular ADF service (psychological distress: 25.2% of Transitioned ADF and 17.5% of Regular ADF; posttraumatic stress: 23.4% of Transitioned ADF and 9.9% of Regular ADF; depression: 23.1% of Transitioned ADF and 9.2% Regular ADF members).

Help-seeking

The Programme Pathways to Care Report shed light on how Regular and Transitioned ADF members seek care and under what conditions (Forbes et al., 2018). With regard to help-seeking, this report highlighted that about half the sample sought help for their mental health within three months of becoming concerned about it. Of those individuals, about 60% had the notion of seeking help suggested to them,

usually by a partner or friend. The most common reasons for seeking support were for symptoms of depression or anxiety, relationship problems and anger.

Interestingly, this report identified high rates of engagement with health services for those who had a mental health concern. Reported rates for consulting health providers by Transitioned ADF and 2015 Regular ADF members are shown in Figure 6 below.

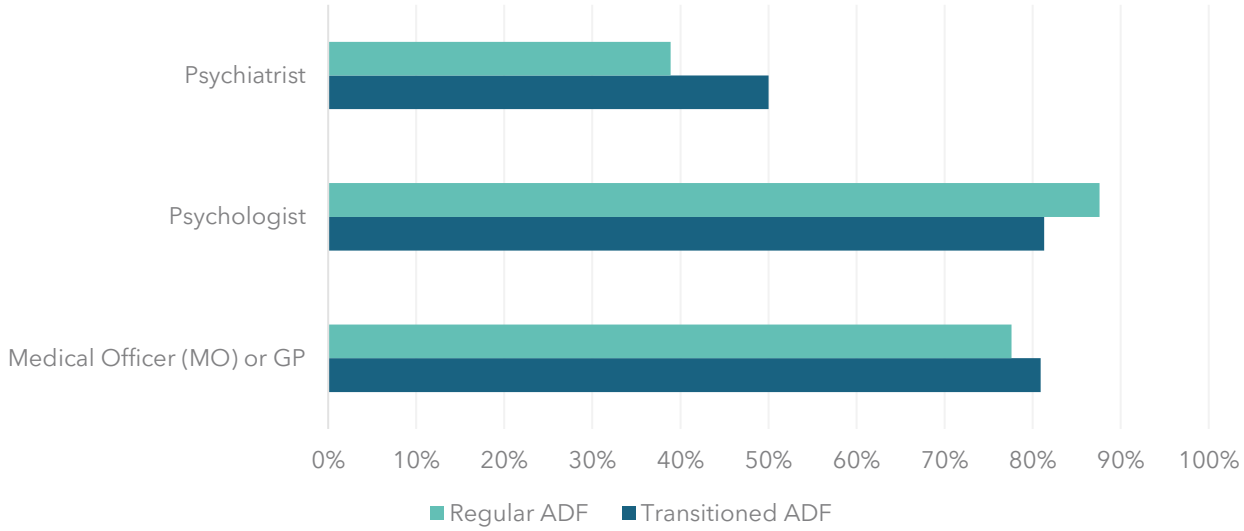


Figure 6. Reported rates of member engagement with different HSPs when experiencing mental health concerns

The most commonly provided service by GPs/MOs was referral to another service, while psychologists provided supportive counselling and psychiatrists provided prescription medicine.

We know that stigma plays a role as a barrier to help-seeking in military populations (Hoge et al., 2004; Kim, Britt, Klocko, Riviere, & Adler, 2011; Kim, Thomas, Wilk, Castro, & Hoge, 2010; Vogt, 2011). Individuals may fear negative impacts on their career or fear being judged as weak (Jones, Campion, Keeling, & Greenberg, 2018; Williamson, Greenberg, & Stevelink, 2019) and as such are more reluctant to seek help for mental health concerns. The Pathways to Care Report provided participants with a list of known stigmas and asked them to endorse those that resonated with them. 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, or that they would feel embarrassed were the most commonly endorsed items. When asked about why they wouldn't seek assistance for mental health concerns, both the Transitioned ADF and 2015 Regular ADF members reported a preference to self-manage, felt they had the ability to function effectively despite health issues and reported feeling afraid to ask. The Regular ADF reported that the primary barriers to seeking help were their concerns about the impact of this behaviour on deployability or their overall career; for Transitioned ADF members, concerns about the impact on career and expense were the most endorsed.

Abbreviations

ADF	Australian Defence Force
Defence	Department of Defence
K10	Kessler Psychological Distress Scale
PHQ-9	Patient Health Questionnaire-9
PCL-C	PTSD Checklist – Civilian Version
GP	General Practitioner
MO	Medical Officer

References

Bryant, R., Lawrence-Wood, E., Baur, J., McFarlane, A., Hodson, S., Sadler, N., . . . Van Hooff, M. (2019). *Mental Health Changes Over Time: a Longitudinal Perspective: Mental Health and Wellbeing Transition Study*. Retrieved from https://www.dva.gov.au/sites/default/files/mental-health-changes-over-time-a-longitudinal-perspective-report.pdf

Dell, L., Fredrickson, J., Cowlishaw, S., Sadler, N., Crane, M., Lewis, V., . . . Forbes, D. (2019). *LASER-Resilience: Patterns and Predictors of Wellbeing. Report prepared for the Australian Government Department of Defence*. Retrieved from https://www.defence.gov.au/sites/default/files/2021-09/20190829-LASER-Resilience-Patterns-and-Predictors-of-Wellbeing-Report.pdf

Dell, L., Fredrickson, J., Sadler, N., Terhaag, S., O'Donnell, M., Crane, M., . . . Forbes, D. (2019). *The Longitudinal Australian Defence Force Study Evaluating Resilience (LASER): 2009-2019. A Summary Report of the Research Program. Report prepared for the Australian Government Department of Defence*. Retrieved from https://www.defence.gov.au/sites/default/files/2021-09/20190829-laser-resilience-summary-report.pdf

Forbes, D., Van Hooff, M., Lawrence-Wood, E., Sadler, N., Hodson, S., Benassi, H., . . . McFarlane, A. (2018). *Pathways to Care, Mental Health and Wellbeing Transition Study*. Retrieved from https://www.dva.gov.au/sites/default/files/twrp_pathways.pdf

Hoge, C., Castro, C., Messer, S., McGurk, D., Cotting, D., & Koffman, R. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine, 351*(1), 13-22. doi:10.1056/NEJMoa040603

Jones, N., Campion, B., Keeling, M., & Greenberg, N. (2018). Cohesion, leadership, mental health stigmatisation and perceived barriers to care in UK military personnel. *Journal of Mental Health, 27*(1), 10-18. doi:10.3109/09638237.2016.1139063

Kim, P., Britt, T., Klocko, R., Riviere, L., & Adler, A. (2011). Stigma, negative attitudes about treatment, and utilization of mental health care among soldiers. *Military Psychology*.

Kim, P., Thomas, J., Wilk, J., Castro, C., & Hoge, C. (2010). Stigma, barriers to care, and use of mental health services among active duty and National Guard soldiers after combat. *Psychiatric Services, 61*(6), 582-588.

Lawrence-Wood, E., McFarlane, A., Lawrence, A., Sadler, N., Hodson, S., Benassi, H., . . . Van Hooff, M. (2019). *Impact of Combat Report, Impact of Combat Study*. Retrieved from Canberra:

Vogt, D. (2011). Mental health-related beliefs as a barrier to service use for military personnel and veterans: a review. *Psychiatric Services, 62*(2), 135-142.

Williamson, V., Greenberg, N., & Stevelink, S. (2019). Perceived stigma and barriers to care in UK Armed Forces personnel and veterans with and without probable mental disorders. *BMC Psychology, 7*(1), 75. doi:10.1186/s40359-019-0351-7

Appendix II

Membership of the Co-Design Working Group

Co-Design member	Position
CMDR Carolyn Nas Jones	Psychiatrist, HQ Joint Health Unit
Dr Duncan Wallace	Psychiatrist, ADF Centre for Mental Health, JHC
CMDR Patricia Kemp	SO1 Health Plans, National Operations, JHC
MAJ Dale Hopcraft	Psychologist, 1 Psych Unit HQ
LTCOL Diana McKay	Reserve Medical Officer, ADF Centre for Mental Health, JHC
Dr Felicity Williams	Senior Medical Advisor – Clinical Medicine
Ms Jen Wheeler	Director Navy Psychology
COL Neanne Bennett	Director Mental Health Strategy and Research
COL Rod Petersen	Senior Medical Officer, MECARS
MAJ David Clarke	SO1 Operational Psychology
LTCOL Kathryn Henderson	SO1 Mental Health and Psychology Garrison Health
Ms Caroline Falconer	Staff Officer Rehabilitation Policy
CHAP Daniel Hynes	Director Spiritual Health and Wellbeing
LTCOL Nicole Walker	SO1 Mental Health and Psychology Garrison Health

Regular representation from 1st Psychology Unit (MAJ Kevin Vowles) and Navy Psychology (Ms Samantha Falon) was also provided.

Appendix III

Triage process for above threshold participants

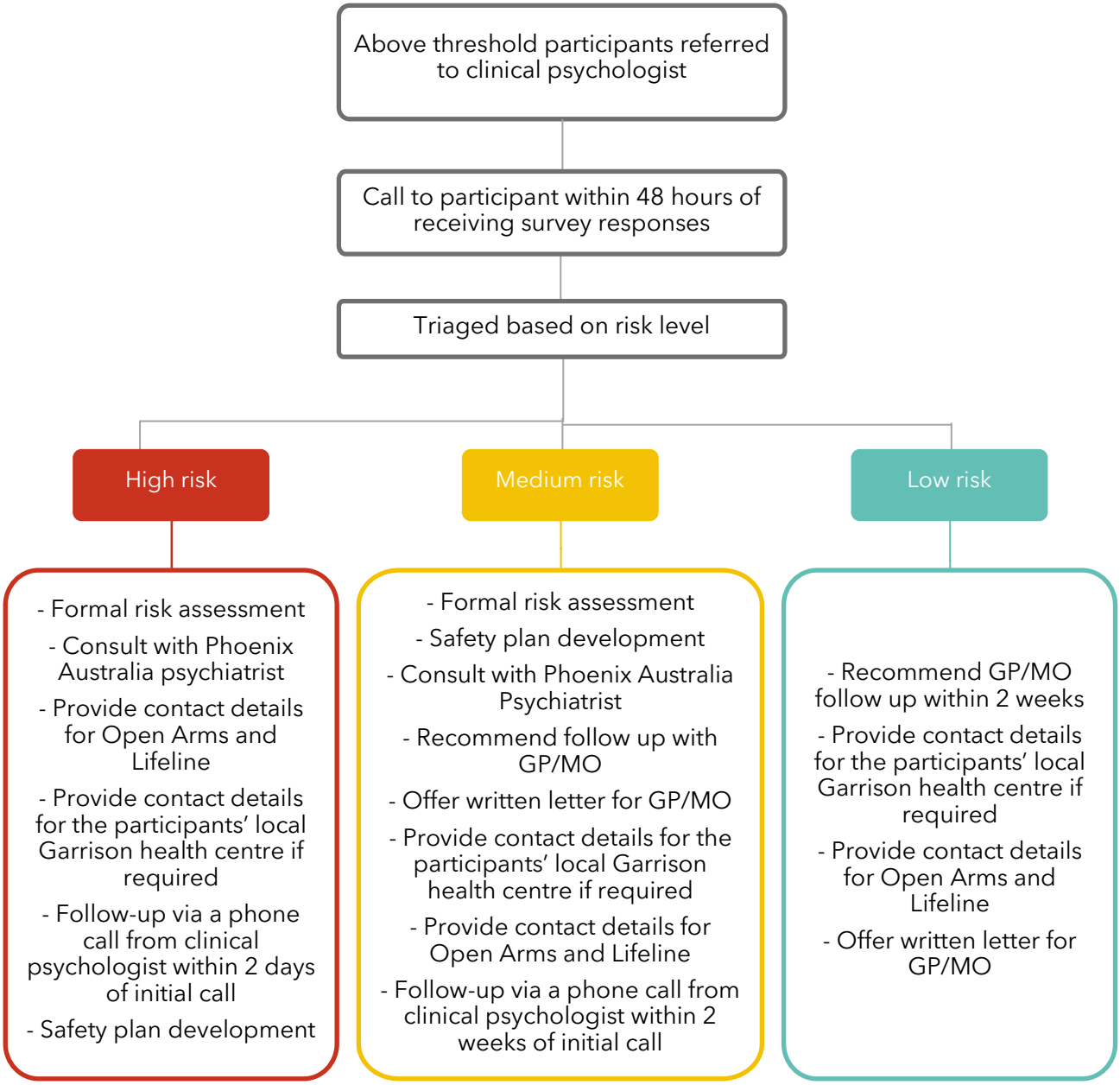


Figure 7. Triage process for participants scoring above threshold on Kessler Psychological Distress Scale (K10), Patient Health Questionnaire-9 (PHQ-9) and PTSD CheckList – Civilian Version (PCL-C).