Pathways to Care

Professor David Forbes, Director
Phoenix Australia Centre for Posttraumatic Mental Health,
Department of Psychiatry,
University of Melbourne
Acknowledgements

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Citation

With great thanks to the team at CTSS for their terrific leadership and conduct of this study, most particularly Dr Miranda Van Hooff and Dr Ellie Lawrence – Wood.
What do we know from the international research?

- Gap between identification of mental health conditions and help-seeking
- Approx. 50-75% seek care for mental health care and 40-50% in the past 12 months
- Many do not receive adequate treatment despite being diagnosed and having contact with mental health services
- Limited and inconsistent data on the latency of help-seeking
- Important role of social support in facilitating help-seeking
- Generally exceed community rates of 30-35% care seeking
International research: Pathways to Care in serving and transitioned military populations

Stigmas and barriers

• Anticipated public stigma and self-stigma
• Impact of cultural values of self-sufficiency, masculine identity and the need for good occupational mental health for deployment / employment

Those reporting more mental health symptoms perceive greater levels of anticipated public stigma and barriers to care

• What is the impact of this on help-seeking?
• An important barrier is the lack of perception of the need to seek treatment or support
• Impact of holding negative attitudes toward mental health care
• Preference to solve or manage their problem on their own
Pathways to Care: Key factors of interest

- Of those with a mental health concern, how many seek assistance?
- Of those with a probable disorder, how many seek assistance?
- When do they first seek help (latency)?
- What/who are the facilitators of help-seeking?
- How many receive evidence-based treatment?
- What are the reported types and rates of negative attitudes and stigma around mental health and care seeking?
- What prevents help seeking?
- What type of care is accessed? Mental health professionals and others
  - What services are being provided
  - Satisfaction with the services delivered
- Use of self-help strategies
Pathways to Care: Population

• Three specific sub-groups of Transitioned ADF and 2015 Regular ADF:
  
  • Those who reported ever having a concern about their mental health
  • Those who reported having had assistance for their mental health
  • Those who scored above (probable 30-day mental disorder) and below the epidemiological cut-off on the screens for anxiety and depression (K10) and posttraumatic stress (PCL) (no probable 30-day mental disorder).

• Analyses were also conducted by transition status – Ex-Serving, Inactive Reservist, Active Reservist but not reported here
Pathways to Care: Key findings

• About 75% of Transitioned and Regular ADF cohorts had received assistance for their mental health at some point
• A high proportion of these had consulted a mental health professional (psychiatrist & psychologist) for these problems
• Around half of these are seeing this professional currently or in the last 12 months
• More than half of these reported likely receiving evidence-based care
• Help seeking rates consistent with other military & veteran populations and significantly better than community rates
Rates of attrition in mental health care

• Best proxy for evidence-based care (psychologist providing Cognitive Behavioural Therapy: CBT).

• Of the Transitioned ADF and 2015 Regular ADF with a lifetime mental health concern and who had a probable 30-day disorder and had sought care in their lifetime:
  • 84% & 93% respectively had consulted a psychologist for these concerns.
    • Of these, 55% & 66% had done so in the last 12 months.
      • Of these, about 63% had received CBT.
    • For Transitioned ADF, this leaves 24% of those with current probable disorder receiving proxy for evidence-based care in last 12 months
Help-seeking latency

- Most Transitioned and 2015 Regular ADF members sought assistance for a mental health concern within one year of concern onset.

- Rates of early treatment seeking were significantly higher in the 2015 Regular ADF.

- Significant minority of Transitioned ADF (14.4%) and 2015 Regular ADF (7.6%) waited more than three years to seek care.

![Help-seeking latency graph](image)
Pathways into Care

• For the majority of Transitioned ADF (62.5%) and 2015 Regular ADF (57.5%) who were concerned about their mental health and had ever sought assistance, engagement with professional care was suggested by another.

• Partners, followed by friends, and supervisors were most likely to suggest seeking help.
Assistance accessing care

- Approximately a third to a quarter of the Transitioned ADF (32.6%) and the 2015 Regular ADF (28.5%) were actively assisted to access care.

- Most commonly this was supervisors / GPs / MOs as well as partners for the Transitioned ADF.
Primary reason for seeking care

- Primary reasons for seeking mental health care in both groups were depression, anxiety, relationship problems, and anger.

- Transitioned ADF with a probable disorder were most likely to seek care for depression whereas 2015 Regular ADF with a probable disorder were most likely to seek help for anxiety.
Aspects of service satisfaction

- Regular ADF were more likely to be satisfied than Transitioned ADF in all service factors – except cost, where there was no significant difference.

- In both Transitioned ADF and 2015 Regular ADF, those with probable 30 day disorders reported lower satisfaction in all service factors.

- Transitioned ADF were most satisfied with friendliness (71.6%) and confidentiality (70.3%) and 2015 Regular ADF were most satisfied with friendliness (90.9%), location (87.3%), and competence (85.7%).
Aspects of service satisfaction

• There were lower rates of satisfaction among 2015 Regular ADF and Transitioned ADF with probable disorder in key areas of competence and effectiveness of care.

• There were high rates of satisfaction with individual practitioners across disciplines, but these are not reflected as strongly in satisfaction across the service systems.
Service satisfaction

• Satisfaction rates were highest for military aware services.
• The Veterans and Veterans Families Counselling Service – Vetline, was the most highly used helpline with very high satisfaction rates.
• Veterans trauma recovery programs also rated very highly.
Attitudes and stigmas

- Included self stigma (what help-seeking would mean about them and their expectations of themselves) and anticipated public stigma (how others would perceive them).

- The most common negative beliefs were perceptions that others would lose confidence in them, they would be seen as weak, be treated differently, feel worse due to being unable to solve their own problems, and feel embarrassed.

- Those with probable 30-day disorder were more likely to endorse most stigma items.
Attitudes and stigmas

- Closer examination of the data indicated that care seeking remained proportional to group size, and did not reduce proportionately with increases in level of stigma experienced.
Barriers to care

• The most common barriers to seeking help for Transitioned ADF were concerns about the impact on career and expense.

• In 2015 Regular ADF the most common barrier was ‘stop me from being deployed’ (47.4%)
Reasons help was not sought

• Most common reasons for not seeking assistance were a perceived preference to self-manage, ability to function effectively and feeling afraid to ask.
Implications of findings

• Very good by community standards and consistent with findings in military and veteran populations in UK, US and Canada.

• Concerning is the estimate that only 25% of those with mental health problems are receiving evidence-based care currently or in the last 12 months.

• The problem is unlikely to be in one particular place:
  • key issue is how best to strengthen the engagement and retention in the health care system
  • ensure the delivery of best practice care at each contact point
Implications of findings

Two key findings from the satisfaction with services:

• Higher satisfaction with services that were *military-aware and had an understanding of veteran and military issues*, including face-to-face and web-based and telephone services (e.g., VVCS helpline).

• Ensure service provision from those with *skills in the assessment and treatment of military and veteran mental health problems* and who follow practice guidelines in the delivery of evidence-based care.
Strategies to increase Pathways to Care

These findings inform us about how we can improve our service system including:

1. Greater integration & coordination of services including development of outreach capabilities – so that when a transitioned member makes contact with services they don’t fall through the cracks.

2. The importance of continuing to build knowledge of military culture and key clinical presentations among community health care providers, so transitioned personnel feel understood when they make contact.

3. Bolstering the skills and effectiveness of treatment through evidence-based treatments for those with disorder, with active quality assurance processes and professional networks of excellence.
Strategies to increase Pathways to Care

4. Bolstering support networks for families and friends as they point the way to care and impacted themselves

5. Enhance early engagement and early intervention practices – given how quickly these problems appear to develop post-separation

6. The need to balance messaging around self-reliance (in a group trained in being able to solve problems), with when to ask for help

7. Coordinate linkages between broader complementary quality of life activities and evidence-based clinical services to minimise the degree to which it is perceived as either/or

This report reinforces much of the work already underway in Defence and DVA but also provides key targets for where the system can be further enhanced.
Thank you