5. Group Discussions

Review into the Suicide and Self-Harm Prevention services available to current and former serving ADF members and their families

National Mental Health Commission

28 March 2017

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Abbreviations and Definitions

Abbreviation	Definition
ACT	Australian Capital Territory
ADF	Australian Defence Force
ADFA	Australian Defence Force Academy
CO	Commanding Officer
DCO	Defence Community Organisation
DFA	Defence Families of Australia
DMO	Defence Materiel Organisation
DO	Divisional Officer
DVA	Department of Veterans Affairs
ESO	Former Organisations
GD	Group Discussions
JHC	Joint Health Command
KYMS	Keep Your Mates Safe (peer support training)
MRCA	Military Rehabilitation and Compensation Act 2004
NCO	Non-Commissioned Officer
NMHC	National Mental Health Commission
NSW	New South Wales
NT	Northern Territory
ORs	Other Ranks
POPS	Post Operational Psych Screen
PTSD	post-traumatic stress disorder
RMS	Rehabilitation Mentoring Service
RSL	Returned Services League
RtAPS	Return to Australia Psychological Screening
SRCA	Safety, Rehabilitation and Compensation Act 1984
VEA	Veterans' Entitlement Act 1986
VVCS	Veterans and Veterans Families Counselling Service
WA	Western Australia

Executive Summary

The National Mental Health Commission (the Commission) has been tasked by the Australian Government to review the suicide and self-harm prevention for serving and former ADF members and their families. A series of data collection strategies were utilised to be engage with these in the community and collect relevant data within the Review timeframe. This report discusses presents the data collected through group discussions conducted through November/December 2016.

Group Discussions (GDs) were conducted with across all ADF force arms in NSW, ACT, Queensland, and WA and involved serving ADF members, former ADF members, family members of serving and former ADF members, and community representatives. A total of 34 GDs were conducted involving 290 individuals.

In general

Family members came at the discussion from a very personal perspective, often discussing a specific case involving a family member who was continuing to experience suicidal behaviours or who had already died due to suicide. Despite a range of efforts to recruit participants, only limited numbers of family members attended the discussions.

Former member concerns largely focussed upon other former members, DVA, health care, allowances, and the need for more support.

Service members primarily were concerned about their treatment within the service and transition issues. In addition, the Command GDs at both Gallipoli and Lavarack Barracks focussed on personnel management, in particular recruitment and post-deployment, in service mental health and suicide prevention programs, aspects of policy, Chain of Command, Welfare Boards, resource management, and the relentless demands of readiness and deployment.

In Sydney, Canberra, Kapooka, Gallipoli Barracks and Lavarack Barracks, teams of health support personnel were also involved in discreet GDs.

During the review, it became apparent that a better understanding of the impact of Defence on members' and former members' experiences of suicide and self-harm is best achieved through exploration of six phases – pre-recruitment, recruitment, training, career, transition, ex-membership.

Incidence of Self-harm and Suicide

> *I didn't have many friends (outside) who suffered but I'm surprised about numbers in Defence who are struggling. (ADFA Female Cadet)*

The incidence of suicide did not garner much discussion, except with the Canberra-based Joint Health Command group (JHC) and the JHC Advisory Panel, who were abreast of current research. The level of knowledge in other serving groups varied but, generally, they were informed by in-house material most likely made available in suicide prevention workshops. The community members' knowledge of suicide rates was gleaned through news reports and hearsay. Former members subscribed to some social media platforms which alerted former members to the suicide of others. The JHC's focus was on the incidence of self-harm and suicide amongst serving members, while community and former members mostly focused on other former members.

Most respondents believed the rate of suicide in serving ADF was most likely lower than the rate in the general community as a consequence of the skewed population (fit, busy, focussed) and the range of support services available. There was some comment about rates varying, depending on which part of the service you were in e.g. Navy, Army, Air Force.

ADFA Cadets see the issue as one of great concern for males, which should be addressed both within and outside the service.

There was some ambiguity surrounding participants' understanding of the suicide rate among former members, as a result of disbelief that all former members were identifiable as such. Many in the groups were aware of the difficulties determining if some incidents were 'accidents' (e.g. single vehicle collision) or were in fact suicide. Many were keen to see definitive evidence of the rates.

Contributing Factors

> *During this period, there were often times that I thought it would be easier if I just ended my life; the only thing that got me up every day was my kids. (Former member, WA.)*

Participants listed 24 factors, which they believe contribute to the incidence of self-harm and suicide among members and former members and their families. Fifteen of these factors could be considered particularly driven by the ADF lifestyle and nine shared with the general population.

Table 1 details the factors respondents believed contribute to self-harm and suicide.

Table 1 Factors contributing to mental illness, self-harm and suicide in ADF and general community

ADF Specific	General Community
1. Stigma – esp. re career limiting one's willingness to ask for help	1. Stigma – reluctance to discuss mental illness
2. Separation/violent separation from loved ones	2. Relationship breakdown
3. Injuries/poor discharge	3. Underlying mental Illness
4. Environmental pressure – nature of the job	4. Personal failure
5. Fatigue	5. Bullying
6. One-off requirements	6. Financial Issues
7. Workplace culture - Macho military values	7. Personal Grief
8. 24/7 workspace	8. Low resilience/Poor coping skills
9. Lack of community respect for service	9. Lack of suitable services for people with acute mental health needs
10. Unaccompanied deployment	
11. Claims process – arduous and difficult	
12. Not enough suitably qualified mental health practitioners, especially in relation to PTSD	
13. Transition to civilian life – feeling lost	
14. Lack of coordinated and proactive ESOs supporting members and families	
15. Illicit drug use amongst submariners	

Services

Participants from each of the target groups mentioned services catering to their needs. Members listed BattleSmart as the frontline suicide prevention program, and the Chain of Command, the Garrison Medical Centre and the Padre service as principal treatment supports. Post Operation Psychological Screening (POPs) was widely commented upon and rated poorly in terms of effectiveness or utility.

There was significant commentary around the value of the training, with a common theme emerging that members were mostly not willing to speak up in these sessions as the groups were too large, the facilitators and mode of delivery were not engaging. ADFA Cadets in particular expressed a wish to play an active role in the design and delivery of future mental health and suicide prevention training. Family participants were especially keen to attend training that would assist them to better understand the situations in which their partners had been, the signs and symptoms of mental illness and strategies they could adopt to assist their partners transition and or recover from their mental illness.

Former members and families spoke of the difficulties of determining where to get support and listed DVA most often along with VVCS as services. Other services like transition services were rarely mentioned without prompting. ESOs were extensively discussed and generally while seen as important, concerns about awareness

of services, quality of services and continuity of care were raised. Some concerns were raised that ESOs were more interested in their own future and not those of the former service members or their families.

Issues, Gaps, Barriers with Delivery of Service

From the data provided in the GDs, the project team identified six phases to the ADF career or life-course: pre-recruitment, recruitment, induction, career member, transitioning, and former member. The report summarises the issues relevant to each life course stage along with the gaps in and barriers to service.

Pre-recruitment

There were common themes across all groups that changing societal experiences has resulted in a more comfortable lifestyle and protection of young from the realities of personal failure, competition, death and threat. Therefore, many candidates were unsuitable as they lacked the 'internal fortitude' or resilience skills that are needed to be in the modern ADF environment. In addition, a range of candidates from broken homes who were seeking a sense of belonging in the ADF, often were without the attendant skills to maintain that attachment.

Recruitment

Given that the environment from which recruits are selected has altered and candidates reflect some qualities which may be unsuitable for ADF, GD participants consistently raised and expressed strong views around appropriate screening of suitable candidates. These discussions included strong criticisms, particularly among serving members. The issues included:

- outsourced recruitment agencies not fully understanding the nature of Defence work, nor having to work with the "product" of their outcomes and being financially incentivised for recruiting a person, rather than making suitable selection choices
- the rank and authority of the ADF representative on the selection panel not having adequate influence recruitment decisions, and
- inconsistency of psychological screening of 'at risk' candidates.

Induction

Once recruited there remains the issue of being unable to maintain the challenging recruit training process of the past, and not being able to exit those recruits who fail to meet standards. Therefore, induction was described as 'dumbed down' and members being ill-equipped for the challenges of ADF service and deployment. This lack of suitability was identified as a factor contributing to ADF members being more perceptible to mental health problems and early discharge.

Career Member

When recruit training is completed members move into a career within the ADF and members described the pathways for care (a mixed Garrison in-house and outsourced model) and the possible outcomes for reporting a mental health incident (treat and remain at work, treat rehabilitate and return to work, discharge). Eleven key issues were widely reported by members, former members and health service providers concerning mental health while a member. These issues are listed below and relate largely to ADF cultural matters, policy and support services.

Table 2 Issues impacting members receiving support

Issue	Consequences
Career - Belief that mental health leads to career loss and or limits promotion and opportunities	Failure to report, and lost opportunity for early intervention
Perceptions of malingering - by using mental health as a way to rort the system to avoid difficult assignments	Failure of team-mates with real mental health issues reporting for fear of being considered a 'malingerer'.
Rank – access varies by rank due to cultural expectations – 'ORs paid to do as they are told'	Officers more pro-active and perhaps aware of wider range of services to retain their careers. ORs dependent on advice and CoC medicalised approach and loss of career.
Increasing tempo of the ADF	Fatigue and wider and prolonged exposure to harm
Mismanagement of POPs	Members are not truthful on tests, no third-party indicators, families not involved, debriefs rushed – lack of accurate assessment.
Isolated from unit for treatment of mental health incident	Protective factors related to being with mates, and a sense of identity with unit, are lost and the person feels more vulnerable.
Institutionalisation – being dependent on a closed community which leads to learned helplessness.	With discharge, members are unable to function in open society and/or unable to know how to get the support they need.
Suicide prevention package – inadequate, poor quality, poor delivery	Has content but process (PowerPoints, large groups, no discussion, lack of expert presenter) limits their effectiveness.
Mandatory reporting – If a member is aware of another member reporting the desire to self-harm or suicide they must report it.	Good for covering risk requirements of ADF but prevents many from discussing their issue.
Failure to involve families	Families have knowledge of members' behaviour and conditions that are often hidden from the workplace; lack knowledge of available services; and often suffer collateral damage (e.g. relationship breakdown, financial hardship and isolation).
Innovative 'Human Performance Programs'	Aiming to de-medicalise mental health discussions to preventative and wellness paradigms in order to be more culturally appropriate to ADF, and normalise discussions of mental health. This has increased positive perceptions about management of mental health.

Transitioning

For the (approximate) 5,000 individuals who leave the ADF each year, the transitioning process is largely an administrative one concentrating on ensuring each member has met all the ADF medical and administrative requirements. Those with 'compromised discharge' were identified as having to trust the system as many were not entirely cognisant of the process or their obligations. It was also noted that some were not psychologically prepared to enter civilian life due to not wanting to be discharged and that for some having a mental health issue complicated their ability to comprehend and make adjustments. Hence many transitioning members were not aware of the services they can access nor how to access these services. Others reported high levels of dissatisfaction with receiving no exit ceremony to recognise them for their service.

Former Members

Issues identified in the discussions relating to former members are summarised in Table 3. The majority of these were generated from within the former members and family member discussions. Apart from dealing with significant health concerns, these issues were identified as potential tipping points for at risk individuals.

While somewhat outside the scope of the Terms of Reference of the Review, significant frustration with the DVA claims process was raised by many former members and family members. This process was a factor contributing to poorer mental health outcomes.

Table 3 Issues/gaps impacting on former ADF members receiving support

Issue	Consequences
Delays with DVA allowances	Members get frustrated with slow response and inefficient process; which can jeopardise their financial future, exacerbate or create mental health issues including suicidal behaviour.
Post-institutional dependency	Ex-members rendered helpless due to their lack of knowledge as to how to access services thus exacerbating existing mental health conditions.
'Wounded warrior' narrative	Allows ex-members to feel comfortable with not coping; encourages ex-members to go for allowance at the expense of rehabilitation; is a stigma (if you served you must be damaged).
Lack of community respect	Some members do not feel appreciated by the broader community for the efforts and risks they have taken to serve their country and therefore feel betrayed and belittled, which negatively impacts their self-efficacy
Lack of employment opportunities	Ex-members are not adequately prepared for employment post Defence due to an inability to articulate their competencies and poor job seeking attributes such as resume writing and interview skills. Some employers are reluctant to employ ex-Defence personnel as they can be seen to be a risk in relation to potential mental health issues given a community view of Defence people being "broken".
We don't ask for help	Defence people have been trained to look after others at the expense of their own well-being, they are "professional soldiers". This impedes their willingness to admit they are not coping and to ask for help. For some members, the asking for help in relation to their mental illness is only when they see that this benefits their family, who is finding their behaviour very difficult to manage.
ESOs promote "benefits" over rehabilitation or lack of availability in regional areas	Some ESOs were identified as focusing too much on ex-members seeking financial entitlements rather than developing the skills to be more self-reliant and independent. These outcomes impeded some ex-members' pursuit of activities that would improve their general mental health and well-being as they were focused on "remaining sick" to receive various entitlements. There is also a lack of ESOs in regional areas.

Identified gaps

A significant number of gaps (23) in service delivery were identified by serving, former members, health service providers family members. Some gaps relate to client groups, some with support to members, some address the quality of actual care, some to do with privacy and policy, and others to address stigma. A general theme from participants was that if these issues were addressed it may be possible to move ADF mental health care from a predominantly risk management, 'one-size fits all' approach to a more patient focussed and stepped care approach.

Table 4 Service gaps and gains as identified by all participants

Identified Gaps in Service Delivery	Gains if addressed
1. Isolated serving members	Mental health needs of isolated individuals will be addressed
2. Lack of holistic approach	A range of upstream contributing factors addressed that collectively build resilience and prevent major mental illness
3. Duty of Care to report to CoC reviewed	Increased willingness to discuss mental health issues before they become a major risk.
4. Dealing with sub-clinical mental health issues	Earlier intervention & non-medicalised, patient specific, stepped process available
5. QA Standard of Acceptable Risk	Practitioner guidelines, improved quality of care
6. Garrison Health Centre Design	Ensure privacy to encourage early intervention
7. Training – members, family and community	Engage members in the design and delivery of the training. Raise competence of members, family and community to identify potential risks, to intervene earlier and offer effective support
8. Competent DVA advocates	Ensure equity of treatment for ex-members
9. Audit and Co-ordination of ESOs	Avoid duplication, build governance, market their services and increase focus on rehabilitation
10. DCO Family Assessments	Better support for families, who can then better support their loved ones who are members
11. Resource constraints on Personnel (psychologists) and mental health expertise of individuals involved with providing support to members	More available access to professional treatment
12. Dealing with NCOs who promote wrong care model	Encourage early intervention. Remove stigma.
13. Tracking former serving members	More support and better data to know what is “happening” to ex-members
14. Performance manage health contractors	Improved quality treatment for members and members more willing to access services due to greater confidence in the quality of service
15. Padre service available in DVA and VVCS	Familiar and trusted support to ex-members
16. Exist ceremony for all members	Dignified and de-stigmatised medical discharge
17. Ensure a ‘warm body’ follow-up in 3 months of discharge	JIT advice/support to transitioning members
18. Better educating Cos and others whose role includes mental health support	Informed and supportive first responder or ongoing suitable support
19. Promotion of suicide awareness	Normalised discussion of mental health
20. Promotion of positive stories about members and ex-members who have recovered	Increased sense of hope which motivates members and ex-members to adopt range of strategies
21. Review recruitment process	**Ensure suitable members are selected**
22. Transition to civilian life	Provide ongoing support post discharge to provide ex-members with early intervention and access to services
23. ECOs – rationalise, coordinate and focus their scope of service	More proactive and early provision of support services that target specific needs and population cohorts

1. Methodology

This report considers the responses gathered during Group Discussions (GDs) with:

- Serving Australian Defence Force (ADF) members – recruits, Australian Defence Force Academy (ADFA) Cadets, Other Ranks (ORs) and Non-Commissioned Officers (NCOs), Garrison Command, Health Workers, Joint Health Command (JHC), JHC Advisory Panel. Confirm names
- Former ADF members
- Family members of serving and former ADF members, and
- Community representatives [includes health support workers, volunteers in Former Organisations (ESOs), professional health workers in community-based organisations, professionals in Veterans and Veterans Families Counselling Service (VVCS) and Defence Community Organisation (DCO), Departmental representatives from both Defence and DVA].

The GDs (N= 34) were conducted during November – December, 2017. Each GD was approximately 90 minutes in duration. A total of 290 participants attended the GDs. Some serving-member groups were of shorter duration due to ADF operational matters. Defence organised groups at the following bases: (Western Australia), RAAF Wagga Wagga, Kapooka, Canberra (head office and ADFA), Fleet Base east (Sydney), Gallipoli Barracks (Brisbane), Lavarack Barracks and community (Townsville), Amberley Airbase (Ipswich). Consultants for the Commission organised the sessions with former ADF members in Toowoomba and Perth.

The following tables (5 and 6) detail the breakdown of participants per category and total numbers of participants and a breakdown of attendances at Serving Member GD sessions.

Table 5 Participants attending Group Discussions by Population Group and total

Other participants per group discussion	Number
Serving members sessions	181
Ex ADF Member sessions	20
Family of Ex-ADF member sessions	11
Health Provider sessions	78
TOTAL	290

Table 6 Group Discusison Participants by Force Arm and Enlisted Type.

Total of serving members in associated group discussions	Total participants	Army	Navy	RAAF	Regular	Reserve	ADF/other participants
Serving member	181	86	40	43	164	5	12

Assumptions made in the preparation of information:

- If not otherwise indicated, attendees at “Serving members” group discussions were Regular members.
- Participants in “Health Provider” group discussions included members of the ADF, community groups and other organisations including VVCS and DVA.

A detailed breakdown of attendees per GD is included in the Appendix (Appendix A)

Organising GDs with former members and family members proved difficult as these cohorts were reluctant to attend public meetings to discuss this sensitive topic in the presence of people with whom they had no personal connection. The former members meeting in Toowoomba was an exception due to the efforts of a mental health advocate and former ADF member.

At the commencement of each session, participants were:

- presented with a Participant Information Sheet
- provided with an overview of the questions and reassured that all information would be reported anonymously, and
- informed that a qualified counsellor was present to support any participants who experienced distress during the meeting.

Each GD had two project team members present to facilitate each session and to assist with accuracy and analysis of the collected data. In addition, a clinical psychologist was present to assist any respondent who may have become distressed a result of the discussion. In addition, Commission staff attended GDs in Townsville, Brisbane and Perth.

Serving GD groups were comprised of volunteers, or participants who were told that they were to attend. In the serving member groups, the overwhelming majority appeared to be free to contribute to the discussion with direct Command only being present in the sessions at Gallipoli and Lavarack Barracks, ADFA, Amberley Command Group and one group at Kapooka. Participants in the current and former members included individuals who had been wounded and or experiencing mental health issues. Some participants who attended the former member GDs are currently engaged with the provision of services to former members and their families.

Each GD was semi-structured to ensure that participants felt comfortable to participate and that issues could be addressed as they arose. This allowed participants to explore issues of relevance to them, contributing both to the variety and depth of group discussions and outcomes. This approach reduces the risk of funnelling information towards a pre-conceived answer and raising matters that while initially may not seem relevant to the topic, prove to be highly relevant.

While it was anticipated that the project team would conduct family GDs these were not possible to organise as people were loath to attend public meetings to discuss this sensitive topic with people with whom they had no relationship. The collation of family member interviews is detailed at the conclusion of this section.

Once data was collated, a thematic analysis was used to identify and collate the themes raised throughout the GDs.

Presentation of the data here includes direct quotes from participants in the GDs. They are shown in *italic* font with attribution in almost all cases. In some instances, shorter phases or statements from participants are included in the analysis. Some attributions are omitted to protect confidentiality.

2. General Points

Former members varied in their experience within ADF. Most described their experience of the ADF as leaving them 'bent or broken' and some were involved in organisations assisting former persons such as RSL, Homeless Shelters and Legacy. In general, former members' concerns largely focussed upon the well-being of other former members, DVA services, health care, allowances, and theirs and others' need for more support. There appeared to be a differentiation between Vietnam and younger veterans in what they believed should be the goals of some of the support agencies. The Vietnam Vets were more focused on seeking allowances, at the expense of rehabilitation and a new career which is, in part, a reflection of their age. While career prospects were more important to former members from Somalia, East Timor, Middle East Area of Operations (MEAO – e.g. Iraq and Afghanistan).

Service members were concerned about their treatment within the service. The participants in the GDs held a variety of positions, including recruits, others who had worked in recruitment, recruit training corporals, Sergeant Majors, RSMs, long term ADF career and ex-ADF career personnel were gathered.

In addition, the Command team including the Brigadier in both Gallipoli and Lavarack Barracks comprised discrete discussion groups and the focus of these discussions was around supporting their people at the Garrison level. The perspective at this level included the context of personnel management, policy, Chain of Command, Welfare Boards, resource management, and the relentless demands of readiness and deployment.

In Sydney, Canberra, Kapooka, Gallipoli Barracks and Lavarack Barracks, teams of health support personnel were gathered and discussed the issue from their various points of view. One point of view is from the internal ADF heath professional (Full Time – 'the green team') and another from the internal paid contractor (casual) assisting the ADF internal staff. Yet another view is captured from the outsourced health supplier to the ADF, offering psychiatric and other services in off-garrison programs.

3. Incidence of suicide

I didn't have many friends (outside) who suffered but I'm surprised about numbers in Defence who are struggling. (ADFA Female Cadet)

Medium exposure to MENTAL HEALTH but behoves us as males to adhere to learning about the topic as it is a large issue for males. There is an epidemic at the moment. (Male Cadet, ADFA).

Anecdotal – From what I see and read the prevalence is higher in the total ADF community (Male Cadet, ADFA)

The group (RAAF) felt there was more suicide in the army and had mates who mentioned that because of deployment levels, suicide is at a higher rate in the army division. Less so in Navy and RAAF. (Recruits Wagga Wagga)

It was remarked that Williamstown has the highest suicide rate in the country when looking at all Defence bases. Sometimes there is contagion, there were 4 in 72 hours at Williamstown. For young people, a lot of suicides are related to relationship problems, for example, boys not being able to deal with a break-up. (Serving member, Command Amberley)

The incidence of suicide failed to gather much discussion except by the Canberra Joint Health group (JHC) and the JHC Advisory Panel. The latter groups were abreast of current literature so had the background to discuss the topic.

The level of knowledge in other serving groups varied but, generally, they were informed by in-house material most likely made available in Suicide Prevention workshops. The community members' knowledge of suicide rates was gleaned through news reports and hearsay. Former members subscribed to some social media platforms which alerted them to the suicide of others.

Most respondents believed the rate of suicide in serving ADF was most likely lower than the rate in the general community because of the skewed population (fit, busy, focussed – known as the 'healthy worker' effect) and the range of support services available to members. There was some comment about rates varying, depending on which part of the service you were in e.g. Navy, Army, Air Force.

ADFA Cadets see the issue as one of great concern for males and an epidemic, which should be addressed both within and outside the service.

There was some ambiguity surrounding participants' understanding of the suicide rate among former members, because of disbelief that all ex-members could be identified as such. Many in the groups were aware of the difficulties determining if some incidents were 'accidents' (e.g. single vehicle collision) or a suicide.

The importance of suicide in the military and ex-military population was an acknowledgement that these men and women put themselves in harm's way for the benefit of their country and that the community would not like to think that they were being abandoned at a later time if their mental health had been effected by their time in the service. Some participants reported that because the population under review is an identified 'community' the incidence of self-harm and suicide are more noticeable and therefore may appear there is a larger incidence than there actually is.

How defence handles suicide, matters to new recruits. Suicide is a hot topic item – yet there are no official reports that mention death by suicide. People are reluctant to share that they have suicidal thoughts as they are worried this will impact their future career opportunities. (Male Cadet, ADFA).

4. Factors that contribute to self-harm and suicide

Discussion groups were asked if they were aware of any factors which contributed to ideation, self-harm and suicide. Factors were offered by all groups and are compiled here as a list, with no order of importance. In addition, participants were asked if there were issues particular to having served in the ADF, which contributed.

Same problems here, as in the community – but Defence adds complexity. (Health worker Gallipoli Barracks)

60% of people who have completed suicide had never even deployed. What might be helpful is a review on recruitment and identification of who falls over within the first 2 years. (Health worker, Gallipoli Barracks)

During this period, there were often times that I thought it would be easier if I just ended my life; the only thing that got me up every day was my kids. Also at this time my daughter was suffering from teenage depression that wasn't picked up by myself or the school. (Former member, WA.)

4.1 Relationship breakdown

The overwhelming response from health workers, padres, and members who deal with suicide in the services is that "relationship breakdown" is the number one factor. Some expressed this as a proof that being in the ADF is irrelevant to the cause, but most offer it as a reality. The relationships referred to are the personal ones involving love partners. This factor is relevant to most members and ex-members, with community members telling harrowing stories of having to deal with their ex-partner's (former member's) serious mental health issues like PTSD, because they believed the person literally "had nowhere else to go."

More than 50% of relationships breakdown, sometimes (members have) multiple relationship breakdowns – some members may not have a diagnosed condition but it (mental health) does causes problems. (Health worker, Sydney.)

I feel I have so much to say about the unique lens of women in the forces who marry and then divorce men from the forces-because of the way forces' training dehumanises and disconnects families and partners from one another. (Former member, WA)

Family is the main factor – there is no family environment when they (member) get out – they have changed but their family hasn't – they move around all the time, don't get settled and they (the family and the member) are not connected to each other. (Former member, Townsville)

Often the media reports deployment as being a cause of suicide, however, this might be a misperception in the community. Often it is to do with relationships. (Serving member, Command, Amberley)

We are in a workplace full of sole parents and broken marriages. (Serving member, Command, Amberley)

4.2 Separating from loved ones and domestic violence

Other relationship stressors include separation from family and domestic violence. 'Separation from loved ones', especially the sense of not being available when family members needed them, created personal tensions. In addition, the incidence of domestic violence was discussed in a number of sessions, with one former member saying: "I was doing a lot of bad stuff to my family and didn't know I was doing it."

Defence is a career of pressure – we are away from families for seven months of the year – we have few friends outside the army – so we feel a lack of support when we are at home. When people fall, they fall hard and it's very hard to get back. The more senior they are the worse it is. (Serving member, NCO, Lavarack Barracks)

The lifestyle within ADF can be challenging – being away from friends, family, big chunks of time being away from home, can be deployed for 6 months or more. Not everyone will be prepared to be away from loved ones for so long. (Recruit, Wagga Wagga)

Domestic violence is high in the Defence Force. As ------ (welfare role), I have seen so much DV in my life. There were four cases last week in ADF, it as a normal part of life. (Serving member, Command, Amberley)

4.3 Underlying Mental Illness

Anybody with an underlying mental illness – anxiety, depression – could be vulnerable for suicide. (Recruit, Kapooka)

Untreated and or existing mental illnesses can be further exacerbated by being in Defence. If left untreated a person could spiral downward towards self-harm and suicide. Several respondents who had experience with family members who have a mental illness were more confident in raising it with people whose wellbeing they were concerned about.

4.4 Unaccompanied deployment

Unaccompanied deployment (e.g. embed with UK or US troops) was cited as a factor by some, as it was reported that these members were outside the protective net of the Australian approach and away from mates and peers.

4.5 Contextual pressure

(Considered suicide) As most of my adult life was in the military - I have lived in every state in Australia - done lots and, whilst I'm very lucky, I have few people I can relate to and that's very lonely. (Former member, WA)

Your whole (Defence) experience tests you – isolation, separation, limited sleep, people you don't know – people are out of their comfort zone (Serving member, Command, Recruit Training, Wagga Wagga)

It is very difficult for a single parent to do a 6-month deployment; it just gets too long. (Serving member, Command Amberley)

Extra stress, is experienced because of working in unsafe environments, constant travel, and relocations were identified as service factors that contributes to poor mental health and then suicide. Unsafe environments that require individuals to place themselves in harm's way, and being exposed to horrific events, sights and places were viewed as added burdens upon one's ability to cope.

Deployment experiences (we see horrible things) would have to be a risk factor. (Recruit, Kapooka)

The army was very open to employing me however having been out of Navy circulation for 3 years, (maternity leave and posting with my husband) they wouldn't consider this option even though all three services within the Signals Corp do the same job, they just wear a different uniform. At this time, I didn't understand why this couldn't occur and, subsequently, this decision effected my mental health as I had to give up a job I loved for my family. I am unsure if this still occurs today but I would like to think that more consideration is given to inter-service marriages and their postings. (Former member, WA)

Defence talks about work-life balance and how important it is but your civilian friends outside notice how little time you have for them, you cannot do anything with them. Civilians do not understand the requirements for a RAAF job and, therefore, it is difficult to maintain social connections. (Recruit, Wagga Wagga)

It was frequently reported that continually moving places pressure on friendship groups, social networks, marriages and career and disrupts study. All this, adds pressure to an already stressful life.

4.6 Fatigue

The ADF and community needs to 'get' that the way warfare is done, is different now. There is no down time from the conflict, it is constant. Sleep deprivation is a constant. (Former member WA)

It was reported that Defence needs a better way of assessing the hypervigilance and fatigue of different people in service. It was asserted that only those whose brains were coping with this duress should be sent out for multiple service stints.

> *There should be better fatigue management in between deployments. (Former member, WA)*

> *It is difficult to leave the mind space of training – being hypervigilant all the time. (Serving member, Amberley)*

Fatigue was a factor which robs an individual of their problem-solving capacity and reduces resilience. Many NCOs in the 'ready regiments' were under a lot of pressure to train the troops when in Australia (out bush 180 days a year), and then heavy deployment rotations, added to their workload, causing them to become fatigued. In addition, there are several times that military people are called upon to operate under extreme fatigue, such as evening manoeuvres. When fatigued, it was reported that usually manageable things can appear less so.

4.7 Personal failure

The issue of having failed at something due to poor performance or not being selected for a special program/job was mentioned by several participants as a possible service-specific trigger for becoming mentally unwell. It was asserted that more so in recent times, the phenomena of 'every child gets a ribbon', has led to younger recruits being less resilient and able to cope with failure.

4.8 One-off requirements

Operating in an organisation which has a 'Can do' culture and being sent to strange places, that required members to deal with the "uniqueness of various deployments" were other factors that were identified as making work in Defence more demanding and stressful. It was also shared that these demanding circumstances could be too difficult for someone lacking resilience.

4.9 Macho values

> *"Guys don't want to seem weak therefore they don't ask for help." (Male Cadet, ADFA)*

In keeping with the Defence organisational culture, the traditional values of the 'Macho' warrior were seen to be a cause that may prevent someone seeking early intervention, as they believe they should be "strong enough" to deal with their emotions. In addition, these values may lead a person to present an external persona of "no concern" to personal humiliation, such as loss of a girlfriend, when in fact for many young men they may be emotionally hurt, in need of support or may make non-compromising decisions that can result in self harm or suicide.

4.10 Bullying

> *There was a general view that RAAF Wagga Wagga recruits have a much better experience than the army recruits at Kapooka – it is less rough, there are better relationships between Command and recruits. An example was given of an army recruit, in Kapooka being hit behind a shed by Command. (Recruits, Wagga Wagga)*

> *Workplace bullying – both peer to peer and top down. (Recruit, Kapooka)*

Bullying because of being a poor fit was identified as a trigger for becoming vulnerable, especially by the younger members such as the cadets at the Defence Academy. This was raised by one of the health groups as well who noted that cases such as this should be better dealt with by in-house psychologists, who can influence the Chain of Command to address relevant workplace cultural issues.

4.11 24/7 Workspace

It feels like 'Isolation Prison'. In the Academy, we are locked away, and at the mercy of the system. Our boss can wander through my room at any time – he has a key. We are supposed to get more leave as we progress through the academy. I'm 20 years old and I have no freedom whatsoever. (Female Cadet, ADFA)

There is no work/life differentiation, we never escape it. This is it. All the time. (Male cadet, ADFA)

You may be living on base which precludes you from being able to switch off – your work is your home. (Recruit, Wagga Wagga)

Young people who stay on base over Christmas, sitting in their room can feel very isolated. This can be bad for their mental health. (Serving member, Command, Amberley)

In the last two and a half years I had been involved in at least 8 suicide ideation cases. Usually these instances have involved single people on base, high alcohol consumption and mental health issues. They first arrive on base wanting to do so many things but they get isolated, stuck in their rooms, get into a pattern of work, come home, go to mess and eat, go home. It becomes like Groundhog Day. (Serving member, Command, Amberley)

The inability to 'switch off' if living on base (Air Force) was considered a factor that adversely effected someone's mental health, as matters became overwhelming when there was ceaseless confrontation with the issue of concern. There was a similar reaction from Cadets and recruits living on base or at the Academy. A scarcity of employment opportunities for members' partners in some areas where bases are located, added to a further sense of isolation for the family unit.

While for some respondents not being able to "get away" from the base was an issue, for others the lack of social activities on the bases, which were once present, such as messes, cinemas, sporting clubs, golf ranges were deemed to have reduced the opportunities to socialise outside of work hours and form strong friendships.

4.12 Lack of Respect

I was 15 years in the army - in the infantry - in East Timor and got discharged on medical grounds. I had a family to raise. I had a wife and 3 boys. I became unemployed and felt pretty isolated and down because I didn't feel valued. I was not given what I needed to transition out properly. (Former member, Perth)

You just feel like you were thrown on the scrapheap - there is nothing of any worth out there for you to do and try. (Former member 2, Perth)

We had a job-providing agency that I had to go through. I've done all those programs - and there is nothing more degrading than them looking at you and they don't have any knowledge or understanding of what you have accomplished and what your skills are. (Former member 3, WA)

I think one of the things that could happen to change the treatment of returning soldiers is related to Defence being so secretive (e.g. about Timor service) …. It would be great if the community got educated about what we actually do. Then they might respect everyone who serves. (Former member 4, WA)

Some Defence members think the civilian population is not grateful for the service they have provided. This is hurtful. (Recruit, Wagga Wagga)

For former members, a common response was their disappointment in military and civilian appreciation for their service. For many, this gnawed at their integrity and confidence in their accomplishments. Hence, their self-worth has been adversely impacted.

4.13 Financial

No one understood the links between Centrelink and DVA - what I was, or was not eligible for. It was almost pointless trying to get ahead because at that stage, anything my wife earned would affect my pension with DVA – so we couldn't get ahead no matter what we did. (Former member, WA)

… because I was more or less forced out – I was pretty low. I couldn't find work, especially as my knee and back were buggered. We lost all our savings, we ended up losing our house. It took nearly a year to get any benefits from the government and it would have taken longer, if I hadn't been casually told by another soldier about getting a copy of all my ADF medical records before I got out. (Former member, WA)

While financial matters are a common concern for the general public and Defence personnel, some participants shared that the impact can be more on Defence personnel, as the latter have been conditioned, some referred to this as "spoiled" by having a regular pay packet and many social and health services organised for them. It was reported several times that upon leaving the service many members didn't know how to open a bank account, or how to organise medical treatment.

4.14 Personal grief

Death – losing friends and/or family can be very distressing. (Recruit, Kapooka)

It was reported that death of a peer, close friend or family were identified as factors that may trigger mental illness or suicide.

4.15 Career opportunities

"If someone says they have a mental illness – they won't go further (with their career), therefore, they do not say anything. For example, if I wanted to be a diver, and said I have anxiety and depression I could not dive." (Cadet, ADFA)

Someone in our team threatened self-harm. They were whisked away, never to be spoken about again. Therefore, no one in our group would ever raise if they had a mental illness. We need a stepped process, so that people with a mental illness are identified early. People need to know that their career will not be ruined. We need more early intervention. (Male cadet, ADFA)

People are reluctant to speak up because they are concerned that to do so will impede their career. This concern along with ongoing stigma around mental illness impedes members' willingness to seek early intervention or support. Consequently, one's mental illness can be exacerbated and their mental health needs become more acute.

4.16 Low Resilience/ Poor coping skills

There is a lack of focus on resilience training. For example, foreign militaries do this well, we don't focus enough on resilience training. (Serving member, Command, Recruit training, Wagga Wagga)

Individuals who have few coping options, or who do not have the life experience, or insight to learn from difficult times may choose self-harm or suicide to solve their problems. The Resilience training being developed and delivered by the Army is proving very valuable. This training uses sporting terms to imply states of mental health and therefore it was far more appealing to the participants.

4.17 Injuries/poor discharge

The member who suicided worked as a "refueller". His job was to burn off the 'toxic goop' – it was found that exposure to these chemicals caused various illnesses including mental health issues. (Serving member, Member, Amberley)

Some members are exposed to physical harm which has shattered their dreams of their career within Defence. Others may be exposed to hazardous materials such as asbestos, or aircraft fuel residues. Whilst controversial, one family blames the injection of the anti-malarial drug for their family member's suicide. Whatever the injury, it was reported that the result can be vulnerability to suicide.

5. Range of services

The following information details the range of services that participants access or are aware of. Comments around the perceived or actual experience of accessing these services are detailed in Section 6. Overall serving members appear to be reasonably familiar with the range of services that are available to support them. Conversely, many former members reported that they and their families were unsure of what services were available to them and how to access these services. In some cases, it was reported as "sheer luck" that I received the support that I needed.

One participant commented on the structural surroundings and its suggestion that suicide is an issue and taken seriously at ADFA.

> *You arrive at academy and check into your room and you immediately notice suicide screens in your building. This was a confronting introduction to ADFA. (Female Cadet, ADFA)*

> *What shits me most about it now - is that the mental health issues for Defence are being brought to light as our top people come forward to share they have a mental illness. Senior Defence people are saying we are doing everything we can – but they are wasting money on bullshit programs that are not happening on the ground, where and when they are needed. There is a distinct disconnect between what the people hear in community and what actually happens within ADF, especially when it comes to preparing us and our families for what we are about to go through and come back to. (Former member, WA)*

> *One individual had PTSD and now he will attend a 6-week course next year, and he will have a 12 month follow up treatment after that. This person is remaining in service and is very open about doing that program. This sort of stuff is seen to have a positive ripple effect, particularly if members are open about it. If they (Defence personnel) hide it, their work falls down and the Defence will take the wrong approach (usually performance management) rather than addressing the mental health issues. (Serving member, Command, Amberley)*

5.1 Training Programs

> *Induction – doesn't help – it is a week-long thing every unit must do just to get ticked off, skimmed through – everyone just sits there – people next to you falling asleep etc. (Serving member, NCO, Gallipoli Barracks)*

> *In thirteen years, I never saw anything about mental health until I got to the point of needing it. (Former member, Toowoomba)*

> *We have just finished a resilience training program that took us out bush. It was fantastic. We need more of this sort of training (Male Cadet ADFA)*

> *We have a range of programs such as "RUOK? Day" and "BattleSmart". They are not enough. When they deliver BattleSmart, there are 400 in a room and the program is delivered by a person with a stern "mother's approach". No one will speak up in this environment as there are too many people. (Female Cadet, ADFA)*

> *Increased time needs to be spent on mental health. We spend three hours a week doing physical training and hardly anything on our mental health. When we did BattleSmart, we spent about 1 hour, with 400 cadets in the room at one time. We were brand new to ADFA. We didn't really know one another and there was no way we would speak up if we needed support with our mental health. The session was "death by power point". We need more. (Male Cadet, ADFA)*

> *BattleSmart is delivered in first few days and we were provided with a booklet but there is no time to read it or take the information in. The program is very rushed and is delivered when you are under the pump (being woken up early hours, drills, adjusting to new structure of defence force). (Recruit, Wagga Wagga)*

There is the RESET program, part of Joint Health Command – it is a sort of resilience based training program. The idea is to train people to be better individuals, not just better pilots. (Serving member, Command, Amberley)

In terms of suicide prevention and proactive mental health promotion, BattleSmart, FamilySmart, KYMS (Keep Yours Mates Safe), and various mental health awareness days were often mentioned. There was universal agreement amongst the ADFA cadets, male and female, that they would like the opportunity to co-design mental health training programs that targeted their cohort. They would also like to deliver this training, which would be to small groups so that participants were more willing to raise and discuss issues. The preferred training would also include reference to a range of support services, Apps and other supports that people could access to maintain and improve their mental health.

5.2 Available services via Chain of Command, Garrison Health, VVCS and Peer systems

Navy has a long standing 'Divisional' method of welfare outside Command. This is used as a communication method outside the usual Command system. (JHC Advisory Panel, Canberra)

VVCS – alcohol, anger management, and family counselling services are good for people who want privacy outside of defence. (Serving member, NCO, Lavarack Barracks)

When I was trying to cope with my husband's death – I was directed to a psychologist and Padre on the base. I was unable to be really open about what I was feeling. When I referred to VVCS who connected to a good psychologist I was more willing to share my inner thoughts. This was most helpful. (Female Cadet ADFA)

Division Officer (DO) – we have most contact with this person about our welfare. If you have a good one you will feel comfortable to share what you are thinking and feeling, but if you are not confident with your DO you will not say anything. (Female Cadet, ADFA)

The most used avenue to seek support is through the Chain of Command from corporals who will then send you up the ladder and a solution may or may not come. I am not entirely sure what will happen. (Recruit, Wagga Wagga)

The DCO has great service if you ask for it. For example, a wife was needing emergency surgery, the ADF member rang the unit welfare officer who contacted DCO and they were at the house looking after the family. (Serving member, Command, Recruit Training, Wagga Wagga)

It should be easier to book psych appointments and it should be a regular occurrence for ADF personnel to debrief with a psych. There is not enough time to debrief and let emotion out. It just builds up. (Recruit, Kapooka)

Members can go to the VVCS however this service is overworked and sometimes refuses to take further clients. It is an issue if a member seeks help and Command does not know about it. (Serving member, Command, Amberley)

Serving members listed a range of available assistance, including Garrison Health, VVCS, some peer systems (more prevalent in RAAF), and DCO. One group commented about their equity advisors as being helpful. 'Defence Family Help Line' was a service mentioned to support member's families.

Rehabilitation Mentoring Service (RMS) was mentioned by recruits at Wagga Wagga. Due to an injury, including a mental health issue, a member may need to back-course (having to repeat previously taught skills or knowledge) and therefore possibly even another group to complete the training program. Both these outcomes were not looked upon favourably, but were preferred to being discharged.

5.3 Padre service

If you don't have access to a Padre, then almost all soldiers end up at a psychiatrist – even if it is just to talk about coping mechanisms – so Padres are essential, every unit should have one, need that first point of

contact – impartial person to bounce ideas off – knows the soldiers – but very individualised. (Serving member, Command, Gallipoli Barracks.)

The Padre training offers recruits an opportunity to attend a three-day training program that involves games with peers and teaches communication skills with fellow recruits. This was really helpful. (Recruit, Kapooka)

The most frequently mentioned service and the most applauded, is the Padre service. Being in the Chain of Command yet slightly outside it, offers a process for members to talk about their issues without direct consequence of their issue becoming medicalised or made public

5.4 Boards of Enquiry

Command groups believe that Boards of Enquiry into deaths have been very influential in adjusting behaviour and awareness towards suicide as well.

5.5 Welfare Boards

Command Welfare Boards are heavily relied upon to keep in touch with the welfare of their members.

5.6 Post Op Screens

POPS (Post Operational Psych Screen), an individual psych check which incorporates a written assessment form and interview with either a psych or counsellor. (Former member, WA)

RtAPS (Return to Australia Psychological Screening) and POPS. RtAPS is a screening tool and POPS is an interview 3-6 months after deployment (Serving member, Amberley)

Accessing available mental health services on base was identified by some as difficult, as their anonymity when accessing these services could not be guaranteed. To some end this has been overcome by making it a requirement that all service members complete a Post-Operation Psychological Screen (POPS) at routine intervals, thus providing a "reason" to access services. This approach was widely reported as a positive means to keep an oversight into the health of individuals. Issues raised about the screen will be discussed later.

5.7 JHC Website

If acute, the Joint Health Command website has accurate information and advice on where to go, family member support, ex-ADF support, VVCS, Soldier On, medical, DCO. (Serving member, Command, Recruit training, Wagga Wagga)

Members can access the JHC website to get alternative approaches to care that are available within the system.

5.8 Peers

While suicide is taboo we are encouraged to talk about it or tell someone if we come across another recruit experiencing ideation. (Recruit, Kapooka)

If we tell a friend that we are feeling down, depressed or have suicidal thoughts, they are obliged to tell their Commanding officer. (Male, ADFA Recruit).

The concentration on workplace teams in the military reinforces the idea of being able to depend on your mates. Several participants discussed how their peers were an important means of getting support.

5.9 Soldier Recovery Centres

At Lavarack Barracks efforts, have been made to assist with both 'decompression' after deployment, and rehabilitation, through establishment of a Soldier Recovery Centre with an emphasis on supporting people while they are mentally unwell and getting them back to work. This service was viewed favourably by participants.

5.10 DVA:

We are part of the problem – spreading horrible stories (about DVA). This leads some ex-members to be unwilling to access services provided by DVA. DVA can't do the same for everyone, more complex cases require more time. (Former member, Townsville.)

DVA: it's like a corporation, their aim is to save a dollar for the government. The fact that you and your family have to prove yourself – when a simpler streamlined process that verifies all your details at the point of discharge back into civilian life could save lots of money and lots of heartache, loss of one's home loss and relationship problems. It's common sense. Why can't systems be more practical and save lives and families at the same time? (Former member, WA)

ADF/DVA need to integrate information and have one case manager for individuals to link services, integrate information, track progression, deal with all the delays and poor turnaround times. This would be essential for more complex cases as some people transition relatively easily. (Serving member, Amberley)

Former members are most frequently offered DVA. There was considerable discussion about the difficulty in accessing services provided by DVA. The claims process in particular, was deemed to be too arduous and further exacerbates a person's mental illness.

5.11 Formers Organisations (ESOs)

The Ex Services Organisations that are out there right now are all corporate focussed. It's great that they are out there, but they are out there to look after their own bottom line. It's all personality driven. They are all focussed on metro areas. The expectation is that we have to go up to meet them where they are at, not the other way around. (Former member, and ESO founder, WA)

Whilst estimates vary about the range of ESOs (3-4,000), Mates for Mates (M4M), and 'Soldier On' were the most frequently mentioned even though many, who mentioned either service, were not involved in, nor had ever used the organisation.

"Young Vets" (WA) was mentioned by the WA community group. 'Partners of Vets' was an organisation referred to by a family group. "With me, With you" was another organisation mentioned on a couple of occasions. This service is a social network that is designed to link separating service members with industry leaders and former members who act as mentors. (Serving member, Command, Lavarack)

5.12 Transition Seminars

There wasn't a lot of support that the transition seminar offered. It was standard issue stuff; it gives you no information you really can use. I was lucky I got plugged into an ex ADF clerk who had a business in Perth and they had funding to help with my CV –it was my saving grace. (Former member, WA)

You can do resettlement training but it focusses a lot on the financial side of things and sometimes job applications. It might need more of a mental support focus to it. Resettlement doesn't talk about adjustment or mental health side of things. They may have had a quick 15-minute presentation but that was it. Usually you will just get a fridge magnet with some service on it, that is about the extent of it. (Serving member, Command, Amberley)

Two-day seminars (Stepping Out) aimed at equipping members departing the ADF to cope better with civilian life. Run by VVCS.

Transition centres are administrative centres around the country where ADF members formally discharge and ensure all paperwork is completed. Some brochures are offered on available services to former members and their families. The identified value of these centres was mixed.

5.13 Families

I was lucky, I had an Uncle who had been in Defence and he told me what services I could access. (Former member, Toowoomba)

We need to provide education to families about what to look out for after deployment. (Serving member, JHC Advisory Panel, Canberra)

Getting support from family members was mentioned directly and indirectly. Several ex-members who finally sought help professionally was because their family had requested it. There were many comments that family members need to better understand the pressures that are experienced by serving members, the potential impact upon a person's mental illness and how to support these individuals post deployment, and if needed, where to go to access mental health support services.

5.14 Medicare - Psychologist

Can access free psychologist from Medicare (Recruit, Wagga Wagga)

Members and their family can access a psychologist for six Medicare-subsidised sessions through their GP. For serving members going private there is an obligation to inform Command. This anonymity was thought to be advantageous for those service men and women who were concerned that their career would be jeopardised if their mental health needs became known.

5.15 Private health care

Public health systems sometimes refer VETS to private providers once they realise a person is a VET and therefore access DVA services. However, these private services are not always adequate to meet the needs of VETS, and there are instances where VETS have been admitted but upon release suicide 48 hours later. (Garrison Health worker, Brisbane)

Public won't take them because they say 'you are Defence you have Defence people (to support you)'. (Garrison Health worker 2, Brisbane)

If public health systems are unable to support the ADF then it can access outside private systems to secure treatment for members.

'Beyondblue' was mentioned by recruits in Wagga Wagga.

5.16 Unit Welfare Officer

I was a made a Welfare Officer with a unit I was with. You just got lumped with that role. There was no training et al. I was just being asked to help out – it's not really a function of a serving member so to be the sole bearer of welfare support doesn't feel fair nor does it feel like we are adequately trained for these roles. Training in how to deal with families who weren't coping certainly wasn't available. As the welfare officer, you are the conduit between the serving member and other services available to the partner (VVCS, DHA etc.). When dealing with spouses who were going through a hard time I found it difficult to deal with, as I was unsure of my boundaries in giving advice, and or, reaching out. Many partners wanted planned events but the unit was not positioned to provide these, as I was still required to perform my actual Army role. The role of Welfare Officer often came second. (Former member, WA)

This appears to be an all too usual story of the Welfare Officer's role. The Townsville Garrison mentioned they were appointing Welfare Officers whose sole role will be welfare, and it is expected that with training they will be able to do this role effectively.

5.17 Family Reunion Flight

Members are entitled to a return flight to visit family each year as an effort to keep members connected to family.

5.18 Facebook

There is a Facebook Page for partners to sign up for. This is mostly accessed by female members. (Female Cadet, ADFA)

5.19 Decompression Process

> *We went on a boat from Timor to Darwin within 24hrs - we were going from nothing to full on home life. (Former member, WA)*

The decompression process appears to vary widely but it is a process to assist members to unwind from their active service and prepare to re-enter the Australian community and be re-united with their families. The example shared above highlights the significant difference between active duty and home life.

5.20 Former member network

> *The best assistance given to me was through network links I made with other ex ADF members in Perth who had been out for a number of years. (Former member, WA)*

Sometimes these networks are 'Formers Organisations', but quite often the network is an unstructured network of 'friends of friends of friends'. They were seen as important in securing employment and making a member feel valued by a number of former members and family members.

6. The Experience of Self Harm and Suicide for Serving and Former Members

Nearly every group was asked to think about issues (services/gaps/barriers), which might impact on an individual through the stages of their career and the stage of being a civilian again.

As a consequence of the open nature of the discussion, first, it was realised there may be more stages than the three originally hypothesised by the project team (Serving, Transition, Former Serving). The range of issues raised was quite broad.

Based on the findings from the GDs, the stages which might be considered useful to discuss are:

- Pre-service
- Enlistment
- Induction (Recruit Training)
- Career Employee
- Transitioning Members, and
- Former Defence Members.

Each of these will be discussed in turn.

6.1 Pre-service

Australia's culture has changed – so it's not that people were tougher before, it is that they had a harder lifestyle. (Former member, Townsville).

Advertising is inaccurate it raises unrealistic expectations. It is nothing like what you could expect. Many have trouble learning how to adapt. (Serving member, Command, Lavarack Barracks)

Society has got softer and we need increased resilience training to cope with the issues we face. The resilience training taught me a lot about me. It taught me I can get through anything, if I put my foot forward and don't give up. (Male cadet, ADFA)

In addition, the proliferation of drug use and abuse, including alcohol, can create social isolation. Anecdotally, there seem to be more people coming into Defence who have dabbled in drugs in the past. (Serving member, Command, Recruit training, Wagga Wagga)

It is obvious in the training environment, that young recruits don't have the resilience that recruits used to have. Resilience levels are perhaps not the same as what it was 15-20 years ago. (Serving member 2, Command, Recruit training, Wagga Wagga)

The popular media tells you that your opinion is the only one that matters, then you enter an environment where you are the most insignificant person. Resilience is gone because we are not challenged nor do many experience adversities. Lifestyles have changed. (Serving member, Command 3, Recruit training, Wagga Wagga)

Many serving and former members believe the issues impacting on self-harm and suicide, begin a long time before the ADF meets the individual. The Australian culture has changed and the community values from which the ADF draws its talent have changed since the 'Diggers' of WW1 and WW2.

It was widely reported that society has become refined and many young people are not aware of the harsh realities of life. Many young people live in houses with many modern conveniences, with rooms of their own, access to a wealth of information political and otherwise, live in families where they are encouraged to have a point of view and their food arrives shrouded in plastic, devoid of offensive odours and sanitised of offensive

colours etc. It was noted, that this reality is in stark contrast with the earlier Diggers who more often saw violence in day to day behaviour, death and chickens slaughtered for Sunday dinner and as a consequence perhaps had developed pockets in their brain for such evocative events to be housed.

Resilience may be like a muscle and exposure to some hardship early on might teach a member that they have 'come through' stressful events previously, because they used certain personal strategies and these might work in the stressful situation they are now facing. Lack of hardship in the modern member's life, it was suggested, has left them with limited resilience skills upon which to draw.

Others (especially Corporals who have worked in recruit training) spoke about the notion that 'every child wins a prize'. Earlier Diggers were accustomed to competing and being categorised in terms of their performance throughout their education. 'Every child wins a prize' is counter to the standards of excellence required in the modern ADF. Not achieving their goal; being publicly evaluated; failing a stage in a course; missing joining their mates due to incompetence in a certain aspect of their skill set is a massive dent to some individual's self-esteem today and may trigger a mental health incident.

Others spoke about modern youngsters' access to, and use of, drugs. Drugs were seen as a solution to many of their problems, rather than hard work and persistence in the face of adversity.

Modern society with its increasing breakdown of traditional family structures and increasing incidence of family violence, is ensuring that many members are being drawn from these types of environments so the member is psychologically vulnerable and or damaged by the time he/she is recruited. It is even argued that one of the attractions of the military life for members drawn from these environments is the 'sense of belonging'. If for any reason (like failing a course or being bullied) this belonging is not achieved, then it is a double disappointment for the individual. This may negatively impact a person's mental health. If relationships are not successfully managed in the new environment, then there is self-evidence for some internal evaluation "It may be me", which exacerbates their vulnerability. In addition, it was reported that experiences of sexual abuse prior to joining the ADF or once enlisted may further worsen a person's sense of self, value and resilience to cope with the pressures of ADF life.

These are the types of views expressed about the environment from which the ADF draws its team. This is not to devalue the thousands of youngsters who turn this experience into a positive opportunity, or to diminish the ability of hundreds of thousands (86%) of people who appear to get through the whole military experience with successful, or well managed lifestyles, but to point out that society is asking its young people to undertake considerable adaption, when calling upon them to serve and that some may find the cost of this too large.

6.2 Defence Enlistment

We find on the Welfare Board that the person before us wasn't suitable when they enlisted to Defence – on review this person was never suitable. We note the psych examination was skipped. Recruitment is outsourced. The ADF representatives who support recruitment are usually first year Captains who haven't seen the consequences of what happens because of recruiting unsuitable people (Serving member, Command, Gallipoli Barracks)

There is an issue where psych screening is sometimes done and sometimes not – I am amazed at people who obviously have a mental illness at the recruitment phase and are enlisted, only to later develop major mental health issues. It is obvious that they would have had these issues, so how did they get recruited? (Garrison Health worker, Gallipoli Barracks)

As a result of Manpower (Private contractor) – people with existing mental health conditions are being let in. Years ago, candidates had to pass a number of tests to be let in, it was a lot tougher in those days. Today the criteria has changed and people take short cuts. The standard has dropped. (Ex-member (officer), Townsville)

We can't have a fault in the recruiting process then spend 5 years fixing it. We need more stringent psychological tests to be put in place. (Serving member, Command, Lavarack Barracks.)

"The Australian way says everyone can be a soldier" – it's not true. (Serving member, Command, Lavarack Barracks.)

If someone is found not psychologically suitable, this cannot be overridden, but if a psychologist says there is a risk, this can be overridden. (Garrison Health member, Lavarack Barracks)

We are recruiting kids straight out of school who have no life skills. They need to have a gap year to learn life skills, how to be a human 101. They need to know how to have a relationship, how to connect with others socially. The life skilling is not there. (Serving member, Command, Amberley)

Given that the environment is offering up some people who may be too vulnerable for defence service, what does ADF do to minimise the acceptable risk? All recruits, were reportedly, required to have a psychological assessment and must meet various criteria. Various groups reported that there is an issue with the outsourcing of Recruitment to private contractors, and that these contractors, to meet their financial targets, push sub-standard applicants into the system. The view expressed consistently by the GD participants is that the contractors get paid on a per head basis, which may be contestable. The ADF representative on the selection panel, they believe, is bullied to accept sub-standard applicants. Some believe that the contractors are putting increasing pressure on the hierarchy to lower the rank of the ADF representative, to diminish their blocking capability to accept inappropriate candidates.[1]

Even if the economic imperative is not creating unsuitable applicants the inexperience of the recruiters in understanding the requirements of Defence may. When the candidate gets into difficulty during recruit training, or later in the service: "Command finds there are things documented during recruitment (e.g. lack of social connectedness, or unable to hold a job etc.). It would therefore appear that, the recruiters did not realise the impact these things may have on Defence and the suitability of the candidate."

Some group members, one of whom worked in Defence Recruitment, with the contractors, believed that sometimes, even when the candidate has been psychologically assessed as unsuitable, that this advice has been overturned and the candidate recruited.[2]

In a GD with a Brigade Command, it was estimated that there were '120 persons, on their Welfare Board list of 600, who were put in an environment (i.e. The Army) for which they were not suitable.' The view was that if inappropriate candidates are recruited, then there is a requirement to put in place a series of buffers and support systems. These of course could be avoided if the 'difficult decisions at the were made at the front end'. If the system that is recruiting (i.e. contractors) doesn't have to work with the product of their recruitment, it takes away their risk and alters their accountability.

Advertising is inaccurate. It raises expectations that are nothing like what you could expect. Many have trouble learning how to adapt. (Serving member, Command, Lavarack Barracks)

Another issue was the link between what candidates expected and what reality provides in the ADF. If these expectations are not managed appropriately then pressure can begin immediately. Stories of recruits turning up with golf bags, and single mothers expecting to go home at night, or weekends during recruit training, were told as examples of the need for realistic data to be provided during recruitment. There is also a call for family assessments to be done on situations, which might indicate future issues. These assessments were regarded not as a tool to reject a candidate but rather to ensure they have all the support they require to meet the arduous requirements of service.

[1] When this point was checked by project team members with JHC Command, it was refuted.

[2] Again, when checked by project team members with JHC Command this was also believed never to occur. JHC Command confirmed that a candidate assessed as a "risk" can be overruled, someone graded "unsuitable" will not occur.

6.3 Induction (Recruit Training)

They can only suck their gut in for so long. If they are not up to the task it becomes obvious, and they should be removed. (Serving member, NCO, Lavarack Barracks)

We should be mentoring younger soldiers that come into the system. We need to provide 3 months of shadowing, then at the end, a review is done to see if they need more assistance and to see what pre-existing conditions they have and how we can assist. (Former member, Townsville)

We have lost the ability to do natural selection. Previously, those that struggled generally left during training. We need to make it hard enough so that those that don't have the resilience can separate during training rather than later. We should have a review after to see how they are travelling after Kapooka, rather than later, after serving. (Serving member, NCO, Lavarack, Barracks.)

If they do not believe recruits can get through training in 6 months, they may be subject to being managed out of defence and transitioned. (Serving member, Command, Recruit Training, Wagga Wagga)

There would be very few readers who have not watched a film or documentary demonstrating the demands of recruit training, where individuals are challenged to undertake tasks they might think are beyond them until they try. They might also recall the relationship that develops between recruits and their trainers, as the latter strive to convince the recruit they can succeed. If someone is struggling to meet standards should they be failed?

Some groups, (especially NCO groups) believe there is a lot of pressure today to not fail recruits. They are quick to assert they do not want a return to the days where people were occasionally bullied, but if someone is not coping, then recruit training is the time to exit them from Defence. Group members reported that there is a Court Case where a recruit successfully challenged their course results and the decision to discharge them was reversed. It was reported that this outcome shows a 'dumbing' down of ADF capability and the acceptance of people who may never fit in and, therefore, may not have the social protectants to avoid self-harm or suicide.

The criteria for a recruit's failure that appeared to be pre-eminent in the discussion were:

- Can't create relationships
- Does not meet potential as per their various aptitude tests
- Has no resilience
- Administrative issues – ill-discipline or moral issues

This was arguably the most impassioned discussion point raised in the groups undertaken by the lead author of this report. It was not so much a concern for the individual's safety (though this is what prompted the discussion) but the implications for the culture and safety of all. It is, obviously, an ongoing discussion where policy and reality do not mesh.

6.4 Career Employee

When there is a psychologist in the field it is usually an operational psychologist, not a psychologist with a clinical focus. If someone encounters an issue when on operation the issue will linger and nothing gets addressed. (Serving member, Command, Amberley)

Groups were asked to reflect upon issues, which may contribute to self-harm and suicide, whilst a member is serving and building their career within the ADF. Identified issues included:

- Which of the three services a person serves in – RAAF was reputed to emerge as having the healthiest culture
- Rank – officers were reputed to get better access to care;
- Type of technical job – if you were within or without the wire; backroom; dealing with instruments not people;

- Your deployment history – if you did not deploy; deployed too often; saw or did horrid things;
- Your health record – were wounded, or injured or suffered a mental health incident (perhaps hid it).

6.5 Pathways to Care

From GDs in various areas, a picture emerges of employees being able to access a wide range of services. A lot of time was taken to explain how this complex system works. There appears to be a Garrison or base system, then a variation like that when at sea or deployed.

At candidate stage a possible member can be screened to ensure they are not going to be exposed to an unsuitable environment for their level of capability. A go/no-go decision to recruit can be made at this point.

Enrolled members can be screened at any stage through the induction process (recruit training) if they suffer a mental health incident and can be supported at the health centre or returned to training at a later date, rehabilitated or discharged.

Upon entering a unit all mental health incidents are officially handled through the Chain of Command, its Welfare Board and the Garrison Health Centre. Cases are triaged and case managed by an internal team of uniformed and contract in-house medical staff. Treatment is largely handled by outsourced contractors and decisions are taken about the long-term viability of the patient/member. Some are managed into rehabilitation and returned to their units, others are discharged medically unfit.

Upon indication of an incident the member is generally isolated from the workplace until recovery, reporting in weekly (if appropriate) to see the Medical Officer. If serving in the Navy, units are generally backfilled with replacements in the member's absence and the ship can sail. When on deployment, or on board a ship, a garrison-style approach is taken to the management of health and mental health incidents through the Chain of Command and perhaps fly in fly out specialists.

Welfare Officers, Divisional Officers, Padres can sometimes offer a buffer between the member and the COC/medicalised approach and differentiate between a mental health incident and a case of maladjustment or legitimate conflict.

Some Battalions have an '11 Platoon' for rehabilitation (mostly physical) and others also have a soldier recovery centre aimed at assisting in decompression and rehabilitation.

Proactive work is done at induction, and annual refreshers through the delivery of BattleSmart, which includes a script for a presentation that has been reported to require 20 mins – 3 hours to deliver. This program is aimed at suicide prevention. Member satisfaction with this training was often not reported favourably, as the training environment was not conducive to small group work and the facilitators were not necessarily engaged.

There appears to be limited effort to identify meaningful work for members not capable for active duty and outsourcing of gardening, cooking and pickets to private contractors, has limited the range of meaningless work available for those incapable of active duty but still a valued member of the ADF team.

To assist members departing the service a Transition service is available to ensure members have met all the administrative requirements prior to losing their security clearance, and a range of brochures is available to support members with queries about non-ADF matters such as DVA, VVCS and DCO. Transition courses are also available however utilisation of this service is dependent upon the member knowing about their availability and then planning to attend.

Families are welcome to the Garrison on the Garrison's terms and requires each member to drive the link between family and unit. Mostly, Garrisons have a very unsuccessful track record of involving families.

Having discharged, some ex-members re-enlist, as they are not able to find meaningful work post Defence and or miss the camaraderie that Defence offers.

6.6 Issues relating to support for Serving Members' Mental Health

Stigma

> *ADF is on a risk minimisation railway track model versus patient-focussed care model. (External Health Provider, Brisbane)*
>
> *The notion of seeking help is seen by many as a potential for being kicked out. This needs to be publicly discussed, as this is not always the case. (Serving member, Command, Lavarack Barracks)*

The first issue and perhaps, most significant, that groups raised is the idea of the stigma of mental health and the punitive outcomes which are at risk from reporting a mental health issue, in particular the impact upon one's career. Serving members believe they will lose their job or, at best, remain at level. It was noted that the obligation to inform senior personnel of a person's disclosed thoughts of suicide or mental illness impedes a person's willingness to discuss their mental help with mates or to seek help as they do not want to burden their colleagues with having to "keep the secret" or feeling worried and possibly responsible for impeding their mate's career if they inform superiors. Likewise, friends can be reluctant to ask about a mate's mental well-being as they do not want then be legally obliged to report a mate's mental state.

This stigma is believed to be getting in the way of early intervention and, hence, raising the prospects of self-harm, or suicide. There is some evidence that the route is not necessarily, one way, and that Defence is, intermittently, finding ways to work with mental health, but the project team were assured that there is 'still a long way to go'. Sometimes being caring attracts unwanted attention and, some serving members are believed to rort the system.

Contrary to the above comments about reporting mental illness and or thoughts of suicide, a senior DVA officer was adamant that the mandatory reporting of thoughts of suicidation needed to continue as there had been instances where thoughts of suicide were not reported and the person had taken their life. Some participants suggested that there was a need to be able to use one's common sense and not be obligated to report suicidation if it was clear that the person was not really intending to take their life but rather expressing a "passing" thought and that the person had around them a supportive network and strategies to stay well.

Malingering preventing early intervention

> *There's not always a lot of help unless they seek it. You never get given a course on how to deal with people, on how to have more mental resilience. I know a lot of guys that if they don't get what they want they pull a sickie or other guys with legitimate issues are afraid to speak up. (Serving member, NCO, Gallipoli Barracks)*
>
> *I worked with soldiers' recovery and saw a lot of people 'playing' the system, but then others who needed help but wouldn't seek help, or would not get what they were entitled to. (Serving member, NCO2, Gallipoli Barracks)*
>
> *We get people who will tell the world they have PTSD and get all this attention, and people who do actually have PTSD will say nothing and wait 'til the last minute to try and get help. (withheld).*
>
> *All the people that need the help don't get it – the ones that don't need it actually get it – people play the psych card – if you go to a psych you can't get touched. (Serving member, NCO3, Gallipoli Barracks)*
>
> *The internal unit handling could be better. People that need the system are not getting help and others are cheating the system – as it could be personality thing rather than PTSD. (Serving member, Command, Lavarack Barracks.)*
>
> *Commanders are afraid to call out these people (malingerers) in case they genuinely do have a problem, so where is the person that can call out those who are not legitimate? (Serving member 2, Command, Lavarack Barracks).*

So called 'rorting' is an issue that is impacting on early intervention. This appears to be based around the cultural issue of malingering. Some individuals get a reputation for reporting to be sick to avoid unpleasant tasks. Team

members disrespect this type of behaviour and therefore avoid the stigma at all cost, even when they realise they are not well and in need of support. It was shared that mental health is a less-visible illness and therefore it is easier to be misinterpreted. High functioning members would rather endure the pain of mental health than the ire of their mates.

Access to treatment varies with rank

> *An Officer in the Navy – yes, they know (MENTAL HEALTH) services. Able seamen, no – they would not be aware of services. (Serving member, JHC Advisory Panel).*

Members in the Officer Corp believe they are in a better position to seek and get care because of their belief system and training, that they should 'lead and take initiative', whereas, the other ranks are told 'you're paid to do as you're told!". A sobering issue that was noted is that the Officer Corp may in fact pose a bigger problem in relation to suicide because as reported by many in Command, welfare boards, and Health Centres, believe this group – the officer Corp will not self-report.

Increasing tempo

> *Role of ADF has changed and number of deployments – some people have a huge number of deployments. (Former member, Townsville)*
>
> *The battle rhythm of the Brigade impacts unit and members. There is a need for more decompression time – time with family, mindfulness. Perhaps a therapeutic retreat in a resort setting. (Health worker, Sydney)*
>
> *A lot of units are task focused. They don't think about managing the person because they are too focused on the task. They therefore do not pick up on the signs of mental illness. Also, there can be a lot of "sitting around" and this can lead to boredom and negatively impact a person's mental health. (Health worker, Sydney)*
>
> *Deployment is important to a soldier. Tempo adds to the pressure. Soldiers therefore might put their hand up (with a MENTAL HEALTH issue) if it would interfere with deployment. (Serving member, JHC Advisory Panel, Canberra)*
>
> *Unit welfare could be better – when online, working 24/7. You might go bush 180 days a year, or you might be on deployment year in year out. There needs to be a limit on how many days a serving member is away in a year (on either deployment or going bush). People go crazy being back such a short amount of time repeatedly. (Serving member, Command, Lavarack Barracks)*
>
> *The intensity of deployments has changed rapidly – you can't keep up with people's changing mental and coping capacities when they are continuously deploying every year for 10 years. When they return is the first time they have space to stop and process everything they have been through and seen, this stuff can take years to process. (Former member, WA)*
>
> *Defence and mental services need to rapidly catch up with the high tempo life of current deployment situations. They need specialist, compassionate and practical skilled teams to do this. (Former member, WA)*
>
> *They jokingly call just before Christmas time, divorce time, because so many divorces happen over this period. Mainly because couples just haven't spent the right amount of time together, they become detached. So, when they see each other they feel foreign. (Serving member, Command, Amberley)*

Members in the Garrisons spoke about the tempo altering during the phases associated with deployment or humanitarian projects (Air Force). Preparing to deploy offers members a purpose for living, and post-deployment seems to lower the tempo and perhaps allow more time for reflection, which may lead to mental health issues.

With the heavy deployment load undertaken by the ADF some believe the middle ranks and NCOs are 'burning out' and worry that this could be a trigger to mental health issues, self-harm and suicide in this group. An unintended consequence of ensuring good remuneration for members deploying may be to encourage

individuals to undertake too many deployments, and to therefore make it less attractive for a member to refuse deployment based on fatigue, family problems, their mental health, or to report mental health concerns.

In addition, preparation for deployment may cut into non-essential courses such as mental health programs.

Mismanagement of POPs

> *Few people are identified at risk through POPs – not sure the juice is worth the squeeze as far as POPS has occurred. (Serving member, Command, Gallipoli Barracks.)*

POPs are an ADF risk management process to track the mental health of members, especially those who have deployed. These are self-report psychological profiles. Respondents from most groups report that it is an open secret that members lie when completing their forms:

- To avoid being targeted as a person struggling with mental health issues
- To get to see their family sooner because they are 'clear'
- Because they can.

> *and they have a transition session: it is inadequate, don't need support that is piece meal when blokes are not coping - information is over load to their hypervigilant, exhausted brains. They need people to come in who can help them rapidly process the most significant events for them – so they can put them to bed quickly - so it doesn't come back as flashbacks later. (Former member, WA).*

While there is an interview component to the POPS process, again, it was reported that most people lie to the psychologist and the interview is often conducted in non-discreet environments (like under a tree some meters from your assembled mates). Family members concerned about their partner can't believe that the professionals are unable to see the problems their partner is having. Without third-party reporting, the system appears to be ineffective.

After deployment, members are given some time with their families (weekend) then return to base and, depending on their screening outcomes, are given support and time to wind back into Australian life, then given a longer furlough. If someone has a suspected mental health issue, then the commencement of their furlough is delayed, so most members are keen to avoid this. (This stepped process is to avoid the problems associated with the post-deployment practice during the Vietnam engagement where members were released straight into the community.)

One benefit of the POPs, a health group in Sydney concedes, is that it is playing a role in normalising mental health as being a part of working in the military. By regularly having to undertake the test, or be called down to do a test, the topic is on member's lips. So, if it does nothing else, it has supported normalisation.

Isolation – negatively impacting mental health

> *Civilian Psyches don't understand how the members feel about the army family, so they then become isolated, blame military and remove them from that environment. The unit is their family and that gets lost a lot, when they move on. DVA is not a family. (Serving member, Command, Gallipoli Barracks.)*

> *Can lead to segregation for that member until he gets help etc. – probably when that person needs the most help is when he gets segregated from his mates. Sometimes if they in hospital or something then they don't get support from friends and feel isolated. (Serving member, NCO, Gallipoli Barracks)*

> *Most at risk are the ones that present in absolute crisis. These are immediately outsourced for 3-12 weeks. Once outsourced there is inconsistent feedback as to their progression, often these individuals will fall through cracks and Command will lose track of them. (Garrison Health worker, Kapooka)*

Former members told of the jolt of being isolated after identifying as having a mental health issue. They say they felt like they were bundled out of the service and kept apart from both their companions and the social structures - 'the defence family', that had kept them stable for so long.

Health practitioners argued, on the other hand, that the person:

- Wants the leave
- Needs the leave
- Often sees Defence as the enemy (or 'trigger' of their issue/s); and anyway,
- Must report into Doctor each week (Command not allowed to make contact other 6 days), so is not isolated.

It is a complex issue, which needs more exploring, but isolation is the enemy of mental health and may need to be thought through more deliberately. The former members, without using these words, felt like pariahs, or someone who might infect the rest. It may be that the wrench is all the harder because of the process of institutionalisation, which has bound these tough members.

Institutionalisation – negatively impacting self-reliance

> *Most guys don't know how to look after themselves – partners do everything and if relationships break down they are lost. They need to learn how to live their own life outside of the army, that is the type of dependency we create in soldiers. (Serving member, Command, Gallipoli Barracks)*
>
> *CO is your dad in the service, so you don't want to let them down, you want them to be proud (Former member, Townsville.)*

From most discussion groups the issue of 'institutionalisation' was raised. The Services must have their members able to be mobile. All personal requirements must be able to be met by the organisation. Members must be independent of their environment. As a consequence, most members of the junior ranks having been recruited in their early teens, grow to see the service as their first allegiance, their CO as 'locus parentis', and become accustomed to having their life and health managed by the system. This leaves them vulnerable if they are required to exit, because many have few ideas about the life skills required outside the service (cooking, banking, problem solving, health care,) and often have no idea they are incompetent.

> *Many have two lives (outside the army and inside) some have none but the military. (Serving member, Command, Gallipoli Barracks)*

Added to this is that some have such strong attachments to the ADF that, even when they have an option being part of a family and community, they tend to contribute solely to the military. Should they find themselves in the position where their service is terminated they are then left with little to rebuild and are vulnerable to mental health issues. Institutionalisation can weaken members.

The suicide prevention package you have when you are not getting one

> *Regional mental health team delivers a package at the start of the year and talk about everything they do – but it's a few days of PowerPoint presentations that just goes over peoples' heads. (Serving member, Command, Gallipoli Barracks.)*
>
> *(Suicide prevention course) Teaches people to go to psych for anything rather than build resilience and deal with issues. (Serving member, Command, Lavarack Barracks)*
>
> *It is so impersonal and clinical. I'm getting involved next time to give a much more personal approach that is required in this topic. We want to get involved to show what the experience (of dealing with suicide) is like and to ensure mandatory courses have more meaning. Not in the old PowerPoint boring lecture. We need more discussion and it needs to be more personal. Then people might assist or get help. (Female Cadet, ADFA)*
>
> *Only time the organisation talks about it is Suicide Awareness – only one hour, yet we spend much longer time doing drills, and this is far more important and we are a younger, and we have to deal with this and it is hard to give advice as I am not sure what to say. (Male Cadet, ADFA)*

The ADF has a range of suicide prevention programs operating as discussed earlier. The feedback from the field is universally unimpressive, with comments that:

- It is death by PowerPoint
- An individual talking at you
- An intimidatingly large group of people
- No safe way to ask questions without feeling exposed
- Lack of activities to make it real
- Part of the mandatory material – like airline safety instructions – we've heard it a number of times.
- Done by people who are not experts
- Done by people who don't understand our business and experiences

It is acknowledged that the team who put this together had their heart in the project and the content may be wonderful, but it is like learning map-reading without experiencing it. There was some discussion in a joint health group about the difficulties of finding the appropriate people to run the programs and, perhaps, more specialisation might be encouraged to build good presenters. It also, is difficult to do anything useful with a hall is stacked full of serving members. Being able to more appropriately respond when someone is having a serious mental health issue is important, so developing and delivering appropriate programs is important.

It's mandatory not to speak the name

> *One coronial enquiry listened to a case where the person said a number of times they were going to harm themselves. No joke about it at all. This is why blanket rules are prescribed. (Serving member, JHC Advisory Panel)*
>
> *I have had two sailors, from my last operational ship, take their lives because they felt they could not speak to anyone in the ADF, without it affecting their livelihood. (Recent former member, Toowoomba)*
>
> *Out bush we talk a lot to one another. There is a lot of doing nothing – told to sit on top of a hill for hours and all we can do is talk and not long before it goes deeper and you want to talk but I feel out of my depth and not sure what to say. (Male Cadet, ADFA)*
>
> *This is my family at ADFA – I don't tell my real family – as my ADFA family 'get it'. Therefore, having regulations about not sharing thoughts about suicide without it be escalated makes it very difficult to speak to anyone. (Male Cadet 2, ADFA)*

Mandatory rules about reporting suicide ideation is part of the ADF risk management strategy. The project team members were privileged to be involved in a discussion with some ADFA Cadets who see the unintended consequences of this rule as stopping anyone sharing with their mates (Mates are often touted by Defence as one of the protective factors against suicide in the service.)

Innovative, human performance programs

There are some innovative programs being trialled using strength-based concepts and the language more akin to sports development (Human performance; mental fitness) and strengthening individuals' ability to be mindful and make decisions under pressure.

The strengths course: HP4 Human Performance

- BattleSmart (up to 3hr)
- Mental fit
- Human Performance Optimisation

- Bio Feedback Profiling

The hours vary for each of the above modules.

This approach may move the agenda from medical, weakness, or "airy fairy", to 'building your capability to perform in all circumstances', with the possibility it will better appeal to the active culture of the ADF. GDs felt there may be a role for a campaign to market the fact that not all mental health issues lead to discharge (like the 'Cancer is not a death sentence' campaign.) In reality, advice offered suggests 50% of patients return to active service. Part of this campaign, someone suggested, may include a role for mental health champions to be created within units to help 'normalise' discussions about mental health.

Failure to involve families

People don't get the link between mental health and suicide no one wants to think that their partner is going to be suicidal, they don't understand mental health. (Garrison Health worker, Brisbane)

Members don't talk to wives/partners. Chain of Command should always know, wives should know, the individual that is having the issues is selfish if not engaging the wife. (Former member, Townsville)

I kept urging him (member) to get support but he kept pushing the idea and me away, saying "you don't understand what that would mean for my career." (Wife of recent former member, Toowoomba)

Once he finally got to talk to a psychologist they were able to take the armour off and he got to understand better what was happening to him. (Wife of former member, Toowoomba.)

When the member finally gets support, the family is so pleased for them and some of the burden of keeping the member alive, carried by the beleaguered family, is shared. (withheld).

I had no idea (my son had mental health issues) because I was away. My son saw violent stuff on the TV about Timor and it traumatised him. It affected him deeply and he was worried heaps about me and my safety – he was checking things a thousand times, and it affected the whole family. In the end, we coughed up funds ourselves- got him up to mental health. (Former member, WA).

Some families are unaware of what their partner is going through. If support agencies provided families with information about members' experiences, perhaps family members would be better prepared and able to support their partner/family member upon their return. Often family members can see that their partner is having issues but they are refusing to get treatment from fear of stigma.

6.7 Transitioning members

After ten years in this business you can be pretty well guaranteed to be broken somewhere. (Serving member, Corporal, Gallipoli Barracks)

8-10% of homeless are ADF (ABS data) and a disproportionate are younger than general population. (Serving member, JHC Advisory Panel.)

5-6 000 administratively discharge each year (AD is often a euphemism for mental health discharge). So, Medical Discharge may be bigger (than reported) as there is some effort to spare an exiting person the stigma associated with mental health. (Serving member, JHC Advisory Panel).

It feels like with all the transition stuff offered, even the psychological stuff- is just tick, flick and churn through as many people you can at a time. (Former member, WA)

When you are discharged it's like they are just ticking boxes- they give you very little information – and with regard to how likely it is to develop PTSD, or in the areas you are talking about, like suicide prevention and self-harm risks linked to post service life- they give you nothing. I have had someone from my crew suicide and it's just hard. (Former member, WA)

In general, the transition phase is often seen as a messy process where personnel leave and come back multiple times – they find it difficult to adjust to civilian life and need the structure of the army. (Serving member, Command, Recruit training, Wagga Wagga)

Most people only go to resettlement seminars for the financial advice, checking superannuation, and don't see it as a mental or emotional reintegration service. (Serving member, Command, Recruitment Training, Wagga Wagga)

Another example of an individual transitioning out last year, was spending a couple days a week on base and weaning off, but eventually the member became disconnected and suicided before Christmas. (Serving member, Command, Recruit training, Wagga Wagga)

All groups were asked to offer comments around services to transitioning members. At the moment, transition is believed, largely, to be an administrative process where a member exiting the service has undertaken his/her medicals, completes the required forms, accesses a few brochures, hands over their security card and is walked to the gate. There are some courses they might be able to attend prior to getting to this point but former members were vague about these – RPL, CV writing were a couple suggested. JHC advised there is a two-day course to which families are welcome to attend.

Discharge is often not when they want to go – they get given 90 days before discharge – and it could be up to 2 days before (they are to discharge) and you ask "have you been to a GP, Centrelink, looked for a job" etc., and they will not have done anything. (Serving member, Command, Gallipoli Barracks)

When asked, what were the signs that someone might be going to have issues after transitioning (or was at most risk), those respondents who have some involvement in the area believed it was the members "who had no plans". These people were going to 'move in with the girlfriend for a while'; 'have a look and see what turns up'; 'might go to another place and check it out', and end up in trouble further down the path and, perhaps, have forgotten what they may have been told re support services such as DVA or VVCS.

Defence culture needs to change and allow for official follow-ups from the service (my 'family'.) to occur. How are you going? They should aim to put M4M out of a job. (Recent former member, Toowoomba.)

Most groups when asked about the adequacy of the transitioning support believed it should be considered as an extended process over some months/years with touch points at times where reality might be starting to emerge about: job hunting, living back with the family, handling the grief of leaving the service and friends, coming to terms with what they experienced as a member, trying to find new friends and similar life matters.

Health practitioners in their groups, and a number of ESO members, believe policy needs to ensure families are involved in the transitioning process and perhaps a holistic approach taken to the process where a discussion is commenced about possible mental health consequences that the family may notice, and the type of support required, financial information, family entitlements, plus introduction to services (e.g. DCO/VVCS/DVA/RSL). If it were a course, then representatives of these organisations should be invited to attend.

What happens when someone is discharged compromised?

Having had ECT, high medication doses and not able to make decisions due to drugs, I just do what I am told. It is very hard to understand the forms; they are written in 'legalise'. You have to ask for specific things, but it is hard to do so if you not aware of them. Also, we were trained not to ask for help. (Recent former member, Toowoomba.)

If injured and you have got to get out and you have a buggered back, PTSD and a stuffed knee, none of the processes can be initiated to get you a white card, or proper health support, until the day after you leave the Defence Force. That's all backwards to me. (Former member, WA)

The transitioning process is basically the same when a serving member is compromised but the member is less able to comprehend what is happening, nor make life choices, which may be in their best interests in the longer

term. Poor choices here can start a series of events, which could accumulate to an overwhelming pressure to self-harm, or suicide.

If you're having a 'compromised' discharge. Where people leave on their own terms get a special morning tea, where for example the CO of the Navy would come up and thank you, if you are discharged for mental health issues you just get dumped. It is shocking. (Recent former member 2, Toowoomba)

Discharge was sent to me in the mail. No 'thank you' (CO didn't bother coming up to thank me for my 25 years of service, because I was discharged because of my mental health issue. On the base, I was isolated during the discharge process. It was humiliating. (Recent former member, Toowoomba.

Those that voluntarily separate generally do well. (Former member, ESO, Townsville).

The medically compromised member may feel discarded and is in danger of entering a downward spiral towards self-harm and suicide. Some members decide to do their own transitioning and appear to get planned ahead of time.

I knew that going to Duntroon- and becoming an officer and upskilling myself was a way I could prepare myself and my CV for when the time came to get out of the army. I had a goal and an end point in mind. It was a more strategic way of thinking. I laid my own seed about getting what I could out of my defence experience and I stayed focussed on that. (Former member, WA)

I'm not going to bother with DVA - I find its too hard- it's not worth hours you put into to get what you need out of it. I had a shoulder injury and went to the doctor. I told him I've got this white card to cover my shoulder, so now I get acupuncture for that, but otherwise my transition was a plan in my mind and I wanted to see how I could make it work the best for me. And it's gone ok for me so far. (Former member, WA)

Such planning may assist members to successfully transition out of the military into civilian life.

6.8 Former members

After I got out it was hard to get the paperwork together, which should have been on my file by ADF. I needed to get my information verified by peers, but one of the key ones had suicided already. (Former member, Navy)

In the Army, you say something and certain things will happen, but when you leave the army and say something - nothing happens. We were taught that we would get support but, once you leave, it's not the case, it is not what you expect or what they are taught. (Serving member, Command, Gallipoli Barracks).

Ultimately health services are different at transition – there is a need for integration of health services (i.e. Co-Plan). (Serving Member, JHC Advisory Panel, Canberra)

Once a soldier leaves Defence, the forces don't have a responsibility – it's the DVA's problem. (Former member, Townsville.)

So, I came really close to topping myself a couple of times during that period (leaving Defence) because I felt useless- it was only my kids and missus that stopped me from doing it. (Former member, WA)

When people leave Defence, they get a shock at all the benefits/services they now do not have access to. Needs to be a level of expectation management when transitioning. (Command, Recruit Training, Wagga Wagga)

The symptoms of suicidality may begin to develop well after deployment (3-10 years) and this is where people fall through the cracks. When symptoms begin to develop, personnel do not recognise them, will not accept help from those around them so the significant lag time of symptoms is a challenge. (Garrison Health worker, Kapooka)

'The day after a member leaves the service then the support stops' was a fairly common comment. The employer's responsibility for them has ceased as it would in most organisations. There appears to be an

unspoken assumption in the former member community, however, that maybe this shouldn't cease. One participant suggested that 86% of those who exit the ADF probably turn out OK.

A number of serving members struggle at some stage after leaving the service. A number suffer mental health issues, health issues, self-harm and suicide. The awareness and increasing acceptance of PTSD as a condition that can, and does, impact heavily on military personnel has made it a little easier for former members and their families to demonstrate work-related incidence of harm. The types of support services that former members were seeking after service, because of their injuries, included allowances (a Gold Card – TPI status) to ensure they and their families were safe. Many get frustrated with the 'administrivia' about their claims from DVA, when they expect ADF has given them all the documentation they need when they transition.

In various groups participants raised the issue of the 'wounded warrior' narrative. This narrative is a consequence of the Vietnam era quest for recognition, and the plot is that if you serve then you get 'busted and broken' and should get looked after. (Some health officers argue that for those former members who have not comfortably found a home in the community then being a wounded warrior offers a permanent link with their former roles. Many advocates still urge former members to pursue allowances rather than perhaps, considering rehabilitation, to get them back into work and into society ('Get a package rather than get well'.).

> *It's getting better now though because it's no longer a life sentence. You can still go on and serve. There is life after your mental health injury – certain treatment, certain time off medication, then people can stay. (Recent former member, Townsville).*

If a young person is paid out but not engaged (being considered TPI) then some believe this is a recipe for concern, and is also an indicator of factors to be watched for if someone may be thinking about suicide. The narrative now may be working against the younger, former members, who wish to translate their military service as a 'character building' experience and seek a post-service career. Employers may be wary of hiring someone for fear the employer will be accepting a lot of collateral issues they could well do without.

Some drew the researchers' attention to the fact that because the former members were so pampered within the service, they do not learn resilience to stand them in good stead outside the service. With the Chain of Command (COC) taking most of the decisions, even sometimes about the member's own family, the member doesn't learn resilience about living in the ambiguous society into which they are discharged.

> *Response of the system – sense of betrayal – I have given you my life and my claim isn't accepted, my paperwork has got lost….more people suffer PTSD type symptoms from the system's response rather than the military situation (External Health Provider Brisbane)*

> *In general, after a suicide attempt or mental health crisis, working towards a future of getting better – part of the problem is the barrier of DVA and everything that goes with it. A claim can go in and then the member is left not knowing what that means. If they start training does that prevent them from accessing things from DVA? – it's ambiguous for the member and the family (Contract Psychologist, Brisbane)*

Whilst they have left the Defence Force, many have to deal with a new system, DVA. It must be said there were very few people who appeared to be in the former groups to sing the praises of DVA (though it must be acknowledged there were some). For many, who were discharged 'compromised', the support from DVA was/is crucial. So what goes wrong?

> *Whole process is tick and flick, 30 years out of date, run by people who don't understand what they mean – people get medically discharged for serious problems but don't get covered because it's not on their 'checklist'. (Garrison Health worker, Brisbane)*

> *Clinicians – how can these people use the system if I can't even understand it. If the process was quicker it would be a lot easier. Symptoms get worse because they wait so long. (Health service provider Brisbane)*

> *I had a DVA claim fail after my 16-month discharge timeline, because their three internal desk officers (one from each act; VEA, MRCA and SRCA) don't talk with each other if it's found the veteran needs to be*

presented under a different act. It's new paperwork and ground zero. (ex- member, Toowoomba) (Follow-up letter was provided by the ex-member detailing this experience in more detail.)

Having to fight DVA for recognition of injuries, even when they're as 'slam-dunk' as reportable wartime incidents which required medical evacuation. I don't need to mention how utterly stupid this is. (Former member, Toowoomba). (Follow up letter)

but because I was more or less forced out – I was pretty low and I couldn't find work, especially as my knee and back were buggered so we lost all our savings, we ended up losing our house. It took nearly a year to get any benefits from the government and it would have taken more than 12 months, if I hadn't been casually told by another soldier about getting a copy of all my ADF medical records before I got out. (Former member, WA)

There were lots of comments suggesting the delay was too long for applications to be processed in order for a member to get some money (1- 2 years was not unusual as a time delay) and by this time, the ex-member's own finances had been depleted. (The white card is considered a major recent improvement.) The processes appear to members to be 'slow', 'complex', 'cover your arse' with an over-abundance of paper-work. Operating under three Acts is considered to confuse even the advocates.

Former members reported administrative issues such as poor record keeping, lost files, lack of communication between Defence and DVA.

In one group the question was raised if DVA had a mental health/suicide KPI to monitor the wellness of the people in its care, and that perhaps if it didn't, it should, in order to drive improvements.

Malingerers – physical wounds vs mental health issues - stigma etc. still there. (Former member, Townsville).

'Malingerer' issues still hang over from their service days and ex-members can point to people who they believe don't deserve allowances, yet get them through good advocacy, whereby, worthy candidates, fail to get support. This continues to irk them. Receiving photos from these malingerers fishing in adventurous sites, when they are supposedly too ill to be able to function, triggers discontent. Injustice erodes their confidence in the system, and adds to their mental health concerns. However, when DVA asks questions, which require evidence, this is seen as questioning ex-members' integrity, which creates a no-win situation for DVA.

7. Gaps identified by serving and former members and health providers

Participants were asked to comment upon any gaps of which they were aware in services, and ideas were offered from all groups. As a consequence of the range of groups, some being health workers for example, the "Gaps" are not always direct services but impact critically upon that service. The gaps are not offered in level of importance.

7.1 Isolated serving members

> *My husband was posted to Wales before Timor for 2 years. This was very tough for me because I had a mental breakdown because there was no support for me in Wales as he was deployed from Wales to Bosnia. I felt like I lost everything at once. (Former member and wife of member, Perth)*

One of the benefits that group members believe is available to serving members is contact with their team and the availability of Garrison Health. GD members were concerned about Reservists, and others working in isolated environments e.g. DMO, embedded with other allied services, head office, major projects, and how they got the support, especially peer support that they needed.

7.2 Lack of holistic approach

> *I was messed up without knowing (heads nodding) we were messed up. Did stupid stuff and didn't know we were doing it. So taxing on my family. All persons in room agreed. (Former member, Toowoomba)*

> *I still do not know why I am divorced? (Former member 2, Toowoomba.)*

> *LGBTI six (6) times more likely to suicide. It must be a personal thing, a personal solution and one size does not fit all. (Male Cadet, ADFA)*

> *We need professionals that are skilled in helping people recreate roles and occupations once out of services. Not just social workers or psychologists. We need people who teach practical life and self-recovery skills, so PTSD doesn't turn into alcohol abuse or self-harm. And we need to 'defrag' soldiers from being soldiers so they aren't the intolerant angry man when they get home. (Former member, WA)*

> *There is no support to reskill, you can get some training but it is often only for one avenue. (Serving Member, Amberley)*

Some ex-clients of the ADF Health Service and a number of outsourced health practitioners made the point that there is a requirement for a holistic approach to treatment, which might involve co-morbid issues, anger management, family therapy, drug and alcohol abuse, nutrition, job search to rebuild the individual. In this light, at various times, the loss of the role of the social worker in Defence was raised as a concern because of the lost flexibility and capability for health to offer a more holistic service.

7.3 Duty of Care

> *Our members have access to powerful weapons, that is one reason they are different to civilians." (Health service member, Sydney)*

One of the benefits of VVCS programs expressed in groups is that they have a contract to advise ADF, or Command, if a member being treated by them is considered a danger to others. It is believed this 'Agreement of Service' contract is required for all treatment centres.

7.4 Dealing with sub-clinical mental health

> *You want to treat a mis-adjustment but it is taken too seriously and you are 'separated' (from Defence). (Female Cadet, ADFA)*

To be sent to the psychologist is very strong, drastic action. Like going to a neuro-surgeon for a cough. (Male Cadet, ADFA)

Defence is very reactive and when someone presents with an acute crisis it reacts well. But the system has not caught up with low level stuff – mild anxiety and depression, the prevention space – the system does not do this well. (Serving member, Command, Recruit training, Wagga Wagga)

One of the major stigmas preventing serving members from seeking mental health assistance appears to be their belief in the 'slippery slope' of losing their job once they identify they are having problems. What many health practitioners discussed is a lack of flexibility in being able to deal with identified persons, and that most cases become 'medicalised', when all that may be required is some adjustment by the individual with coaching and guidance by a professional.

… to non-medicalise symptoms. The accumulative stress effect as a result of their career. Yes, it might be PTSD symptoms, but it is a result of their day to day lives in Defence (occupational hazard due to working in Defence). Give them resources and things to cope so that they don't get into the medical system as having PTSD. We are not doing enough preventative work – not reaching the guys on the ground. (Garrison Health worker, Sydney)

Another approach may be to have a drop-in centre on base where people can be assisted to manage their condition and may attract others who have failed to present previously.

… drop in support network centre – couple of days a week take newspapers and things for people to use – casual – so then when they are unwell they can come to you. We can develop trust with someone who is not a stranger etc. – rather than using the same old systems that aren't working." (Garrison Health worker, Gallipoli Barracks.)

Some believe there is no language to deal with it, to define a mental health problem vs. mental health disorder. VVCS appears to have the flexibility and being outside the Chain of Command can assist individuals identified as such.

7.5 QA Standard of Acceptable Risk

Need to track and maintain right from the beginning, we need to be well informed and involved – to steer people back early on. This relies on relationship with the Command Chain. (Serving member, NCO, Lavarack Barracks.)

If it can be identified earlier those at risk of developing PTSD in the forces and those who are likely to shut down and self-harm or be at risk of suicide, then they can flag that and do that in the very beginning enlistment process. It's not hard to ask the right questions and to discuss how they have coped with trauma before coming in or if they have faced any, as some people might be really capable in life and death situations and others might crumble. (Former Member, WA)

The implications for mental health issues are serious in the ADF. This issue of risk is related to the foregoing issue of sub-clinical cases. The health GDs, which discussed this issue, suggest that the ADF has to develop the ability to understand a level of acceptable risk. At the moment, Defence might be considered to be risk averse in this area and uses a "one size fits all" approach, which simplifies things for Command but can devastate the individual. This will take a lot of intellectual rigor to develop successfully to determine which conditions require what treatment and rehabilitation protocol? When is a member considered 'safe', what drug regimes can be utilised by someone back at work? It was recommended that criteria/guidelines to start support (for sub-clinical issues) should be developed.

7.6 Garrison Health Centre design

Serving members identified in one GD that it might be possible to design the layout of health centres to make it less obvious that a serving member is on a mental health visit. The waiting room in some centres are very

exposed and a member might be sitting there and the CO walk past and in a caring and respectful mode ask "What are you in here for Smith?" More confidential triage, is another practice that might reduce the resistance of serving members to seek assistance. If there were rooms allocated to practitioners on a random basis and the serving member be sent to the room, rather than the practitioner coming out to get the member, might also be a practice to improve confidentiality.

7.7 Training

> *There's not always a lot of help unless you seek it. You never get given a course on how to deal with people to help them have more mental resilience. I know a lot of guys that if they don't get what they want 'they pull a sickie'– other guys with legitimate issues are afraid to speak up. (Serving member, NCO, Gallipoli Barracks)*

> *There is a lack of focus on resilience training. For example, foreign militaries do this well, we don't focus enough on resilience training. (Serving member, Command, Recruit Training, Wagga Wagga)*

> *We need resilience training - Getting people out there and put them into uncomfortable, hard and challenging situations, such as resistance to interrogation. There is not enough of this type of physically and mentally challenging training. (Serving member, Command, Recruit Training, Wagga Wagga)*

In a number of groups, mention was made that there is not enough time spent in training/service on topics related to mental health. The time spent on mental health topics appears to range from (1-3 hours). Learning some skills to build resilience, to relate better, to build relationship communication skills is offered, by some, as a useful addition to their training, and when challenged by the idea their training curriculum might already be packed (e.g. at ADFA) they explained "there is always time for (efficacy weakening) tools like relentless, mindless drilling" so there must be time for something useful.

> *Maybe we should have a Resilience centre – "pre-hab", which will get hold of people when they are vulnerable and heading in the wrong direction. It will help them to on the right path. Set them (members) up with skills at the beginning. (Serving member, NCO, Lavarack Barracks)*

Whilst there may be some questions about the possibility of building resilience, how much time would be optimum to put an interesting program together, not power points, but an experiential, action-based approach to build their capability needs to be considered.

7.8 Competent DVA advocates

Some DVA advocates are believed to be incompetent and former members believe there should be a program to ensure they are current, knowledgeable, and able to navigate their away around the system in order to assist their client. Those who raised this were mindful of a new qualification regime being organised by DVA, but many were fearful that it will exclude older competent ones as well, who will not wish to gain the qualifications.

7.9 Audit and Co-ordination of ESOs

> *They all do a good job but need to be integrated if they are serious about helping veterans. They need to come to the table with a common goal*

> *Lots of duplication of activity. (Serving member, Command, Recruit Training, Wagga Wagga)*

When discussing ESOs, numerous former members believed there were too many of them (numbers estimated varied widely) and if the numbers were not to be reduced, at least they should be coordinated. The problem with having too many is the inability to gather a united voice, to ensure accurate statistics or ensure valid practices and governance. These factors make it difficult for policy makers to settle on appropriate services. Many see the outgrowth of these agencies as a snub to the RSL, which they consider is not meeting the needs of ex-members. Those against interfering, expressed a belief in the creative benefits attained through 'letting a

thousand flowers bloom'. Others argued that policymakers also need to be mindful of 'the dearth of regional support available for the former members' and any help is a blessing.

A health group in Sydney believed it needed to find a way to work more collaboratively with the ESOs whose marketing in many contexts is "the system can't, or doesn't want to help you, we can." Another suggestion was that a list of registered services provided by these organisations should be made available to Command.

7.10 DCO family Assessment

> *Family situations can contribute to a member's mental health issues. Risks need to be identified during recruitment because people underestimate impacts on families and levels of risk needs to be identified. (Serving member, NCO, Lavarack Barracks)*

Those who had experience of DCO appeared to be appreciative of their support. (E.g. They visited a Cadet's mother when he was unable to give her support and he was very relieved.) What was expressed in a couple of forums was the lack of ability to get DCO family assessments done to give Command and some health workers, better information to support decision making about a member. It was suggested that this information could also be used at the time of recruitment decision to ensure family support is available (e.g. for single mum considered possibly unaware of the real obligations of military life) and later, on request by MO and CO to ensure they were coping; or for a soldier on deployment. The impression gained was that this was more readily/easily done in the past.

7.11 Resource constraints on personnel

> *There's a bucket of money that constrains how many people (e.g. psychologists) we can employ in defence. (Serving member, Command. Recruit Training, Wagga Wagga.)*

Psychologists across the system noted the rise in workload as a consequence of the success of their awareness programs. Prevention and promotion was split from care since the Dunt Review and, whilst the establishment staffing figures may not have reduced, the numbers of psychologists available to treat clients/members has not been increased, causing pressure on access to timely treatment. Where once a psychologist dealt with 20-30 clients now the workload is 70 – 100. Attempts to attract further staff numbers appear to have not been successful.

7.12 Dealing with NCOs who promote wrong care model

> *need to change the culture at that level – listen to Commanders saying "you're weak (physically and mentally), you're gonna get kicked out". We need to change the culture at that leadership level or it will not change. (Garrison Health worker, Brisbane)*

Group members in health centres enquired if there was a co-ordinated approach to exiting out first-line leaders/immediate supervisors of serving members who may be creating a culture that suggests "only weak people have illness". Some members were concerned that sometimes the banter that occurs during drilling can pass on this notion. The project team were advised that the Health Centre, upon hearing a pattern of negative comments about an individual NCO will often pass this information on to the Welfare Board, with the expectation that such behaviour will be addressed by Command.

7.13 Tracking Former Members

Former members, in various locations, lamented the "lack of ability to track a vet once they've left military service". People believe this would enable a welfare check, better collection of data about their welfare, and better targeting/marketing of welfare programs. Some suggested it shouldn't be too difficult to link through their Tax File number or Medicare number. Apart from the issues of privacy and the fact that many former members want nothing to do with their former (military) life, the proposal would have difficulty to get accepted. It may be possible for a link to allow ABS to track their welfare.

7.14 Performance-manage contractors

Some former members and families, raised questions about the competency of in-house health professionals. Some in-house managers of health also believed competency was a problem and argued that they lacked the ability to performance manage contractors for in-house services. As it was explained, the contractor gets penalised if they fail to fill a position, so their obligation is to put "bums on seats" and quality varies, markedly. In-house managers have been warned off getting involved in performance management as this would/could void the contract and place Defence at risk. If incompetent people put serving members at risk, then this is also unacceptable. It would appear there needs to be controls placed in the contract.

7.15 Place to link kids and families in the ADF community.

The issue of families and the ADF is a vexed one and a complex issue. Some group members spoke about the need to "normalise families" in the service. This topic is raised elsewhere in this report. One suggestion was that a family centre be available on each base. It may provide day care and be a place where social events can be held, and partners and children can feel comfortable coming and going. Apparently in some bases (e.g. Tindall), where there is not a range of commercial providers available, then this service is offered. It can be appreciated why Defence would prefer members to be involved in the community to 'normalise' that part of their life, rather than having a base dependence. Yet, there is also a need to avoid family members being cut out of a member's life when they are not coping.

7.16 Padre service not available in DVA/VVCS

One group member had heard of a Padre service being available in the Canadian equivalent of the DVA and their ancillary support services. He had heard that it was very successful in assisting former members and believed it would be beneficial in Australia. His rationale was that it is a trusted concept in the military and is a 'key cog' in a holistic service to deal with moral injury.

7.17 Every exiting member needs a ceremony

> *My discharge was sent in the mail. No 'thank you'. The CO didn't bother coming up to thank me for my 25 years of service, because my discharge was related to my mental health issue. I was in isolation during the discharge process and sent out into isolation. (Recent former member, Toowoomba)*
>
> *When I was discharged (after 19 years), I got a letter. (Former member and wife of member, WA)*
>
> *He (her husband medically discharged) now resents people in uniform due to his rough discharge. (Member wife of former member, Amberley)*

Many sad cases were cited where after years of service and being discharged due to mental illness, their senior management did not make the effort to come and thank them personally for their service as they would to a person being voluntarily discharged. This greatly upsets former members and replays each time they think of anything to do with their service. A letter is not sufficient. They believe a 'warm body' is required to give them a sense of dignity about, unfortunately, "being broken".

7.18 Ensure a warm body follow-up three months out of service

> *It could have saved us years of emotional and physical self-harm pain if someone had followed me up in the navy when I had to transition, when I became redundant and then again when I returned to Australia. These events are all the net result of being not valued or validated for the service you provide to your country and they are made all the worse by being a female. (Ex-member, WA)*
>
> *There are so many discrepancies within the ADF system- like there is the debriefing whilst on deployment just before you come home and then there is no follow up – there needs to be staged follow up offered – some might not need it but I know many of us feel lost when we get back. (Ex-member, WA)*

There were many stories reported of members being cut loose from the service. Sometimes heading off on sick leave and never returning, others leaving voluntarily but often not fully aware of the civilian life that awaits them. Various suggestions amount to the same thing but some believe that someone from their old workplace should be tasked with visiting them to check how they are travelling, to see if there are any unresolved issues, to see if their plans are working out, sharing some gossip to make the cut less sudden/final. At this stage, such contact would be valuable as the unknowns/known concerns are staring the ex-member in the face. For example, "I didn't get that job. It's difficult to find a place in a family which has learned to function for long periods without me; my health card is being contested". An alternative suggestion is a case management team to assist the individual transitioning. At this point the individual is more ready to see the need for advice and to be reminded of support services. (Command, Amberley))

> *Generally, income will stop straight away and then you have to wait for benefits – there is so much unknown during this period. People resort to living in their cars because they can't afford or source any housing. You are shown the gate, not connected to any services and they hope you don't kill yourself. (Serving member, Command, Amberley)*

An alternative suggestion is to lengthen the transition period from 28 days to 6 months and allow person to remain in their housing during this time but perhaps, pay market rent.

7.19 Better educating COs on how to handle mental health

> *60% of us will be officers – give us the interpersonal skills or conversational skills to enable us to have deeper conversations. (All agreed on this.) (Male Cadet, ADFA)*

> *... need to step in when you see something going wrong, being able to tell the difference between a bad day and someone who is genuinely not coping. Essential training of Command is required. (Serving member, Command, Recruit Training)*

> *… when looking at airman courses –in the general work environment it is corporals they're immediately connected with. They could be given a bit more training to have difficult conversations around mental health. (Serving member, Command, Recruit Training, Wagga Wagga)*

> *Sometimes a Command referral is due to the personnel's attitude and it is not always mental health. (Health professional, Kapooka)*

Whilst many in the service admit that the treatment of mental health has improved in recent years and that COs are more aware of issues, some group members believe they need more than the two hours they get in their training to be better equipped to handle the issues they face, especially suicide. As a group member said of the COs: "They still don't ask the question." That question is asking someone with a mental health issue: "Are you considering harming yourself?"

Again, participants believed the beefed-up program should be more than a PowerPoint presentation but have some experiential elements to move their knowledge from 'I know' to "I can do". This is not to make counsellors out of them. The reality is they are having the conversations so, as a first port of call, it would be useful for the member/client to ensure their first conversation about the issue is a supportive one, and with someone they can trust.

7.20 Promotion of suicide awareness

> *Perhaps there needs to be some commercialisation of mental health in ADFA. Just like the white ribbon movement – it is OK to hire consultants to run programs and generate a belief that "my organisation supports me". Like '22 Push Ups' – commercialise to a point. We need to motivate people to a point where they realise this is important. (Male cadet, ADFA)*

Cadets were keen to see that more creative approaches to marketing mental health were taken within the service.

7.21 Barriers:

- Very complex administrative system – myriad of instruments/forms/questionnaires.
- People don't know who the advocates are.
- No simple guides
- Not told what services are available (you only find out after you apply) Catch 22. Need to ask them then they will approve. No one sits down and runs through all possible supports.
- Three Acts with a myriad of Orders, procedures etc
- Not told they can re-apply for services, allowances if things change, or had incorrect data.
- VVCS - Limits on MENTAL HEALTH vouchers (only 10)
- Lack of one-on-one support.
- No transport in Toowoomba until Gold Card is granted. Services in Brisbane.
- No one-stop shop.
- Information written in legalese.
- Family not included in transition discussions, nor are their needs directly considered.
- Promises made about support during transition but none in the room had witnessed it occurring.

People that do actually get help and go online because they think it's a quick way, don't get the help because people on the other end don't get enough information etc. – computer systems (Health, DVA, ADF) don't talk to one another so huge time lag. (Former member, Townsville.)

8. Families

The following information relates directly to the range of issues shared by family members who attended the GDs or one-on-one interviews. Family members included partners, parents or siblings of serving ADF members or former members. Discussions occurred in Toowoomba, Sunshine Coast, Townsville and Perth.

These interactions were deeply personal, with participants sharing stories relating to their loved ones' suicide or experiences of living with their loved one who had experiences of self harm, suicidation thoughts, difficulties with day to day living as a result of their Defence experiences the loss of loved ones to suicide.

The location from where the quotes have originated have not been included to ensure that the anonymity of the participants is maintained, as there were only a small number of participants at each location. A total of 11 family members provided feedback.

The following quotes highlights the stark reality of losing a loved one and the need for early intervention.

> *I don't think he knew what he was doing. The day after that he died, it was just too late. You can't come back from death- that's the reality. There are lifelong consequences for those they leave.*
>
> *In my experience, you always see suicide coming. It doesn't just happen out of nowhere. If there was more support early on they would not feel hopeless and they would know that their problems can be solved, no matter what they are. They often feel absolutely hopeless and they get more desperate. I myself as a wife have felt this way (hopeless) many times. But now I know this too will pass. This (traumatic/difficult event) is not our life - now I know to count for a week, as I know this will come up again but it will also pass. I would give anything to have him back and to give him that insight too.*

Through these discussions, the critical role families play in the recovery of their loved ones was clearly evident. Family members described how their support role was demanding, constant and at times exhausting. There was a view expressed by some participants that it seemed unfair that "their loved ones had put their lives on the line to protect our nation, but when they needed care as a result of their service, there was no, or limited care available." One family member shared how she had to quit her high paying job to become a full time carer for her husband. Similarly, an ex-member shared how his partner quit her executive position to accept a less demanding role, so that she could care for him.

It was shared that often, these families are caring for ADF ex-members who have "put their life on the line to serve and protect our nation", surely as asked by some participants it is only reasonable to expect that their needs are addressed in times of distress that are directly related to their service.

8.1 Gaps in Services

The bulk of this section identifies a range of gaps in services, systems, supports and barriers to care that if addressed would result in more effective support for serving members and former members and their families. The following table identified these gaps and potential benefits.

A key finding related to the plethora of ESOs and the often-associated confusion as to what they offered and how they could be accessed. It was strongly asserted by some that there were too many ESOs, that their services need to more directly relate to the needs of former members, families or children and that these services needed to more proactively reach out and support their intended audiences.

Table 7 Gaps and barriers and potential benefits as identified by family members

Gap & Barriers	Potential Benefits Identified by Family Members
Provide more systemic solutions to address needs for families	More sustainable outcome as myriad of issues are addressed and outcomes are strengthened by more positive outcomes
Proactive support	
Streamline the Claims process	Better motivate ex members to submit claims and feel that the process is manageable – a sense of hope
Transition to civilian life	More support systems to enable members to positively adjust to civilian life
Holistic services	Provide members with access to a range of complimentary services that will strengthen the likelihood of positive and sustainable outcomes.
Warm transfer to ESOs	Ex-members will be more willing to meet with and attend ESO support groups if they feel a connection with the convenors
Listen to the family members	More appropriate services and supports offered to the members and ex-members as more evidence and insights about the person's condition is gathered from the family. The family is better prepared to support their family member.
Education – Members, families and community	Education is critical to all members of the community, families and members understanding the likely impact of their Defence experience and how to offer support that is advantageous and likely to minimise self-harm and suicide.
Address Stigma	By increasing people's willingness to discuss mental health and suicide and understanding that people can still have thriving lives people will be more willing to divulge their mental illness. Increase people's ability to have constructive conversations with people who are becoming unwell and their families – maintain a sense of connectedness
Children	There needs to be more support for children so that they can better cope with the behaviour of their parent or sibling
Engagement with schools	Schools can play an important role in supporting children and their parents to cope with the stressors of their parents/siblings' behaviour and therefore be more productive at school.
Non-physical activities	Many Former members have physical injuries that prevent them from partaking in physical activity. Offering a range of other support type networks will ensure they are better able to stay connected with others
Accept the reality – drug use	By acknowledging drug problems there is a better chance of unearthing potential causes and appropriate mitigation strategies
Separated partners access to services	Family partners that leave their loved one because of their behaviour have no access to services. This is bad for the children and the non-Defence partner and can lead to people staying in relationships that are not safe nor fulfilling.
Domestic Violence	Address the unique Defence circumstances that lead to domestic violence and create a whole of organisation response so that there is greater change of significantly reducing its prevalence
Positive Stories from others	Give people a sense of hope and use more positive messaging to generate wanted behavioural change
Specialist mental health skills	Ensure members and ex members receive the quality of care they need to recover
Available mental health services	Access to more appropriate services that keep people connected to family and friends when they are very unwell will improve and sustain recovery
Support parents and siblings who have lost loved (ex members) ones to suicide	Increased ability of grieving parents to recover from the loss of their loved ones and to not develop mental illnesses
It's never too late to seek counselling	Share stories that promote the benefits of members and ex members accessing counselling and reinforce that it is never too late to recover. Create that sense of hope which is fundamental to recovery.

8.2 Available Services

There were mixed responses to awareness and use of available Ex-Service Organisations (ESOs).

> *The ESOs are not proactive. They don't come to potential clients. You have to know what is available and go to them. This needs to change.*

We were never told what services were out there for us to access. No one was offering anything up front post discharge. We certainly weren't made aware as family about what to expect and how to get help if we were worried- which was a lot of the time.

It depends on individual communities as to how much follow up is offered- we need mass advertising of the same- we need to advertise how ex ADF can get help and sooner.

I wish I knew then, what I now know about available services. It would have made my life so much easier.

Don't ask me how I (ESO) can help you, because I don't know what will help me. Tell me what's on offer so I can then choose what will be beneficial and suit my needs.

An example of the lack of awareness, was a case of "sheer luck" that a widow who lost her serving husband to suicide recounted. She just mentioned in passing her need to a former member who informed her that RSL could support her. She accessed the support, and while grateful, expressed that it would have been beneficial to have known what services were available to better manage the grief of her loss: "*(I felt) so alone in needing to deal with the realities of life post his death*".

Other concerns related to the plethora of ESOs, the lack of coordination between services and the lack of clear pathways to assistance. There was also an expressed concern about the cost of so many ESOs and the need to improve the standard of services offered.

There are way too many ESOs blowing their own horn, it's all about them and they are competing for funds. No one (ESO) has contacted me and it's been two years since I lost my husband to suicide. They are not proactive. They need to be rationalised and standards need to be introduced. We need a suite of ESOs that are categorised according to providing services for families, children, ex-members.

Another participant also noted that she was not interested in attending support groups that consisted of people "re-hashing" their sad stories and focusing on their dilemma as she was keen to be forward looking and to find solutions to manage her family situation effectively and continue to "grow" as an individual. Similarly, another family member shared that her partner while he really valued connecting with former servicemen, he could not tolerate listening to other people's problems. He wanted to be around thriving former service men; people who could show him "how to move on".

Services that were provided by individuals with a strong faith, while identified as being valuable to many, were less attractive to other families who were not religious. The family member who shared this comment also expressed exasperation at the effort she needed to go to not have the padre involved with the offered support and welfare board meetings that her husband attended, who had attempted suicide on a number of occasions. In her own words:

I had to fight to not have him (Padre) there.

Specific ESOs that were mentioned included: Soldier On; Mates for Mates; Save Our Veterans; VETs off the Street; First responder; Legacy; Overwatch; Vets 360; RSL; Legacy; Alongside; Exit Wounds; Vietnam VETs; Walking Wounded; Modern Solider

Non-ESO services mentioned were VVCS and the Solider Recovery Centres (SRC).

It was stated that it would be beneficial if a social worker was available at the SRC:

You don't want to be "fixed by someone, you just want to talk and vent your feelings.

Access to more respite services for family members and their loved one who has the mental illness was also raised:

Supporting someone who is suicidal is exhausting. I just needed a break, but there was nothing ….

It was also reported that it would have been advantageous if the Welfare Officers from RSL were more proactive. One participant who lost her husband to suicide shared that she had never been contacted by the RSL and that she had no idea what services were available to her.

Services or support networks that have been useful are those that offer a chance to "just get together and socialise" and have some fun and feel connected with other individuals.

8.3 Service and support gaps and potential solutions

> *For a system (Defence) that is very professional, systematic and process driven in their training of soldiers, they are failing in this area of after care for staff (ex-members) and families. They need to do more as a matter of national urgency there is still a gap and it needs to be filled quickly.*
>
> *They break them and they just give them back.*
>
> *I was trying to get him help for PTSD for 10 years and prior to that I was just living in the chaos, paranoia and hypervigilance that comes with living with someone with PTSD.*

The following information details a range of services, supports, experiences and broader systemic issues that were identified as needing to be addressed to meet the needs of families and their loved ones who are members or former members.

Provide families with access to a range of supports and address broad systemic issues

Interestingly, one participant shared that she works in mental health and even though she has a strong theoretical and practical knowledge of mental health she found it extraordinarily difficult to cope with her partner's PTSD and attempted suicides and the impact on her children. While she strongly agreed that other members' families needed to better understand mental illness and the impact of Defence's experiences, what she mostly needed was support for him so that she could focus on the well-being of their children and the management of day to day needs.

She acknowledged that their teenage daughter played a key role in being able to relate to her Dad about his behaviour and shared a story about a day when her daughter was in the car, while he was driving and showing signs of car rage, and she in sheer exasperation told him to:

> *… "stop yelling, calm down and stop being so difficult". Fortunately, he did as she requested.*

The mother acknowledged that this was a very big responsibility for her daughter to carry. His acknowledgement about the impact of his behaviour on his children has been critical to him agreeing to seek help. Interestingly this mother also shared that because her family has moved several times with Defence and had now settled where her husband was last posted, they actually had no close social ties and therefore felt isolated. While they knew they were welcome to socialise with other Defence families they were reluctant to do this as they know that Defence families often relocate so why go through the effort of "small talk" to establish a friendship only to see it vanish when the family is posted to their next location.

This highlights the need to ensure that a range of integrated systemic solutions are implemented to better support families and their loved ones who are Defence members or former members.

Ongoing proactive support management

> *We need ongoing services from cradle to grave for Defence personnel.*
>
> *My husband was sick and tired of having to repeat his story over and over to different services/personnel. His notes were never passed on, which meant he needed to relive his trauma over and over again.*
>
> *After he attempted suicide, I phoned Vets Off the Street and they organised someone through VVCS to sit with him at the hospital so I could get the kids home and back into a normal routine. They were helping him get back on track and they got him into Central 55 for people at risk of homelessness. Unfortunately, its full*

of drug users so he did ok for 1.5 weeks and then ended up using drugs with them, so he got kicked out. Then they got him into a house in Maylands - Cypress Cottage for ex Vets, who got him an advocate, and helped him to get his claims through DVA, which no one had even ever spoken to us about before then. In no time, he was seeing a GP, was on meds and eventually was coming home on weekends, watching footy with us and having a beer with us and we could start to see glimpses of the old him or so we thought.

He got some work and finally EIGHT years after leaving Defence he was seen by a psychiatrist and correctly diagnosed with PTSD. It felt like a relief on the day for us all to be able to understand this hypervigilance and unpredictable behaviour we had been living with.

Government needs to create an administrative system that catches up with modern approaches of document management, one-stop-shop access to services, seamless treatment (stepped care), electronic access to services and tele health.

It was reported by one former member who had accessed ESO services, which at first were beneficial and improved his health, had later resulted in him becoming more unwell as a result of the groups of people with whom he associated, these being drug addicts at a supported accommodation facility. It was asserted that more stringent support management that provided ongoing facilitation and support for one's needs would have been advantageous. It was emphasised that the phrase "case" management should be avoided as people could consider this to mean they are a "nut case" or a "sad case". Getting the language right was seen as being very important to the member/former member acknowledging the need for support and then accessing this support. It was also deemed essential to:

Work with the person rather than doing things to the person.

It was shared that it is so important to not just focus on the "mental illness" but rather the person as a whole. One family member, with a background in mental health reinforced the need for a strength based approach and the potential of a program such as Partners in Recovery was discussed. This family member had a background in mental health and advocated for a strengths-based approach which would serve to build members' and former members' self-efficacy and acceptance that they had many skills and capabilities that they could draw on to deal with any adverse experiences that may have occurred while in Defence.

Many of the situations described in the GDs align with the notion of members and former members' illnesses being persistent and complex. Wrapping needed services around the member or former member would be advantageous.

The claims process – way too difficult

When a person has experienced significant trauma family members reported they often find it difficult to process information. Hence an 18 Claim Form from DVA is just too difficult.

If you didn't have a mental illness before completing the form, you would after.

It was suggested that the form could be in 2 parts that allow you to initially submit a claim so there is a sense that the "ball is rolling" and then completion of a more detailed form to identify eligibility. There was also reference to the need to improve the overall quality of the advocates so that they could more effectively provide the needed support and guidance for former members who were submitting claims.

Transition to civilian life

My husband was in the experimental counter terrorism training that the SAS received. They exposed soldiers to torture, my husband received a number of different terrorist torture methods. He thought initially they were training him to be tough, but now realises they were training officers to provide terrorist torture to others, using junior soldiers as their guinea pigs. There is a …. video of him on his carter course, boxing and being tested to see if they have anger problems. They revered men who could be so self-controlled that they could bury their anger deep and never express it even when being physically punished. In the end though it

backfired for my husband - they call it being a "Social Hand grenade". He finally got himself discharged from service and he went bush for years and lived disconnected, it took years to integrate into civilian life and he still hasn't really. He is extremely intelligent and physically able, so for him to have any kind of dysfunction or inability in any area of his life is unacceptable, so we have been trying to live with that and manage that the best we can. No one from the SAS suggested that he was entitled to a civilian life, only that he had failed by not having stayed in the special forces.

They find they can get well-paying jobs because they are self-reliant roles and good in roles where they have strict policies and processes to follow, they can follow orders well. But they need to be coached in tolerating others better, as they keep losing jobs.

Even though the army is a long time in the past, they can't escape it, and still live with it (memories) everyday. It is conditioned into them, the hyper vigilance, wanting people to follow orders, needing things to be lined up perfectly military style.

One of the biggest issues is the self-isolation. They (Ex-members) find security in sterile, minimal contact environments. It's very restrictive living and they can only socialise when using AOD to cope. We don't go to people's places, as these troubled veterans have no social skills, are socially very awkward. They live with massive anxiety. I too became reclusive, anxious, dependent and fearful.

All ex Defence members need to be trained to come home. They need to be slowly and gradually reintegrated. Not just discharged and assumed they will be right.

Making the transition to civilian life is difficult as the lifestyle is so different to Defence life. There was an expressed sadness and anger over the sacrifices that their family member, and indeed family had made for their country and the harsh realities of life post-Defence as a result of the mental injuries experienced while in Defence. There was a real need for more support for members, former members and their families.

Members need to be better supported before and after leaving to ensure they have made the necessary preparations (financially, mentally, socially, personally) to adjust to their new way of life. They need to get used to having to make their own decisions, realising that they do not need to be on guard all the time and knowing how to access services. There needs to be checks to see how the person and their family is adjusting and if they need assistance. If they do need assistance, there needs to be services readily available to avert crisis and or to support families that do experience crisis.

Holistic Services

Access to more holistic services were identified as proving to be very advantageous in supporting recovery.

The health retreat in QLD is the only thing that assisted him at all. It is a holistic service that allows people to recover their full sense of self through planned and structured approaches to diet, exercise and all those basics that get us back on track. They take families as well as individuals - its exercise, meditation and all holistic programs in one and its pitched at addicts. It looks at breaking down addictive behaviour, without them we would all be dead- we owe our life to them. The health retreat we sent my hubby to in Qld, cost us $15K. The health retreat is what saved all of our lives- we wouldn't be here without it. They detoxed him properly. Everyone needs this kind of health retreat, who has PTSD from the war. He had a substance abuse problem left untreated with PTSD underneath. He had to be holistically healed, it was a normalised, natural self-regulation process. It was about showing extreme empathy and non-violent ways of recovery.

You can't institutionalise them they have to sit around with other VETS and other people who suffer trauma so they recover. He said it was extremely valuable as he was put in the same mix of community as everyone else. These kinds of retreats- normalise these processes, normalise parts of recovery in life.

Unfortunately, he was meant to be there 21 days, but he lasted 10 days, as one counsellor was left wing and when he (counsellor) was talking about ISIS, my hubby had a severe 'triggering episode in relation to that topic so had to be sent home as he 'went off' and staff could not manage that whilst others were recovering.

Warm transfer – to encourage attendance at ESOs

One family member reported that even though her husband knew of available services he was reluctant to access them as he was embarrassed about his mental illness and subsequent behaviours and did not know anyone else in the local groups. It was only as a result of attending the GD in Toowoomba where he met representatives from the Mates for Mates Group that he then agreed to attend one of their meetings. This "warm greeting" paved the way for him to develop the confidence to attend. It also became apparent that this ex-member was more motivated to access support services because he had become more aware of how he was impacting his family and the ultimatum had been given by his wife:

> *"You either get help, or we are leaving. We cannot live like this anymore".*

A key learning from this was that members and former members will often seek help when they realise that this will benefit their loved ones, as they are very proud and to admit that they are not coping is very difficult to do, as they are "professional soldiers". The Defence profession is 'to serve' and not to appear to 'take, take, take" or to put their needs ahead of others. Perhaps access to support can be reframed in the Defence context as a role to continue looking after and protecting family and mates/team.

Listen to family members

> *We know our husbands, please listen when we say he is not well and do something.*
>
> *When he was unwell he could suddenly pull himself together in front of authority figures like at the hospital. We would be pleading, 'don't let him out – don't let him harm himself or us'… but he sounded articulate to the mental health triage staff when he would tell them he was not a harm to himself or others, and so they would be willing to let him go because they just saw him as drug addict and not someone with PTSD trying to medicate away his suffering. It was ludicrous.*

Sadly, there were also shared stories of wives contacting their husband's Command to inform them that he was unwell, yet no timely action was available. There was an expressed need to involve families more in the care offered to their loved ones as they often have a very good understanding of their partner's behaviours which they can share and are the main carer who plays a key role in supporting their loved ones' recovery.

Other stories were shared that family members were excluded from discussions about the well-being of their partners because their partner wished such conversations to remain confidential. This posed a major issue for families who were having to live with the consequences of a member's mental illness. Strategies need to be developed to find ways to influence members and former members to better involve their family members in their care management plans as this will increase the likelihood of sustained outcomes. However, in those situations, where a member refuses to include their family and or inform them of their situation, it would be advantageous if support was offered to the family so that they could better cope with their loved one's behaviour.

Another story related to the access to available services to support a family whose member had had several suicide attempts. This person worked full time, was caring for their adolescent daughter who was still at school and was spending on average two to three hours a day in the hospital to be with her husband. She was asked what she needed and she said a "cleaner" but this did not fit the "criteria" so she received no support. She was told that someone could be sent to offer her counselling, at considerable travel expense (traveling across Australia) but this is not what she needed even though it was more expensive than the cost of the cleaner. Flexibility in service offerings from DVA would be beneficial.

Educate the members

> *They (members) need to be advised and taught that they are going to see some trauma and that this may trigger negative emotions for them. They need to be educated in how to come down from that hypervigilant state to ---- safely come back to a place of normality, that may take months. We cannot just bumble along*

like we have done and I know they would get a longer service mode out of them if they looked after them better.

More educating for members about the experiences they will encounter when deployed and coping strategies will assist them to put in place constructive management mechanisms while deployed and back home. This will greatly benefit them and their families.

Educate the families about what to expect

They come home 'broken'. They are different and we don't know what to do.

Families and friends need to understand this is my partner and that is my emotional connection, and this cannot be replaced by another person. My life wasn't perfect, but I still had him, and that was important.

I was trying to get him help for PTSD for 10 yrs. and prior to that I was just living in the chaos, paranoia and hypervigilance that is living with someone with PTSD. I've tried to leave and I've tried at points when it's becoming damaging to all of us to kick him out, but he has nowhere to go. He is just injured mentally, so I show him compassion even though he can't show it to me. I guess I had to ask myself if he was my son or my brother, if he had any other kind of terminal illness would I abandon him? When the answer was no, I knew if we could get him to see he was an injured soldier then we might have a chance. Once I became aware it was a psychological injury, caused by his war experiences then I could deal with it better.

He was a sub mariner, so he never told me where he went. They don't receive recognition - and they aren't allowed to tell anyone where they have been for at least 20 years, so over half his life and what he did at work was a complete blank to me. I know he went to sea in a submarine - but have no idea where he went and what he did.

There were numerous references to the fact that the members and former members were different individuals as a result of their experiences, especially those who had experienced deployment. Words and phrases often used to describe their behaviour included: on edge, controlling, hypervigilant, not being able to sit still, erratic, excessive use of alcohol and drugs, being reclusive.

Some family members said that while they recognised these signs they were not prepared for the changes in behaviour, did not understand how this had happened and did not know what to do. They would have greatly benefitted from education on:

- their loved one's probable experiences
- what to expect when they returned home
- the signs and symptoms of mental illnesses and suicide
- how to have a conversation with people who are vulnerable
- available services and other support strategies.

One family member who is a former member and lost his brother who was a submariner shared an experience at a local gym where he trains that is also attended by many wives of service men. Given that these women knew of his personal military experience and loss of his brother they would open up to him as they felt they could trust him. These women shared that upon the return of their partners from home deployment they were:

Walking on egg shells, and not knowing how their loved one will respond. Fitting back in to the routine at home was very difficult, as the days were not so structured, children and wives did not necessarily follow instructions and there was no need to always be doing things and have everything in order. Domestic violence was a reality for some of these women.

This family member, who had lost his brother to suicide and also had personal military experience had been involved with the Partners in Recovery Program and assisted in developing broader social support services for people who were at risk of losing their tenancy. Given his understanding of the needs of these women he took it

upon himself to also leave several copies of the materials on the counter at the gym. It was well received and additional copies have had to be made for distribution. He pointed to this as an example of how the community at large can play a role in supporting Defence families.

Educate the Community

> *People in the community need to understand the constant disappointments for families living with someone who has PTSD. PTSD has a cycle of remorse, shame, don't mention and pretend it's all ok, wait for the things to begin to smooth over, then watch the tension build all over again. Complex PTSD, has a path of self-destruction and co destruction. It causes collateral damage to everyone close to that person.*

> *My neighbour is withdrawing - people needed to be brave (to have a conversation with us).*

> *We had all become very socially isolated, his behaviour isolated us and I hid away, as I was a bit ashamed at what was happening to us all.*

The community needs to better understand the experiences of Defence personnel so that they develop a healthier respect for the sacrifices these individuals make. This will hopefully translate into more community support and a greater willingness to proactively support returned members and their families within their local communities. Teaching community members how to have conversations with others who they see as vulnerable would be beneficial for all.

Address Stigma

Many members expressed the impact of stigma in the general community as well as Defence in people's willingness to acknowledge that they or others close to them have a mental illness. Increased awareness about the prevalence of mental illness, that it is not a sign of "weakness" and that people with a mental illness can lead fulfilling and flourishing lives needs to be promoted across the community and within Defence.

> *It is essential that more support is available for families - there needs to be less shame and more people willing to step up and ask if we are ok.*

> *They knew he was mentally ill, but no one asked him, he was just left alone. Having been a senior sniper and now not being allowed to touch a weapon was soul destroying and so very isolating. His mates were busy, but he had nothing meaningful to do. He just got sicker and he hated having to be on base. He felt that it was thought that he was a nuttier that could no longer do his job.*

> *The men need to realise that they do not lose their manhood as a result of asking for help.*

> *We need to ensure people are not bullied or victimised when they say they have a mental illness and need help.*

In relation to the above case relating to the access to weapons, the family member shared the paradox that if her husband had not shared that he had a mental illness he would have been able to touch a weapon. Hence there was a sense of being penalised for being honest.

It was also noted that sometimes family members are reluctant to seek help as they too feel embarrassed about their loved one's mental illness and or that they feel embarrassed and annoyed with themselves for not being able to offer their partner the assistance they need to recover. This latter points further emphasises the need for members and families to have improved mental health literacy and the ability to have constructive conversations about a person's behaviour, its impact on themselves and others and a range of personal and external support networks and professional services that specialise in supporting people with persistent and complex mental illness.

Children

While some participants shared that their children had received support from VVCS, there were expressed needs from other participants about needing more services available for their children. As shared by one participant:

There isn't enough for our kids. My daughter really struggled when her Dad was sick and later suicided.

Sadly, many children of serving and ex-members suffer long term consequences of living with parents who have PTSD. These consequences include difficulty in developing close and trusting relationships, mental health issues, substance abuse and anger management. Proactive marketing of available access to counselling and support services for children, including adult children would be very beneficial.

Engagement with schools

One participant reported that her school aged children were finding it difficult to live with their Dad who had PTSD and was self-harming. The schools that the girls attended were not aware of the family's situation as the family was not confident that the school would be supported. It was only after discussion with the project team about the available support services that the family seriously considered informing the school. Defence families need to be better connected with their local schools so that children receive proactive support from school counsellors.

Non-Physical Activities

Some former members due to their injuries are not able to participate in many of the physical activities offered by ESOs, which resulted in one former member feeling even more isolated and "angry" about their discharge. Realising this, a family member in attendance at one of the GDs who runs computer classes and "gaming" sessions offered former members the free use of her IT as a way of interacting with one another and learning new skills.

Accept the reality – drug use amongst submariners

We need to blow the cover that nearly all sub mariners are abusing drugs whilst within services. They are self-medicating. It's a very close brotherhood they live together in close confines under the sea for up to 6 months at a time. I wonder how there is no awareness of the slippery slope from self-medicating away trauma, to self-harm to suicidality.

… he was a sub mariner so he never told me where he went - they don't receive recognition- and they aren't allowed to tell anyone where they have been for at least 20 years - so over half his life and what he did at work was a complete blank to me. I know he went to sea in a submarine, but have no idea where he went and what he did. His history as a sub mariner is unknown to me and I don't think it was recorded that I was his wife. I would like to know his service history, so I can understand why things got so bad for him and I think it would be good to share with his daughter when she is older. He used drugs to manage his PTSD. (He later suicided).

--- was a sub mariner. He worked hard, partied hard and used drugs on the base. There was a lot of sitting around with not much to do. --- begged Mum to get him home, he was desperate to leave. We don't know what happened to him and we never will (He suicided in 2014).

The use of drugs, as identified in the above quote highlights the broad issue of needing to be transparent about existing problems within Defence so that there is a greater chance of understanding and addressing factors seriously impeding the well-being of Defence personnel. In addition, the secret nature of some postings makes it hard for families to connect and for families to understand the pressures experienced by their loved ones while in Defence.

Separated partners – access to services

There was significant concern about the fact that once families separated from their loved one, as they could no longer live together because of the former member's unacceptable behaviour, that the wife was no longer eligible for any Defence services. This was described as being "grossly unfair" given what the family had endured and that in some instances led families to "stay together" even when circumstances were exceptionally difficult and at times dangerous.

In some situations, where partners had left their partners to escape domestic violence, it was shared that they were needing to "live in their cars with their children as they had nowhere else to go". It was also reported that ex-wives were continuing to care for their ex-partners as the latter had "nowhere else to go". Support for ex-wives was strongly encouraged.

Domestic violence

> *When the ads on domestic violence came on, it was the first time my husband first identified that we had DV in our household. That ad campaign was really useful, as he finally linked it to us and what was happening with us.*
>
> *He also expects me to have that type of rigid army officer, to follow orders ---- over time he broke me down and rebuilt me into the machine he needed me to be. But because I am a woman and I retained my family ties, he didn't fully win, there were times when he was nearly successful. Luckily I had retained my sense of identity and sense of self and because of the moments I disconnected from him and left him to own his own behaviour, I regained a sense of self.*
>
> *Once he was out of the army he had a short fuse, actually no fuse, there are no moments when he can self-regulate-it's the PTSD.*
>
> *It was so confusing because I was annoyed at him for going down this path but I also loved him and knew this wasn't the person I had met.*
>
> *Domestic violence is not acceptable and we need to stop it.*

Wives shared stories relating to their experiences of domestic violence and their reluctance to leave their partner as they loved them dearly and understood that their violent behaviour was due to their Defence experience. Sadly, in some instances, when they did ask for assistance from their husband's Command they were ignored and this left the wives and in many instances their children at risk of repeated violence.

There was also a shared story of families that had "generational" Defence members and how this resulted in a refusal to identify and acknowledge the presence of PTSD and its effects on day to day living. Hence there was no support offered by family members as there was no "identified problem" even though the member was obviously experiencing difficulties. As eloquently shared by the participant:

> *As family, you put up and shut up with whatever behaviour they did - so it's a big cone of silence.*

It would be advantageous to address domestic violence within Defence. This needs to be seen as a "whole of organisation" issue with inclusion of family members who together could develop a shared understanding of the reasons behind domestic violence, its impact and effective solutions.

Learn from the positive stories of others

> *We don't hear enough stories about the others who gave others hope or who got through the worst of the PTSD and are out the other side.*
>
> *We need good positive messages.*

There is a need to show case the stories about members' and ex members' and their families who have managed to recover from PTSD. Their coping strategies, the services they accessed and the role of others around them would provide a sense of hope and direction for others who are currently experiencing the adverse effects of PTSD. These insights paint positive pictures that are often more motivating than negative messages that aim to stir guilt and remorse.

More specialist skills in mental health, especially PTSD

There was an expressed concern that the people who were in the Welfare Officer or Rehabilitation Officer roles lacked adequate mental health expertise to be able to effectively support their loved ones. As reported by one wife, who lost her husband to suicide:

Mental health is not physical health. You need different skill sets.

While it was noted that they were well intentioned, it was essential that they were skilled to address the complex mental health issues that were being experienced by members.

In addition, it was shared that psychologists needed to have a strong understanding of PTSD and the experiences of Defence personnel if they were to be able to effectively engage with Defence personnel and establish a trusting therapeutic rapport with them. Without mutual trust, any interactions would never get to the real issues underpinning a person's mental illness and potential for self-harm or suicide.

Available mental health services and safe houses

The only place we have is Emergency Services, so in desperation we send them to these poorly resourced places. We need a safe house to take them to where people understand AOD and suicidality and impulsivity.

At the local mental health service, he was told he was better off to continue with some synthetic cannabis use then go cold turkey, but that just gave him permission to keep using. Eventually he was diagnosed by the mental health service with an adjustment disorder with related AOD issues, but still there was no inpatient admissions offered. We were wanting him to have some time in rehab but had no clue how to access it all.

He was living between his car and the beach and a few mates' places. The day after my first granddaughter was born, he rang to tell me he was going to end his life. So, I got in the car and rang the mental health service for some back up advice. When I got to him, he was on the ground in a ball crying and broken. I had all the kids were in the car. It haunts me to this day that they had to see their dad and former male role model father like this. I got him to hospital and he was assessed in triage. They were going to discharge him, however I persisted and I told them all the ways he had said he would end his life if he was discharged. I explained that the AOD was his way of self-medicating against traumatic memories that would slip out now and then. However, there were no beds available, so they tried to find him a bed, but they also needed his cubicle for a physical emergency. He had to sit outside in the waiting room until an inpatient bed could be found somewhere in the state. He sat there from 9am-3pm - defeated and knowing he needed to go into hospital. By 3pm that arvo, I got frustrated as I knew he wasn't safe to come home with us and the kids. We were emotionally exhausted. My husband did later suicide. His advocate was very insensitive and said he would withdraw my husband's claim. His claim was rejected.

It was reported that there is a lack of services available to support a family member who is suicidal and has issues with substance abuse. Taking a person to emergency departments was not identified as a preferred nor long term solution and more safe houses need to be available. In addition, it was shared that once you finally get a person to agree to access a "safe house" if they don't take the opportunity when available, they lose that opportunity. Hence there is a need to be constantly working with individuals who are mentally very ill to support them to take advantage of opportunities when they arise. This further supports the need for proactive care management.

Overall, there was an expressed need to have services that matched a person's mental health and other service and support needs. Availability of this stepped care would better meet the needs of the individual.

Suicide Watch Services

A family member of a former member, who suicided in a very graphic manner, suggested there needed to be better standards and training of Command and in-house health team to manage a person on suicide watch. His son-in-law attempted suicide a number of times before being discharged. On the first occasion the member declared at the health centre he had gone as far with his planning as to purchase radiator coolant in order to suicide. He was ordered to go out to his car and get it immediately. No one accompanied him. He got the bottle from his vehicle and drank it. Apart from this there were other reports of officers being placed outside the watch house door, or hospital bedroom, to protect the person. This approach was described as being very "cold" and created a further sense of embarrassment and shame for members who had attempted suicide.

Support for Parents and Siblings of lost members to suicide

A number of participants shared that there was no or very limited services available to parents and siblings who lost their loved ones to suicide post their Defence career. There was much sadness experienced by these individuals.:

> *… their son/daughter had defended their country, put their lives on the line but when they needed support – there was nothing. They were simply forgotten. No one from the army has ever contacted them. Many families in this predicament are grief stricken.*

It's never too late to seek counselling and to change

One participant, who was also a member of the project team shared the story of her father who is a returned serviceman from World War 2. Her experience of childhood and adolescence was one she now realises was dominated by the effects of her father's PTSD as a result of his active service. Excessive use of alcohol to self-medicate to relieve the "painful memories", regular angry outbursts, walking on "egg shells to keep the peace" and avoiding certain topics so as to avoid confrontation were regular occurrences in her home. Her father never spoke of his war experiences and actively promoted non-war solutions to conflicts. It was her mother who "kept the peace" and shouldered many of the responsibilities to keep the household engaging and filled with love and support.

It was not until her father was in his mid 70s that he sought counselling through DVA that his mood altered and he became more relaxed and hospitable. It is with much gratitude that her father is still alive today at 95 and that his position as an elder statesman in her family is treasured and he is much loved by his extended family.

While her father declined to participate in this research as he shared "it (war memories) still keep me awake at night" he has learnt to live with the burden of his war duty and to lead a modest but rewarding life. Key to these outcomes have been the ability of his family to better understand the impact of PTSD, to forgive past inappropriate behaviours and contextualise current behaviours, to regularly visit him and to frequently rally to offer him support when he is unwell or in need of a task to be performed that he is unable to complete. He prefers to not dwell on the past and to avoid discussing war related issues that stir sad memories.

9. Appendix A - Group Discussions Participant Lists

The following table lists each Group Discussion that was complete in November and December 2016 and indicates the number of participants who attended each event. Key detail relating to each session is also provided.

The four types of group discussions were:

- Serving member sessions (including classification by the branch of the Defence Force, if they were regular or reservists, and if there were non-serving people attending from the community or the Department)
- Former ADF member sessions,
- Family of former ADF member sessions, and
- Health provider sessions.

Event	Date	Facilitators	Number in Attendance	Army	Navy	RAAF	Regular	Reserve	APS / Community *
Toowoomba – Ex-ADF	3/11/16	Marion Wands and Peter Long	9	NA	NA	NA	NA	NA	NA
Toowoomba – Family of Ex-ADF	3/11/16	Marion Wands and Peter Long	3	NA	NA	NA	NA	NA	NA
Kapooka - Recruits	15/11/16	Tanya Bell and Alex Stretton	13	13	NA	NA	13	NA	NA
Kapooka – Health Providers	15/11/16	Tanya Bell and Alex Stretton	16	NA	NA	NA	NA	NA	NA
Kapooka – Command/Staff	15/11/16	Tanya Bell and Alex Stretton	6	5	NA	NA	3	2	1
Sunshine Coast – Family of ex-ADF	16/11/16	Marion Wands	2	NA	NA	NA	NA	NA	NA
Wagga Wagga - Recruits	16/11/16	Tanya Bell and Alex Stretton	12	NA	NA	12	12	NA	NA
Wagga Wagga Command/Staff	16/11/16	Tanya Bell and Alex Stretton	10	NA	NA	10	10	NA	NA
Mandurah – Family of Ex ADF	16/11/16	Lisa Wood and Melody Birrell	2	NA	NA	NA	NA	NA	NA
Bunbury – Ex ADF	16/11/16	Lisa Wood and Rob	3	NA	NA	NA	NA	NA	NA

		Donovan							
Sunshine Coast – Family of ex-ADF	16/11/16	Marion Wands	2	NA	NA	NA	NA	NA	NA
Perth – ADF Members	18/11/16	Lisa Wood and Rob Donovan	14	NA	14	NA	14	NA	NA
Perth – ADF Members	18/11/16	Lisa Wood and Rob Donovan	1	NA	1	NA	1	NA	NA
Perth – Health Providers	18/11/16	Lisa Wood and Rob Donovan	9	NA	NA	NA	NA	NA	NA
Perth – Command/Staff	18/11/16	Lisa Wood and Rob Donovan	15	NA	15	NA	15	NA	NA
Perth – Health Providers	18/11/16	Lisa Wood and Rob Donovan	1	NA	NA	NA	NA	NA	NA
Ipswich - Family of Ex-ADF	20/10/16	Marion Wands	1	NA	NA	NA	NA	NA	NA
Ipswich - Ex-ADF	20/10/16	Marion Wands	1	NA	NA	NA	NA	NA	NA
Brisbane – ADF Member	22/11/16	Peter Long and Larisa Karklins	10	10	NA	NA	10	NA	NA
Brisbane – Health Providers	22/11/16	Peter Long and Larisa Karklins	16	NA	NA	NA	NA	NA	NA
Brisbane – Command/Staff	23/11/16	Peter Long and Larisa Karklins	12	12	NA	NA	11	1	NA
Canberra – Health Providers	24/11/16	Marion Wands and Peter Long	8	NA	NA	NA	NA	NA	NA
Sydney – JHU/Single Service Health Command	25/11/16	Marion Wands and Peter Long	14	4	NA	NA	4	NA	10
Ipswich – ADF Members	29/11/16	Lisa Wood and Alex Stretton	7	NA	NA	7	5	2	NA
Ipswich – Command/Staff	29/11/16	Lisa Wood and Alex Stretton	2	NA	NA	2	2	NA	NA
Townsville – Ex-ADF	29/11/16	Peter Long and Larisa Karklins	7	NA	NA	NA	NA	NA	NA
Townsville – Family of Ex-ADF	29/11/16	Peter Long and Larisa Karklins	1	NA	NA	NA	NA	NA	NA
Townsville - Command	30/11/16	Peter Long and Larisa Karklins	21	20	NA	1	21	NA	NA
Townsville – Health Providers	30/11/16	Peter Long and Larisa Karklins	11	NA	NA	NA	NA	NA	NA

Townsville – ADF Members	30/11/16	Peter Long and Larisa Karklins	17	17	NA	NA	17	NA	NA
Canberra – OCDTS Male	2/12/16	Marion Wands and Peter Long	10	2	5	3	10	NA	NA
Canberra - JHC Mental Health Advisory Group	2/12/16	Marion Wands and Peter Long	17	NA	NA	NA	NA	NA	NA
Canberra -OCDTS Female	2/12/16	Marion Wands and Peter Long	5	2	1	2	5	NA	NA
Canberra – ADFA Command/Staff	2/12/16	Marion Wands and Peter Long	12	1	4	6	11	NA	1
TOTAL			**290**	**86**	**40**	**43**	**164**	**5**	**12**