3. Surveys – Preliminary Results

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

National Mental Health Commission

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Abbreviations

Abbreviation	Definition
ADF	Australian Defence Force
AIHW	Australian Institute of Health and Welfare
CHF	Consumer Health Forum (of Australia)
DVA	Department of Veterans Affairs
ESO	Ex-Service Organisations
PTSD	Post Traumatic Stress Disorder
RSL	Returned & Services League
TWRP	Transition and Wellbeing Research Program
VVCS	Veterans and Veterans Families Counselling Service

Executive Summary

The National Mental Health Commission (the Commission) was tasked by the Australian Government to conduct a review of suicide and self-harm prevention services available to serving and ex-serving members of the Australian Defence Force (ADF) and their families. As a part of data collection, a survey of experiences of care of current and former ADF members and family members was conducted, along with a brief survey of service providers. This Report presents the results of those surveys. Respondents were representative of the Defence population, and a cross-section of forces (Army, Navy and Air Force) responded. The data gathered through the surveys of current and former members, family of current and former members and service providers provides a valuable complement to the findings elucidated in other components of this review.

Whilst overall, more than half of the respondents indicated having ever sought support or treatment for a mental health problem and/or suicidal and self-harm behaviour, less than half had received treatment for mental health related issues in the preceding 12 months, suggesting that a substantial number of people may not be seeking or accessing support when it is needed. Resonating strongly with findings from other elements of this Review, the most common reasons for not seeking support among current serving members related to the perceived adverse impact on their defence career (including deployment), along with a cluster of reasons relating to stigma associated with having a mental health problem or seeking help. Stigma around help seeking was also a commonly articulated reason among former ADF members, along with feeling that their health professional would not understand. This is congruent with comments frequently articulated in the key informant interviews and group discussions with former members and families about services that may often not adequately understand the unique and complex confluence of factors influencing mental health and wellbeing among veterans and their families.

The survey included a series of questions about people's experiences of care and treatment. Of those who had received treatment, services were generally rated positively, however there was considerable variation at the level of individual service types, and also variation in response between current and former members and families. This variability highlights the imperative to recognise the heterogeneity of service access and experiences, and the need to take into account client experiences of care in identifying service gaps and areas for improvement.

All survey respondents were asked their perceptions on the effectiveness of a number of services available in Australia to current or former members and/or their families. Again, there was considerable variability across the responses for each service type, but of concern is the fact that overall, existing services were more likely to be rated as low effectiveness rather than high. The lowest rated services across all survey respondent groups were mental health and/or suicide prevention support programs, PTSD treatment services and support for families. Again, these survey findings empirically mirror many of the themes that have emerged elsewhere in this Review, and highlight gaps warranting attention.

1. Introduction

1.1 Review of Suicide and Self-Harm Prevention Services for Australian Veterans and Defence Force members

The National Mental Health Commission (the Commission) was tasked by the Australian Government to conduct a review of suicide and self-harm prevention services available to serving and ex-serving members of the ADF and their families. The Prime Minister announced the Review on 11 August 2016.

The terms of reference for this Review focused on six specific issues:

1. The incidence of suicide among serving and former serving ADF members compared to the broader Australian community.
2. The range of services available to current and former serving members and their families.
3. The effectiveness of these services in supporting members and their families while they serve, as they transition from Defence to civilian life, and later in their civilian life.
4. Any duplication or gaps in current services and how they might be addressed.
5. Any barriers to current and former serving members accessing services, considering cultural relevance, availability of providers, employment, functional capacity and degree of ill health.
6. The extent to which former serving members utilise services provided by other parts of government, ex-service organisations, the private sector or non-government organisations

A mix of qualitative and quantitative data collection processes were used to inform the Review findings and recommendations. As a part of data collection, a survey of experiences of care of current and former ADF members and family members was conducted, along with a brief survey of service providers. The questionnaires were accessible through the Commission website.

This Report presents the preliminary results of those surveys.

1.2 Survey Methodology

Survey construction - current and former members/family members

A core survey for current and former ADF members and family members of current and former ADF members was designed in collaboration with the Commission and with input from both the ADF and DVA. The input of the two departments was particularly valuable in ensuring the accuracy of references to services and programs. The survey for current and former members and family of current or former members focussed on four main areas pertaining to services relating to mental health, self-harm and suicide prevention, with minor adaption of question wording and services appropriate to each of the target groups:

1. Perceived effectiveness at a local level of a list of ADF, DVA and other services.
2. Direct experiences of ADF (current) / DVA and ESO (former) mental health and suicide and self-harm prevention services.
3. Direct experience with private and public general community services.
4. Direct experience with services provided to someone close to the respondent who may have a mental health need.

Copies of each survey are available upon request.

Capturing Experiences of Care

In designing the survey for current and former members and their families, a set of questions was included to capture people's experiences of the health care system and services (CHF, 2014). In contrast to common forms of evidence about health services and health care system performance (such as patient satisfaction ratings, unit cost measures, clinical safety or errors), consumer experiences of care can provide detailed 'whole of system' narratives and assessments of healthcare and health outcomes (CHF, 2014).

Experiences of care surveys for mental health care consumers first started to be used in the 1990s to better measure the effect of stigma and discrimination and to gain an understanding of experiences of mental health services from the consumer's perspective. This type of survey was first used in Australia by the Mental Health Council of Australia in 2003 (Groom, Hickie et al, 2003). The MHCA again undertook large community surveys of experiences of care in 2004-5 (MHCA, 2005), and this was repeated by Mendoza et al (2013) using a similar instrument. The surveys used in these works were modelled on the pioneering work of the Picker Europe and Picker Institute USA and principles of patient-centred care, and compared the 'lived experience' with the standards set out in national policy frameworks.

Advocacy by mental health consumers saw a commitment under the Fourth National Mental Health Plan (2009-14) to develop, evaluate and implement a national Consumer Experiences of Care Survey instrument. That instrument has been developed and evaluated but was unfortunately not available for this Review. As such, for this aspect of the Review, a short experience of care survey was developed based on the draft national consumer survey and the earlier work. The aim of the survey was to provide the Review with data to contribute to a broader understanding of the quality, accessibility and effectiveness of mental health and suicide prevention services available to serving and former Defence personnel and their families, and to produce evidence relevant to strategic decision-making.

The questionnaires for this Review were internally tested to ensure the logic worked correctly and that the questions were easy to understand and navigate. Time limitations precluded the pre-testing of surveys with the target audiences.

Service Provider Survey

Organisations providing services for current or former ADF members of their families had the opportunity to complete a complementary survey to elicit their feedback on the perceived effectiveness of services currently available. This survey assessed service providers' perceptions of effectiveness at a local level of the same list of ADF, DVA and other services. This measure of effectiveness used a five point scale.

Recruitment

A number of strategies were employed to recruit survey participants from among current and former ADF members and family members who had experience with services in relation to mental health problems, self-harm and suicide prevention. Flyers about the survey were given to participants in the group discussions, the Commission promoted the surveys through a range of relevant networks, and a number of organisations with members in the veteran community promoted the survey on their websites. The survey was open from November 11 to November 25.

The service provider questionnaire was also promoted through the Commission website and via the flyer distributed in group discussions.

Number of respondents

The number of respondents by respondent category who partially or fully completed their questionnaire is displayed in Table 1. These numbers are derived from the number of respondents who completed at least the first section of the survey on demographic information.

TABLE 1 NUMBER OF RESPONDENTS

Survey	Number of Respondents
Current Members	778
Former Members	1557
Family of Current Members	128
Family of Former Members	175
Service Providers	114
Total	**2752**

Limitations and Cautionary Notes.

It is important to note here the number of studies and surveys that the ADF and veteran communities have been asked to be involved in over recent years, and that potential respondents may have been experiencing survey fatigue at the time of this survey. For example, a major study involving thousands of individuals over an extended period has recently been completed: the 'Transition and Wellbeing Research Program' (TWRP). This study assesses a range of issues to do with deployment, number of deployments, time deployed, and timing of leaving the ADF in relation to deployments, plus a host of mental health and suicide ideation and behavioural measures. It is a comprehensive and exhaustive study. Consequently, the project team were mindful of the scope of this work, the limitations on this new work and careful to ensure that this survey in the limited time available, complemented the TWRP.

Nevertheless, the sample sizes achieved in the various categories, along with the consistency of data patterns across and within these samples, suggest that the data can be considered reliable in terms of reflecting the most frequently experienced issues and their implications.

2. Sample characteristics

2.1 Comment on analyses

Percentages in the data tables are calculated from the total 'n' value indicated in the table headers. These values represent the total number of respondents who completed at least the initial demographic section of the survey. Commentary in the text explains percentages calculated from responses to individual questions where these differ from the total sample (e.g., excluding non-responses to specific questions).

2.2 Demographics and personal characteristics of current and former members/family members

Respondents were asked a series of demographic based questions, in order to ascertain an understanding of particular characteristics of respondents, and to enable comparisons with public data on the general population. Respondent characteristics are shown in Tables 2 – 7 for each of the four survey groups.

Table 2 shows that the gender distribution of current members (74% male) was generally representative of the ADF Census data: 79% male (Department of Defence, 2015). Former member respondents were predominantly male (90%), whereas family respondents were predominantly female (91% current; 83% former).

TABLE 2 GENDER

Gender	% Current Members (n = 778)	% Former Members (n = 1557)	% Family of Current Members (n = 128)	% Family of Former Members (n = 175)
Male	73.7	90.6	7.0	15.4
Female	26.2	9.2	91.4	83.4
Non-Gender Defined	0.1	0.3	1.6	1.1
Total	100.0	100.0	100.0	100.0

Not unexpectedly, Table 3 shows that current members and family respondents were younger than former members and family respondents. The age distribution for serving members appears somewhat older than Defence Census data (Department of Defence, 2015), which showed the largest segment of permanent ADF members was in the category 25-29 years.

TABLE 3 AGE

Age	% Current Members (n = 778)	% Former Members (n = 1557)	% Family of Current Members (n = 128)	% Family of Former Members (n = 175)
15 – 24	5.8	0.1	4.7	1.1
25 – 34	27.0	3.3	32.8	8.6
35 – 44	29.8	9.0	31.3	27.4
45 – 54	26.7	15.0	18.8	22.9
55 – 64	9.9	19.4	8.6	23.4
65 – 74	0.8	43.3	3.9	13.7
75 – 84	0.0	8.5	0.0	2.9
85 – 94	0.0	1.4	0.0	0.0
95 – 104	0.0	0.0	0.0	0.0
105 and over	0.0	0.0	0.0	0.0
Total	100.0	100	100.0	100.0

Table 4 shows that the survey captured a reasonable number of respondents in each of the force arms within ADF, although the relative proportions differed markedly across respondent type, and differed from Defence Census data (Department of Defence, 2015) on current serving members: 56% Army, 25% Navy and 19% Air Force. In this survey, the proportion of current member respondents in the Army was somewhat lower than Defence census data (43%), the proportion of survey respondents from Navy was almost identical to Defence census data (24%), and the proportion in Air Force higher (33%). It is noted that approximately two thirds of family respondents were associated with Army.

TABLE 4 FORCE ARM

Force Arm	% Current Members (n = 778)	% Former Members (n = 1557)	% Family of Current Members (n = 128)	% Family of Former Members (n = 175)
Army	42.5	41.2	67.2	62.9
Navy	24.0	41.9	16.4	16.6
Air Force	33.4	16.9	16.4	20.6
Total	100.0	100.0	100.0	100.0

Table 5 shows that apart from Family of current members (37%), approximately half of each respondent group reported serving for 16 + years, with approximately 40% of current members and family of former members reporting 'more than 21 years' of service.

TABLE 5 YEARS SERVED

Years Served	% Current Members (n = 778)	% Former Members (n = 1557)	% Family of Current Members (n = 128)	% Family of Former Members (n = 175)
Less than 2 years	3.7	2.5	9.4	4.0
2-5 years	8.0	12.1	18.0	12.6
6-10 years	19.8	21.9	24.2	16.6
11-15 years	15.7	13.2	10.9	16.6
16-20 years	14.7	19.1	11.7	9.1
More than 21 years	38.2	31.3	25.8	41.1
Total	100.0	100.0	100.0	100.0

Table 6 shows that this sample was representative of the Aboriginal and Torres Strait Islander population, with between 1.5% and 4.0% being Aboriginal and between 0.4 and 0.6% being both Aboriginal and Torres Strait Islander. 2015 Defence Census data shows 2.3% of permanent members are Aboriginal and Torres Strait Islander.

TABLE 6 ABORIGINAL AND/OR TORRES STRAIT ISLANDER

Aboriginal and/or Torres Strait Islander	% Current Members (n = 778)	% Former Members (n = 1557)	% Family of Current Members (n = 128)	% Family of Former Members (n = 175)
Yes, Aboriginal	1.5	1.5	3.1	4.0
Yes, Torres Strait Islander	0.0	0.1	0.0	0.6
Yes, both Aboriginal and Torres Strait Islander	0.4	0.3	0.0	0.6
No	98.1	98.1	96.9	94.9
Total	100.0	100.0	100.0	100.0

Table 7 shows that the vast majority of former members (86%) and both current (94%) and former (88%) family respondents did not live alone. Three-quarters of current members did not live alone. In Australia, of the 7.8 million households, 24% were lone-person households (AIHW, 2014).

TABLE 7 LIVING ALONE

Living Alone	% Current Members (n = 778)	% Former Members (n = 1557)	% Family of Current Members (n = 128)	% Family of Former Members (n = 175)
Yes	24.6	13.5	6.3	12.0
No	75.4	86.5	93.8	88.0
Total	100.0	100.0	100.0	100.0

Current members and family of current members were asked if they were a full-time member or reservist, and family of current members were asked if they were associated with a full-time member or reservist. Census data (Department of Defence, 2015) had 61% permanent members, 18% reservists, and 21% APS employees. Results of this survey were similar, though there was a higher rate of full-time members (Table 8).

TABLE 8 FULL TIME OR RESERVIST?

Full time or reservist	% Current Members (n = 778)	% Family of Current Members (n = 128)
Full-time member	78.9	71.1
Reservist	19.2	2.3
Other (please specify)	1.9	2.3
No response	0	24.3
Total	100.0	100.0

Current members and family of current members were also asked if they had any plans to leave. The majority of respondents indicated that they did not have any intention of leaving the ADF in the next 12 months, though 15.0% said they did (Table 9). This is comparable to the annual discharge rate, which is approximately 11-12%.

TABLE 9 PLANS TO LEAVE IN NEXT 12 MONTHS

Plans to Leave	% Current Members (n = 778)	% Family of Current Members (n = 128)
Yes	15.0	9.4
No	67.9	73.4
Not sure/Can't say	17.1	17.2
Total	100.0	100.0

Former members and family of former members were asked if they had transitioned out of service in the past two years. Most had not, though almost a quarter of family of former members had (Table 10).

TABLE 10 TRANSITIONED OUT

Transitioned Out	% Former Members (n = 1557)	% Family of Former Members (n = 175)
Yes	8.9	24.0
No	91.1	76.0

Total	100.0	100.0

2.4 Characteristics of service providers

A total of 114 service providers responded to the survey. Almost half were private providers of specialist treatment for current or former serving members or their families, with a further 18% from an Ex-Service Organisation (ESO) (Table 11).

The vast majority of service providers (82% - 91%) provided services to each of the service arms (Table 12). Most providers supported current and former members, and family of current and former members (Table 13), and most had up to 10 staff members (60%) (note that respondents could select more than one response for Table 12 and Table 13).

TABLE 11 DESCRIPTION OF SERVICE

Description	% (n = 114)
Private provider of specialist treatment	49.1
Public provider of specialist treatment	11.4
General Practitioner	1.8
Ex Service Organisation	18.4
Non-government community service provider	5.3
Human services agency other than health	0.9
ADF/DVA/Health policy maker or advisor	2.6
Mental health or suicide prevention research or evaluation	1.8
Other (please specify)	8.8
Total	100

TABLE 12 FORCE ARM SERVICE SUPPORTS

Force Arm	% (n = 114)
Army	91.2
Navy	82.5
Air Force	82.5
Other	17.5

TABLE 13 CLIENT SERVICE SUPPORTS

Client	% (n = 114)
ADF current members	77.2
ADF former members	73.7
Family of current ADF members	50.0
Family of former ADF members	59.6
Don't know / Unsure	3.5
Other (please specify)	4.4

The most commonly provided services included Allied Health Care (43%), specialist health providers (34%), information and support (27%) and case management (25%) (Table 14). Respondents could select more than one response.

TABLE 14 TYPES OF SERVICES

Service	% (n = 114)
Primary Health Care	19.3
NDIS - Disability Services	3.5
Allied Health Care	43.0
Specialist Health provider	34.2
Housing	6.1

Transport/Accessibility	7.0
Education services	11.4
Cultural and social services	8.8
Employment services	4.4
Case Management	24.6
24/7 Crisis Telephone / internet service	6.1
Information and support	27.2
Other health care	4.4
Other (please specify)	22.8

As shown in Table 15, approximately one third reported funding from ADF and one third reported funding from DVA. Almost two thirds of services (65%) received clients through direct access, with almost 60% via a referral from a health provider.

TABLE 15 FUNDING SOURCES OF SERVICES

Funding	% (n = 114)
ADF	34.2
DVA	34.2
Not DVA or ADF	35.1
Not applicable	11.4
No response	1.8

TABLE 16 PRIMARY POINTS OF ACCESS

Type	% (n = 114)
Referral from ADF	45.6
Referral from DVA	28.9
Referral from Health provider	58.8
Direct access - self referral	64.9
Other (please specify)	17.5

3. Key Findings

Each survey covered a range of topics including:

- Respondent's Health,
- Inhibitors of seeking support,
- Experiences of care, including services used and experiences of that treatment, and
- Views on effectiveness of particular services.

Each of these areas will be discussed in turn. It is important to note that participants could leave the survey at any time, therefore those who did not respond to a question most likely left the survey (as responses were required for the majority of questions before respondents could proceed to the next question).

3.1 Health

Respondents were asked to rate their health from 'poor' to 'excellent' on the five-point scale shown in Table 17. A number of respondents dropped off the survey at this point and discontinued answering questions. For current members, this was 16.7%, former members 20.2%, for family of current members 25.0%, and for family of former members 41.1%. Updated 'n' values of remaining participants are in the header row.

Over 60% of the current members reported having 'good', 'very good' or 'excellent' health, whilst just over 30% of current members felt that they had 'fair' or 'poor' health. Among former members, the proportion indicating 'good', 'very good' or 'excellent' health was considerably lower (43.6%) and over 50% of former members felt that had 'fair' or 'poor' health (Table 17). Of the responding family of current and family of former members, over 30% rated their health as 'fair' or 'poor'. In each of the survey respondent categories, the proportion of people indicating their health to be 'fair' or 'poor' was higher than the general population, were 14.6 % rate themselves as having fair/poor health (PHIDU, 2011-13). It is important to note however that there was a significant number of people who did not respond to this question, so these proportions need to be interpreted with caution.

TABLE 17 SELF-REPORTED HEALTH

Health	% Current Members (n = 648)	% Former Members (n = 1243)	% Family of Current Members (n = 96)	% Family of Former Members (n = 103)
Poor	9.6	16.9	6.3	14.6
Fair	24.7	39.3	31.3	31.1
Good	32.7	29.5	37.5	36.9
Very good	26.9	12.1	21.9	14.6
Excellent	6.2	2.2	3.	2.9
Total	100.0	100.0	100.0	100.0

Respondents were more likely to be satisfied with their health than not satisfied (Table 18), and across the sample, around approximately half reported they had 'good' or 'very good' quality of life (Table 19).

TABLE 18 SATISFACTION WITH HEALTH

Satisfaction	% Current Members (n = 648)	% Former Members (n = 1243)	% Family of Current Members (n = 96)	% Family of Former Members (n = 103)
Very Dissatisfied	7.4	15.4	7.3	10.7
Fairly dissatisfied	23.9	25.7	25.0	26.2
Neither satisfied or dissatisfied	18.5	24.8	22.9	27.2
Satisfied	41.2	30.3	40.6	33.0
Very satisfied	9.0	3.8	4.2	2.9
Total	100.0	100.0	100.0	100.0

TABLE 19 QUALITY OF LIFE

Quality	% Current Members (n = 648)	% Former Members (n = 1243)	% Family of Current Members (n = 96)	% Family of Former Members (n = 103)
Very Poor	2.3	6.8	2.1	5.8
Poor	14.7	17.8	12.5	11.7
Neither good nor poor	20.5	27.5	12.5	37.9
Good	46.0	37.2	60.4	34.0
Very good	16.5	10.6	12.5	10.7
Total	100.0	100.0	100.0	100.0

3.2 Inhibitors of seeking support

Respondents were asked whether they had 'ever sought support, care or treatment for a mental health problem or suicidal thinking or behaviour'.

More than half of current and former members had 'ever sought support' for a mental health problem and/or suicidal thinking or behaviour (Table 20). This is considerable higher than reported in the ADF Mental Health Prevalence and Wellbeing Study (2010), which stated that in the previous 12 months, 17.9% of ADF members sought help for stress, emotional, mental health or family problems. However, it is important to note that the survey for this Review particularly targeted people who had experiences of services. Around two thirds of family members responding to the survey had also sought support.

TABLE 20 SOUGHT SUPPORT FOR A MENTAL HEALTH PROBLEM AND/OR SUICIDAL THINKING OR BEHAVIOUR

Sought support	% Current Members (n = 648)	% Former Members (n = 1243)	% Family of Current Members (n = 96)	% Family of Former Members (n = 103)
Yes	62.8	63.6	60.4	74.8
No	37.2	36.4	39.6	25.2
Total	100.0	100.0	100.0	100.0

Those who answered 'no' to the question about seeking support were then presented with the list of 'reasons' (as shown in Table 21) and asked to rate the importance of these as a reason for not seeking support on a 5-point scale where 1 = not important, 5 = extremely important. Percentages in Table 21 are calculated out of those who had answered 'no', and therefore those who were provided the question (rather than calculating from the total sample). 'Low' is anyone who rated that reason as 1 or 2, and 'High' is anyone who rated that reason 4 or 5, shown in Table 21. Respondents were asked to rate each item.

It is important to note here that that 7.9% of current members, 9.5% of former members, 2.6% of family of current members, and 23.0% of family of former members did not provide a response to this question. Furthermore, respondents could choose not to rate a particular reason, or they could select 'N/A'. Therefore, percentages depicted are of those who rated each reason only, and excluding those who did not respond or selected 'N/A'. The 'n' value in the header row is the total amount who responded to at least one of the services. Remaining respondents are those who would have selected "3" as their rating, indicating they had a neutral position on its effectiveness.

Given the small number of responses for family members who actually rated each reason (less than 5 for family of former and less than 10 for family of current), these percentages will not be reported, and it is noted that the majority of those who did respond to this question selected 'N/A' for each response.

The reasons most often rated as important were both specific to the impact on defence career or service, namely, that it 'would harm their career or career prospects', followed by the thought that it would 'prevent deployment' (Table 21). Of relevance to this Review, the third, fourth and fifth most highly ranked reasons among current members in this survey suggest that mental health stigma is a major barrier, along with feeling embarrassed, feeling worse about one's self, and the fear that people would see them differently.

TABLE 21 REASONS FOR NOT SEEKING SUPPORT

	% Current Members (n = 222)	% Former Members (n = 410)
Reason	**High (Low)**	**High (Low)**
I wouldn't know where to get help	10.1 (70.3)	38.3 (37.4)
I would have difficulty getting time off work	21.9 (61.9)	30.8 (58.0)
It would harm my career or career prospects	49.1 (32.2)	36.9 (47.0)
It would be difficult to get an appointment	27.2 (53.7)	23.1 (51.6)
People would see me differently	40.6 (37.6)	41.6 (37.6)
It would stop me from being deployed	47.9 (35.5)	31.5 (59.6)
I don't trust mental health professionals	19.0 (60.1)	31.1 (44.9)
I feel that they wouldn't understand problems related to my veteran and military experience	20.5 (59.6)	48.0 (34.8)
It is too expensive	16.1 (67.8)	38.8 (44.1)
Most of what would happen if I sought treatment for a mental health issue would be beyond my control	31.7 (45.5)	40.6 (35.7)
I would feel inadequate if I went to a mental health professional for psychological help	24.0 (59.9)	36.2 (41.7)
I would feel embarrassed if I had a mental health problem	32.4 (48.0)	42.0 (37.4)
I would feel worse about myself if I could not solve my own problems	35.2 (46.6)	51.3 (27.4)
People with a mental health problem could snap out of it if they wanted to	3.8 (87.3)	13.7 (73.9)
If I sought mental health treatment from a professional, I might feel worse	13.3 (66.9)	27.5 (51.0)
I would worry that seeking treatment might lead to me losing control of my emotions or reactions	18.1 (65.7)	36.4 (44.0)

The reason for not seeking help that were most often rated as not important were that people with a mental health problem 'could snap out of it if they wanted to'.

A number of barriers to help seeking identified in this survey are consistent with the results of the ADF Prevalence and Wellbeing Study (2010), which indicated the highest rated reasons for not seeking help were the thought that it would prevent deployment, followed by the thought that it would harm their career or career prospects. A high proportion of former members also rated these highly, with nearly one third of former members indicating that they would feel worse about themselves if they couldn't solve their own problems.

3.3 Agencies support sought from

Former members and family of former members were asked if they had sought assistance from a list of service agency categories in the previous 12 months, and could pick more than one response. Slightly more than one third of respondents indicated that they hadn't needed any assistance.

Of those who has sought support from one of the organisations in the listed categories, DVA was the most common of these for both former members and family of former members. The second most commonly accessed service was VVCS (13%) for former members and 27% for families of former members) (Table 22). Of mainstream services (i.e. not Defence specific), Centrelink was the most likely to have been used.

TABLE 22 TYPES OF SERVICES ASSISTANCE WAS SOUGHT FROM IN PREVIOUS 12 MONTHS

Agencies	% Former Members (n = 1557)	% Family of Former Members (n = 175)
No I did not need any assistance	37.4	38.3
DVA	43.4	31.4
VVCS	13.5	26.9
Defence Housing Australia	1.2	1.1
Centrelink	10.9	17.1
Public housing	0.8	2.3
NDIS or Disability services	1.3	2.3
Job Access	0.7	1.1
Disability employment services	0.9	1.1
Defence Community Organisation	2.7	5.1
Career Transition Assistance Scheme	1.0	0.6
Other (please specify)	11.2	11.4
No response	2.9	7.4

3.4 Use of treatment services

All respondents were asked the following: "have you received treatment or support for a mental illness and/or suicidal and self harm behaviour, in the last 12 months?". As shown in Table 23, around one third of current and former members indicated that they had received treatment or support in the last 12 months, whilst the numbers for family where slightly lower and less than one quarter. As noted earlier, the number who had received treatment was higher than that observed in a previous ADF survey (Mental Health and Wellbeing Prevalence Study, 2010), as this survey reflecting the intentional emphasis for this survey on recruiting people with experiences of services.

It is important to note that there were quite a large number of people who did not respond to this question (see No response row in Table 23). For example, just under one half of current members indicated that they hadn't received treatment or support in the last 12 months, but nearly 20% did not respond. Unfortunately, the way the question was worded does not elucidate reasons for non response, but this plausibly could include:

- Not needing support or treatment,
- Needing support or treatment but not seeking support, or
- Needing support or treatment but not seeking treatment.

Respondents could have also exited the survey at any time, and therefore those who had dropped out of the survey and did not provide a response, are reported under "No response".

TABLE 23 RECEIVED TREATMENT FOR A MENTAL ILLNESS AND/OR SUICIDAL AND SELF HARM BEHAVIOUR, IN THE LAST 12 MONTHS

	% Current Members (n = 778)	% Former Members (n = 1557)	% Family of Current Members (n = 128)	% Family of Former Members (n = 175)
Yes	32.1	33.2	22.7	22.3
No	48.7	44.0	51.6	33.1
No response	19.1	22.9	25.8	44.6
Total	100.0	100.0	100.0	100.0

The subsample who responded that they had received treatment or support in the last 12 months, they were then asked a series of questions in regards to their service use.

The first of these questions about service experiences asked current members if they were a client of either an ADF or non ADF service relating to mental health and/or suicide and self harm concern. Family of current members were asked these questions in regards to general mental health services (See table 24). Former members were asked if they accessed services using their DVA card or not using their card (Table 24). It is important to note here that non-ADF services, and services used by former members using their card or not using their card are external to ADF, and therefore, ADF have no control over. These results are provided side by side for ease of comparison.

TABLE 24 ACCESSING MENTAL HEALTH SERVICES

	% Current Members (n = 250)		% Former Members (n = 517)	
Access	ADF	Non-ADF	Using Card	Not Using Card
Yes	50.0	50.8	72.3	37.3
No	50.0	46.4	27.7	57.6
No response	0.0	3.2	0.0	5.2
Total	100.0	100.0	100.0	100.0

The following results relate only to those respondents who indicated that they had received treatment or support in the last 12 months. Given the small numbers of those who had utilised services or responded to these questions, results should be interpreted with caution. From Table 25 onwards, results are displayed in terms of those who had used services (answered "yes" to questions in both Table 23 and Table 24). The 'n' values in the table header indicates the number of respondents who had used services. Given the small numbers of people among family of current members who have received treatment (n=29) and family of former members (n=39), the individual question percentages are not reported for this group. However, patterns observed in the responses will be reported.

Please note that for the question displayed in Table 25, the response option "I have never been in contact with mental health services", was only asked for current members in relation to the use of ADF services. This is because a member could be a client of ADF services through a referral through ADF, but may not have utilised them or been in contact with them (i.e., not made any appointments).

As evident in Table 25, the majority of current members who had received treatment in the last 12 months indicated that they had been in contact with services for either one year or less, or one to five years. A similar pattern was observed among members of current serving members. Conversely,

almost half of former members using their DVA card to access services have been in contact for more than five years, though more than half of those not using their card have been in contact with services for either one year or less or one to five years.

TABLE 25 LENGTH OF TIME IN CONTACT WITH MENTAL HEALTH SERVICES

	% Current Members (n = 250)		% Former Members (n = 517)	
Time	**ADF (n=125)**	**Non-ADF (n=127)**	**Using Card (n=374)**	**Not Using Card (n=193)**
One year or less	47.2	45.7	17.9	23.8
One to five years	43.2	42.5	29.1	36.8
More than five years	4.8	10.2	48.7	26.4
Don't know/ Can't remember	0.8	1.6	2.9	13.0
I have never been in contact with mental health services	1.6	N/A	N/A	N/A
No response	0.2	0.0	1.3	0.0
Total	100.0	100.0	100.0	100.0

Around two thirds of current members who had used ADF services felt they were able to find a health professional "to talk to about [their] concerns" either ""or "to some extent", and this was consistent for non-ADF services and family of current members (Table 26). These findings are congruent with findings from community surveys of the general population presented in *Obsessive Hope Disorder (*Mendoza et al., 2013), which indicated that 86% were able to find a health professional to talk about their concerns. Former members had slightly higher proportions of respondents for services where they could use their DVA card, though this was lower when not using their DVA card. Family members had slightly lower rates, with almost 20% of family of current members who had used services stating that they could only find a health professional 'a little'.

TABLE 26 FIND A HEALTH PROFESSIONAL TO TALK TO ABOUT CONCERNS

	% Current Members (n = 250)		% Former Members (n = 517)	
Response	**ADF (n=125)**	**Non-ADF (n=127)**	**Using Card (n=374)**	**Not Using Card (n=193)**
Yes, definitely	51.2	50.4	57.0	37.8
Yes, to some extent	24.8	22.8	22.7	24.9
Yes, a little	16.8	15.0	14.7	15.5
No	4.0	6.3	3.5	16.1
I had no concerns	0.8	0.0	0.0	2.1
Not sure/Can't say	0.0	5.5	0.8	3.6
No response	0.2	0.0	1.3	37.8
Total	100.0	100.0	100.0	100.0

More than half of all respondents who had received treatment in the last 12 months felt they had adequate access to services ('always' or 'nearly always') (Table 27). This is higher than community surveys of the general population presented in *Obsessive Hope Disorder* (Mendoza et al., 2013), which indicated that less than half (43%) of respondents who had used services felt that they could access adequate services for their mental health problem 'always' or 'nearly always'. Results were similar for former members and family members. However, almost 40% of family of current members indicated they only had access 'sometimes'.

TABLE 27 ACCESS TO SERVICES

	% Current Members (n = 250)		% Former Members (n = 517)	
Access	ADF (n=125)	Non-ADF (n=127)	Using Card (n=374)	Not Using Card (n=193)
Always	27.2	22.8	37.2	24.9
Nearly always	35.2	37.8	30.2	29.0
Sometimes	20.0	28.3	17.1	25.4
Not often	13.6	7.9	9.6	15.5
Never	0.8	0.0	1.3	3.1
Not sure/Can't say	0.8	3.1	3.2	2.1
No response	0.2	0.0	1.3	0.0
Total	100.0	100.0	100.0	100.0

The survey asked respondents who had used a service relating to mental health or suicide in the last 12 months to rate these on a 6 point scale, from very poor through to excellent. Overall, almost one third of current members rated their treatment as 'fair' or 'poor', and this was closer to 40% among former members not using a DVA card (Table 28).

TABLE 28 HEALTH CARE RATING FOR TREATMENT IN PREVIOUS 12 MONTHS

	% Current Members (n = 250)		% Former Members (n = 517)	
Rating	ADF (n=125)	Non-ADF (n=127)	Using Card (n=374)	Not Using Card (n=193)
Excellent	17.6	17.3	24.6	13.5
Very good	18.4	28.3	31.6	29.0
Good	24.8	22.8	21.7	26.4
Fair	16.8	21.3	11.5	13.5
Poor	13.6	8.7	4.8	11.4
Very poor	6.4	1.6	4.5	6.2
No response	0.2	0.0	1.3	0.0
Total	100.0	100.0	100.0	100.0

Roughly three quarters of current members who had used services felt that they were 'always' or 'nearly always' treated with respect and dignity by ADF mental health service, and this was similar for non-ADF services (Table 29). Results were slightly higher for former members. Conversely, it is pertinent to note that among current members, nearly one quarter rated this as either 'sometimes' or 'not often', and these less positive views were slightly higher for ADF services. These results are higher than community surveys of the general population (Mendoza et al., 2013), which found that 69% of respondents (mostly consumers) reported that they were treated with dignity 'nearly always' or 'always'.

TABLE 29 OVERALL, TREATED WITH RESPECT AND DIGNITY

	% Current Members (n = 250)		% Former Members (n = 517)	
Response	ADF (n=125)	Non-ADF (n=127)	Using Card (n=374)	Not Using Card (n=193)
Always	51.2	61.4	57.8	48.7
Nearly always	23.2	22.8	26.5	29.0
Sometimes	12.0	11.8	8.8	12.4
Not often	9.6	3.1	2.9	6.7
Never	0.0	0.0	2.1	1.0
Not sure/Can't say	1.6	0.8	0.5	2.1
No response	0.2	0.0	1.3	48.7
Total	100.0	100.0	100.0	100.0

There were a number of other questions regarding services, including information about care given to family, opportunities for family members to talk to health professionals, information about medications, and suicide risk assessments which are not reported in this report. However, this data is available upon request.

3.5 Service types

Of those respondents who had used services relating to mental health and suicide in the last 12 months (n=250 for current members and n=517 for former members), an ADF provided GP and Psychologist were the most common responses (and seen by the majority of those who has accessed as service), whilst just over half had seen an ADF service psychiatrist, and two fifths reported accessing another ADF provider (not specified, note that people could select more than one response (Table 30)). Not surprisingly, current members were less likely to have used non-ADF services compared with ADF services.

Among former members, the most frequent responses were for GP and psychiatrist using a DVA card, whilst nearly half of the former members had accessed a psychologist, either with or without use of a DVA card. The proportion of current and former members who had seen a GP in the last 12 months for a mental health issue is similar to that seen in the general population (98%) Mendoza et al., 2013), but current members were somewhat more likely to have seen a psychologist compared with the general population cohort in the Mendoza study.

Respondents were also asked a series of questions in regards to other services they may have used. For current members, 7.6% had visited a rehabilitation centre through ADF services and 10.0% through non-ADF services, and around two thirds of current members reported that they had the numbers for after-hours ADF provided mental health services, compared to close to 70% from non-ADF. Among former members, 8.8% had visited a rehabilitation centre using their card compared to 10.1% not using their card. Just under one half of former members reported having the number for the VVCS Crisis Line, with 23% having called it, and 38.5% reported that they had after-hours telephone numbers for other services not provided through their DVA card.

The survey did not delve into therapy modalities used by services in any detail, but an item relating to 'talking therapy' was included, as well as items relating to prescribing and use of medication (see later subsections). Among current members, 72% reporting having received talking therapy through ADF services and 65.8% through non-ADF services. For former members using their card, 9.8% had talking therapy, compared to 39.8% not using their card.

For family of current members and family of former members, given the low numbers of responses to these questions, individual service types will not be discussed here.

TABLE 30 USE OF SPECIFIC SERVICES

	% Current Members (n = 250)		% Former Members (n = 517)	
Service	**ADF (n=125)**	**Non-ADF (n=127)**	**Using Card (n=374)**	**Not Using Card (n=193)**
General Practitioner	94.4	43.3	90.4	70.5
Psychologist	85.6	66.1	43.6	45.6
Psychiatrist	56.8	30.7	73.3	28.0
Other ADF Health Provider	41.6	28.3	24.9	29.5
No response	4.0	0.8	1.3	1.0

Experiences of Services

The types of health professionals seen by respondents included GP, Psychologist, Psychiatrist, and a mix of other Health Providers. Respondents who had used services were asked a series of questions about their experience, including whether they felt listened to, felt trust and confidence in their Health Professional, and if they were given enough time to discussion their condition. People were asked these questions for each of the types of service they indicated seeing (for example if they had seen a GP and Psychologist in the last 12 months, they were asked these items for each type of service).

The following two figures show the results of these questions (Figure 1 and Figure 2). Amongst current members, Non-ADF Psychologists has the highest proportion of members rate them highly in regards to all four questions asking about experiences. Furthermore, non-ADF GP's and Psychologists were consistently rated higher than ADF GP's and Psychologists. ADF Psychiatrists, however, had slightly higher ratings of listening careful and treating members with respect and dignity than Non-ADF Psychiatrists.

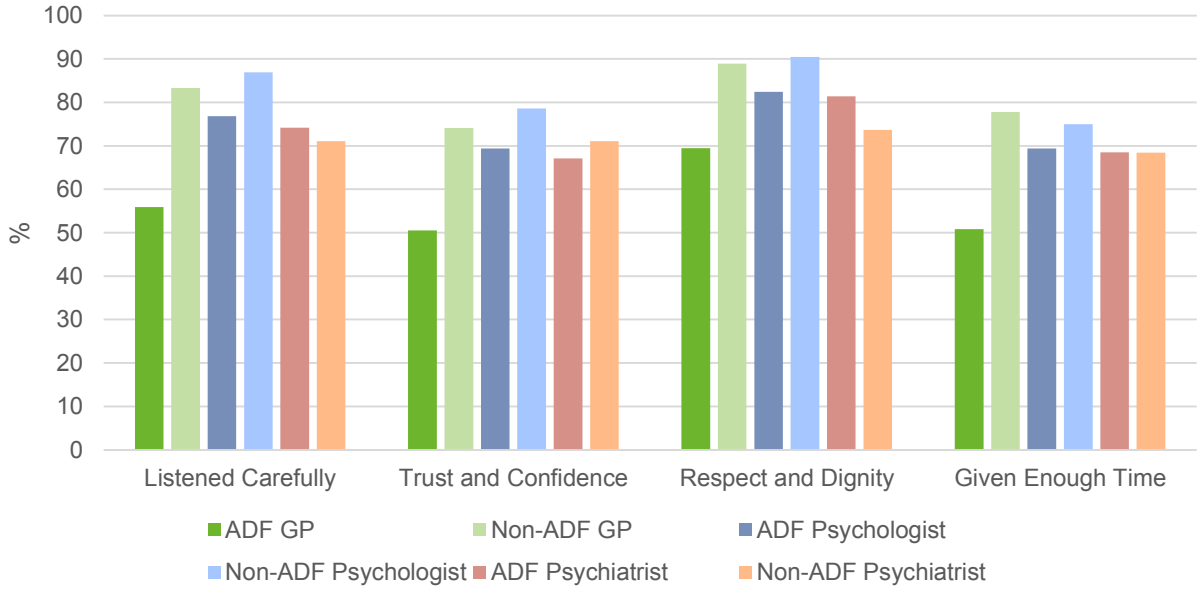


FIGURE 1 CURRENT MEMBERS EXPERIENCES OF SERVICES

For former members, across all services, those who had used their DVA card, rated services higher than those not using their DVA card. GP's and Psychiatrists were generally given similar ratings, though GP's accessed without using a DVA card were consistently rated lower than other services.

All services, however, were consistently rated higher than previously reported for the Australian average by Mendoza et al. (2013), which stated that 30% of respondents did not feel they had enough say in decisions about care and treatment, and one in five respondents had not had their diagnosis discussed with them.

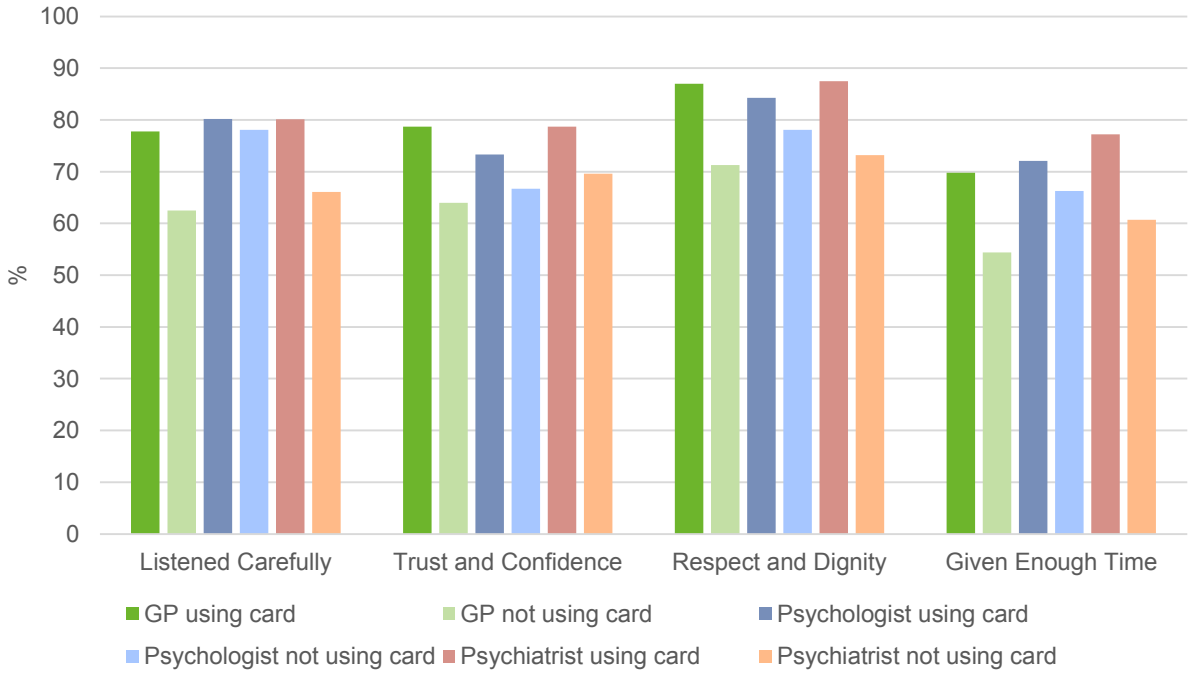


FIGURE 2 FORMER MEMBERS EXPERIENCES OF SERVICES

Experiences with Prescribed Medications

Respondents were asked several questions in regards to their use of services and if medications had been prescribed, as well as questions about these medications and their experiences with services that prescribed them. Figure 3 shows the results of these questions for both current and former members.

The following proportions of individuals were prescribed medications for their mental health condition and/or suicidal behaviour, with more than half of all respondents being prescribed these by a Psychiatrist.

- 50.8% of current members by ADF provided services. 66.6% had been prescribed new medications.
- 36.4% of current members by non-ADF provided services. 67.4% had been prescribed new medications.
- 82.7% of former members by services using their DVA card. 56.8% had been prescribed new medications.
- 68.1% of former members by services not using their DVA card. 59.3% had been prescribed new medications.

The results of experiences of care regarding medications indicate that less than half (aside from current members using non-ADF services) felt they had a say in decisions regarding their medications. Less than half also felt that their medications helped, though more felt the purpose was explained.

Former members using services but not using them consistently rated all items lower than the other groups, with the exception of having a say in decisions. These findings are consistent with the general population (Mendoza et al., 2013), though slightly higher in situations where medication was prescribed for the mental health problem: 55% responded that the purpose and benefits were fully explained.

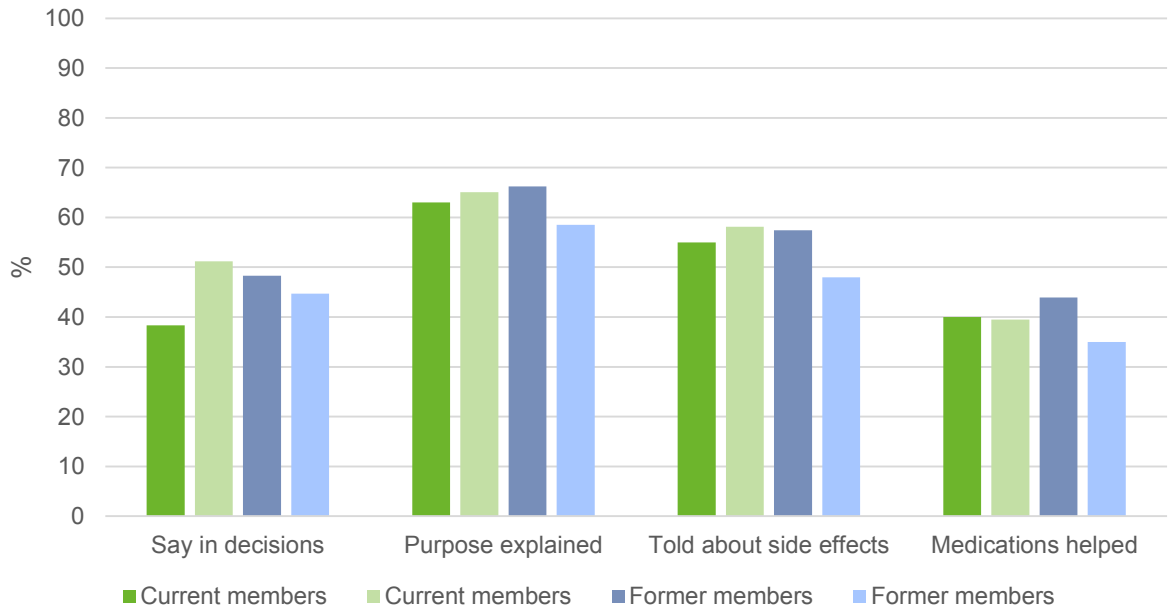


FIGURE 3 EXPERIENCES WITH SERVICES PRESCRIBING MEDICATIONS

ESOs

Former members and family of former members were asked about their experiences with ESOs. Among family of former members, only 2 people had accessed an ESO, and therefore this will not be discussed in any further detail.

Among former members, 6% reported having accessed an ESO. Of this 6%, more than half had been using an ESO for more than five years, and a slight majority rated their treatment as "very good" or "excellent", felt they were always treated with respect and dignity, and felt that information regarding mental health and/or suicide prevention programs was readily available through ESOs.

3.6 Perceived effectiveness of services at a local level

All respondents, were provided with a list of the services shown in Table 31, and asked the following question:

> "Please rate the effectiveness of any services that you, or others, have experienced from the list below. You may choose one or several to rate. If you have not experienced or observed any of these services, please proceed to the next question. Please note that 1 indicates very low effectiveness and 5 the highest level."

In the table, responses were coded as "Low" for anyone who rated that reason as 1 or 2, and "High" for those who rated that reason 4 or 5.

The service provider survey contained an identical question. Both the member, former member and service provider findings are presented below.

TABLE 31 EFFECTIVENESS OF SERVICES

	% Current Members (n = 644)	% Former Members (n = 1098)	% Family of Current Members (n = 88)	% Family of Former Members (n = 94)
	High (Low)	High (Low)	High (Low)	High (Low)
ADF Alcohol management and treatment programs	34.5 (33.6)	22.1 (58.3)	3.3 (76.7)	11.1 (77.8)
ADF Drug use prevention and treatment services	34.7 (34.0)	19.4 (62.6)	4.2 (66.7)	3.3 (83.3)
ADF Suicide prevention awareness training	41.1 (30.8)	21.8 (61.0)	13.0 (65.2)	10.4 (75.0)
ADF Mental health and suicide prevention assessment and treatment services	29.9 (44.5)	18.8 (66.3)	6.4 (72.3)	6.1 (79.6)
ADF Suicide risk assessments	27.2 (49.7)	12.5 (73.7)	9.5 (73.8)	4.4 (80.0)
ADF Rehabilitation Program (ADFRP)	29.7 (42.1)	14.1 (68.3)	3.0 (78.8)	5.4 (91.9)
Defence family services (i.e. family engagement, preventative measures, family health program)	20.8 (54.2)	15.2 (66.6)	7.1 (69.6)	4.3 (83.0)
Defence Family Helpline	24.9 (45.9)	11.6 (68.6)	16.7 (64.3)	2.4 (83.3)
Defence Community Organisation (e.g. Family SMART, KidSMART, support to Commanders)	30.4 (44.4)	13.5 (67.9)	22.2 (64.4)	5.6 (80.6)
National Welfare Coordination Centre	30.3% (43.2)	12.1 (69.8)	20.6 (58.8)	7.1 (85.7)
Defence transition support services (i.e. Transition Handbook, ADF Transition Centres, Transition Health Support)	41.2% (30.4)	15.7 (67.7)	12.1 (72.7)	2.3 (81.4)
DVA Operation Life Workshops	18.4 (56.0)	16.7 (72.5)	5.9 (82.4)	6.1 (78.8)
DVA Operation Life website and mobile App	19.5 (56.0)	14.6 (72.4)	6.3 (87.5)	3.8 (92.3)
DVA Rehabilitation Service	19.6 (55.0)	22.3 (64.6)	5.6 (88.9)	2.6 (81.6)
VVCS 24-hour Crisis Line	49.1 (30.6)	32.3 (47.7)	37.9 (51.7)	31.0 (50.0)
VVCS Counselling	56.4 (26.0)	51.8 (33.2)	38.5 (38.5)	43.6 (43.6)
VVCS Group Treatment Programs	39.2 (35.8)	37.5 (48.0)	15.0 (70.0)	20.6 (67.7)
DVA Gold Card access to clinical services	35.1 (42.1)	71.9 (21.9)	46.7 (53.3)	53.5 (41.9)
DVA White Care access to clinical services	31.4 (42.8)	37.8 (42.4)	36.8 (47.4)	12.5 (70.0)
Post discharge GP Health Assessment	23.4 (50.0)	23.6 (64.3)	23.1 (61.5)	11.8 (76.5)
The At Ease Online Resources	19.0 (47.2)	17.8 (63.6)	15.8 (68.4)	6.7 (83.3)
Health and wellbeing programs (inc. Stepping Out, Day Club, Men's Health Peer education, Veterans Health Week)	23.6 (46.0)	34.5 (45.9)	11.5 (69.2)	10.8 (67.6)
Mental Health and/or Suicide prevention and support programs available through Medicare in the community	19.5 (53.2)	14.9 (70.1)	24.3 (59.5)	11.1 (72.2)
Post-traumatic stress disorder treatment services in the community and hospitals	22.6 (51.2)	31.7 (53.5)	15.0 (67.5)	18.3 (70.0)
National ADF Family Health Program	44.6 (31.2)	12.6 (72.8)	46.9 (30.6)	2.9 (88.2)

It is important to note here that a number of respondents did not respond to this question at all. For current members, 17.2% did not respond, for former members, 29.5% did not respond, for family of current members, 31.3% did not respond, and for family of former members, 46.3% did not respond. Furthermore, respondents could choose not to rate a particular service, or they could select N/A. Therefore, percentages depicted in Table 31 are from those who rated each service only, and excluding those who did not respond or selected 'N/A'. Importantly, a significant number of current members selected 'N/A', with more than half selecting this response for close to half of the services listed.

The ‘n’ value in the header row is the total amount who responded to at least one of the services. Remaining respondents are those who would have selected “3” as their rating, indicated they had a neutral position on its effectiveness.

It is evident through examination of responses below, that of those who rated services, the majority of services had higher “low” rating of effectiveness than “high” ratings. ADF suicide risk assessments were among the lowest rated, however, VVCS counselling was rated quite well among current members and family of current members but less so by family of former members and former members.

Worthy of note are the ratings for Defence transition support services (i.e. Transition Handbook, ADF Transition Centres, Transition Health Support). Whilst the gap between “low” and “high” ratings for current members is small, former members and family members had considerable differences between “low” and “high” ratings, with notably higher ratings for “low” effectiveness. This was also the case for Defence Community Organisations, and National Welfare Coordination Centres.

DVA Gold Card access to clinical services had favourable ratings among family members, but less so for current former members. Furthermore, the National ADF Family Health Program had higher ratings of effectiveness among current members and family of current members than “low” ratings, however, former members and family of former members had considerably higher “low” ratings.

Thoughts on how effective mental health services can be provided

Respondents were given the option to comment on how they believe effective mental health services can be provided. The most common themes provided through the text responses were:

- De-stigmatising mental health
- Further support and awareness about what is available
- Follow up later after transitioning out
- Better resilience training
- Better training when transitioning out of the ADF
- Greater awareness/education around mental illness
- Families need more time together

Thoughts on how effective suicide prevention services can be provided

Respondents were given the option to comment on how they believe effective suicide prevention services can be provided. The most common themes provided through the text responses were:

- The need for better suicide prevention awareness training when joining – needs to be delivered by ADF people who have relevant experience and expertise
- Continuous contact and follow up (perhaps monthly and then yearly, especially when leaving the ADF)
- Having appropriate and efficient support networks in place
- Keep things simple and easy to access
- More support from chain of command – move away from the era of “suck it up princess”
- Listen – communication
- One respected member to go to in each unit that is like family
- Give a safety net for families outside of Defence

- Provide all with a DVA card
- Encourage former members to be a part of a Defence community once discharged – remain a part of the 'family'

3.7 Someone Close

Respondents were asked a series of questions regarding someone close to them and if they had ever received treatment or support. Most respondents either had no one close to them need treatment or support or did not respond to the question. Therefore, these results are not displayed here but are available upon request.

3.8 Other comments

Current and former members, and family members were given the option to comment on anything particularly good about care they had received, as well as improvements they believe can be made. Common themes regarding comments about what was good about care included:

- GPs being compassionate
- Mental health nurses and chaplains do a great job – "first respondents"
- Psychologists and psychiatrists are very good once you get one
- 'VVCS are excellent'
- Seeing someone outside ADF so that it is private and confidential – no stigma and doesn't affect career (this of course would change if they were prescribed anything)
- Treated much better than previously

Common themes regarding improvements that could be made were:

- Remove automatic downgrading if seeing a psychologist too long – people go through tough times and sometimes need support – ADF focused more on money and are stigmatising towards those who are proactive in seeking support
- Promotion of suicide prevention initiatives and more education – more early intervention work
- Stigma
- Removing blanket MEC downgrade policy – need to be case by case
- Honest information and messaging about disclosing mental health issues and how this affects careers
- Less waiting for appointments, claims etc.
- Increased work force – too many people being turned away due to not enough staff
- Quicker referrals
- Better pay from DVA and an easier system (less time consuming)
- Reduce the red tape
- DVA needs a complete overhaul (majority of these comments are about how poor DVA operates)
- Focus on upskilling and education of partners
- Discharge due to mental illness needs to be addressed – people will ignore their problems as long as there is this association

- Communication is a big problem
- There needs to be training and education to help people deal with leaving service as they deal with a loss of identity, networks and conditioned behaviour
- Support for families – families should not be struggling to care for their loved one with PTSD and fighting with the ADF

At the conclusion of the survey, respondents were given the option to make any other comments. Common themes were:

- There is not enough support for families – when members discharge, if they need treatment, or if they suicide
- Change in culture – older veterans struggle as things were a lot harsher when they were serving – now there are 'too many hurt feelings' – young members get upset to easily, so lack resilience
- More thorough process before prescribing medications on base
- Things are process driven – isolates the individual
- Need psychiatrists etc. to have experience in the military
- Cancelling medical appointments at short notice – exacerbates symptoms
- Better services for people in remote areas

4. Service Providers - Effectiveness of services

Service providers were asked the following in regards to effectiveness of services:

> "Based on your observations and/or experience, how effective you think each of the following services or initiatives in your local area is in meeting the needs of current and/or former ADF members and their families and those transitioning out of the permanent ADF in relation to mental health and/or self-harm and suicide prevention?"

Of the 114 service providers, 27.2% of service providers did not respond to this question at all. It is also important to note that respondents could choose which services from the list to rate, and had the option of selecting 'N/A'. Therefore, percentages depicted in Table 31 (on the following page) are from those who rated each service only, and excluding those who did not respond or selected 'N/A'. The 'n' value in the header row is the total amount who responded to at least one of the services. Remaining respondents are those who would have selected "3" as their rating, indicated they had a neutral position on its effectiveness.

Amongst service providers, the majority of services were more likely to be perceived as having low effectiveness compared to high effectiveness. This is consistent with the responses from current and former members and families with regard to service effectiveness. The services most likely to be rated as effective fell into the categories of DVA Gold Card access to services, DVA White Card access to services, VVCS Counselling, and the VVCS 24-hour Crisis Line. The services most likely to be rated as not effective were mental health and/or suicide prevention support programs available through Medicare in the community, National Welfare Coordination Centres, ADF Drug Use prevention and treatment services, Post discharge GP health assessments and PTSD treatment services. The latter finding about the perceived ineffectiveness of PTSD treatment services mirrors the many concerns about PTSD expressed in interviews and group discussions (as detailed in other reports that form part of this overall review).

TABLE 32 EFFECTIVENESS OF SERVICES

Service	% Service Providers (n = 83) High (Low)
ADF Alcohol management and treatment programs	23.0 (42.6)
ADF Drug use prevention and treatment services	18.3 (53.3)
ADF Suicide prevention awareness training	29.7 (45.3)
ADF Mental health and suicide prevention assessment and treatment services	27.3 (40.9)
ADF Suicide risk assessments	31.3 (39.1)
ADF Rehabilitation Program (ADFRP)	25.4 (40.7)
Defence family services (i.e. family engagement, preventative measures, family health program)	16.9 (52.3)
Defence Family Helpline	31.4 (39.2)
Defence Community Organisation (e.g. Family SMART, KidSMART, support to Commanders)	29.2 (43.8)
National Welfare Coordination Centre	12.5 (57.5)
Defence transition support services (i.e. Transition Handbook, ADF Transition Centres, Transition Health Support)	26.3 (45.6)
DVA Operation Life Workshops	23.8 (42.9)
DVA Operation Life website and mobile App	31.8 (45.5)
VVCS 24-hour Crisis Line	43.4 (22.6)
VVCS Counselling	46.6 (32.8)
VVCS Group Treatment Programs	39.6 (32.1)
DVA Gold Card access to clinical services	65.5 (20.7)
DVA White Care access to clinical services	62.7 (23.7)
Post discharge GP Health Assessment	28.3 (49.1)
The At Ease Online Resources	40.7 (35.2)
Health and wellbeing programs (inc. Stepping Out, Day Club, Men's Health Peer education, Veterans Health Week)	35.9 (31.3)
Mental Health and/or Suicide prevention and support programs available through Medicare in the community	32.4 (52.1)
Post-traumatic stress disorder treatment services in the community and hospitals	32.5 (49.4)
National ADF Family Health Program	19.0 (40.5)

4.1 Important ways mental health services can be provided

Service providers were also given the option to comment on how they believe effective mental health services can be provided. The following points highlight the main themes evident in these responses:

- Support and education for families
- Mentoring programs
- Mental health awareness and education – signs symptoms etc.
- Dissemination of information about support that is available

4.2 Important ways suicide prevention services can be provided

Similarly, service providers had the opportunity to comment on how more effective suicide prevention services could be provided. The following points highlight the main themes evident in these responses:

- Have more staff available 24/7
- Remove stigma
- Better communication with families
- Encouraging a culture change in the ADF streamlining discharge processes
- Recovery focused environment
- Improved pathways between ADF and DVA
- More rapid referral processes without red tape
- Preventative measures for those who are “falling of the ADF/DVA radar”

4.3 Other Comments

At the conclusion of the survey, service providers were given the option to make any other comments. Common themes were:

- More resources, staff and support for regional areas
- Lack of direct contact with people
- Serious review of psychotropic medications over long periods of time
- Lack of adequate resources
- VVCS governance becoming too restrictive
- Mental health should be just as important as physical health
- Shortage of psychologists and psychiatrists working with ADF

5. Conclusion

The data gathered through the surveys of current and former members, family of current and former members and service providers provides a valuable complement to the findings elucidated in other components of this Review.

Overall, more than half of the respondents had ever sought support or treatment for a mental health problem and/or suicidal and self-harm behaviour, indicating that a substantial number of people are not seeking help or support. Moreover, less than half of all respondents, had received treatment within the last 12 months.

When asked why support or treatment had not been sought, amongst current members, the primary reasons for not seeking support related to perceived adverse impact on their career and to stigma associated with having a mental health problem or seeking help. Among former members, a common reason also was the feeling that their health professional would not understand. This is congruent with comments frequently articulated in the key informant interviews and group discussions with former members and families, whereby the predominant view is that services and health professionals do not often understand the unique and complex factors influencing mental health and wellbeing among veterans and their families.

Of those who had received treatment, GPs, psychologists, and psychiatrists were the most used type of service, but others included rehab facilities, telephone counselling lines and a mix of other health services. Of the respondents who had used a service relating to mental health or suicide in the last 12 months, overall, the proportions rating treatment as excellent, very good, good, fair or poor were fairly evenly distributed. However, almost one third of current members rated their treatment as 'fair' or 'poor', and this was closer to 40% among former members not using a DVA card.

Questions about perceived effectiveness of services were asked of current and former members, family members and service providers. Overall, services were more likely to be rated as low effectiveness rather than high effectiveness, although this did vary across services and respondent category. VVCS was rated quite favourably, whilst transition support services, suicide risk assessments and PTSD treatment services were some of the lowest rated.

Respondents who had used services were asked a series of questions about their experience, including whether they felt listened to, felt trust and confidence in their health professional, and if they were given enough time to discussion their condition, and whether they felt they had a say if being prescribed medications. Whilst the overall tenor of responses was favourable, it is clear that for some current and former members their experiences of services have not been ideal, and this is of concern if it deters future help-seeking behaviour. For example, of those who reported being prescribed medications, less than half felt that they had had a say in this and similarly less than half felt that it had helped.

When given the opportunity to provide additional open ended comments on how services relating to mental health and suicide can be more effective, there were clear messages around:

- Tackling stigma
- Improving the DVA claims process and simplifying it
- A need for continuous contact and follow up once leaving the service
- A need for improved resilience and mental health training
- More support for families.

When compared with the general population, there are common results on ADF services, suicide risk assessments, transition support, accessibility, simplicity of access, and positive responses on the

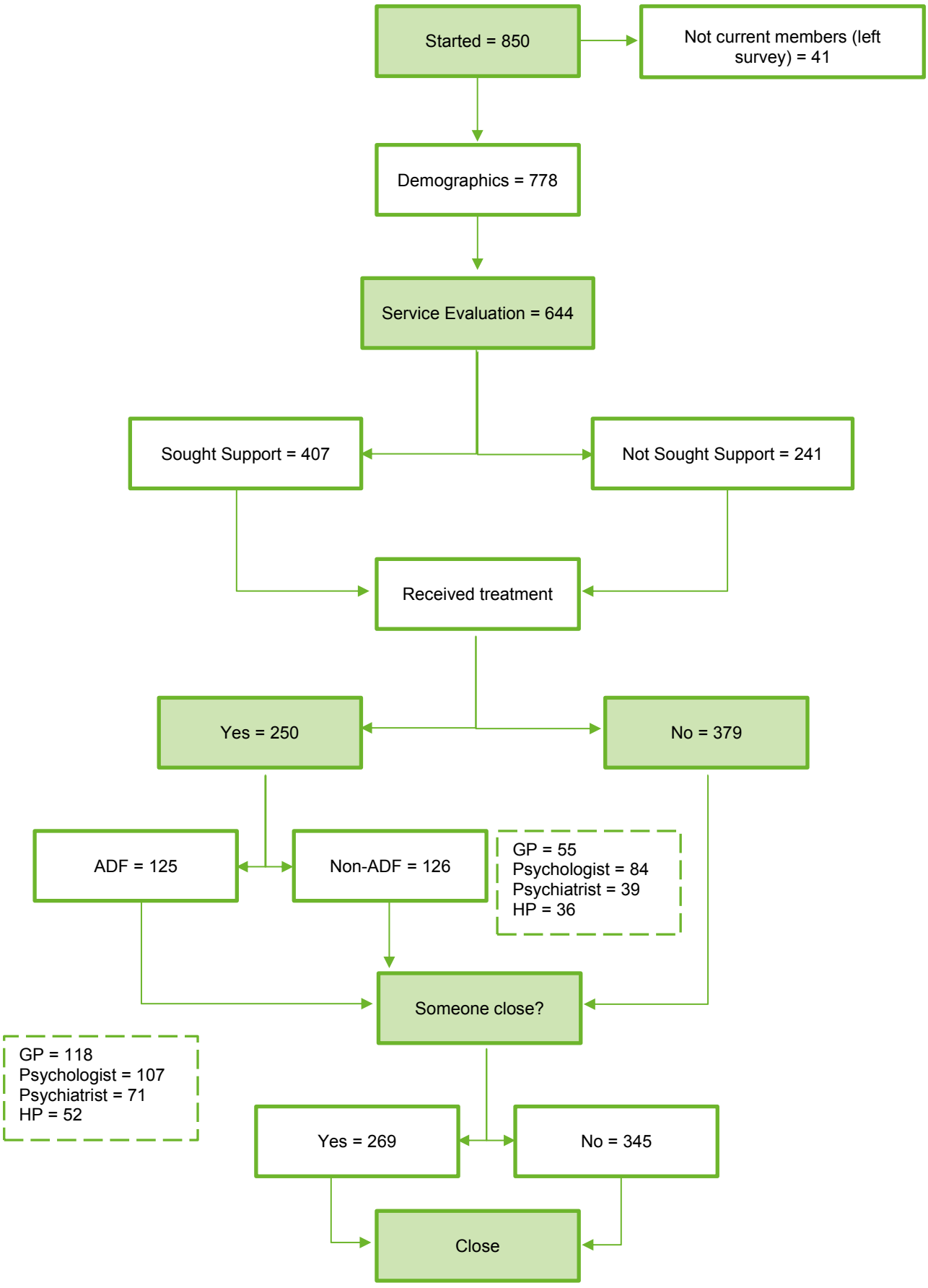
experience of care, that people have had much more positive experiences with services (Mendoza et al., 2013).

The results of these surveys, in conjunction with findings from qualitative data collection for this review, can inform where the gaps are in services for members and their families, and were further training and awareness may be required.

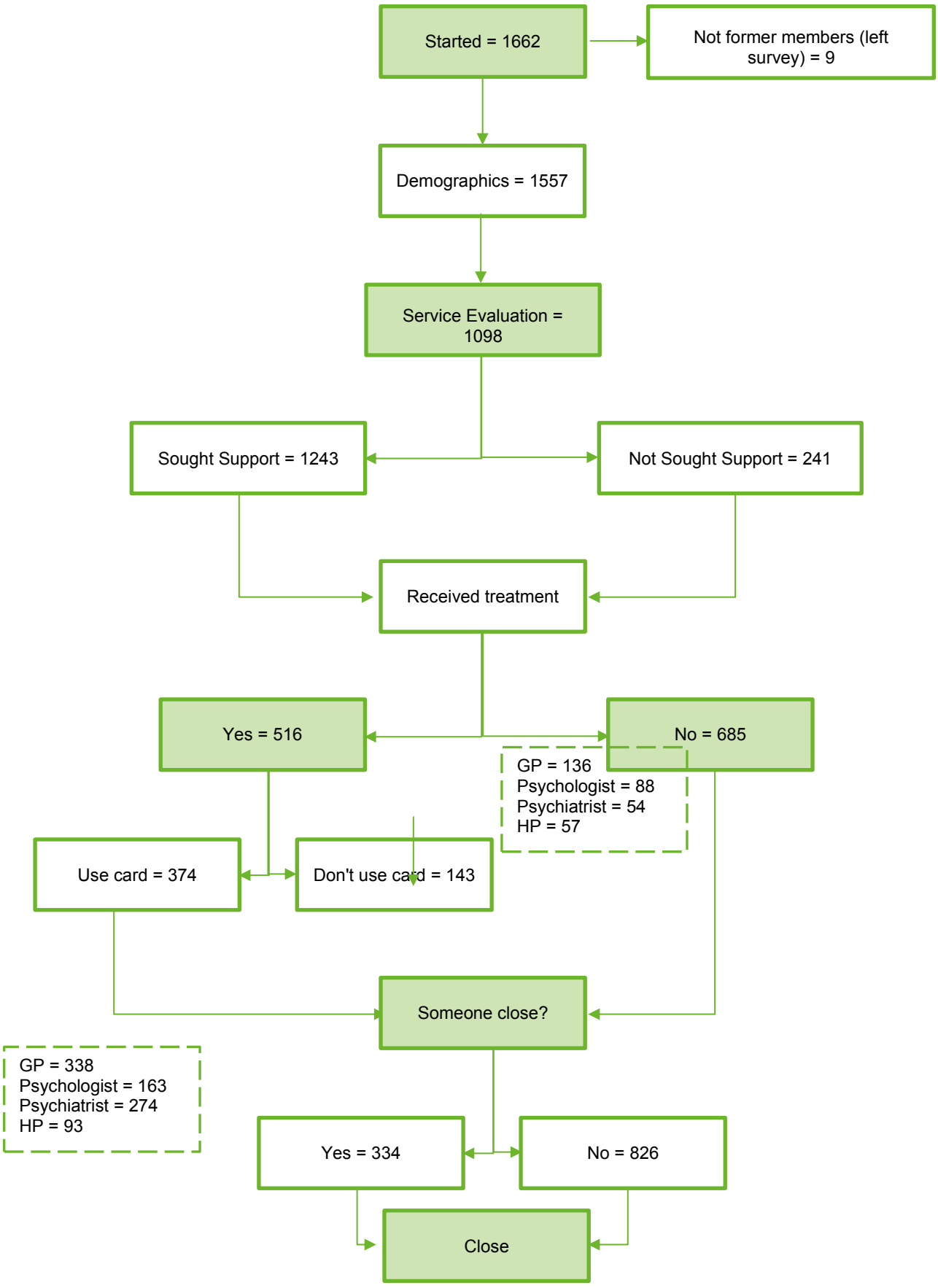
6. Appendices

The four following pages outline the survey process and the number of respondents throughout each of the questionnaires.

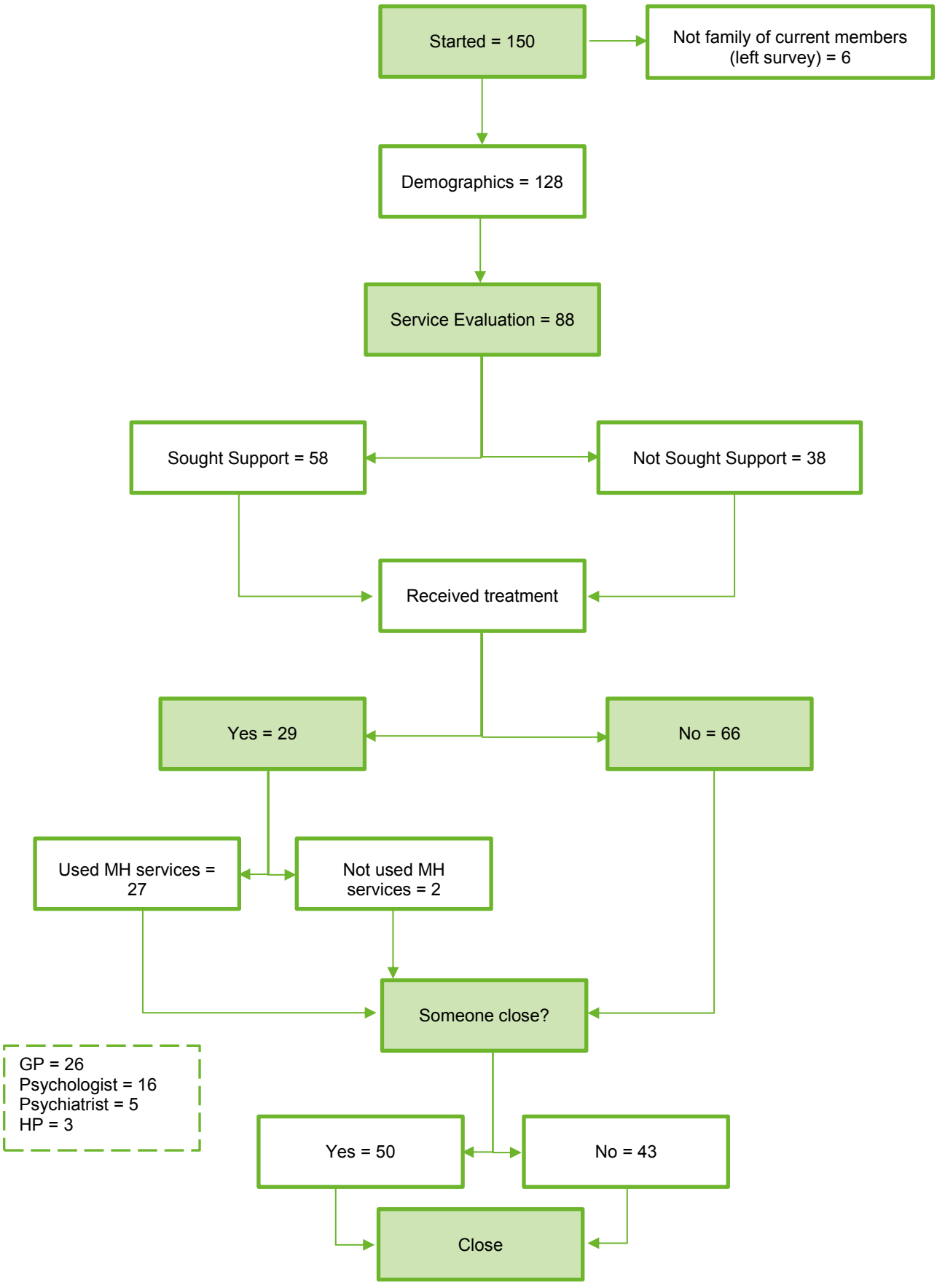
Current Members Survey Outline



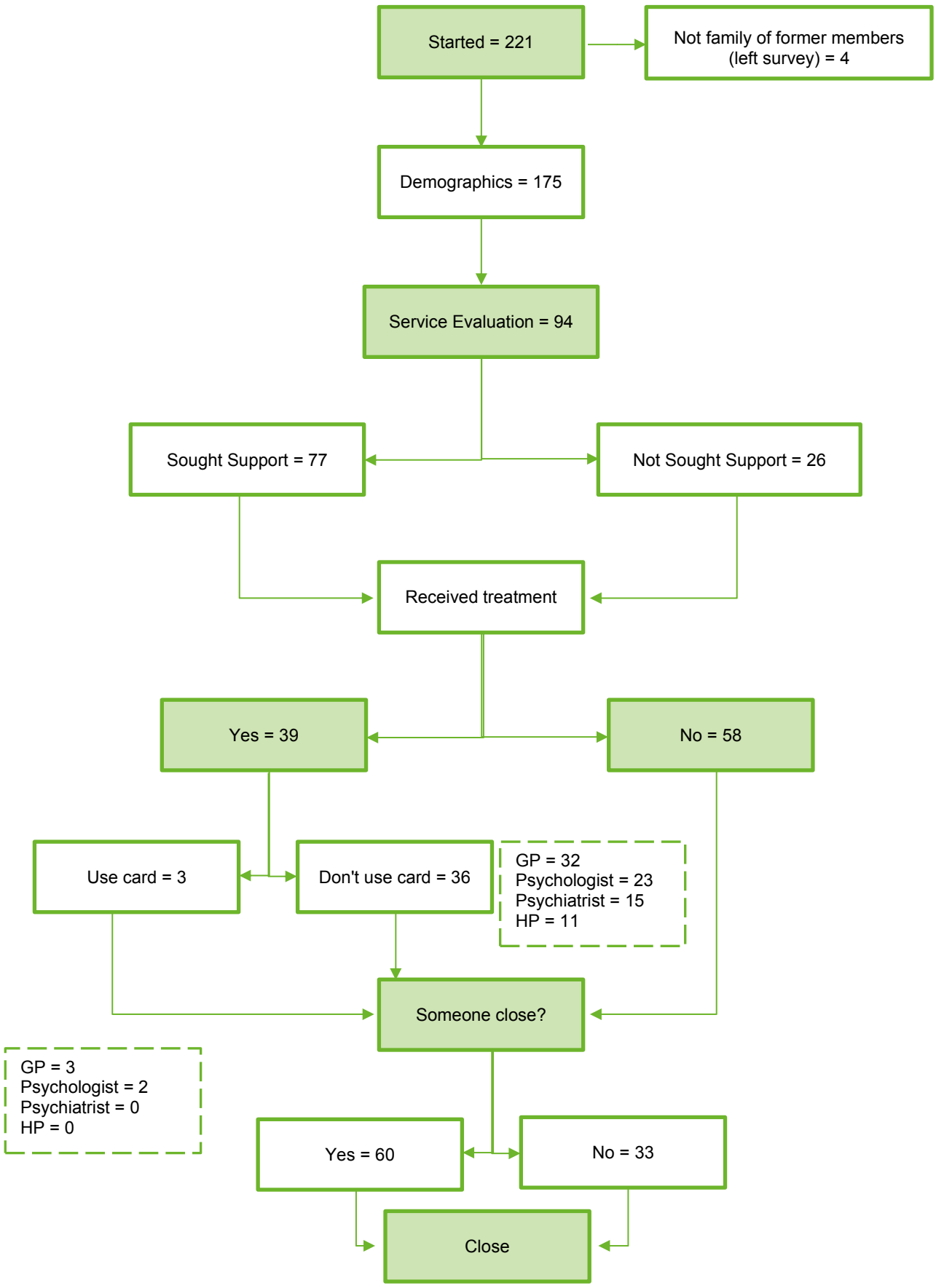
Former Members Survey Outline



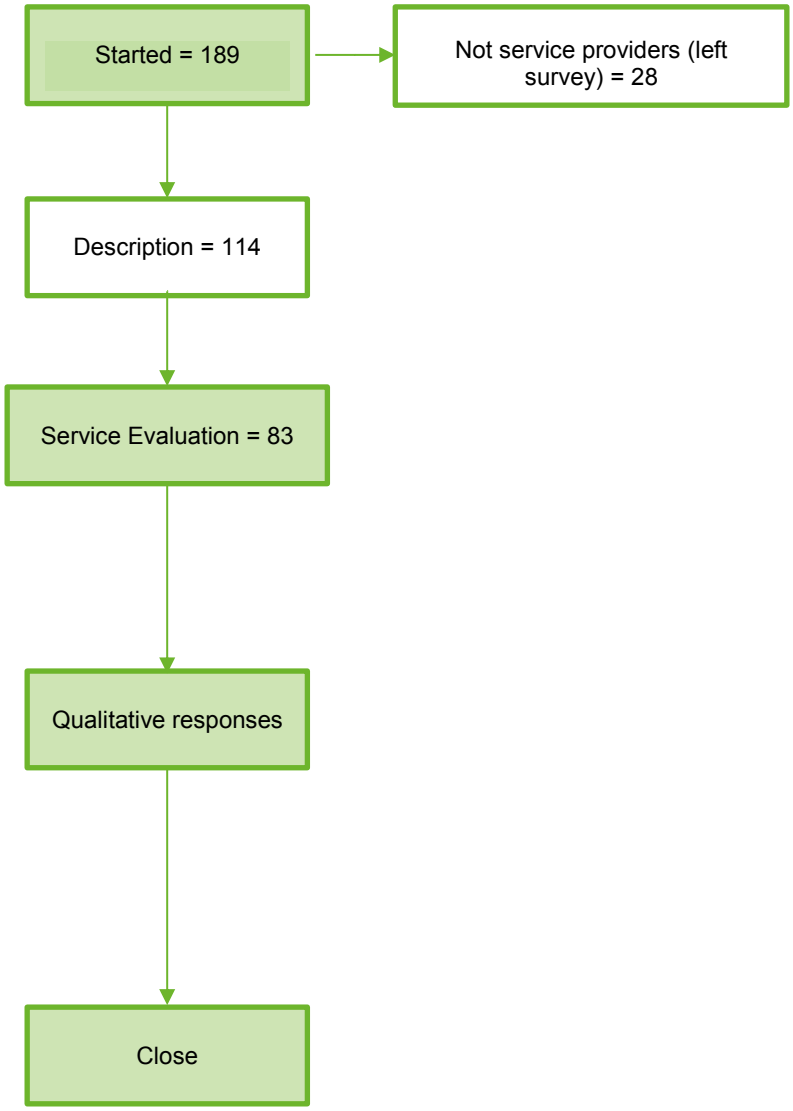
Family of Current Survey Outline



Family of Former Survey Outline



Service Providers Survey Outline



7. References

Australian Bureau of Statistics. (2011). Census of Population and Housing.

Australian Institute of Health and Welfare. (2014). Australia's Health, 2014. *Australia's health series, 14* (178). Canberra: AIHW.

Commonwealth of Australia. (2009). *Fourth National Mental Health Plan (2009-14).* Available from: http://www.ag.gov.au/cca

Department of Defence. (2016). *Defence Census, 2015: Public report.*

Groom, G., Hickie, I., & Davenport, T. (2003). *Out of hospital, out of mind*. Canberra: Mental Health Council of Australia.

Mendoza, J., Bresnan, A., Rosenberg, S., Elson, A., Gilbert, Y., Long, P., Wilson, K., & Hopkins, J. (2013). *Obsessive Hope Disorder: Reflections on 30 years of mental health reform in Australia and visions for the future. Technical Report.* Caloundra, QLD.

Mental Health Council of Australia. (2005). *Not for service: Experiences of injustice and despair in mental health care in Australia.* Canberra.

Public Health Information Development Unit (PHIDU) (2016). Social Health Atlas of Australia: Primary Health Networks (online). At: http://www.phidu.torrens.edu.au/social-health-atlases/data