The Defence Community Organisation is run by ADF personnel, and provides services and information to Defence families. The services provided include support from social workers, education and employment, childcare and transition assistance.[292] The Defence Community Organisation also has a website and administers the Defence Family Helpline, which ADF members can access 24 hours a day.[293]

Defence Families of Australia is a Ministerial appointed group that represents the views of Defence families by reporting, making recommendations and influencing policy that directly affects families.[294] Defence Families of Australia receives its funding from Defence and external sponsorship, and currently has a civilian executive and a number of ADF members as delegates.[295] In addition to offering input at the policy level, Defence Families of Australia maintains an accessible and informative website offering advice for families and partners in a series of areas including health, money and education.

Appendix O.2 – Mental health research and initiatives

The ADF has undertaken a number of studies and initiatives over the previous decade. In 2002, the ADF Mental Health Strategy developed an agenda for the planning and provision of mental health care.[296] In 2009, Professor David Dunt's *Review of Mental Health Care in the ADF and Transition through Discharge* was submitted to the ADF.[297] The *2010 ADF Mental Health Prevalence and Wellbeing Study* established 'baseline data' to 'enable Defence to better inform and prioritise initiatives in the ADF Mental Health Reform Program'.[298] This led to the *2011 ADF Mental Health and Wellbeing Strategy* which provides a blueprint for the development of the 2012-2015 Mental Health and Wellbeing Action Plan.[299] The Plan seeks to finalise 'Dunt Review recommendations, align of Defence with the national mental health reform agenda, and put in place a system that is self-monitoring and continuously improving'.[300]

The *Review of Mental Health Care in the ADF and Transition through Discharge* (Dunt Report) was submitted on 4 February 2009. Its major recommendations were:

1. Expanding the mental health workforce
2. Improving mental health training
3. Making prevention strategies (including stress management and positive coping strategies) a core component of military training
4. Improving mental health governance (including with e-health data management)
5. Improving mental health policy, with a focus on rehabilitation
6. Enhancing research and surveillance, and mental health screening
7. Enhancing rehabilitation and return to work programs
8. Enhancing military to civilian transition services
9. Including and informing families about mental health issues
10. Developing new and improved facilities.[301]

The ADF then set about collecting baseline data to inform the implementation of these recommendations and policy changes through the *2010 ADF Mental Health Prevalence and Wellbeing Study*.

This was the first comprehensive investigation of the mental health of an ADF serving population, and has been described by Professor Ian Hickie of the Brain and Mind Research Institute as a world's best practice study.[302] Nearly 49% of ADF current serving members participated between April 2010 and January 2011.[303]

The study found that 22% of the ADF population experienced a mental disorder in the past 12 months, a prevalence rate similar to the Australian community. ADF lifetime prevalence rates, however, are higher than the wider community's.[304]

It also found that anxiety disorders are the most common type of medical disorder in the ADF. There was a higher prevalence of anxiety disorders among women compared to men, and among other ranks compared to officers.[305] ADF males experience higher rates of mood disorders than the wider community, mostly accounted for by depressive episodes. Officers were as likely to experience affective disorders as other ranks.[306]

According to the study, there were high levels of alcohol use, but alcohol disorder was significantly lower in the ADF than in the wider community. Most disorder was in males in the 18-27 age group. ADF Females 18-27 had lower rates than their community counterparts. There were no significant differences between the Services with regards to alcohol dependence disorder, but members of Navy and Army were significantly more likely than Air Force to experience alcohol harmful use disorder.[307]

ADF personnel reported thinking about and planning suicide at a higher rate than the community. The number of suicide attempts is not significantly greater than in the general community, and the number of reported deaths by suicide is lower.[308]

43% of ADF members reported multiple deployments, 19% had one and 39% had never been deployed. Deployed personnel did not report greater levels of mental disorder, but were 10% more likely to seek care for mental health or family problems.[309]

In the previous year 17.9% of ADF members sought help for stress, emotional, mental health or family problems. Two main factors contribute to the low uptake of mental health services: the fear of stigma, and perceived barriers.[310] The most cited barrier was a concern that seeking help would reduce their deployability (39.6% of respondents). The most cited stigmas were a fear of being treated differently (27.6%) and of harm to career (26.9%).[311]

Based on these findings, the 2012-2015 Mental Health and Wellbeing Action Plan is currently being finalised. Defence senior leadership has identified the following seven priority areas for immediate action:

- a communications strategy to address stigma and barriers to care
- enhanced service delivery
- development of e-mental health approaches
- up-skilling health providers
- improving pathways to care
- strengthening the mental health screening continuum and
- developing a comprehensive peer support network.[312]

This plan will aim to 'align Defence with the national mental health reform agenda, and put in place a system that is self-monitoring and continuously improving.'[313]